September 2021

Emerson Health

2022-2024 Strategic Implementation Plan

Submitted to:

Emerson Health

Health Resources in Action
Advancing Public Health and Medical Research

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Please address written comments on the Community Health Needs Assessment (CHNA) and Strategic Implementation Plan (SIP) and requests for a copy of the CHNA or SIP to:

Emerson Health
133 Old Road to Nine Acre Corner
Concord, MA 01742
Email: CommunityBenefits@emersonhosp.org

Introduction

About Emerson Health

Emerson Health is a full-service, regional medical center headquartered in Concord, Massachusetts, with a 179-bed hospital and more than 300 primary care doctors and specialists. Emerson Health provides advanced medical services to more than 300,000 people in 25 towns. The Hospital's core mission is to make high-quality health care more accessible to those who live and work in our community. To further this mission, Emerson

has health centers in Bedford, Maynard, Westford, Groton, Sudbury, and Concord, as well as urgent care centers in Hudson and Littleton.

Emerson's Commitment to Diversity, Equity, Inclusion

Emerson is committed to a culture of belongingness, inclusivity, diversity, and equity. We value and appreciate individuality and diversity of thought, experience, and perspective and support a culture where every person is respected and treated equally. Emerson embraces the principles of DE&I through continual dialogue, learning and growth with our patients at the very center of our actions.

Emerson's Mission Statement

Emerson will deliver exceptional patient-centered care that is compassionate, equitable, efficient and coordinated.

Emerson's Vision Statement

Emerson strives to be a trusted healthcare provider, valued community partner, and creator of positive change for all people in our region to achieve their full potential for health and well-being throughout their lives.

Community Benefits Mission Statement

Emerson Health is committed to collaborating with our community partners to: improve the health status of all those it serves, address root causes of health disparities; and educate the community in prevention and self-care strategies.

Emerson Health Community Benefits

The Emerson Health Community Benefit Program builds on the hospital's history of commitment to the community and the core values of providing care to all regardless of ability to pay. Emerson continues to work to understand and address the health needs of the Emerson Health community by undertaking a Community Health Needs Assessment, developing a Strategic Implementation Plan, and offering funding for initiatives through a Community Benefits Grant Program.

Community Health Needs Assessment and Strategic Implementation Plan

Improving the health of a community is essential to enhancing the quality of life for residents in the region and supporting future social and economic well-being. To fulfill the federal IRS requirements and the Massachusetts Attorney General Community Benefits Guidelines and as a continuing best practice in community health, Emerson Health engaged in a community health planning process to improve the health of residents in 25 towns. This effort included two phases: (1) a community health needs assessment (CHNA) to identify the health- and wellness-related needs and strengths of the region and (2) a strategic implementation plan to identify major health priorities, develop goals, select strategies and identify partners to address these priority issues across the region.

Methods

The community health needs assessment entailed a participatory, collaborative approach, which examined health and wellness in its broadest sense and recognizes that numerous factors at multiple levels impact a community's health. Frameworks of social determinants of health and health equity guided the overarching process of the CHNA. Both quantitative and qualitative data collection methods were used to understand public perceptions around health issues. These methods included:

- 1 resident and health/social service provider survey which was administered online in English, Spanish, and Portuguese. A total of 3,589 respondents (3,176 residents and 413 providers) who identified as living or working in the Emerson Health services area completed the survey.
- 4 focus groups were conducted. HRiA facilitated three focus groups, with 19 individuals, each representing three different population groups in the service area: seniors, caretakers, and high school students. Emerson Health conducted one focus group with the Patient/Family Advisory Committee.
- 10 key informant interviews were completed with 11 individuals engaging institutional, organizational, and community leaders and front-line staff across sectors.

CHNA Key Findings

The key health issues that emerged as areas of concern in the CHNA were raised in the community resident and provider survey, interviews and focus groups, and supported by secondary data. The following issues were considered in the selection of the Strategic Implementation Plan (SIP) health priorities (please refer to the CHNA for additional data and more detailed information pertaining to race/ethnicity breakdowns on each of these issues):

- **Aging health concerns**
  Interviewees noted that the large senior citizen population continues to grow in the area, and the American Community Survey also showed a number of towns in the service area with a greater proportion of the population over 65 than the state (MA: 16.1%; Lincoln 28.4%; Concord 20.6%; Carlisle 19.4%; Hudson 17.9%; and Harvard 17.5%). When Community Survey participants were asked about personal and community health concerns, aging health concerns was a top concern for respondents and/or their family (50.2%) and for their community (54.8%). Aging health concerns was also cited by 66.2% of provider survey respondents as a common health concern.
- **Availability and affordability of housing**, specifically around low-income individuals and households.
  Housing concerns – including finding affordable housing, fear of eviction, overcrowding of housing units, and housing quality – was the top community-level concern ranked by respondents, with about 6 in 10 (59.8%) respondents citing this concern. Provider respondents included housing concerns (76.6%) among their top concerns.
  Interviewees and focus group participants from across communities in the service area discussed the high cost of purchasing or renting homes and limited availability of homes in the area, as well as a lack of affordable units. The high housing costs were associated with it being a difficult place for young people, immigrant communities and low-income families to move, and the high tax rate was also challenging for families to stay in the community after their children graduated and for older adults on a fixed income or looking to downsize but stay in the area.
  Notably, approximately 1 in 4 (25.1%) residences in the primary service area were occupied by owners who were not paying a mortgage. Nearly 1 in 5 (19.4%) residences in the primary service area were renter-occupied, and nearly 1 in 4 (24.7%) residences in the secondary service area were renter occupied, which was below average of 37.6% of renter occupied housing units across Massachusetts and in Middlesex County.

- **Chronic health conditions**, including high blood pressure, overweight/obesity, cancer, and diabetes.
  Both providers and community survey respondents were asked to indicate current health issues of concern. The most frequently cited health issues among respondents for the community and for themselves and/or their family were high blood pressure (community: 28.9%; themselves: 36.6%)) and overweight/obesity (community: 27.6%; themselves: 31.1%)). Other chronic health concerns indicated by providers included: overweight/obesity (69.1%), high blood pressure/hypertension (59%), diabetes (57.4%), heart disease/heart attacks (56.8%), and cