ESSEX COUNTY ACCESS TO CARE FEASIBILITY STUDY

Prepared for

Essex County Office of Public Health Management

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Prepared by

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Orientation to this Report

This report is intended to be a concise overview of the data collected from the Essex County Access to Care Feasibility Study and an outline of the resulting recommendations. The report is presented in five sections:

Introduction

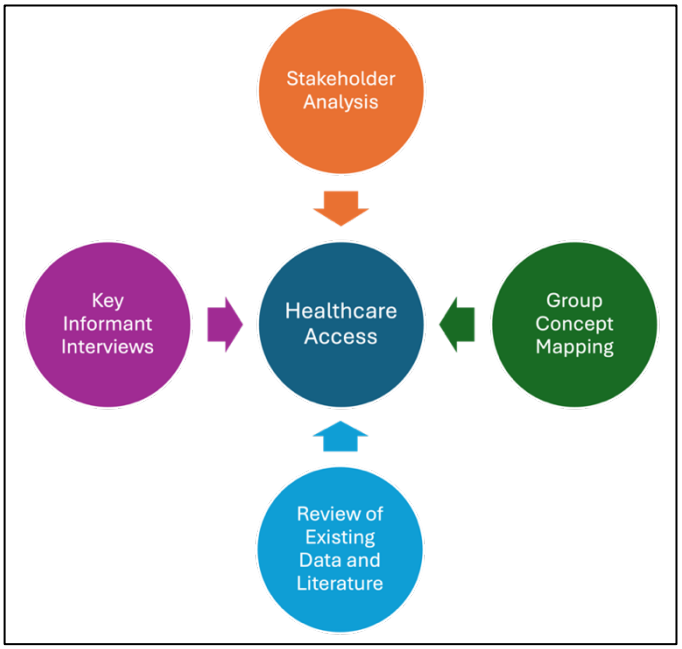
The Essex County Office of Public Health Management (ECOPHM) commissioned a county-wide *Access to Care Feasibility Study* to enhance healthcare access for all Essex County residents. The study, conducted by Concept Systems, Inc., employed a multi-phasic participatory approach to actively engage broad groups of stakeholders, capturing their diverse perspectives and insights, to explore and guide efforts to achieve this goal.

Feasibility Study Approach

The ECOPHM Access to Care Feasibility Study (Feasibility Study or Study) involved an inclusive approach, allowing for broad stakeholder input and engagement. It incorporated four components: a formal stakeholder inventory and analysis, followed by three unique data collection activities ─ modified Group Concept Mapping (GCM), key informant interviews, and a review of existing data and related literature. The convergent study design combined these methods to gather diverse data sets and insights from multiple sources.

Figure 1 depicts the Feasibility Study components and data sources, illustrating how they interlink to create a framework for expanding healthcare access in Essex County. We integrated the data from each of the four study components to gain an in-depth understanding of how Essex County can improve access to primary and preventive health care. The use of multiple and varied data sources allowed us to validate and strengthen the findings, as well as address some of the limitations that each source may pose individually. A robust analysis of the combined data, across all sources, generated seven strategic objectives and related strategies and recommendations that the ECOPHM may decide to incorporate as they plan and implement future initiatives to enhance access to preventive and primary health care.

Figure 1: Feasibility Study Components



A summary of the rationale and methodology for each study component is provided below. Detailed information regarding the methodology, analysis, and results can be found in the appendix of this report.

Stakeholder Inventory and Analysis

The stakeholder inventory and analysis assessed the potential interest and influence of a diverse pool of stakeholders to ensure that varied perspectives, insights, and needs are considered in the Study's outcomes. This approach provided an understanding of the stakeholders' unique impact, influence, and interests. Additionally, the inventory and analysis enabled informed decisions

regarding participant engagement, including effectively eliciting distinct interest and participation in the project. See Appendix D for a detailed description of this study component.

Modified Group Concept Mapping

Group Concept Mapping (GCM) is a participatory approach that intentionally seeks input from a broad and inclusive group of participants; it brings together varied ideas and perspectives of multiple individuals to gain insight into their priorities. For this study, we used a **modified** GCM approach to obtain a breadth of ideas, perceptions, and opinions from the individuals and organizations identified in the Stakeholder Analysis. The modified GCM approach consisted of two distinct phases:

> *GCM Phase 1: Brainstorming* - In this activity, participants contributed their thoughts and ideas about how Essex County can address healthcare access issues, allowing us to tap into the depth and extensive insights emanating from their unique experiences and perspectives.
>
> *GCM Phase 2: Rating* – In this activity, participants were asked to rate ideas obtained in the Brainstorming Activity on two scales: Importance and Feasibility. This allowed us to understand how the stakeholders attach value and priority to each of the ideas, based on their individual perceptions and experiences.

The findings from the modified GCM process led to the identification of seven strategic objectives for expanding access to primary and preventive healthcare in Essex County. See Appendix E for a detailed description of this study component.

Key Informant Interviews

We conducted virtual interviews with key informants to gather their opinions on the seven strategic objectives identified through the modified GCM process. We consulted with ECOPHM staff to identify knowledgeable parties who represent a broad set of related experiences to take part in the interviews. The interviews addressed the following topics:

1. The resources necessary to implement the priority objectives for healthcare access;
2. The sustainability of the objectives over time; and
3. The potential role ECOPHM in implementing the objectives.

The interview data identified the resources required to support the objectives and the related sustainability implications. It also indicates how ECOPHM might lead or act upon the objectives to ensure their successful implementation. See Appendix F for a detailed description of this study component.

Review of Existing Data and Literature

Analysis of existing data, research, and publications provided context around the current healthcare landscape, status, systems, and services in Essex County. This data was also used to inform final recommendations for priority interventions to expand access to primary and preventive healthcare.

Essex County Health Landscape

Population Demographics

Essex County has a population of 853,375, with a 1-year growth rate (*0.0747%) of less than one percent.[1,2] The population distribution helps to identify target areas for intervention, as well as the type of health interventions needed, when combined with municipality-specific health data. The municipalities with the highest total population and highest population per square mile are highlighted below[3]:

Highest total population:
- Newark City – 305,344
- Orange City – 68,446
- Irvington Township – 59,997

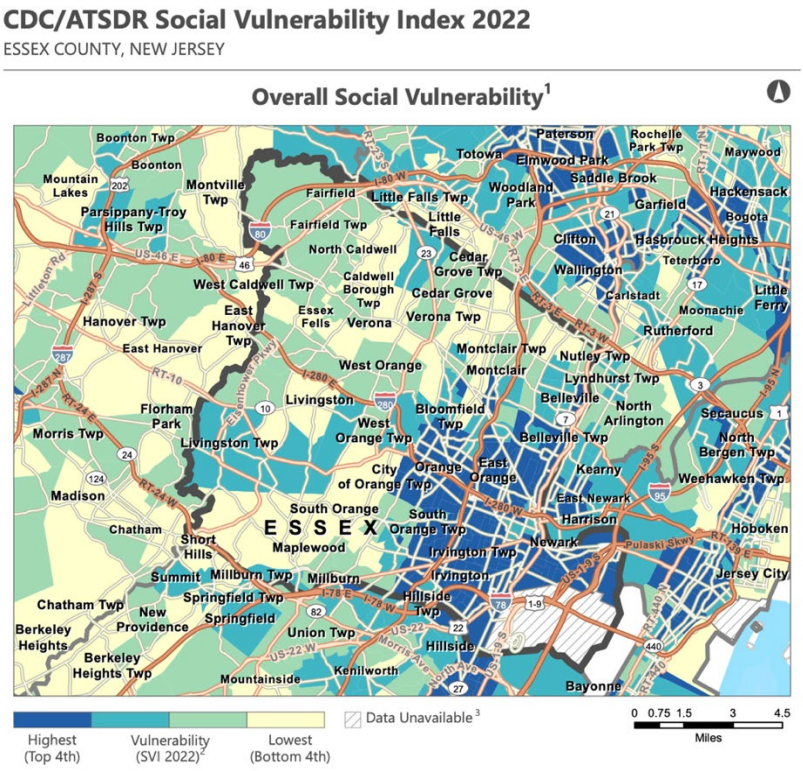
Highest population per sq mile:
- Irvington Township – 20,580.9
- East Orange City – 17,427
- City of Orange Township – 15,220

Social Vulnerability

Socioeconomic factors, specifically social determinants of health (SDOH), significantly impact health care access. This widely accepted fact is supported by the findings from the modified Group Concept Mapping and key informant interview findings. Addressing SDOH is a critical factor driving public health interventions across Essex County.

The Center for Disease Control and Prevention (CDC) developed the "Social Vulnerability Index" (SVI), which uses U.S. Census and American Community Survey data to identify communities that may need additional support before, during, or after disasters. Sixteen Census variables are included in the SVI,

Figure 2: Social Vulnerability Index Map- Essex County, NJ



[1]Yeung AWK, Torkamani A, Butte AJ, et al. The promise of digital healthcare technologies. *Front Public Health.* 2023;11:1196596. doi:10.3389/fpubh.2023.1196596.
[2]Arias López MDP, Ong BA, Borrat Frigola X, et al. Digital literacy as a new determinant of health: A scoping review. *PLOS Digit Health*. 2023;2(10):e0000279. doi:10.1371/journal.pdig.0000279.
[3]New Jersey Department of Health. Internet access by county. Available from: https://www-doh.nj.gov/doh-shad/indicator/view/Dem_Internet.County.html.

encompassing SDOH factors in four major areas of social vulnerability (Socioeconomic Status, Household Characteristics, Racial and Ethnic Minority Status, and Housing Type and Transportation). The results are useful to state and local health departments to inform community-based health promotion initiatives.[4]

The SVI map[5] (Figure 2), shows that municipalities located in the southeastern regions of Essex County have the highest levels of social vulnerability.

Provider Availability and Accessibility

Access (or the lack thereof) to healthcare providers is an important health indicator, and Essex County faces a shortage of primary care providers (PCP). The County's population-to-PCP ratio is 1,330:1.[6] Orange Township, East Orange, the City of Orange, and Irvington Township are designated as Medically Underserved Areas,[7] indicating a shortage of primary care health services in those areas and substantial access barriers due to SDOH.

Community Needs Assessment Priority Intervention Areas

County health needs assessments were conducted by ECOPHM,[8] Newark Beth Israel Medical Center,[9] Mountainside Medical Center,[10] and University Hospital System[11] in recent years. One or more of these reports identified four key priority needs or areas for intervention.

Food Insecurity

In Essex County, 12.3% of the population lack proper access to food.[12] Food insecurity impacts health care outcomes and health status, as noted by all four needs assessments in this report. It is a priority area of need for Newark and Irvington municipalities.

Transportation

Transportation was identified as a barrier to health care access by the Essex County 2023 Community Health Assessment Report, the Newark Beth Israel Medical Center, and the Mountainside Medical Center. These reports identified the following groups as having significant transportation needs:

- Seniors 65 years and older in Livingston area
- Special needs children in Maplewood

[4] https://www.atsdr.cdc.gov/placeandhealth/svi/index.html
[5] https://svi.cdc.gov/Documents/CountyMaps/2022/New%20Jersey/NewJersey2022_Essex%20County.pdf
[6] https://www.countyhealthrankings.org/health-data/new-jersey/essex?year=2024
[7] https://www.njpca.org/muahpsa/mua-essex/
[8] Essex County Community Health Assessment Report 2023. https://essexcountynjhealth.org/wp-content/uploads/2024/02/CHA-2023-Essex-County_FINAL.pdf
[9] Newark Beth Israel Medical Center 2022 Community Health Needs Assessment. https://www.rwjbh.org/documents/community-health-needs-assessment/NBI-CHNA-2022.pdf
[10] Mountainside Medical Center 2022 Community Health Needs Assessment. https://www.hackensackmeridianhealth.org/-/media/project/hmh/hmh/public/about-us/files/2022/2022-mountainside-medical-center-chna-report.pdf
[11] University Hospital 2022 Community Health Needs Assessment. https://www.uhnj.org/wp-content/uploads/2022/12/UH_2022_CHNA.pdf
[12] https://datausa.io/profile/geo/essex-county-nj

- Mothers and young children in Newark

Insurance Coverage

Being uninsured or underinsured is a major barrier to health care access. County-wide, 11.5% of residents are uninsured, and 27.1% have Medicaid.[13]

The reports from the Essex County Community Health Assessment, Newark Beth Israel Medical Center, Mountainside Medical Center, and University Hospital all highlight insurance issues as a critical concern for populations they serve. Priority populations identified in the reports noted are:

- Special needs children
- Residents under 65 who are uninsured
- Hispanic/Latino population (Newark, Hillside, Irvington)
- Youth under age 19 (Newark, Hillside, Irvington)
- Black/African American (Newark)

Housing Insecurity

People experiencing homelessness often struggle to access health care. In Essex County, 27.5% of residents face severe housing issues. A 2024 annual point-in-time (PIT) count showed a 54% rise in homelessness in Essex County and a 24% rise across New Jersey. Newark had the highest percentage (85.4%) of people experiencing homelessness, followed by Irvington at 4%.[14]

Although representing a small part of Essex County's population, with 2,451 individuals counted, housing and homelessness was tagged as priority areas for intervention in addressing healthcare barriers by the Essex County Community Health Assessment and Newark Beth Israel Medical Center.

[13] https://datausa.io/profile/geo/essex-county-nj
[14] https://monarchhousing.org/wp-content/uploads/2024/10/Essex-PIT-Report-2024.pdf

Roadmap for Action

The modified GCM process involved engaging a diverse group of stakeholders from Essex County, including healthcare providers, community leaders, consumer representatives, and public health workers, to solicit their input for this Feasibility Study. This step resulted in a stakeholder, co-developed, community-based approach to addressing healthcare access in the County. Based on the participants' input, the study identified twenty-two priority ideas considered important and feasible for improving healthcare access. A thematic analysis of these ideas produced seven key themes, which form the Seven Strategic Objectives that outline the proposed **Roadmap for Action.**

The seven strategic objectives identified by the GCM process are:

1. **Localize Health Services** - Localize public health services by providing access to primary and preventive health care using mobile clinics/programs.
2. **Enhance Collaboration** - Establish partnerships and collaborations to expand enrollment in programs that address priority issues affecting health and well-being.
3. **Advance Health Education** - Create and implement health education campaigns to increase awareness of preventative healthcare issues and programs.
4. **Centralize County Health Data Collection and Reporting** - Implement ECOPHM-led data collection and reporting systems to inform public health initiatives, report outcomes, and assess impact.
5. **Develop Resource Awareness Tools** - Create, maintain, and disseminate an accessible repository of information about available resources that address Social Determinants of Health and assist residents in obtaining healthcare services.
6. **Improve Language Services** - Implement and manage effective and culturally competent translation services to address language barriers to healthcare.
7. **Expand Advocacy to Secure Funding** - Lead advocacy efforts to secure state and federal funding to support targeted healthcare access programs.

As outlined in the *Feasibility Study Approach* section of this report and detailed in Appendices D-F, the **Roadmap for Action** combines data from four study components (GCM, key informant interviews, stakeholder analysis, and data review) to provide a thorough look at how Essex County can improve healthcare access. The following section offers an outline of the cross-cutting themes present across all Seven Strategic Objectives, followed by 2-3 pages for each, The section contains an overview of the objective, a description of key topics within each, the anticipated challenges, and recommendations for implementation.

Cross-Cutting Concepts and Ideas

Several concepts and topics emerged from the modified GCM and Key Informant Interview findings as overarching concepts and ideas across all Seven Strategic Objectives. These concepts highlight the need to ensure a focus on understanding and addressing the unique socio/economic and cultural contexts of Essex County's diverse communities. These findings support a community-based approach to improving healthcare access, emphasizing localized, collaborative, and culturally competent public health interventions.

These concepts and ideas were consistently present across all seven Strategic Objectives in the Roadmap for Action. But it should be noted that *the findings of the ideas in this study do not necessarily suggest these cross-cutting concerns are not being addressed or that these and other ideas are not already being implemented in Essex County. Instead, it underscores that participants consider them to be essential* for Essex County to successfully implement strategies to increase access to primary and preventive care.

Trust and Community Engagement

- *Trust in public health initiatives* represents a crucial factor for successful engagement and utilization of public health services. Trust is a vital component to any public health intervention and can be built through many of the ideas presented in this study, including transparency, health and resource education, health systems that are built on equity, stakeholder engagement, and the presence of a well-trained and resourced healthcare workforce.[15]
- The development of strong relationships between community leaders, faith-based organizations, schools, and other local institutions is essential to encourage the uptake of primary and preventive healthcare services. Such focus on *community engagement has been shown to play a significant role in reducing health inequalities*, improving social justice, enhancing the benefits of public health interventions, and developing a shared responsibility for public health.[16]
- Interview and GCM participants indicated that *transparency in data collection and decision-making* increases public confidence in healthcare services.

Equity and Accessibility

- Regardless of the topic addressed, interviewees repeatedly focused on the *centrality of culturally competent services*, highlighting the need for equity in primary and preventive healthcare.
- Localized health care services, including mobile vans and permanent clinics, should be *strategically placed to ensure accessibility for vulnerable populations*. Interviewees regularly stressed the need to "meet people where they are at."

[15]Correia T. Trust building in public health approaches: The importance of a "people-centered" concept in crisis response. *Risk Manag Health Policy*. 2024 Aug 1;17:1903-1908.
[16]Yuan M, Lin H, Wu H, Yu M, Tu J, Lü Y. Community engagement in public health: a bibliometric mapping of global research. *Arch Public Health*. 2021 Jan 12;79(1):6.

- Multiple interviewees emphasized the importance of overcoming language and literacy barriers to make healthcare information accessible to all.

Coordination Across Agencies and Systems

- Inter-agency collaboration was identified in multiple interviews as *essential for addressing many challenges*, including increasing awareness of healthcare resources, expanding public health education, and centralizing data collection.
- Coordinated efforts among municipalities, health departments, and nonprofits are needed to *streamline health services.*
- Sharing data and aligning resources can prevent duplication, *maximizing the impact and effectiveness* of healthcare interventions.

Sustainability and Long-Term Planning

- Funding challenges were repeatedly cited for each strategic objective, with many interview participants indicating *increased concerns in light of the potential federal policy changes* in public health and healthcare.
- County-wide strategic planning should *include long-term investment in infrastructure, staffing, and programmatic sustainability*.
- Legislation and policy support may provide *stability for ongoing initiatives*, though this may be challenging given current public policy priorities.

Objective 1: Localize Health Services

The *Localize Health Services objective* focuses on a community-based approach to improving healthcare access, specifically through the expansion of mobile health vans. The GCM data highlighted ideas that prioritized using mobile health vans for primary and preventative care, as well as referral services (Statements 63 and 66, Appendix 1). Additionally, it underscored the importance of locating the health vans at trusted and accessible community sites, such as churches, schools, and venues serving WIC-eligible clients (Statements 67 and 20, Appendix 1). The study results also suggest prioritizing resources to address violence prevention and conflict resolution to improve overall community safety and well-being (Statement 25, Appendix 1). However, the ***key informant interviews and other data sources consistently confirmed the use of mobile health vans as the priority initiative*** driving this objective.

Mobile Health Vans

The assessment data provides compelling evidence for significantly expanding the use of mobile health vans within the county. Study participants highlighted the multifaceted roles these vans can fulfill, strongly recommending their utilization for primary and preventative care services. Additionally, they emphasized the vans' potential to serve as essential entry points to the broader healthcare system, community services, and long-term medical homes.

Interview participants further underlined the importance of coordinating with existing local health service providers to maximize the reach and efficiency of mobile services throughout the county by preventing duplication of effort. They also reiterated the necessity of using culturally relatable staff to build community trust, thereby encouraging utilization of the vans.

The study findings align with existing research that underscores mobile health vans are vital resources in overcoming barriers to health care access. The vans not only address immediate health care needs but also connect individuals to ongoing primary care (medical homes) and other services, ensuring continuity of care and timely interventions. Mobile health service vans contribute significantly to improving health outcomes and overall population health.

However, while mobile health vans are viewed as critical resources for reaching underserved areas and improving healthcare access, the data identified multiple challenges for successful implementation, which are outlined below:

- Vans require significant resources, including funding and culturally competent staff, to implement and sustain them.
- The political climate may discourage immigrants from using the services and affect funding.
- There could be perceived duplication of effort and competition with existing providers.
- Navigating dense areas and finding accessible locations can cause logistical issues.
- Liability concerns might prevent schools from hosting the vans, as schools become more sensitive to associated risks.

Overcoming these challenges and unforeseen obstacles necessitate careful, strategic implementation of the mobile health services.

Recommendations

The study data and research literature support mobile health vans as an effective way to improve access to healthcare.[17] The recommendations for expanding van services align with a community-based approach to localize critical health services. The recommendations also emphasize the need for concerted, planned expansion and utilization of the vans. These recommendations include:

- Strategically utilize mobile vans, focusing on preventive care, including screenings and vaccinations, and incorporating health education and resource awareness into their services.
- Collaborate with primary care providers and organizations to connect residents with primary care homes and facilitate referrals and access to primary and specialty care services. Promote continuity of care by positioning mobile health services as a conduit to consistent primary care services.
- Partner with existing mobile health service providers, such as Federally Qualified Health Centers (FQHCs) and the Newark City Health Department, to prevent duplication of efforts and resources. Coordinate efforts to extend the reach of vans to underserved areas and populations and to augment existing van services.
- Regularly assess the needs of potential communities and populations targeted for mobile health services, considering cultural, linguistic, and socioeconomic factors.
- Target van services to vulnerable groups, including senior residents, unhoused individuals and those in public housing, communities with limited transportation access, including suburban areas facing transportation barriers, and low-income and uninsured people.
- Develop a sustainability plan that includes diversified funding sources. Regularly evaluate the impact of mobile health vans to support funding efforts.
- Engage representatives from the communities and populations targeted for van services in the planning and evaluation processes of the mobile health van initiatives
- Develop violence prevention ideas further. Engage the appropriate Essex County Coalition of stakeholders to address this initiative collaboratively. Use mobile vans to share information and raise awareness about community programs focused on violence prevention and conflict resolution.

Best Practices

Mobile health clinics are emerging as an effective means to reach more populations with essential primary and preventive care across rural, suburban, and urban settings. These clinics have been found to be beneficial in many way, including the delivery of health care to vulnerable

[17]Yu, S. W., Hill, C., Ricks, M. L., Bennet, J., & Oriol, N. E. (2017). The scope and impact of mobile health clinics in the United States: a literature review. *International Journal for Equity in Health*, *16*, 1-12.

populations,[18] providing adaptive and lower cost care to the communities they serve,[19] and are able to provide access to healthcare for those who may have otherwise gone without due to variety of factors and barriers.[20] The research suggests that mobile health clinics are most impactful in communities when established in collaboration and partnership with multiple stakeholders in a community.[21] The following examples highlight mobile health clinic programs increasing access to primary and preventive care in the communities they service.

- ***NYC Health + Hospitals' Street Health Outreach and Wellness (SHOW) Mobile Units*** provides comprehensive healthcare services and social support for residents of the Queens community who are unsheltered or living on the street. The eight SHOW Mobile Units leverage "the mobile medical model NYC Health + Hospital's pioneered during the COVID-19 pandemic and the public health system's foundational principles of patient-centered care and harm reduction to bring health care services to New Yorkers in need." Between the program's launch in April 2021 and June 2023, the mobile units had conducted more than 20,000 medical consultations, provided 9,000 vaccinations, and enabled 60,000 social work engagements.[22]
- ***The Children's Hospital of Chicago*** has mobile health clinics that provide sports physicals, immunization, well-child visit, and asthma care services to communities across the Chicago metro area. This program partners with are FQHCs to bring their services to under-resourced neighborhoods.[23,24]

[18]Gupta A, Misra SM, Garcia C, Ugalde M. Utilizing lean principles to improve immunization administration efficiency in a pediatric mobile clinic program. *Pediatr Qual Saf.* 2017;2:0. doi:10.1097/pq9.0000000000000037.
[19]Hill CF, Powers BW, Jain SH, Bennet J, Vavasis A, Oriol NE. Mobile health clinics in the era of reform. *Am J Manag Care*. 2014;20:261–264. Available from: https://pubmed.ncbi.nlm.nih.gov/24884754/.
[20]Yu SW, Hill C, Ricks ML, Bennet J, Oriol NE. The scope and impact of mobile health clinics in the United States: a literature review. Int J Equity Health. 2017;16:178. doi:10.1186/s12939-017-0671-2. Available from: https://doi.org/10.1186/s12939-017-0671-2.
[21]McShane MP, Zechman A, McNally R, Stephens M. Mobile health clinic: Lessons learned building partnerships across health systems. *Am J Accountable Care.* 2023;11(1):38-41. Available from: https://doi.org/10.37765/ajac.2023.89342.
[22]https://www.nychealthandhospitals.org/pressrelease/show-program-brings-mobile-health-and-social-services-to-unsheltered-queens-residents/
[23]https://www.luriechildrens.org/en/serving-the-community/magoon-institute-for-healthy-communities/linking-clinic-community/
[24]https://www.childrenshospitals.org/news/childrens-hospitals-today/2023/01/mobile-health-clinics-close-gaps-in-care

Objective 2: Enhance Collaboration

The *Enhance Collaboration* objective focuses on strengthening partnerships to optimize resources to overcome access barriers. This objective involves establishing intentional partnerships to address social determinants of health, such as food insecurity and lack of insurance, and bolstering ECOPHM's capacity to build or reinforce strategic, sustainable partnerships.

Strategic Partnerships

The GCM data identified multiple opportunities for cross-sector collaboration: it prioritized partnering with trusted community programs and organizations to target efforts tackling social determinants of health (SDOH) (Statement 1, Appendix A) and with FQHCs to help consumers establish primary care homes. (Statement 2, Appendix A).

The interview participant data highlighted that strategic and clear goals are essential for all partnerships, and that alliances should aim to maximize resources and prevent service duplication. Strategic partnering should also focus on relationship-building through data sharing, enhanced communications, and regular evaluation.

Participants identified language and transportation barriers, as well as food insecurity as critical areas where effective collaborations are needed. The recommendations' section summarizes opportunities to address these barriers, collaboratively.

The data also suggests ECOPHM adopt a long-term strategy for forging collaborative efforts. Participants indicated they would welcome ECOPHM taking the lead to create a multi-sector community health improvement coalition to coordinate and drive future efforts to achieve shared goals. Several participants noted that multiple coalitions are working to improve County residents' health and well-being, but they highlighted the need for a coordinated, county-wide strategic plan to align goals and resources for greater impact.

Organizational Capacity

The study data highlights that effective collaboration requires sufficient organizational capacity, such as adequate staffing and funding. Interviewees also emphasized that ECOPHM should consider increasing its visibility and communication with partners, as well as improve its data capabilities as it seeks to build or strengthen collaborative relationships.

Interview participants noted that some capacity issues can be partially solved by co-locating services with trusted community partners and sharing resources. However, they also stressed the importance of ensuring consistent, dedicated staffing to support coordination of services and guide effective communications.

The data suggests that a significant challenge in enhancing collaboration is the lack of long-term funding to maintain such efforts over time. Interview participants discussed the challenges associated with sustaining coalitions in general, particularly those working to address SDOH. They cited the lack of infrastructure to support long-term collaborative efforts, like community coalitions.

Recommendations

To improve collaboration, ECOPHM should focus on building organizational capacity for sustainable coalition building, leading strategic partnerships to address SDOH, and coordinating efforts for impactful healthcare access expansion. Near-term recommendations include:

- Partner with NJ Transit and ride-share services to create or enhance affordable transportation options.
- Integrate nutrition programs and food resources' information into healthcare visits, especially for WIC-eligible families.
- Provide culturally competent outreach services to engage residents in the healthcare system
- Co-locate services to expand access, building partnerships with schools, FQHCs, and health departments.

Other recommendations include:

- Strengthen ECOHPM's capacity to build and sustain strategic partnerships by dedicating staff and resources to this effort.
- Secure funding to support collaboration and maximize resource sharing.
- Improve communication with partners and engage them up front in planning and executing healthcare access initiatives.
- Focus on purposeful partnerships and regularly evaluate their impact.

Best practices

Research shows that collaboration and stakeholder strategic involvement can enhance access to primary care and improve health outcomes; collaboration can drive coordinated efforts to overcome access barriers more effectively. However, building effective partnerships is resource-intensive and the overall impact remains inconclusive.[25] The literature suggests that shared resources, data sharing, and policy development to promote preventive care are strategies that support effective collaboration.[26]

Many communities have implemented collaborative efforts to enhance access to primary and preventive healthcare. Two examples are provided below.

- ***Southwestern Health Resources (SWHR) – North Texas*** partners with physicians and clinicians to proactively deliver preventive care to at-risk patients, focusing on colorectal

[25]Alderwick H, Hutchings A, Briggs A, Mays N. The impacts of collaboration between local health care and non-health care organizations and factors shaping how they work: a systematic review of reviews. *BMC Public Health*. 2021;21:753. doi:10.1186/s12889-021-10630-1. Available from: https://doi.org/10.1186/s12889-021-10630-1.
[26]Elliott L, McBride TD, Allen P, Jacob RR, Jones E, Kerner J, et al. Health care system collaboration to address chronic diseases: a nationwide snapshot from state public health practitioners. *Prev Chronic Dis.* 2014;11:140075. doi:10.5888/pcd11.140075. Available from: http://dx.doi.org/10.5888/pcd11.140075.

cancer screening and diabetes management. Through engaging with community partners within the region, they utilized data sharing, targeting outreach activities, and innovative interventions to engage patients in their health management, resulting in increased uptake of test kits, improved diabetes measures, and increases in uptake of early interventions.[27]

- ***The Summit Community Care Clinic*** began as a volunteer-run facility under the county health department. It now provides comprehensive services—including primary, preventive, behavioral, and oral healthcare—to uninsured residents of Summit and neighboring counties. The clinic's growth has been supported by state and local government grants, emphasizing the importance of collaborative funding in expanding healthcare access.[28]

[27] https://www.southwesternhealth.org/sites/default/files/2024-08/SWHR-Case-Study-Closing-Care-Gaps-Collaborative-Approaches-for-Population-Health.pdf
[28] https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CollaborativePrimaryCare.pdf

Objective 3: Advance Health Education

The *Advance Health Education* objective aims to enable individuals to make informed decisions about their health and well-being by improving their ability to understand and use health information. The study data targets specific areas for health education: curtailing communicable diseases and promoting healthy choices and lifestyles. The data recommends an initial focus on implementing targeted health education campaigns to increase awareness and knowledge about prevalent communicable diseases, such as sexually transmitted diseases (Statement 40, Appendix A), and promote preventative care and healthy lifestyles (Statement 49, Appendix A).

Health Education Campaigns

Health education fosters the ability to make informed decisions, leading to better health literacy, and enhanced capacity to access healthcare services and engage in healthier lifestyles.[29,30] The GCM and interview data suggest that ECOPHM should lead comprehensive campaigns to address immediate health needs. They should also promote regular and comprehensive health education to communicate public health issues and share relevant health and resource information. Interviewees suggested ECOPHM collaborate with community partners to ensure comprehensive far-reaching health education. They noted that the Newark Health Department's health education program can serve as a catalyst and model for broader initiatives.

Additionally, the study findings suggest it is crucial to develop culturally relevant campaigns tailored to diverse communities. Materials and outreach efforts must consider language needs, literacy levels, and specific barriers faced by different populations and communities. Health education programs should employ multiple, accessible formats, including online print and community outreach, to ensure wide dissemination of information.

Key informant interview data underscored the challenges for sustaining health education programs due to their heavy reliance on grant funding. To mitigate this and other challenges, interviewees suggested advocating for better funding, leveraging existing resources through collaboration, and building on national health education campaigns.

Recommendations

Health education equips individuals with the knowledge and tools to make informed health decisions and navigate the healthcare system, enabling their ability to access healthcare. Recommendations to enhance health education that arose from the study include:

- Create and lead culturally relevant county-wide health education campaigns.
- Engage trusted community organizations and stakeholders in developing and implementing these campaigns for maximum impact.

[29]Education Matters to Health: Exploring the Causes Center on Society and Health, Virginia Commonwealth University https://societyhealth.vcu.edu/work/the-projects/why-education-matters-to-health-exploring-the-causes.html#gsc.tab=0

[30]Levy H, Janke A. Health literacy and access to care. *J Health Commun*. 2016;21 Suppl 1:43–50. doi:10.1080/10810730.2015.1131776. Available from: https://doi.org/10.1080/10810730.2015.1131776.

- Collaborate with partners like the Newark Health Department to build on existing campaigns.
- Partner with local schools and higher education institutions to create health education materials and promote public health messaging.

Utilize national campaigns and resources for guidance and support. For examples of national resources to guide and inform health education campaigns, refer to:

- Office of Disease Prevention and Health Promotion *National Action Plan to Improve Health Literacy.*[31]
- Office of Disease Prevention and Health Promotion *Healthy People 2030.*[32]

Best Practices

Health education campaigns have long been an important component of public health initiatives, and public health professionals are experienced in designing and implementing effective campaigns. Two recent case studies emphasize the significance of collaboration, cultural competence, and utilizing national campaigns.

- The ***Albany County (NY) Department of Health*** launched the "Move Your Way Albany County" campaign to encourage residents to meet physical activity guidelines. Targeting adults aged 25-60, the initiative promotes integrating simple physical activities into daily routines, such as carrying groceries, parking farther from destinations, or dancing at home. This campaign, part of a national effort by the U.S. Department of Health and Human Services, emphasizes accessibility and inclusivity in fitness, aiming to improve both mental and physical health outcomes.[33]
- In 2024, the ***Healthy Schools Campaign*** launched a project to help states and school districts leverage Medicaid as a sustainable and scalable funding source to support school-based substance use prevention and early intervention health services. The initiative convened a community advisory board and focus groups to identify how school-based substance use programming could better meet the needs of young people, their families, and communities.[34]

[31]Office of Disease Prevention and Health Promotion website for information on the National Action *Plan to Improve Health Literacy* (U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). https://odphp.health.gov/our-work/national-health-initiatives/health-literacy/national-action-plan-improve-health-literacy

[32]Office of Disease Prevention and Health Promotion. (n.d.). Healthy Literacy. *Healthy People 2030*. U.S. Department of Health and Human Services. https://odphp.health.gov/healthypeople/priority-areas/health-literacy-healthy-people-2030

[33]https://www.albanycountyny.gov/departments/health/programs-services/move-your-way

[34]https://healthyschoolscampaign.org/issues/school-health-services/substance-use-prevention

Objective 4: Centralize County Health Data Collection and Reporting

This objective aims to strengthen health related data collection and reporting in the county. It proposes ECOPHM lead and expand its role in this effort. To achieve this objective, the GCM findings emphasized the need to conduct regular community health needs assessments to identify service and access gaps (Statement 44, Appendix A) and enhancing ECOPHM's involvement in implementing robust data collection and reporting mechanisms to track outcomes and the impact of services (Statement 45, Appendix A).

The significant advantages of an effective data collection management and reporting system is widely noted. Centralizing data functions or establishing a countywide health data management system can enhance stakeholders' ability to track health trends and measure impact more efficiently and effectively: this can improve the quality and timing of health interventions and access to services. Reliable data is crucial for identifying and addressing needs with targeted interventions. However, effective data management requires sufficient and sustainable organizational capacity.

Interview participants noted several challenges that could affect the feasibility of this objective, including:

- Public health databases and municipal databases are not completely linked, causing inefficiencies in data tracking and communication across municipalities.
- Public mistrust in data collection and its use hinders consumer participation due to privacy concerns and fear of political misuse of information.
- Sustainable data management requires stable resources, plus adequate organizational capacity and data infrastructure. The ability to institute a dedicated data department or access to data management staff is essential to expanding ECOPHM's role in data management and reporting.

Given the challenges and extensive resources needed to implement a comprehensive, robust data collection and management system, interview participants recommended that ECOHM assume a coordinating role in guiding and reporting county-wide data collection efforts and information sharing. The findings from this study suggest that such a coordinating role could involve:

- Raising awareness about current data collection efforts, reporting, and data sharing.
- Enhancing ECOHM's role as a convener to centralize data collected by trusted stakeholders and facilitating data sharing through collaboration.
- Advocating to ensure that every municipality has a database or access to data that communicates with the county-level database.
- Securing resources, including long-term resources supported by a legislative mandate, to enable ECOPHM to serve as a hub for centralizing and reporting public health data.

- Ensuring timely community health needs assessments. Although ECOPHM currently conducts county-wide health needs assessments, including the most recent assessment in 2023, the data underscores the need for heightened communication and awareness of ECOPHM's efforts to conduct such assessments and report the findings.

Recommendations

Overall, key informant interview participants emphasized the critical importance of prioritizing data collection and management while recognizing the substantial challenges that affect the feasibility and sustainability of large-scale data initiatives. Nonetheless, the composite data suggests measures to enable ECOPHM to assume a more prominent role in coordinating data collection and reporting at the County level. It proposes strategies for ECOPHM to leverage existing resources to coordinate and disseminate information effectively to address public health issues and enhance healthcare access. Toward these ends ECOPHM could:

- Enhance visibility and raise awareness about its current data collection, management, and reporting role. For example, ECOPHM is highly involved with the NJ Local Information Network and Communications System (LINCS.) It may be helpful to ensure stakeholders across Essex County are aware of the ECOPHM's involvement and how municipalities can access and get involved in this program.
- Initiate small-scale pilot projects to coordinate data reporting across public health offices. Initial steps might involve convening stakeholders to share information on public health data.
- Build trust and solicit support for future data initiatives by engaging stakeholders across the public health sector and residents from the outset to provide input on data collection initiatives, ensuring clear communication around the purpose and use of the data.
- Educate end users, professionals, and consumers on how to interpret and utilize public health data for decision-making, including enhancing healthcare access.
- Facilitate the adoption of clear, coordinated goals among county public health offices to guide data handling and access at the County level.
- Plan and allocate additional resources to advance and expand a data initiative aimed at enhancing access to healthcare.

Best Practices

Healthcare and public health are built on the premise of good data. Shared and centralized county health data can help ensure effectiveness and efficiency of interventions focused on increasing access to primary and preventive healthcare in Essex County. The two examples below highlight the importance of establishing and supporting shared local health data.

- The ***Greater New Orleans Health Information Exchange (GNOHIE***) is a data infrastructure apparatus using data and technology to facilitate innovative health data

sharing between private hospitals and community health clinics. This initiative supports the GNOHIE's objectives to improve population health, reduce health costs, and enhance patient experiences.[35] Key lessons learned from the implementation of this initiative include the importance of long-term planning for sustainability to ensure data sharing received sufficient funding to persist over time, and integrating data sharing requirements into new and updated healthcare policies.

- The ***National COVID Cohort Collaborative*** is a centralized database that aggregates de-identified patient records from 56 institutions, totaling 6.3 million records, including 2.1 million COVID-19 cases. This centralized database provides real-time, comprehensive data that helps officials track disease trends and outbreaks more effectively. It enables local health departments to identify high-risk populations and allocate resources such as testing, vaccines, and treatments more efficiently. By consolidating patient records from multiple institutions, the system enhances data accuracy, allowing for better decision-making in public health interventions. Researchers and local agencies can use the system to evaluate the effectiveness of policies and treatments, leading to more locally informed, data-driven responses. Additionally, the centralized platform fosters collaboration between local and national health organizations, improving coordination in emergency responses and long-term health planning.[36]

[35]https://nam.edu/wp-content/uploads/2022/01/Sharing-Health-Data-prepub-FINAL.pdf
[36]https://www.technologyreview.com/2021/06/21/1026590/us-covid-database-n3c-nih-privacy/

Objective 5: Develop Resource Awareness Tools

The *Develop Resource Awareness Tools* objective is intended to help consumers and providers obtain information about services to address Social Determinants of Health (SDOH) and facilitate access to primary and preventive services. GCM data suggest a focus on raising awareness among residents about housing assistance and applying for New Jersey Family Care (Medicaid) (Statement 16 and 21, Appendix A). Additionally, it also highlights the importance of informing clinicians about available community resources to help link patients to necessary services (Statement 50, Appendix A).

The Full Statement Set (Appendix A) also recommends boosting outreach through partnering with schools and community leaders to disseminate information (Statement 62 and 3, Appendix A), especially to reach vulnerable groups. Interview data further suggested that ECOPHM should increase visibility and public knowledge of its services. Some interviewees noted that residents may be unaware of the department's initiatives and services. Literature indicates that knowing about resources can empower people to seek health care proactively and overcome access barriers.[37,38,39]

Repository for Community and Healthcare Resource Information

GCM and key informants' interview data suggest that ECOHM create and maintain an accessible resource repository. Interview data supports the need for a central source to manage resource information and proposes that ECOPHM serve as the hub for oversight and support of this idea. Interviewees recommended involving stakeholders as subject matter experts in developing the repository and ensuring the information remains current and accurate. This approach leverages partnerships and existing resources to collect and maintain relevant information.

The interview participants highlighted that advancing this strategy requires a thorough implementation and maintenance plan, along with staff to manage and sustain it. It also requires attention to understanding and accommodating the end users' needs and abilities to access the information. The repository should be culturally and linguistically accessible and address the needs of Essex County communities, residents, and healthcare partners.

Recommendations

A health services information repository is a valuable tool that enables awareness of available health services and community resources. It helps bridge the gap in understanding and utilizing measures to seek and obtain necessary services. Important considerations emerging from the data sources for planning and implementing such a repository include:

- Make information accessible via multiple channels, including a dedicated website, mobile app, and printed materials.

[37]Bhatt J, Bathija P. Ensuring access to quality health care in vulnerable communities. *Acad Med*. 2018;93(9):1271–1275. doi:10.1097/ACM.00000000000. Available from: https://doi.org/10.1097/ACM.00000000000.
[38]Healthcare Access in Rural Communities (2025). RHIhub: Rural Health Information Hub. https://www.ruralhealthinfo.org/topics/healthcare-access
[39]Witting, Lillian (2023). Limited Access: Poverty and Barriers to Accessible Healthcare. National Health Council. https://nationalhealthcouncil.org/blog/limited-access-poverty-and-barriers-to-accessible-health-care/

• Engage trusted partners and culturally competent outreach workers to communicate resource information.
• Ensure robust data vetting to ensure trust in the content and resources.
• Maintain and update information regularly.
• Expand marketing efforts to promote awareness and utilization of the repository.
• Enable independent access to the information to facilitate its use and reduce dependency on intermediaries to navigate the information site.

Objective 6: Improve Language Services

The *Improve Language Services* objective aims *to reduce healthcare language barriers for Essex County residents with limited English p*roficiency (LEP). This involves increasing the use of language line translation services and multilingual public health staff to improve access for LEP individuals (Statement 15, 22, and 23, Appendix A). The data - across all sources- emphasizes the need for culturally competent multilingual team members to navigate diverse cultural norms and enhance communication for better healthcare outcomes.

Essex County's demographic data underlines the identified importance of the Language Services objective. Fifteen percent (15%) of Essex County residents have limited English proficiency, and 30% speak a language other than English, indicating a significant need for culturally competent language translation services throughout the county.

Language translation services

The literature on healthcare access fines that language barriers pose significant challenges for individuals with limited English proficiency (LEP), such as difficulties in getting appointments and misunderstanding diagnoses and treatment, leading to poorer health outcomes and higher costs. LEP patients report they often face barriers to healthcare or avoid services due to system navigation fears.[40] The Essex County Community Health Assessment also noted that the CHA Spanish speaking participants highlighted the challenges Essex County LEP populations encounter in navigating healthcare services and understanding medical information.[41]

Aligned with these findings, the interview participants in the Feasibility Study stressed that the lack of *culturally appropriate and relevant* translation services exacerbates language barriers, emphasizing the need for translation services that take into account cultural differences, regional nuances of language use, and linguistic meaning among the diverse communities in Essex County to ensure translation services are effective.

Culturally Competent Multilingual Translation Staff

GCM participants identified the need for more bilingual navigators and case workers to assist families enrolling in programs that address SDOH access barriers, such as NJ Family Care. (Statement 22, Appendix A). Building on this idea, Feasibility Study interviewees emphasized that hiring more translators should result in hiring more culturally competent bilingual staff to enhance trust and interpretation accuracy, both of which are crucial to increasing the actual and timely use of services.

The literature supports the interview findings: significantly it shows that culturally competent translation services are crucial for improving communication and trust between providers and patients. Studies highlight that providers are often not equipped to convey culturally competent information due to language barriers, reducing patient and provider satisfaction and the effectiveness of healthcare services. While language line services may be available to providers,

[40]Al Shamsi H, Almutairi AG, Al Mashrafi S, Al Kalbani T. Implications of language barriers for healthcare: a systematic review. *Oman Med J*. 2020;35(2):e122.
[41]Essex County Community Health Assessment Report 2023. https://essexcountynjhealth.org/wp-content/uploads/2024/02/CHA-2023-Essex-County_FINAL.pdf

they may face difficulties navigating the services and the nuanced cultural differences that can affect meaning and interpretation.[42]

Implementing language services faces challenges like high costs and a shortage of trained providers for culturally competent translation in clinical settings. Interviewees suggested that increasing the use of language line services or tools like Google Translate could help bridge language barriers, though they noted that the cost may present obstacles for this approach. The literature also pointed out the difficulty of recruiting and retaining enough culturally competent staff to effectively enable the use of language line services and to assist LEP individuals to navigate and use the healthcare system effectively.

Recommendations

The data across all sources strongly encourage the enhancement of language services to improve healthcare access for limited English proficiency populations. Recommendations to overcome the cost and capacity challenges to implementing the Language Services objective include:

- Strengthen partnerships with community stakeholders to improve translation services within and across the healthcare community, strategically.
- Partner with schools, libraries, and higher education institutions to optimize resources and create accessible venues for language translation services and printed materials in residents' primary languages.
- Enhance language line services or online tools such as Google Translate as immediate, available options.
- Enhance the use of language line services by employing fluent, culturally competent bilingual staff to enable communication between individuals with LEP and clinical providers and others within the healthcare community.
- Provide training and education to clinical providers on using language line services and working with translators. Also, they should be educated about the populations they serve and the importance of culturally appropriate communications.
- Train and use trusted, culturally competent bilingual community members, including navigators and case workers, to serve as translators. Ensure adequate compensation to retain them.
- Partner with community leaders, healthcare institutions, and others to develop training initiatives to increase the number of culturally competent translators across Essex County. Co-locate trained translators to maximize their availability in community and clinical settings.
- Seek grants and stable funding sources to support long-term efforts to enhance language services**.**

[42]Racial and Ethnic Approaches to Community Health (2023–2028). https://odphp.health.gov/foodismedicine/federal-resource-hub/racial-and-ethnic-approaches-community-health-2023-2028

Best Practices

Study participants identified a best practice that can serve as a model for partnering and building translation services and a community resource that could provide expertise and guidance. The resources are:

- ***Su Salud Medical Program, RWJ Barnabas Health, NJ.*** - This program institutes a one-stop services approach utilizing patient navigators to assist patients and support them by helping with all aspects of their health care, such as appointments, paperwork requirements, transportation, case management, and referrals, while also understanding their needs and communicating those needs to their health services team members.[43]
- ***The Language Bank, Rutgers University and the Translation and Interpreting Program, Rutgers University, New Brunswick, NJ*** - The Language Bank supports community-based organizations through free translation and interpreting services. The Translation and Interpreting Program provides advanced training for translators and interpreters.[44]

[43] https://www.rwjbh.org/rwj-university-hospital-new-brunswick/treatment-care/su-salud-medical-program/
[44] https://tlc.rutgers.edu/request-translation-or-interpreting-services-na

Objective 7: Expand Advocacy to Secure Funding

The *Expand Advocacy to Secure Funding objective* proposes that ECOPHM lead efforts to secure stable resources for public health initiatives, including advocating for funding for local health departments. (Statements 33 and 53, Appendix A).

Public health funding typically relies on government sources that are affected by changing policy priorities, making program sustainability challenging. This dynamic underscore the need for proactive planning and advocacy to sustain public health access programs. Further, it emphasizes the importance of multi-source funding and the adoption of innovative financial models. One such model includes generating revenue through insurance billing for essential services, like language translation.

Sufficient and regular funding fosters sustainability and the public's perceived reliability of programs, leading to greater community buy-in and ability to access health services.

Recommendations

Securing and maintaining public health funding is challenging and requires multi-faceted strategies to enhance sustainability of public health access initiatives. Study participants suggest that ECOPHM can play a role in bolstering their capacity and work to acquire stable funding for county/municipal health departments and public health initiatives. Key recommendations include the following:

- Advocate on behalf of all public health departments to identify, secure, and diversify funding support
- Explore and implement innovative funding models for public health. The Centers for Disease Control and Prevention and the U.S. Department of Health and Human Services are information sources for funding models and best practices.
- Enhance ECOPHM's visibility and engage with the private philanthropy sector to communicate the county's public health priorities. The interview data indicates that although the private sector typically does not support government entities, there could be interest in exploring collaboration opportunities with ECOPHM to direct funding to community organizations addressing the county's health priorities, especially SDOH and related health care issues.
- Pursue legislative mandates to institutionalize sustainable funding streams for public health initiatives.
- Leverage short-term funding effectively to align with long-term goals. Incorporate and build upon targeted, intermittent funding to augment and sustain access initiatives. This involves planning for and mitigating any potential service interruptions once short-term funding periods conclude.

Best Practices

The need for diversification of public health funding is widely understood. especially in light of the termination of significant government public health investments during the COVID-19 pandemic and the uncertainty of future public funding. diversified public health funding strategy is increasingly essential.[45] Two examples of initiatives to advocate for diversified funding for local public health departments are provided below.

- The ***California Can't Wait Coalition*** is a broad-based coalition of eighty-four organizations that are dedicated to protecting the health and safety of California communities and expanding health equity throughout the state. The coalition is led by local public health departments and focuses on advocating with the state legislature to continue their funding for local public health infrastructure and rebuilding the public health workforce, as well as dedicating budget surpluses to fund programs that address public health workforce recruitment and retention.[46]
- ***The National Association of County and City Health Officials (NACCHO)*** is a non-profit organization that represents local health departments in the United States. One of its key activities is conducting Policy and Advocacy efforts with federal policymakers. Their 2025 priorities include:
    - Strengthening and supporting the public health workforce
    - Improving access to federal public health funding, including resources to support the public health infrastructure and data modernization at the local health department level;
    - Ensuring that public health funding flows from the federal to states and local communities quickly and equitably.[47]

[45] https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00037
[46] https://cheac.org/wp-content/uploads/2022/01/CACantWait-Budget-Legislative-Proposals-v2-01.11.22.pdf
[47] https://www.naccho.org/advocacy/policy-and-advocacy

Conclusion

This Access to Care Feasibility Study, commissioned by the Essex County Office of Public Health Management, presents an actionable *pathway* to expand healthcare access in Essex County --- ***A Roadmap for Action*** (Appendix C). The roadmap reflects a stakeholder-informed plan that represents the diverse perspectives and expertise of those community and healthcare representatives participating in the study.

The study identified seven key Strategic Objectives from twenty-two priority ideas that participants found most important and feasible. These ideas, and stakeholder-sourced recommendations for implementing them, are central to the Roadmap for Action.

The ***Roadmap for Action***, presented as a separate document accompanying this report, includes recommendations and strategies unique to each Strategic Objective for immediate and near-term implementation. It also highlights cross-cutting recommendations for all the Objectives. The focus is on community-based approaches that emphasize strategic collaboration, equity, and localizing services to provide sustainable access to primary and preventive health care while addressing social determinants of health.

The ***Roadmap for Action*** includes community-based strategies that promise the most significant impact in improving access to healthcare, where it is most needed throughout Essex County. The document offers clear directions while recognizing the need for careful planning by ECOPHM as the first step to putting some of the recommendations into action, as emphasized by study participants.

We trust this report and the ***Roadmap for Action*** will inspire and guide ECOPHM's efforts to improve healthcare access across Essex County, ultimately enhancing the health and well-being of its residents.

APPENDICES

Report Appendices

Appendix A: Full statement Set Used for Modified GCM Rating Phase

Appendix B: Table of 22 Priority Ideas

Appendix C: Roadmap for Action Guide

Detailed methods and results

Appendix D: Stakeholder Inventory and Analysis

Appendix E: Modified Group Concept Mapping (GCM)

Appendix F: Key Informant Interview Methods

Appendix A:

Full Statement Set Used for Modified GCM Rating Phase

#	Statements
1	Partner with Women, Infants, and Children (WIC) sites and Food Pantries to ensure all who qualify are enrolled.
2	Partner with Essex County Federally Qualified Health Centers (FQHCs), such as Zufall Health, to schedule follow-up primary care appointments at the FQHCs in conjunction with the mobile health van visits.
3	Partner with community leaders to disseminate information about local health resources.
4	Partner with local providers, such as Summit Health or Care Station, to offer access to more clinical treatment services where needed.
5	Partner with local pharmacies to offer preventative services such as blood pressure checks, immunizations, and cholesterol screenings.
6	Partner with Schools of Nursing to have Nurse Practitioner students provide primary care services at local health care satellite sites.
7	Partner with restaurants or big box stores to donate surplus food for residents across the county.
8	Partner with speech therapy and audiology students at Montclair State University to help screen students at local schools.
9	Coordinate with school nurses to bring health services (such as vaccinations and physicals) into the schools.
10	Coordinate with Head Start and Early Head Start programs to invite staff from Federally Qualified Health Centers (FQHCs) to become part of their community advisory boards.
11	Help establish a position within school districts for a person to coordinate and connect students who need primary care to local FQHCs and other providers.
12	Facilitate door-to-door transportation like a tram/light rail that stops at the hospital and primary care centers.
13	Help streamline the process for local partners, like health officers, to secure NJ transit bus vouchers and train passes to assist individuals and families who need transport to health centers.
14	Provide transportation as needed for low-income families and others without reliable transportation to get to and from appointments.
15	Provide language line translation services to facilitate communication with new non-English speaking immigrants to assist with clinical care for this population.
16	Connect uninsured eligible residents with available resources to help them apply for Medicaid (NJ Family Care).
17	Expand the number of primary care providers in underserved areas.
18	Offer Essex County Office of Public Health Management (ECOPHM) services in the evening and weekends.

19	Assist with obtaining food vouchers/coupons/discounts from multiple local resources for healthy food delivery services.
20	Designate locations managed by the Essex County Office of Public Health Management (ECOPH) for eligible clients to apply for and receive WIC benefits.
21	Provide information about resources that can help individuals obtain assistance with affordable housing.
22	Offer translation services, such as bilingual navigators and health insurance case workers, to assist families with enrolling in NJ Family care.
23	Offer translation services, such as language line translation services to assist non-English speaking patients with accessing services.
24	Institute biannual health days where doctors/Nurse PAs give back to the community by visiting residents in a mobile health van.
25	Implement community programs focused on violence prevention and conflict resolution to improve overall community safety and health.
26	Create or enhance Essex County Office of Public Health Management (ECOPHM)/ County sponsored community wellness/fitness programs that promote physical activity.
27	Provide outreach such as cold calls from people (not recordings) to schedule screenings, immunizations, and other services.
28	Create a variety of clubs or initiatives for seniors to provide enriching opportunities for social engagement, skill development, and physical activity.
29	Link providers to a hub of volunteers who can assist with translation services in non-English speaking communities.
30	Host a series of health education events that focus on relevant topics for specific priority groups.
31	Host an annual meeting, to foster collaboration and networking among Essex County healthcare stakeholders.
32	Provide referrals to pediatric pulmonologists for free services for low-income children who have had two or more asthma exacerbations in schools.
33	Assist local health departments in accessing resources and initiatives that will enable them to offer more preventive care to vulnerable populations.
34	Advocate for state-level initiatives to facilitate coordinated, county-wide streamlined testing for TB, as well as referrals for chest X-rays and preventative treatment.
35	Enhance the role of the Essex County Office of Public Health Management (ECOPHM) in the monitoring and case management of latent (not active) tuberculosis (TB) services across Essex County.
36	Partner with local libraries to provide private spaces for accessing online therapists through services like Teladoc Health.
37	Facilitate mental health support for youth and young families in coordination with schools.
38	Promote integration of mental health services into primary care to provide comprehensive care and reduce stigma.
39	Facilitate use of dog therapy to visit the homebound.
40	Increase efforts toward raising sexually transmitted disease (STD) awareness and treatment.

41	Expand access to free dental clinics, preventive care, and education on oral hygiene.
42	Provide vaccination and purified protein derivative (PPD) skin testing services in communities for elementary school-aged children at municipal buildings.
43	Provide health education presentations to school assemblies and PTA groups.
44	Conduct regular community health needs assessments to identify and address gaps in services.
45	Implement robust data collection and reporting mechanisms to track outcomes and demonstrate the impact of services.
46	Utilize the mobile health van to continuously gather information about community needs and services.
47	Use local health departments to introduce youth to careers in health of all kinds.
48	Recruit interested youth to serve as health ambassadors in their communities.
49	Implement targeted public health education campaigns to raise awareness about preventive care, healthy lifestyles, immunizations, and local health resources.
50	Increase efforts to inform health providers of available resources in Essex County.
51	Maintain current information on comprehensive resources for primary and preventative care that is shared in multiple languages and in an accessible format, both online and in print.
52	Train and employ community health workers to screen and connect residents to necessary services.
53	Advocate for increased funding for needed services from state and federal sources.
54	Educate Essex County public health educators about Essex County Office of Public Health Management (ECOPHM) priority areas to enhance their awareness/knowledge about currently identified priority issues.
55	Enable Essex County Office of Public Health Management (ECOPHM) to train master trainers who can then educate public health educators.
56	Promote local and regional continuing education opportunities for Essex County public health officers and educators in relevant subjects, such as chronic disease self-management.
57	Improve the social media presence of Essex County Office of Public Health Management (ECOPHM).
58	Pursue features highlighting local health services, programs and resources on News 12.
59	Manage content on Instagram to highlight services and locations, with a strong emphasis on where the uninsured can go to receive assistance.
60	Implement a marketing campaign to advertise available services and emphasize their importance to the public.
61	Utilize a Facebook page as a marketing tool to inform the community about programs and services.
62	Engage principals/superintendents of schools to include on their websites information that directs parents to free medical/dental care.
63	Increase the use of mobile health vans for screenings and vaccinations.
64	Hire nurse practitioners to provide primary care services at satellite clinics.

65	Encourage community members to suggest locations for conducting mobile health van services.
66	Utilize mobile health vans at schools to provide needed services, such as primary care, urgent care, vision screening, dental care, immunizations, and referral services.
67	Establish mobile health van clinics in more places accessible to the communities that need it, such as houses of worship and schools.
68	Provide a one-stop place for new immigrants to get healthcare, such as purified protein derivative PPD skin test, vaccinations, Family Care services, and a first medical appointment with a provider.
69	Provide home-based care for those who are homebound and their caretakers.

Appendix B:

22 Priority Ideas by Strategic Objective

Localize Health Services
- Increase the use of mobile health vans for screenings and vaccinations (63) - Utilize mobile health vans at schools to provide needed services, such as primary care, urgent care, vision screening, dental care, immunizations, and referral services. (66) - Establish mobile health van clinics in more places accessible to the communities that need it, such as houses of worship and schools. (67) - Designate locations managed by the Essex County Office of Public Health Management (ECOPH) for eligible clients to apply for and receive WIC benefits(20) - Implement community programs focused on violence prevention and conflict resolution to improve overall community safety and health (25).
Enhance Collaboration
- Partner with Women, Infants, and Children (WIC) sites and Food Pantries to ensure all who qualify are enrolled. (1) - Partner with Essex County Federally Qualified Health Centers (FQHCs), such as Zufall Health, to schedule follow-up primary care appointments at the FQHCs in conjunction with the mobile health van visits (2).
Advance Health Education
- Increase efforts toward raising sexually transmitted disease (STD) awareness and treatment. (40) - Implement targeted public health education campaigns to raise awareness about preventive care, healthy lifestyles, immunizations, and local health resources.(49)
Centralize County Health Data Collection and Reporting
- Conduct regular community health needs assessments to identify and address gaps in services. (44) - Implement robust data collection and reporting mechanisms to track outcomes and demonstrate the impact of services. (45)
Develop Resource Awareness Tools
- Partner with community leaders to disseminate information about local health resources (3) - Connect uninsured eligible residents with available resources to help them apply for Medicaid (NJ Family Care) (16)

- Provide information about resources that can help individuals obtain assistance with affordable housing(21)
- Increase efforts to inform health providers of available resources in Essex County. (50)
- Engage principals/superintendents of schools to include on their websites information that directs parents to free medical/dental care.(62)
- Maintain current information on comprehensive resources for primary and preventative care that is shared in multiple languages and in an accessible format, both online and in print. (51)

Improve Language Translation Services

- Provide language line translation services to facilitate communication with new non-English speaking immigrants to assist with clinical care for this population.(15)
- Offer translation services, such as bilingual navigators and health insurance case workers, to assist families with enrolling in NJ Family care.(22)
- Offer translation services, such as language line translation services to assist non-English speaking patients with accessing services.(23)

Expand Advocacy to Secure Funding

- Assist local health departments in accessing resources and initiatives that will enable them to offer more preventive care to vulnerable populations.(33)
- Advocate for increased funding for needed services from state and federal sources.(53)

Appendix C: Roadmap for Action Guide

OVERVIEW – 2025 -2026 STRATEGIC GUIDE TO ENHANCE HEALTHCARE ACCESS

STRATEGIC OBJECTIVES & KEY RECOMMENDATIONS FOR IMPLEMENTATION

LOCALIZE HEALTH SERVICES

KEY STRATEGY: ***EXPAND THE USE OF MOBILE HEALTH SERVICE VANS WITHIN ESSEX COUNTY TO LOCALIZE HEALTH SERVICES: THIS STRATEGY PRESENTS AS THE OVERARCHING AND INTEGRATING INITIATIVE TO IMPROVE HEALTHCARE ACCESS, SUPPORTED BY THE OBJECTIVES AND RECOMMENDATIONS OUTLINED IN THIS STRATEGIC GUIDE.***

Key recommendations:

- Focus van services on preventative care, education & information sharing.
- Coordinate with existing mobile health services across the County to optimize van availability and deployment, targeting underserved areas and populations.
- Use van services to facilitate access to primary care homes and community services, also.

ENHANCE COLLABORATION

KEY STRATEGY: ***FOSTER SUSTAINABLE COALITIONS AND STRATEGIC PARTNERSHIPS***

Key Recommendations:

- Strengthen internal capacity/ability to build and sustain strategic partnerships.
- Co-locate services/leverage partnerships with FQHCs, schools & health departments.
- Integrate initiatives/programs into van services to address SDOH.
- **Enhance communications with partners/community**

ADVANCE HEALTH EDUCATION

Key Strategy: ***Create and lead county-wide health education campaigns***

Key Recommendations:

- **Build on existing health education campaigns (i.e., national & state campaigns)**
- **Partner with local schools and higher education to create content for campaigns**
- **Engage with community stakeholders to promote health messaging**

IMPROVE LANGUAGE TRANSLATION SERVICES

KEY STRATEGY: ***EXPAND AND FACILITATE THE USE OF LANGUAGE TRANSLATION SERVICES***

Key Recommendations:

- Increase use of language line translation services
- Employ linguistically culturally competent staff to complement the language line services.
- Partner with community leaders and institutions to develop training initiatives to increase the availability of culturally competent translators in community and clinical settings.
- Collaborate with the community to increase the availability of linguistically competent navigators and case workers
- Train clinical providers on using language line services and working with translators

CENTRALIZE COUNTY HEALTH DATA COLLECTION AND REPORTING

KEY STRATEGY: ***LEAD COORDINATION OF DATA COLLECTION AND REPORTING EFFORTS WITHIN THE COUNTY***

Key Recommendations:

- **Conduct a pilot project to coordinate data reporting across public health offices**
- **Facilitate the adoption of clear, coordinated goals among the County's public health offices to guide data handling and access at the County level.**
- **Plan and allocate resources to advance a coordinated initiative to handle and report data at the County level**
- **Enhance visibility and raise awareness about ECOPHM's current capacity and role for data management and reporting.**

DEVELOP RESOURCE AWARENESS TOOL

KEY STRATEGY: ***DEVELOP AND MAINTAIN A HEALTH & COMMUNITY SERVICES INFORMATION REPOSITORY***

Key Recommendations

- Ensure robust data vetting & maintain current information
- Disseminate information via multiple accessible channels
- Enable independent, consumer-friendly access to information

EXPAND ADVOCACY TO SECURE PUBLIC HEALTH FUNDING

KEY STRATEGY: ***BOLSTER CAPACITY TO FOSTER INCREASED FUNDING SUPPORT FOR PUBLIC HEALTH INITIATIVES***

Key Recommendations:

- Explore and adopt innovative funding models for public health
- Engage with the private philanthropy sector to communicate priority health needs and collaborate on directing funding to community organizations addressing SDOH.
- Pursue legislative mandates to secure sustainable public health funding.

OVERVIEW – 2025 -2026 STRATEGIC GUIDE TO ENHANCE HEALTHCARE ACCESS

CROSS-CUTTING RECOMMENDATIONS TO SUPPORT THE IMPLEMENTATION OF THE STRATEGIC OBJECTIVES

Cross-cutting themes, linking the seven strategic objectives and recommendations for implementation, emphasize the importance of adopting intentional, culturally competent and coordinated community-based public health initiatives to improve access to preventative and primary care, and to address social health determinants.

- **Ensure stakeholder trust and community engagement:** Increase ECOPHM's visibility and communication among stakeholders and partners. Enhance community-based partnerships and engagement by dedicating resources to facilitate collaborations and partnerships. Promote transparency in data collection, management, and usage.
- **Ensure equity and accessibility for marginalized groups:** Foster intentional efforts to provide culturally and linguistically competent services, focusing on equity in primary and preventive healthcare, targeting underserved communities. Implement strategies that focus on localizing and tailoring services that align with the needs and culture of the targeted communities and locations.
- **Enhance coordination across agencies and systems: L**ead initiatives to coordinate services for maximum impact and effectiveness through resource alignment. Streamline and guide collaborative efforts to address access barriers, including social determinants of health.
- **Ensure planning and intentional actions to affect an integrated strategy to improve healthcare access:** Develop a comprehensive plan to implement the seven objectives. The strategic implementation plan should consider long-term investments in capacity building, including infrastructure, staffing, and programmatic sustainability. Incorporate an evaluation component to measure the impact and effectiveness of planned initiatives.

NOTE: *The findings and recommendations in this study do not imply that they are not already present, but rather that participants considered them crucial for Essex County to successfully implement strategies to enhance access to primary and preventive care.*

For further details regarding the Essex County Healthcare Access Feasibility Study findings and recommendations, please see the full report: Essex County Office of Public Health Management-Access to Care Feasibility Study.

Appendix D:

Stakeholder Inventory and Analysis

The stakeholder inventory and analysis comprised the first phase of the Healthcare Access Feasibility Study. In this phase, we identified a diverse pool of stakeholders, assessed their interests, concerns, and influence relative to the project. The goal was to manage stakeholders' engagement effectively and ensure that diverse perspectives and needs were considered and included in the study. This step informed and facilitated decision-making regarding participant engagement across the subsequent phases of the study.

The process included working with the ECOPHM team to compile a comprehensive list of knowledgeable or affected individuals or groups who could impact or be affected by the project or could bring different perspectives on the issue. We identified a pool of 207 potential participants. By iteratively vetting the list with the ECOPHM, we created a final database of prospective participants, a representative set of 169 individuals who were invited to join one or more parts of the Study. This final stakeholder set of 169 individuals included diverse representatives from various invested parties, ensuring balanced representation. Tables 1 and 2 show the municipalities and sectors represented

The stakeholder database enabled the creation of a stakeholder matrix to strategically target potential participants, facilitating communication, outreach, and participant engagement throughout the study. The matrix categorizes stakeholders by sector based on their relationship with, or interest in, healthcare and access issues, as described below:

a) **Key Stakeholders:** Decision makers, funders; policy makers, potential partners.

b) **Informers:** Subject matter experts: knowledge sources

c) **Consumer Representatives or Residents:** Those with experience and/or insight into consumer healthcare access needs, priorities and challenges

d) **Influencers:** Those indirectly impacted, including funders; distractors; or otherwise interested parties.

To ensure inclusion and participation, stakeholders in the final database received multiple strategic communications. To introduce the project and encourage participation, the Essex County Executive first sent background information and an invitation to join the Feasibility Study. Subsequent outreach and communications involved invitations for each Study component, timely reminders, and targeted outreach by both the ECOPHM and the consultants to encourage participation across each phase of the Study.

Table 1

Municipalities Represented in Stakeholder List

Table 1 shows the number of stakeholders representing each of the municipalities in Essex County. Essex Fells, Caldwell, and Glen Ridge are the only municipalities not represented.

*Many stakeholders represent or serve multiple municipalities

Municipality	Stakeholder Count
Bellville	4
Bloomfield	19
Caldwell	—
Cedar Grove	1
East Orange	6
Essex Fells	—
Fairfield	2
Glen Ridge	—
Irvington	10
Livingston	9
Maplewood	5
Millburn	2
Montclair	14
Newark	25
North Caldwell	1
Nutley	3
Orange	8
Roseland	1
South Orange	2
Verona	2
West Caldwell	8
West Orange	16
Multiple Municipalities*	31

Table 2

Sectors Represented in Stakeholder List

Table 2 shows the sectors represented by stakeholders identified in the stakeholder inventory and analysis.

Sector	Stakeholder Count
Community Based Organizations/Local Schools	44
Education	6
Healthcare Clinicians	3
Hospitals/FQHCs/Other Healthcare Org.	22
Local & County Government	9
Local Public Health Nurses/Managers	28
Other Public Health	41
Public Health Officers/Back-Ups	14
School Nurses	2

Appendix E:

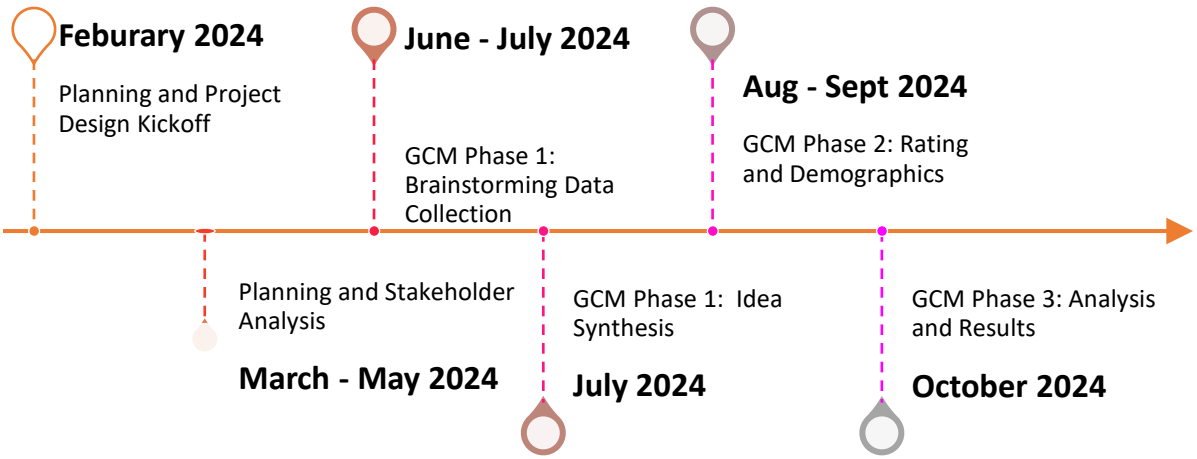
Modified Group Concept Mapping Methods

GCM is a highly participatory research method that intentionally elicits ideas from any or all individuals in a group, assesses the perceived conceptual similarities of those ideas, rates their importance and capacity for action, and informs plans for follow up on critical findings. For the Essex County Access to Healthcare Feasibility Study (Feasibility Study), we used a modified GCM process to best fit the goals and objectives of the study.

Figure 1 describes the Feasibility Study's timeframe and associated activities that enabled completion of the project between January 2024 and March 2025.

Figure 1

Modified GCM Project Timeframe



The project began in early 2024 with the Concept Systems, Inc (CSI) and the Essex County Office of Public Health Management (ECOPHM) project team members meeting to confirm the project's parameters and goals, and to discuss the overall project design. These early meetings entailed finalizing the focus prompt and the preamble language for the brainstorming data collection step. Together, CSI and ECOPHM also identified (see Appendix D) and recruited participants for the study and facilitated vital decision-making and communications throughout the project relative to stakeholder engagement.

The stakeholder engagement and modified GCM process progressed over several months, in conjunction with other data collection activities

Modified Group Concept Mapping to Inform Healthcare Access

The purpose of this Feasibility Study was to identify strategies to enhance healthcare access for all Essex County residents. This project focused on a broad range of Essex County Healthcare, Health System, and Public Health stakeholders (see Appendix D) to inform this effort. This

appendix describes the planning and modified Group Concept Mapping activities, the data produced and the results from the GCM process.

Group Concept Mapping (GCM) involves a participatory, multi-step process designed to build a co-authored framework for strategic planning to create a workable action plan. It elicits ideas from many individuals and produces a group-authored framework that encompasses all related ideas and reflects the priorities and perspectives of those engaged in the process. The results allow an organization or group to interpret and assess their own opinions and values collectively, and to prepare plans to address the priority findings.

In collaboration with ECOPHM leaders, the CSI team developed a focus prompt to stimulate discussion and meaningful input from all stakeholders. A focus prompt is a one-question catalyst to generate brainstorming on an issue of relevance to the participant; it is typically phrased as a sentence completion prompt.

The focus prompt for this project was:

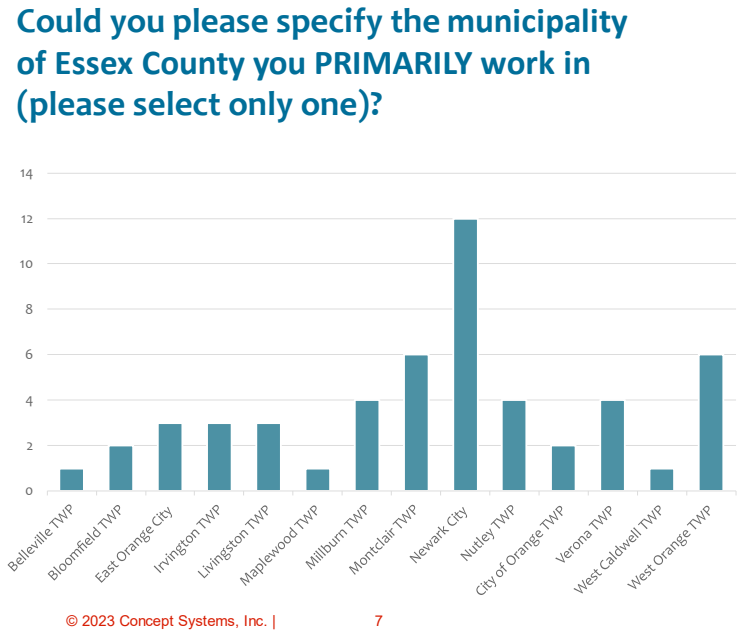
"A specific thing the Essex County Office of Public Health Management can do to improve access to primary and preventive health care services across the County is……"

Who Took Part: Demographics

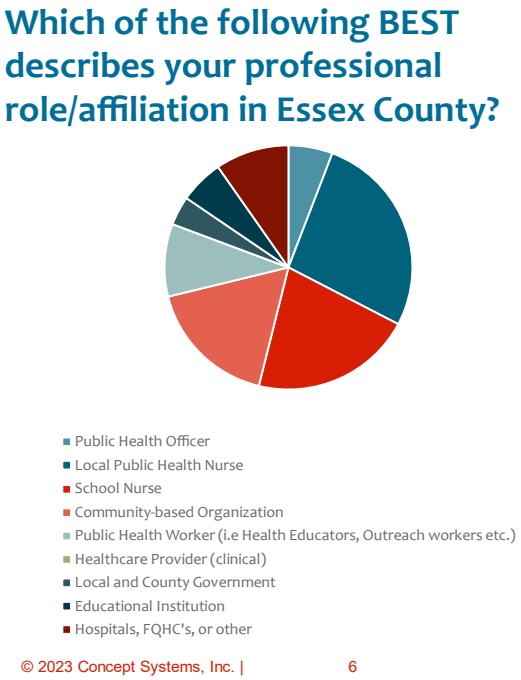
The study collected demographic information from participants via specific *Participant Questions* included in the GCM activities, which consisted of brainstorming and rating activities. Demographic information enables comparisons regarding values and observations between and among groups, if there is enough participants in a subgroup. Figures 2 and 3 show the demographic questions asked of participants for the brainstorming and rating activities, and their responses.

Figure 2

Participant Questions Results: Brainstorming Activity



Municipality	Frequency	Percent (%)
Belleville TWP	1	1.92%
Bloomfield TWP	2	3.85%
Caldwell Boro TWP	0	0.00%
Cedar Grove TWP	0	0.00%
East Orange City	3	5.77%
Essex Fells TWP	0	0.00%
Fairfield TWP	0	0.00%
Glen Ridge Boro TWP	0	0.00%
Irvington TWP	3	5.77%
Livingston TWP	3	5.77%
Maplewood TWP	1	1.92%
Millburn TWP	4	7.69%
Montclair TWP	6	11.54%
Newark City	12	23.08%
North Caldwell Boro	0	0.00%
Nutley TWP	4	7.69%
City of Orange TWP	2	3.85%
Roseland Boro	0	0.00%
South Orange Village TWP	0	0.00%
Verona TWP	4	7.69%
West Caldwell TWP	1	1.92%
West Orange TWP	6	11.54%



Please select your primary role:	Frequency	Percent (%)
Public Health Officer	3	5.77%
Local Public Health Nurse	14	26.92%
School Nurse	11	21.15%
Community-based Organization	9	17.31%
Public Health Worker (i.e Health Educators, Outreach workers etc.)	5	9.62%
Healthcare Provider (clinical)	0	0.00%
Local and County Government	2	3.85%
Educational Institution	3	5.77%
Hospitals, FQHC's, or other	5	9.62%
	52	100

Figure 3

Participant Questions Results: Rating Activity

Q2: Could you please specify the municipality of Essex County you PRIMARILY work in (please select only one)?

- Answered: 27 | Skipped: 0

ANSWER CHOICES	RESPONSES
Belleville TWP	0
Bloomfield TWP	4
Caldwell Boro TWP	0
Cedar Grove TWP	0
East Orange City	2
Essex Fells TWP	0
Fairfield TWP	0
Glen Ridge Boro TWP	0
Irvington TWP	2
Livingston TWP	2
Maplewood TWP	0
Millburn TWP	0

ANSWER CHOICES	RESPONSES
Montclair TWP	2
Newark City	7
North Caldwell Boro	0
Nutley TWP	2
City of Orange TWP	1
Roseland Boro	0
South Orange Village TWP	0
Verona TWP	1
West Caldwell TWP	2
West Orange TWP	2
TOTAL	27

Powered by SurveyMonkey

Q1: Which of the following BEST describes your professional role/affiliation in Essex County?

- Answered: 27 | Skipped: 0

ANSWER CHOICES	RESPONSES	
Public Health Officer	7.41%	2
Local Public Health Nurse	40.74%	11
School Nurse	3.70%	1
Community-based Organization	18.52%	5
Public Health Worker (i.e Health Educators, Outreach workers etc.)	11.11%	3
Healthcare Provider (clinical)	0.00%	0
Local and County Government	7.41%	2
Educational Institution	11.11%	3
Hospitals, FQHC's, or other	0.00%	0
TOTAL		27

Powered by SurveyMonkey

Contributing Content: Brainstorming

As noted above, CSI worked with the ECOPHM team to invite the 169 individuals identified as stakeholders to participate in the Study. Stakeholders were invited to contribute responses to the brainstorming focus prompt via an online survey distributed on SurveyMonkey. The Brainstorming survey was open during the months of June and July 2024. During that timeframe, 52 individuals contributed 124 unique ideas in response to the focus prompt.

After editing the 124 brainstorming ideas and eliminating redundancies, CSI collaborated with ECOPHM to finalize the list, refining it to 69 unique items, while retaining the integrity of all the ideas submitted. The final list of items is included in Appendix D.1 The brainstorming items are the building blocks of the GCM process, as participants use these items in the Rating activity to provide guidance on values and priorities.

Structuring the Ideas: Value Ratings

160 of the 169 stakeholders identified in the stakeholder analysis process were again invited to take part in the second GCM step of rating (nine of the original stakeholders were removed from the list, due to emails bouncing back during the brainstorming activity.)

The ratings data collected from each participant shows the commonly shared values and differing opinions among the participant groups. The rating step is considered part of the "sensemaking" process, which allows for deeper understanding of how participants experience the concepts addressed in this study. The result of this process is a framework authored by all participants that offers insight about the group's perceptions of the value and prioritization of the stated topic.

In the rating step, we asked participants to respond to two rating questions for each of the 69 unique brainstormed items, as listed in Table 1 below. Participants received the following instructions:

Table 1

Ratings questions and response options

Importance				
For each of the 69 ideas presented in this survey, please select a number from 1 to 5 to rate **how important you think the** idea is for increasing healthcare access in Essex County, in relation to the other ideas.				
1 Relatively Unimportant	2	3	4	5 Extremely Important

Current Presence				
For each of the 69 ideas presented in this survey, please select a number from 1 to 5 to rate **how feasible or doable you think it is** for the idea to be implemented in Essex County.				
1 Not Feasible	2	3	4	5 Very Feasible

After participants submitted ratings, the CSI team reviewed each individual rating in order to determine if they should be included in the analysis. This step ensures that only thoughtfully considered data is used in the analysis. Below are commonly used guidelines for marking participant data for inclusion:

- Did the participant use at least three of the numbers on the rating scale (i.e., they did not use all 3s and 4s, or all 4s)?
- Does the order of ratings used seem to indicate that the participant thoughtfully completed the activity (i.e., the first third of the statements are not all "4s", the second third all "3s," the last third all "2"s)?

There were several participants whose data was rejected due to their not meeting the specified requirements as noted above. For example, a couple of participants rated all the statements with the same rating value. In total, 29 participants completed and were approved for at least one rating activity. Most of the participants completed and were approved for both activities. The total number of participants who submitted usable input for each activity can be found below.

- 29 participants contributed usable input on the *Importance* rating
- 27 participants contributed usable input on the *Feasibility* rating

Ratings Results: Values and Observations

We used two rating scales to gather feedback on Importance and Feasibility from participants, using a 5-point scale for each. (see Table 1 for the rating questions and response options). The resulting data helps us to identify priority ideas from the group. The Go-zones generated in the GCM process enable identification of concepts and individual ideas that have high value for implementation planning, and those that are less urgent. Tables 2-5 depict the top five highest and lowest rated ideas for importance and feasibility. All items were rated relatively *high* for

both importance and feasibility, with the average importance ratings ranging from 3.38-4.77 (out of 5) and the average feasibility ratings ranging from 3.13-4.58 (out of 5). See appendices D.2-D.3 for the average Importance and Feasibility ratings for each statement.

Table 2

Five Highest Rated Importance Statements

#	*STATEMENT*	*AVG RATING*
38	Promote integration of mental health services into primary care to provide comprehensive care and reduce stigma.	4.77
41	Expand access to free dental clinics, preventive care, and education on oral hygiene.	4.77
23	Offer translation services, such as language line translation services to assist non-English speaking patients with accessing services.	4.69
37	Facilitate mental health support for youth and young families in coordination with schools.	4.69
53	Advocate for increased funding for needed services from state and federal sources.	4.68

Table 3

Five Lowest Rated Importance Statements

#	*STATEMENT*	*AVG RATING*
31	Host an annual meeting, to foster collaboration and networking among Essex County healthcare stakeholders.	3.88
18	Offer Essex County Office of Public Health Management (ECOPHM) services in the evening and weekends.	3.88
8	Partner with speech therapy and audiology students at Montclair State University to help screen students at local schools.	3.81
27	Provide outreach such as cold calls from people (not recordings) to schedule screenings, immunizations, and other services.	3.58
39	Facilitate use of dog therapy to visit the homebound.	3.38

Table 4

Five Highest Rated Feasibility Statements

#	*STATEMENT*	*AVG RATING*
15	Provide language line translation services to facilitate communication with new non-English speaking immigrants to assist with clinical care for this population.	4.58
59	Manage content on Instagram to highlight services and locations, with a strong emphasis on where the uninsured can go to receive assistance.	4.54
23	Offer translation services, such as language line translation services to assist non-English speaking patients with accessing services.	4.5
53	Advocate for increased funding for needed services from state and federal sources.	4.5
57	Improve the social media presence of Essex County Office of Public Health Management (ECOPHM).	4.5

Table 5

Five Lowest Rated Feasibility Statements

#	*STATEMENT*	*AVG RATING*
17	Expand the number of primary care providers in underserved areas.	3.30
42	Provide vaccination and purified protein derivative (PPD) skin testing services in communities for elementary school-aged children at municipal buildings.	3.25
27	Provide outreach such as cold calls from people (not recordings) to schedule screenings, immunizations, and other services.	3.17
39	Facilitate use of dog therapy to visit the homebound.	3.17
12	Facilitate door-to-door transportation like a tram/light rail that stops at the hospital and primary care centers.	3.13

Of the 69 statements used for the ratings activity, more than 10% (n=7) specifically referenced the use of mobile health vans to increase access to healthcare in Essex County, suggesting that mobile vans could be a priority for implementation and expansion within the county. All items referencing mobile health vans received high importance ratings, with none having an average rating below 4.08 (out of 5). These items were also rated high for feasibility, with none having an average rating below 3.5 (out of 5) Table 6 presents the importance ratings for each of the statements that reference mobile health vans.

Table 6

Mobile Health Van Statement Importance

IMPORTANCE RANK (out of 69)	STATEMENT	AVG IMPORTANCE RATING	AVG FEASIBILITY RATING
11	Increase the use of mobile health vans for screenings and vaccinations.	4.60	4.25
21	Utilize mobile health vans at schools to provide needed services, such as primary care, urgent care, vision screening, dental care, immunizations, and referral services.	4.48	4.13
25	Establish mobile health van clinics in more places accessible to the communities that need it, such as houses of worship and schools.	4.44	4.13
27	Partner with Essex County Federally Qualified Health Centers (FQHCs), such as Zufall Health, to schedule follow-up primary care appointments at the FQHCs in conjunction with the mobile health van visits.	4.38	4.17
41	Utilize the mobile health van to continuously gather information about community needs and services.	4.19	4.25
51	Encourage community members to suggest locations for conducting mobile health van services.	4.08	4.04
52	Institute biannual health days where doctors/Nurse PAs give back to the community by visiting residents in a mobile health van.	4.08	3.5

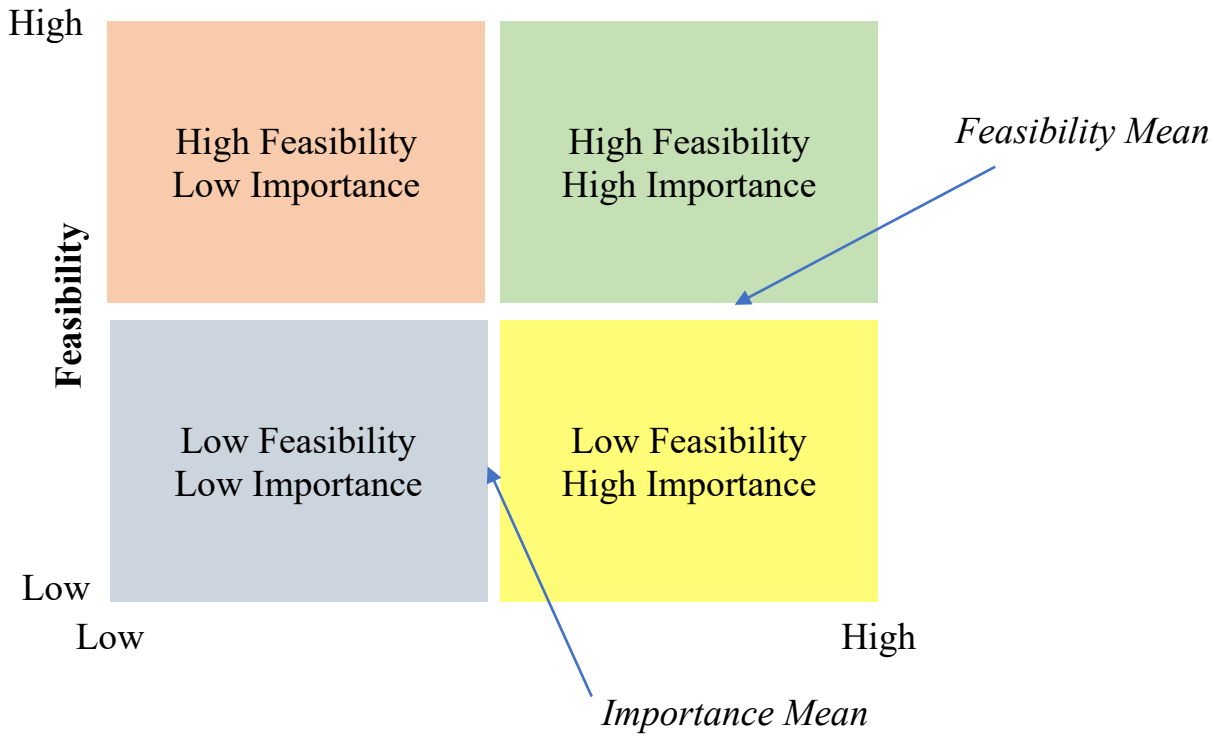
Ratings Results: Go-Zones

A Go-zone displays stakeholder values for each brainstorming item included in the project: this enables a more in-depth understanding of the issue at hand. Go-zones allow decision-makers to observe the relationship and relative value of concepts at an organizational or strategic level; they facilitate discussion among planners and the use of tactical or objective level details.

Go-zones use ratings data to show how important and present each statement is. This helps prioritize ideas for implementation planning. The Go-zone is a color-coded scatterplot. Figure 4 illustrates the application of Go-Zones and their use for the Essex County Access to Care Feasibility Study. The green (or "go") quadrant contains ideas that rated high for both importance and feasibility. The yellow and orange quadrants highlight the "gap" areas, where one rating is higher on average than the other rating. The grey quadrant is an agreement zone: this quadrant shows ideas that are rated as less important and feasible, relative to other ideas.

Figure 4

Essex County Access to Care Feasibility Study Go-Zone Explanation



We consider ideas in the green zone to offer the most support for immediate action, because participants rated those items as relatively *more* important *and* feasible than other items. These ideas represent the priority areas of focus for improving access to primary and preventive healthcare in Essex County.

Go-zone analyses enable stakeholders to view the detailed contents of the brainstorming data to support decision-making while keeping the larger conceptual view in mind. Each go-zone has an *r* value, a correlation coefficient. The *r* values range from -1.00 to +1.00: And it indicates the degree of the predictable relationship between the two rating value results as represented in the go-zone. The higher the absolute value of the *r* value, the more predictable the relationship. The *r* values help us observe the level of alignment between each item's importance and feasibility; it is helpful in planning and prioritizing for action and implementation.

We include here a Go-zone that plots each statement based on its average rating for both importance and feasibility, followed by a table of statements color-coded by the quadrant of the Go-zone they inhabit. The Go-zones help us understand prioritization of which items were rated the highest in importance and current presence. (See Appendix D.4 for a list of all statements and the Go-Zone quadrant they fall into.)

Figure 5

Go-zone: All Statements – Essex County Access to Care Feasibility Study

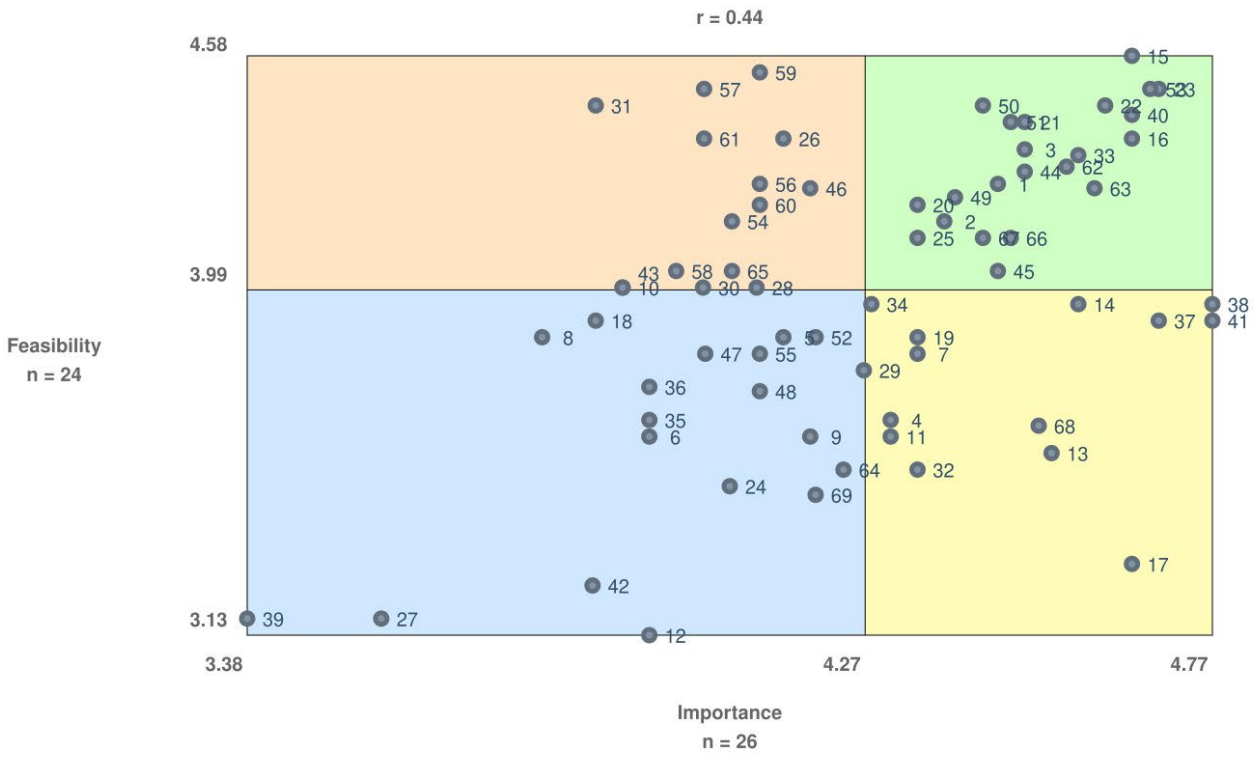


Figure 5 above shows the Go-zone for all statements in the Feasibility Study. Twenty-two items, listed in Table 7, are in the green zone, which represents the priority ideas for implementation to improve access to healthcare in Essex County. These ideas were rated the highest for both importance and feasibility.

Table 7

Essex County Access to Care Priority Statements: Green Go-Zone Quadrant

R=0.44			
		Importance Scale [3.38]-[4.76] Median =2.38 n=26	Feasibility Scale [3.12]-[4.58] Median=2.29 n=24
#	**Statements**	**Average Rating**	**Average Rating**
67	Establish mobile health van clinics in more places accessible to the communities that need it, such as houses of worship and schools.	4.44	4.12
66	Utilize mobile health vans at schools to provide needed services, such as primary care, urgent care, vision screening, dental care, immunizations, and referral services.	4.48	4.12
63	Increase the use of mobile health vans for screenings and vaccinations.	4.60	4.25
62	Engage principals/superintendents of schools to include on their websites information that directs parents to free medical/dental care.	4.56	4.30
53	Advocate for increased funding for needed services from state and federal sources.	4.68	4.50
51	Maintain current information on comprehensive resources for primary and preventative care that is shared in multiple languages and in an accessible format, both online and in print.	4.48	4.41
50	Increase efforts to inform health providers of available resources in Essex County.	4.44	4.45
49	Implement targeted public health education campaigns to raise awareness about preventive care, healthy lifestyles, immunizations, and local health resources.	4.40	4.22
45	Implement robust data collection and reporting mechanisms to track outcomes and demonstrate the impact of services.	4.46	4.04
44	Conduct regular community health needs assessments to identify and address gaps in services.	4.50	4.29
40	Increase efforts toward raising sexually transmitted disease (STD) awareness and treatment.	4.65	4.43
33	Assist local health departments in accessing resources and initiatives that will enable them to offer more preventive care to vulnerable populations.	4.57	4.33

25	Implement community programs focused on violence prevention and conflict resolution to improve overall community safety and health.	4.34	4.12
23	Offer translation services, such as language line translation services to assist non-English speaking patients with accessing services.	4.69	4.50
22	Offer translation services, such as bilingual navigators and health insurance case workers, to assist families with enrolling in NJ Family care.	4.61	4.45
21	Provide information about resources that can help individuals obtain assistance with affordable housing.	4.50	4.41
20	Designate locations managed by the Essex County Office of Public Health Management (ECOPH) for eligible clients to apply for and receive WIC benefits.	4.34	4.20
16	Connect uninsured eligible residents with available resources to help them apply for Medicaid (NJ Family Care).	4.65	4.37
15	Provide language line translation services to facilitate communication with new non-English speaking immigrants to assist with clinical care for this population.	4.65	4.58
3	Partner with community leaders to disseminate information about local health resources.	4.50	4.34
2	Partner with Essex County Federally Qualified Health Centers (FQHCs), such as Zufall Health, to schedule follow-up primary care appointments at the FQHCs in conjunction with the mobile health van visits.	4.38	4.16
1	Partner with Women, Infants, and Children (WIC) sites and Food Pantries to ensure all who qualify are enrolled.	4.46	4.26

Next Steps & Recommendations

This GCM data was used to inform the final phase of the Feasibility Study, which consisted of key informant interviews. The twenty-two priority statements identified in the Go-Zone Rating analysis guided the development of the interview approach and question development. The interview data was combined with the GCM data to develop recommendations for a "Roadmap for Action," that consists of seven strategic objectives to increase access to primary and preventive care in Essex County. For the discussion of the combined results and Feasibility Study findings, please review the full report.

Appendix D.1: Final GCM Statement Set

#	Statements
1	Partner with Women, Infants, and Children (WIC) sites and Food Pantries to ensure all who qualify are enrolled.
2	Partner with Essex County Federally Qualified Health Centers (FQHCs), such as Zufall Health, to schedule follow-up primary care appointments at the FQHCs in conjunction with the mobile health van visits.
3	Partner with community leaders to disseminate information about local health resources.
4	Partner with local providers, such as Summit Health or Care Station, to offer access to more clinical treatment services where needed.
5	Partner with local pharmacies to offer preventative services such as blood pressure checks, immunizations, and cholesterol screenings.
6	Partner with Schools of Nursing to have Nurse Practitioner students provide primary care services at local health care satellite sites.
7	Partner with restaurants or big box stores to donate surplus food for residents across the county.
8	Partner with speech therapy and audiology students at Montclair State University to help screen students at local schools.
9	Coordinate with school nurses to bring health services (such as vaccinations and physicals) into the schools.
10	Coordinate with Head Start and Early Head Start programs to invite staff from Federally Qualified Health Centers (FQHCs) to become part of their community advisory boards.
11	Help establish a position within school districts for a person to coordinate and connect students who need primary care to local FQHCs and other providers.
12	Facilitate door-to-door transportation like a tram/light rail that stops at the hospital and primary care centers.
13	Help streamline the process for local partners, like health officers, to secure NJ transit bus vouchers and train passes to assist individuals and families who need transport to health centers.
14	Provide transportation as needed for low-income families and others without reliable transportation to get to and from appointments.
15	Provide language line translation services to facilitate communication with new non-English speaking immigrants to assist with clinical care for this population.
16	Connect uninsured eligible residents with available resources to help them apply for Medicaid (NJ Family Care).
17	Expand the number of primary care providers in underserved areas.
18	Offer Essex County Office of Public Health Management (ECOPHM) services in the evening and weekends.
19	Assist with obtaining food vouchers/coupons/discounts from multiple local resources for healthy food delivery services.
20	Designate locations managed by the Essex County Office of Public Health Management (ECOPH) for eligible clients to apply for and receive WIC benefits.

21	Provide information about resources that can help individuals obtain assistance with affordable housing.
22	Offer translation services, such as bilingual navigators and health insurance case workers, to assist families with enrolling in NJ Family care.
23	Offer translation services, such as language line translation services to assist non-English speaking patients with accessing services.
24	Institute biannual health days where doctors/Nurse PAs give back to the community by visiting residents in a mobile health van.
25	Implement community programs focused on violence prevention and conflict resolution to improve overall community safety and health.
26	Create or enhance Essex County Office of Public Health Management (ECOPHM)/ County sponsored community wellness/fitness programs that promote physical activity.
27	Provide outreach such as cold calls from people (not recordings) to schedule screenings, immunizations, and other services.
28	Create a variety of clubs or initiatives for seniors to provide enriching opportunities for social engagement, skill development, and physical activity.
29	Link providers to a hub of volunteers who can assist with translation services in non-English speaking communities.
30	Host a series of health education events that focus on relevant topics for specific priority groups.
31	Host an annual meeting, to foster collaboration and networking among Essex County healthcare stakeholders.
32	Provide referrals to pediatric pulmonologists for free services for low-income children who have had two or more asthma exacerbations in schools.
33	Assist local health departments in accessing resources and initiatives that will enable them to offer more preventive care to vulnerable populations.
34	Advocate for state-level initiatives to facilitate coordinated, county-wide streamlined testing for TB, as well as referrals for chest X-rays and preventative treatment.
35	Enhance the role of the Essex County Office of Public Health Management (ECOPHM) in the monitoring and case management of latent (not active) tuberculosis (TB) services across Essex County.
36	Partner with local libraries to provide private spaces for accessing online therapists through services like Teladoc Health.
37	Facilitate mental health support for youth and young families in coordination with schools.
38	Promote integration of mental health services into primary care to provide comprehensive care and reduce stigma.
39	Facilitate use of dog therapy to visit the homebound.
40	Increase efforts toward raising sexually transmitted disease (STD) awareness and treatment.
41	Expand access to free dental clinics, preventive care, and education on oral hygiene.
42	Provide vaccination and purified protein derivative (PPD) skin testing services in communities for elementary school-aged children at municipal buildings.
43	Provide health education presentations to school assemblies and PTA groups.

44	Conduct regular community health needs assessments to identify and address gaps in services.
45	Implement robust data collection and reporting mechanisms to track outcomes and demonstrate the impact of services.
46	Utilize the mobile health van to continuously gather information about community needs and services.
47	Use local health departments to introduce youth to careers in health of all kinds.
48	Recruit interested youth to serve as health ambassadors in their communities.
49	Implement targeted public health education campaigns to raise awareness about preventive care, healthy lifestyles, immunizations, and local health resources.
50	Increase efforts to inform health providers of available resources in Essex County.
51	Maintain current information on comprehensive resources for primary and preventative care that is shared in multiple languages and in an accessible format, both online and in print.
52	Train and employ community health workers to screen and connect residents to necessary services.
53	Advocate for increased funding for needed services from state and federal sources.
54	Educate Essex County public health educators about Essex County Office of Public Health Management (ECOPHM) priority areas to enhance their awareness/knowledge about currently identified priority issues.
55	Enable Essex County Office of Public Health Management (ECOPHM) to train master trainers who can then educate public health educators.
56	Promote local and regional continuing education opportunities for Essex County public health officers and educators in relevant subjects, such as chronic disease self-management.
57	Improve the social media presence of Essex County Office of Public Health Management (ECOPHM).
58	Pursue features highlighting local health services, programs and resources on News 12.
59	Manage content on Instagram to highlight services and locations, with a strong emphasis on where the uninsured can go to receive assistance.
60	Implement a marketing campaign to advertise available services and emphasize their importance to the public.
61	Utilize a Facebook page as a marketing tool to inform the community about programs and services.
62	Engage principals/superintendents of schools to include on their websites information that directs parents to free medical/dental care.
63	Increase the use of mobile health vans for screenings and vaccinations.
64	Hire nurse practitioners to provide primary care services at satellite clinics.
65	Encourage community members to suggest locations for conducting mobile health van services.
66	Utilize mobile health vans at schools to provide needed services, such as primary care, urgent care, vision screening, dental care, immunizations, and referral services.

67	Establish mobile health van clinics in more places accessible to the communities that need it, such as houses of worship and schools.
68	Provide a one-stop place for new immigrants to get healthcare, such as purified protein derivative PPD skin test, vaccinations, Family Care services, and a first medical appointment with a provider.
69	Provide home-based care for those who are homebound and their caretakers.

Appendix D.2: Statements and their Importance Ratings

Range [3.38]-[4.77]; n = 26

#	Statements	Average Importance Rating
67	Establish mobile health van clinics in more places accessible to the communities that need it, such as houses of worship and schools.	4.44
66	Utilize mobile health vans at schools to provide needed services, such as primary care, urgent care, vision screening, dental care, immunizations, and referral services.	4.48
63	Increase the use of mobile health vans for screenings and vaccinations.	4.60
62	Engage principals/superintendents of schools to include on their websites information that directs parents to free medical/dental care.	4.56
53	Advocate for increased funding for needed services from state and federal sources.	4.68
51	Maintain current information on comprehensive resources for primary and preventative care that is shared in multiple languages and in an accessible format, both online and in print.	4.48
50	Increase efforts to inform health providers of available resources in Essex County.	4.44
49	Implement targeted public health education campaigns to raise awareness about preventive care, healthy lifestyles, immunizations, and local health resources.	4.40
45	Implement robust data collection and reporting mechanisms to track outcomes and demonstrate the impact of services.	4.46
44	Conduct regular community health needs assessments to identify and address gaps in services.	4.50
40	Increase efforts toward raising sexually transmitted disease (STD) awareness and treatment.	4.65
33	Assist local health departments in accessing resources and initiatives that will enable them to offer more preventive care to vulnerable populations.	4.57
25	Implement community programs focused on violence prevention and conflict resolution to improve overall community safety and health.	4.34
23	Offer translation services, such as language line translation services to assist non-English speaking patients with accessing services.	4.69
22	Offer translation services, such as bilingual navigators and health insurance case workers, to assist families with enrolling in NJ Family care.	4.61
21	Provide information about resources that can help individuals obtain assistance with affordable housing.	4.50

20	Designate locations managed by the Essex County Office of Public Health Management (ECOPH) for eligible clients to apply for and receive WIC benefits.	4.34
16	Connect uninsured eligible residents with available resources to help them apply for Medicaid (NJ Family Care).	4.65
15	Provide language line translation services to facilitate communication with new non-English speaking immigrants to assist with clinical care for this population.	4.65
3	Partner with community leaders to disseminate information about local health resources.	4.50
2	Partner with Essex County Federally Qualified Health Centers (FQHCs), such as Zufall Health, to schedule follow-up primary care appointments at the FQHCs in conjunction with the mobile health van visits.	4.38
1	Partner with Women, Infants, and Children (WIC) sites and Food Pantries to ensure all who qualify are enrolled.	4.46
65	Encourage community members to suggest locations for conducting mobile health van services.	4.08
61	Utilize a Facebook page as a marketing tool to inform the community about programs and services.	4.04
60	Implement a marketing campaign to advertise available services and emphasize their importance to the public.	4.12
59	Manage content on Instagram to highlight services and locations, with a strong emphasis on where the uninsured can go to receive assistance.	4.12
58	Pursue features highlighting local health services, programs and resources on News 12.	4.00
57	Improve the social media presence of Essex County Office of Public Health Management (ECOPHM).	4.04
56	Promote local and regional continuing education opportunities for Essex County public health officers and educators in relevant subjects, such as chronic disease self-management.	4.12
54	Educate Essex County public health educators about Essex County Office of Public Health Management (ECOPHM) priority areas to enhance their awareness/knowledge about currently identified priority issues.	4.08
46	Utilize the mobile health van to continuously gather information about community needs and services.	4.19
43	Provide health education presentations to school assemblies and PTA groups.	3.92
31	Host an annual meeting, to foster collaboration and networking among Essex County healthcare stakeholders.	3.88
30	Host a series of health education events that focus on relevant topics for specific priority groups.	4.03

28	Create a variety of clubs or initiatives for seniors to provide enriching opportunities for social engagement, skill development, and physical activity.	4.11
26	Create or enhance Essex County Office of Public Health Management (ECOPHM)/ County sponsored community wellness/fitness programs that promote physical activity.	4.15
10	Coordinate with Head Start and Early Head Start programs to invite staff from Federally Qualified Health Centers (FQHCs) to become part of their community advisory boards.	3.92
68	Provide a one-stop place for new immigrants to get healthcare, such as purified protein derivative PPD skin test, vaccinations, Family Care services, and a first medical appointment with a provider.	4.52
41	Expand access to free dental clinics, preventive care, and education on oral hygiene.	4.76
38	Promote integration of mental health services into primary care to provide comprehensive care and reduce stigma.	4.76
37	Facilitate mental health support for youth and young families in coordination with schools.	4.69
34	Advocate for state-level initiatives to facilitate coordinated, county-wide streamlined testing for TB, as well as referrals for chest X-rays and preventative treatment.	4.28
32	Provide referrals to pediatric pulmonologists for free services for low-income children who have had two or more asthma exacerbations in schools.	4.34
19	Assist with obtaining food vouchers/coupons/discounts from multiple local resources for healthy food delivery services.	4.34
17	Expand the number of primary care providers in underserved areas.	4.65
14	Provide transportation as needed for low-income families and others without reliable transportation to get to and from appointments.	4.57
13	Help streamline the process for local partners, like health officers, to secure NJ transit bus vouchers and train passes to assist individuals and families who need transport to health centers.	4.53
11	Help establish a position within school districts for a person to coordinate and connect students who need primary care to local FQHCs and other providers.	4.30
7	Partner with restaurants or big box stores to donate surplus food for residents across the county.	4.34
4	Partner with local providers, such as Summit Health or Care Station, to offer access to more clinical treatment services where needed.	4.30
69	Provide home-based care for those who are homebound and their caretakers.	4.20
64	Hire nurse practitioners to provide primary care services at satellite clinics.	4.24

55	Enable Essex County Office of Public Health Management (ECOPHM) to train master trainers who can then educate public health educators.	4.12
52	Train and employ community health workers to screen and connect residents to necessary services.	4.20
48	Recruit interested youth to serve as health ambassadors in their communities.	4.12
47	Use local health departments to introduce youth to careers in health of all kinds.	4.04
42	Provide vaccination and purified protein derivative (PPD) skin testing services in communities for elementary school-aged children at municipal buildings.	3.88
39	Facilitate use of dog therapy to visit the homebound.	3.38
36	Partner with local libraries to provide private spaces for accessing online therapists through services like Teladoc Health.	3.96
35	Enhance the role of the Essex County Office of Public Health Management (ECOPHM) in the monitoring and case management of latent (not active) tuberculosis (TB) services across Essex County.	3.96
29	Link providers to a hub of volunteers who can assist with translation services in non-English speaking communities.	4.26
27	Provide outreach such as cold calls from people (not recordings) to schedule screenings, immunizations, and other services.	3.57
24	Institute biannual health days where doctors/Nurse PAs give back to the community by visiting residents in a mobile health van.	4.07
18	Offer Essex County Office of Public Health Management (ECOPHM) services in the evening and weekends.	3.88
12	Facilitate door-to-door transportation like a tram/light rail that stops at the hospital and primary care centers.	3.96
9	Coordinate with school nurses to bring health services (such as vaccinations and physicals) into the schools.	4.19
8	Partner with speech therapy and audiology students at Montclair State University to help screen students at local schools.	3.80
6	Partner with Schools of Nursing to have Nurse Practitioner students provide primary care services at local health care satellite sites.	3.96
5	Partner with local pharmacies to offer preventative services such as blood pressure checks, immunizations, and cholesterol screenings.	4.15

Appendix D.3: Statements and their Feasibility Ratings

Feasibility Scale [3.13]-[4.58]; n = 24

#	Statements	Average Feasibility Rating
67	Establish mobile health van clinics in more places accessible to the communities that need it, such as houses of worship and schools.	4.12
66	Utilize mobile health vans at schools to provide needed services, such as primary care, urgent care, vision screening, dental care, immunizations, and referral services.	4.12
63	Increase the use of mobile health vans for screenings and vaccinations.	4.25
62	Engage principals/superintendents of schools to include on their websites information that directs parents to free medical/dental care.	4.30
53	Advocate for increased funding for needed services from state and federal sources.	4.50
51	Maintain current information on comprehensive resources for primary and preventative care that is shared in multiple languages and in an accessible format, both online and in print.	4.41
50	Increase efforts to inform health providers of available resources in Essex County.	4.45
49	Implement targeted public health education campaigns to raise awareness about preventive care, healthy lifestyles, immunizations, and local health resources.	4.22
45	Implement robust data collection and reporting mechanisms to track outcomes and demonstrate the impact of services.	4.04
44	Conduct regular community health needs assessments to identify and address gaps in services.	4.29
40	Increase efforts toward raising sexually transmitted disease (STD) awareness and treatment.	4.43
33	Assist local health departments in accessing resources and initiatives that will enable them to offer more preventive care to vulnerable populations.	4.33
25	Implement community programs focused on violence prevention and conflict resolution to improve overall community safety and health.	4.12
23	Offer translation services, such as language line translation services to assist non-English speaking patients with accessing services.	4.50
22	Offer translation services, such as bilingual navigators and health insurance case workers, to assist families with enrolling in NJ Family care.	4.45
21	Provide information about resources that can help individuals obtain assistance with affordable housing.	4.41

20	Designate locations managed by the Essex County Office of Public Health Management (ECOPH) for eligible clients to apply for and receive WIC benefits.	4.20
16	Connect uninsured eligible residents with available resources to help them apply for Medicaid (NJ Family Care).	4.37
15	Provide language line translation services to facilitate communication with new non-English speaking immigrants to assist with clinical care for this population.	4.58
3	Partner with community leaders to disseminate information about local health resources.	4.34
2	Partner with Essex County Federally Qualified Health Centers (FQHCs), such as Zufall Health, to schedule follow-up primary care appointments at the FQHCs in conjunction with the mobile health van visits.	4.16
1	Partner with Women, Infants, and Children (WIC) sites and Food Pantries to ensure all who qualify are enrolled.	4.26
65	Encourage community members to suggest locations for conducting mobile health van services.	4.04
61	Utilize a Facebook page as a marketing tool to inform the community about programs and services.	4.37
60	Implement a marketing campaign to advertise available services and emphasize their importance to the public.	4.20
59	Manage content on Instagram to highlight services and locations, with a strong emphasis on where the uninsured can go to receive assistance.	4.54
58	Pursue features highlighting local health services, programs and resources on News 12.	4.04
57	Improve the social media presence of Essex County Office of Public Health Management (ECOPHM).	4.50
56	Promote local and regional continuing education opportunities for Essex County public health officers and educators in relevant subjects, such as chronic disease self-management.	4.26
54	Educate Essex County public health educators about Essex County Office of Public Health Management (ECOPHM) priority areas to enhance their awareness/knowledge about currently identified priority issues.	4.16
46	Utilize the mobile health van to continuously gather information about community needs and services.	4.25
43	Provide health education presentations to school assemblies and PTA groups.	4.00
31	Host an annual meeting, to foster collaboration and networking among Essex County healthcare stakeholders.	4.45
30	Host a series of health education events that focus on relevant topics for specific priority groups.	4.00

28	Create a variety of clubs or initiatives for seniors to provide enriching opportunities for social engagement, skill development, and physical activity.	4.00
26	Create or enhance Essex County Office of Public Health Management (ECOPHM)/ County sponsored community wellness/fitness programs that promote physical activity.	4.37
10	Coordinate with Head Start and Early Head Start programs to invite staff from Federally Qualified Health Centers (FQHCs) to become part of their community advisory boards.	4.00
68	Provide a one-stop place for new immigrants to get healthcare, such as purified protein derivative PPD skin test, vaccinations, Family Care services, and a first medical appointment with a provider.	3.65
41	Expand access to free dental clinics, preventive care, and education on oral hygiene.	3.91
38	Promote integration of mental health services into primary care to provide comprehensive care and reduce stigma.	3.95
37	Facilitate mental health support for youth and young families in coordination with schools.	3.91
34	Advocate for state-level initiatives to facilitate coordinated, county-wide streamlined testing for TB, as well as referrals for chest X-rays and preventative treatment.	3.95
32	Provide referrals to pediatric pulmonologists for free services for low-income children who have had two or more asthma exacerbations in schools.	3.54
19	Assist with obtaining food vouchers/coupons/discounts from multiple local resources for healthy food delivery services.	3.87
17	Expand the number of primary care providers in underserved areas.	3.30
14	Provide transportation as needed for low-income families and others without reliable transportation to get to and from appointments.	3.95
13	Help streamline the process for local partners, like health officers, to secure NJ transit bus vouchers and train passes to assist individuals and families who need transport to health centers.	3.58
11	Help establish a position within school districts for a person to coordinate and connect students who need primary care to local FQHCs and other providers.	3.62
7	Partner with restaurants or big box stores to donate surplus food for residents across the county.	3.83
4	Partner with local providers, such as Summit Health or Care Station, to offer access to more clinical treatment services where needed.	3.66
69	Provide home-based care for those who are homebound and their caretakers.	3.47
64	Hire nurse practitioners to provide primary care services at satellite clinics.	3.54

55	Enable Essex County Office of Public Health Management (ECOPHM) to train master trainers who can then educate public health educators.	3.83
52	Train and employ community health workers to screen and connect residents to necessary services.	3.87
48	Recruit interested youth to serve as health ambassadors in their communities.	3.73
47	Use local health departments to introduce youth to careers in health of all kinds.	3.83
42	Provide vaccination and purified protein derivative (PPD) skin testing services in communities for elementary school-aged children at municipal buildings.	3.25
39	Facilitate use of dog therapy to visit the homebound.	3.16
36	Partner with local libraries to provide private spaces for accessing online therapists through services like Teladoc Health.	3.75
35	Enhance the role of the Essex County Office of Public Health Management (ECOPHM) in the monitoring and case management of latent (not active) tuberculosis (TB) services across Essex County.	3.66
29	Link providers to a hub of volunteers who can assist with translation services in non-English speaking communities.	3.79
27	Provide outreach such as cold calls from people (not recordings) to schedule screenings, immunizations, and other services.	3.16
24	Institute biannual health days where doctors/Nurse PAs give back to the community by visiting residents in a mobile health van.	3.50
18	Offer Essex County Office of Public Health Management (ECOPHM) services in the evening and weekends.	3.91
12	Facilitate door-to-door transportation like a tram/light rail that stops at the hospital and primary care centers.	3.12
9	Coordinate with school nurses to bring health services (such as vaccinations and physicals) into the schools.	3.62
8	Partner with speech therapy and audiology students at Montclair State University to help screen students at local schools.	3.87
6	Partner with Schools of Nursing to have Nurse Practitioner students provide primary care services at local health care satellite sites.	3.62
5	Partner with local pharmacies to offer preventative services such as blood pressure checks, immunizations, and cholesterol screenings.	3.87

Appendix D.4: Statements by Go-Zone Category

Statements by Go-Zone Category

R=0.44			
		Importance Scale [3.38]-[4.77] Median = 2.38 n = 26	Feasibility Scale [3.13]-[4.58] Median = 2.29 n = 24
#	**Statements**	**Average Rating**	**Average Rating**
67	Establish mobile health van clinics in more places accessible to the communities that need it, such as houses of worship and schools.	4.44	4.13
66	Utilize mobile health vans at schools to provide needed services, such as primary care, urgent care, vision screening, dental care, immunizations, and referral services.	4.48	4.13
63	Increase the use of mobile health vans for screenings and vaccinations.	4.60	4.25
62	Engage principals/superintendents of schools to include on their websites information that directs parents to free medical/dental care.	4.56	4.30
53	Advocate for increased funding for needed services from state and federal sources.	4.68	4.50
51	Maintain current information on comprehensive resources for primary and preventative care that is shared in multiple languages and in an accessible format, both online and in print.	4.48	4.46
50	Increase efforts to inform health providers of available resources in Essex County.	4.44	4.46
49	Implement targeted public health education campaigns to raise awareness about preventive care, healthy lifestyles, immunizations, and local health resources.	4.40	4.23
45	Implement robust data collection and reporting mechanisms to track outcomes and demonstrate the impact of services.	4.46	4.04
44	Conduct regular community health needs assessments to identify and address gaps in services.	4.50	4.29
40	Increase efforts toward raising sexually transmitted disease (STD) awareness and treatment.	4.65	4.43
33	Assist local health departments in accessing resources and initiatives that will enable them to offer more preventive care to vulnerable populations.	4.58	4.33

25	Implement community programs focused on violence prevention and conflict resolution to improve overall community safety and health.	4.35	4.13
23	Offer translation services, such as language line translation services to assist non-English speaking patients with accessing services.	4.69	4.5
22	Offer translation services, such as bilingual navigators and health insurance case workers, to assist families with enrolling in NJ Family care.	4.62	4.46
21	Provide information about resources that can help individuals obtain assistance with affordable housing.	4.50	4.42
20	Designate locations managed by the Essex County Office of Public Health Management (ECOPH) for eligible clients to apply for and receive WIC benefits.	4.35	4.21
16	Connect uninsured eligible residents with available resources to help them apply for Medicaid (NJ Family Care).	4.65	4.38
15	Provide language line translation services to facilitate communication with new non-English speaking immigrants to assist with clinical care for this population.	4.65	4.58
3	Partner with community leaders to disseminate information about local health resources.	4.50	4.35
2	Partner with Essex County Federally Qualified Health Centers (FQHCs), such as Zufall Health, to schedule follow-up primary care appointments at the FQHCs in conjunction with the mobile health van visits.	4.38	4.17
1	Partner with Women, Infants, and Children (WIC) sites and Food Pantries to ensure all who qualify are enrolled.	4.46	4.26
65	Encourage community members to suggest locations for conducting mobile health van services.	4.08	4.04
61	Utilize a Facebook page as a marketing tool to inform the community about programs and services.	4.04	4.38
60	Implement a marketing campaign to advertise available services and emphasize their importance to the public.	4.12	4.21
59	Manage content on Instagram to highlight services and locations, with a strong emphasis on where the uninsured can go to receive assistance.	4.12	4.54
58	Pursue features highlighting local health services, programs and resources on News 12.	4.00	4.04
57	Improve the social media presence of Essex County Office of Public Health Management (ECOPHM).	4.04	4.50

56	Promote local and regional continuing education opportunities for Essex County public health officers and educators in relevant subjects, such as chronic disease self-management.	4.12	4.26
54	Educate Essex County public health educators about Essex County Office of Public Health Management (ECOPHM) priority areas to enhance their awareness/knowledge about currently identified priority issues.	4.08	4.17
46	Utilize the mobile health van to continuously gather information about community needs and services.	4.19	4.25
43	Provide health education presentations to school assemblies and PTA groups.	3.92	4.00
31	Host an annual meeting, to foster collaboration and networking among Essex County healthcare stakeholders.	3.88	4.46
30	Host a series of health education events that focus on relevant topics for specific priority groups.	4.04	4.00
28	Create a variety of clubs or initiatives for seniors to provide enriching opportunities for social engagement, skill development, and physical activity.	4.12	4.00
26	Create or enhance Essex County Office of Public Health Management (ECOPHM)/ County sponsored community wellness/fitness programs that promote physical activity.	4.15	4.38
10	Coordinate with Head Start and Early Head Start programs to invite staff from Federally Qualified Health Centers (FQHCs) to become part of their community advisory boards.	3.92	4.00
68	Provide a one-stop place for new immigrants to get healthcare, such as purified protein derivative PPD skin test, vaccinations, Family Care services, and a first medical appointment with a provider.	4.52	3.65
41	Expand access to free dental clinics, preventive care, and education on oral hygiene.	4.77	3.96
38	Promote integration of mental health services into primary care to provide comprehensive care and reduce stigma.	4.77	3.96
37	Facilitate mental health support for youth and young families in coordination with schools.	4.69	3.92
34	Advocate for state-level initiatives to facilitate coordinated, county-wide streamlined testing for TB, as well as referrals for chest X-rays and preventative treatment.	4.28	3.96

32	Provide referrals to pediatric pulmonologists for free services for low-income children who have had two or more asthma exacerbations in schools.	4.35	3.54
19	Assist with obtaining food vouchers/coupons/discounts from multiple local resources for healthy food delivery services.	4.35	3.88
17	Expand the number of primary care providers in underserved areas.	4.65	3.30
14	Provide transportation as needed for low-income families and others without reliable transportation to get to and from appointments.	4.58	3.96
13	Help streamline the process for local partners, like health officers, to secure NJ transit bus vouchers and train passes to assist individuals and families who need transport to health centers.	4.54	3.58
11	Help establish a position within school districts for a person to coordinate and connect students who need primary care to local FQHCs and other providers.	4.31	3.6
7	Partner with restaurants or big box stores to donate surplus food for residents across the county.	4.35	3.83
4	Partner with local providers, such as Summit Health or Care Station, to offer access to more clinical treatment services where needed.	4.31	3.67
69	Provide home-based care for those who are homebound and their caretakers.	4.20	3.48
64	Hire nurse practitioners to provide primary care services at satellite clinics.	4.24	3.54
55	Enable Essex County Office of Public Health Management (ECOPHM) to train master trainers who can then educate public health educators.	4.12	3.83
52	Train and employ community health workers to screen and connect residents to necessary services.	4.20	3.88
48	Recruit interested youth to serve as health ambassadors in their communities.	4.12	3.74
47	Use local health departments to introduce youth to careers in health of all kinds.	4.04	3.83
42	Provide vaccination and purified protein derivative (PPD) skin testing services in communities for elementary school-aged children at municipal buildings.	3.88	3.25
39	Facilitate use of dog therapy to visit the homebound.	3.38	3.17
36	Partner with local libraries to provide private spaces for accessing online therapists through services like Teladoc Health.	3.96	3.75

35	Enhance the role of the Essex County Office of Public Health Management (ECOPHM) in the monitoring and case management of latent (not active) tuberculosis (TB) services across Essex County.	3.96	3.67
29	Link providers to a hub of volunteers who can assist with translation services in non-English speaking communities.	4.27	3.79
27	Provide outreach such as cold calls from people (not recordings) to schedule screenings, immunizations, and other services.	3.58	3.17
24	Institute biannual health days where doctors/Nurse PAs give back to the community by visiting residents in a mobile health van.	4.08	3.50
18	Offer Essex County Office of Public Health Management (ECOPHM) services in the evening and weekends.	3.88	3.92
12	Facilitate door-to-door transportation like a tram/light rail that stops at the hospital and primary care centers.	3.96	3.13
9	Coordinate with school nurses to bring health services (such as vaccinations and physicals) into the schools.	4.19	3.63
8	Partner with speech therapy and audiology students at Montclair State University to help screen students at local schools.	3.81	3.88
6	Partner with Schools of Nursing to have Nurse Practitioner students provide primary care services at local health care satellite sites.	3.96	3.62
5	Partner with local pharmacies to offer preventative services such as blood pressure checks, immunizations, and cholesterol screenings.	4.15	3.88

Appendix F:

Key Informant Interview Methods

The Essex County Access to Care Feasibility Study (Feasibility Study) utilized Key Informant Interviews to gain greater insights into stakeholders' perceptions and opinions about the identified objectives, relative to the following topics:

1. The opportunities and challenges of implementing the seven strategic objectives identified during the modified GCM study phase,
2. The resources needed to support sustainability of the objectives, and
3. The potential role(s) the Essex County Office of Public Health Management (ECOPHM) in implementing and sustaining the recommended strategic objectives.

Key Informant Interviewee Identification

In fall 2024, the ECOPHM and CSI teams identified potential stakeholders for the key informant interviews. Together, they reviewed the final stakeholder list developed during the Stakeholder Inventory and Analysis phase of the Feasibility Study (see Appendix D) and incorporated additional members from the Healthy Essex Coalition to generate a list of 75 potential key informants for this phase of the study.

In the second round of reviewing the list, the team narrowed the pool of potential interviewees using two criteria: 1) stakeholders identified as having in-depth experience with the opportunities and challenges of implementing healthcare access interventions, and 2) those who represent diverse perspectives across health and community sectors and Essex County municipalities. This analysis resulted in the identification of 40 key informants who were invited to participate in the interviews.

The CSI team performed a third review of the stakeholder list to assign two of the seven strategic objectives for discussion with each potential interviewee, based on their organizational affiliation and specific role within their organization. This approach served to focus the interviews and align the topics for discussion with the interviewees' areas of expertise.

Recruitment

The interview recruitment was initiated in October 2024. The first step consisted of an email from the ECOPHM to potential interviewees. This email outlined the Feasibility Study as well as the purpose of the Key Informant Interview phase. Stakeholders were invited to sign up for a 30-minute interview timeslot using a Doodle poll. Interviewers from the CSI team then followed up with a calendar invite and information. Multiple reminder emails were sent from the study team to the 40 potential interviewees October through December 2024.

Two days prior to the interview data, participants received a reminder email from their interviewer, which provided further information about the format of the interview and the two strategic objectives that would be discussed. The purpose of this introductory email was to allow interviewees time before the interview to consider their experience with the specific content that would be covered in the interview.

Data Collection

Interviews were conducted by two members of the CSI team via Zoom, the online audio/video software, and were recorded using Zoom's audio recording function. Each interview lasted between 30-40 minutes and followed the Interview Guide (see appendix F.1) to conduct a semi-structured interview. The audio recordings were transcribed using Zoom's transcription function.

All interviews were conducted between November 2024 and January 2025. A total of 13 interviews were conducted with 14 participants. An overview of participant demographics is presented in Table 1.

Professional Sector	**Professional Role**	**Primary Municipality for work/services**	**Primary Strategic Objective Covered in interview**
School Nurse	Consultant/Executive Board – School Nurses' Association	Irvington and State and Local focus	- Localize Health Services - Language
School Nurse	School Nurse & School Nurses' Association	West Orange and State and Local focus	- Localize Health Services - Collaboration
CBO	Project Manager	Irvington	- Resource Awareness - Education
Public Health	Executive Management	Newark	- Localize Health Services - Collaboration - Education
Philanthropy	Executive Management	Newark and Metro areas of Essex	- Funding - Data
Higher Education	Dean/Professor	Newark and greater Essex	- Language - Data
School Nurse	School Nurse & Local Nurses' Association	Milburn	- Collaboration - Resource Awareness
Community Based Organization/Higher Education	Educator/Assist. Prof	Newark	- Data - Education

Federally Qualified Health Center	Executive Management	West Orange	- Collaboration - Localize Health Services
Federally Qualified Health Center	Community Engagement	West Orange	- Collaboration - Localize Health Services
Non-Profit	Community Engagement	Essex County	- Collaboration - Resource Awareness
Public Health	Executive Management	Newark	- Health Education - Localize Health Services
Community Based Organization	Executive Management	Newark, Essex County	- Language - Collaboration
Public Health	Data Management	Irvington	- Data - Resource Awareness

Data Analysis

After each interview, the interviewer immediately documented key ideas and themes in an interview log. During analysis, the interview logs and interview transcripts were used to identify key themes and findings.

The first step for analysis was to use ChatGPT to do an initial scan of the interview logs and transcripts to identify key ideas and themes. For each interview and transcript, ChatGPT was prompted to do a qualitative analysis to identify key themes, key words, and main ideas. Next, ChatGPT was prompted to review the combined data of all the interviews to identify cross-cutting themes and ideas.

The ChatGPT results were reviewed by two members of the study team to validate the findings and confirm the accuracy of the analysis. The findings were then presented by describing key findings, challenges, and recommendations for each of the seven strategic interviews. The results of this analysis are presented in the main body of the report.

Appendix F.1

Interview Guide – Essex County Feasibility Study: Phase 3

*[**Before calling the participant** - Write down the participant's name AND your name on the interview log. Review the interview guide and the participant's name. Be sure that you are in a quiet, enclosed area where no one can hear or interrupt the interview. You should be the only one in the room. Record the participant's name at the top of the Log. Remember, take notes as needed in the Log.]*

Initiate the Zoom meeting. Greet the participant.

Thank you so much for your time. Today, you will participate in an individual interview about your perspectives and opinions on how Essex County can increase access to preventive and primary health care. Other healthcare leaders throughout Essex County are also participating in these interviews. This is part of a larger Feasibility Study sponsored by the Essex County Office of Public Health Management to explore ways to increase access to primary and preventative health care in Essex County. I work with Concept Systems, Inc., a research firm the OPHM has hired to conduct this study. These interviews are the third and final phase of this study. We have also collected data through a Brainstorming Survey and a Ratings Survey, which you may have participated in.

The interview should last about 30 minutes. Your participation is voluntary. If you do not wish to participate, you may stop anytime. Responses will be confidential –your name will not appear anywhere in the final write-up. Aggregate results will be shared in person with the Essex County Office of Public Health Management and may be shared publicly.

This interview will be audio recorded via Zoom. The audio file will only be shared with members of the CSI research team and will be deleted once transcribed. If you have questions regarding the research, contact me.

Do you agree to participate in this interview? [*Document participant's response to consent procedure in Log.*]

Now I will start the audio recording. [*Start recording in Zoom*]

Today's date is _____ [*document in Log]* _____.

The time is _____ [*document in Log]* _____.

This is an interview with [name] _____ [*document in Log*] _____.

As I mentioned earlier, I'm interested in your perspectives and opinions regarding potential solutions to increase access to preventive and primary healthcare in Essex County. We have already collected ideas from healthcare and public health leaders in Essex County about how to increase access. We have also asked these same leaders to provide their opinions about how important and feasible the collected ideas are by rating each of the ideas. The ideas we will discuss were identified as priorities in Essex County, meaning they were rated as both the most important and the most feasible ideas.

There are no right or wrong answers, we highly value your honest opinion and perspective on the ideas and solutions we will be discussing. Please provide as much information as you feel is necessary to answer the question.

Do you have any questions before we start?

[Introduction]

Can you please describe your role in healthcare or public health in Essex County?

Probe: what municipality(ies) do you mostly work with?

Probe: How long have you served in this role?

Thank you. For the rest of our time together, I will ask you about one or two specific priority ideas identified during the earlier phases of this study.

[Strategic Objective #1] -

1. First, I want to ask you some questions about what would be needed to implement this idea. From your perspective, what do you think it would take to implement this idea?
    a. Human resources
        i. *Probe:* What kind of buy in would be needed?
        ii. Do you think it would be difficult to obtain this buy-in? Why or why not?
        iii. *Probe:* What kind of staffing would be needed to implement this idea?
        iv. *Probe:* Are there multiple groups or stakeholders that would need to collaborate to successfully implement this idea?
        v. *Probe:* Is there a need for training or skill development?
    b. Physical resources:
        i. *Probe:* What type of funding is needed? Do you think it will be easy to secure this funding?
        ii. *Probe:* What types of facilities or physical space would be needed?
        iii. *Probe:* Technology needs?
    c. Are you already seeing this idea being done in your organization or community?
    d. Do you think this could be improved? If so, how?
2. Next, I want to ask your opinions on what it would take for this idea to be sustainable over time.
    a. From your opinion and experience, what challenges or barriers might this idea face over time?
    b. What opportunities or drivers could be capitalized on to support this idea's long-term success?
    c. What type of data do you think would need to be collected to be able to measure the success of this idea?

3. What role do you think ECOPHM should take in the implementation of this initiative? Why? (Owner, facilitator, key partner, funder, convener, etc.)
    a. What opportunities do you see, if any, for your organization partnering with ECOPHM in this area/initiative/etc.?
4. Is there anything else you would like to share about this idea?

[Strategic Objective #2] -

1. I'm now going to ask you the same questions about this idea as i did for the previous idea. From your perspective, what do you think it would take to implement this idea?
    a. Human resources
        i. *Probe:* What kind of buy in would be needed?
        ii. Do you think it would be difficult to obtain this buy-in? Why or why not?
        iii. *Probe:* What kind of staffing would be needed to implement this idea?
        iv. *Probe:* Are there multiple groups or stakeholders that would need to collaborate to successfully implement this idea?
        v. *Probe:* Is there a need for training or skill development?
    b. Physical resources:
        i. *Probe:* What type of funding is needed? Do you think it will be easy to secure this funding?
        ii. *Probe:* What types of facilities or physical space would be needed?
        iii. *Probe:* Technology needs?
    c. Are you already seeing this idea being done in your organization or community?
    d. Do you think this could be improved? If so, how?
2. Next, I want to ask your opinions on what it would take for this idea to be sustainable over time.
    a. From your opinion and experience, what challenges or barriers might this idea face over time?
    b. What opportunities or drivers could be capitalized on to support this idea's long-term success?
    c. What type of data do you think would need to be collected to be able to measure the success of this idea?
3. What role do you think ECOPHM should take in the implementation of this initiative? Why? (Owner, facilitator, key partner, funder, convener, etc.)
    a. What opportunities do you see, if any, for your organization partnering with ECOPHM in this area/initiative/etc.?
4. Is there anything else you would like to share about this idea?

Thank you so much for your time and participation in this interview. Is there anything else you would like to share before we end?

If you have any questions or thoughts over the next few days, please feel free to reach out to me at the email you received the Zoom information from.

End the call with the participant.

[After the interview ends:

1) Turn off Zoom's recording capability, save the audio file to SharePoint, and ensure copy of file is not saved to Zoom. Exit Zoom software.

2) Put the interview Log in the participant's electronic folder.

Be sure the IDs on the folder and Log match!

3) Write your thoughts, impressions, and logistical notes on the interview log form.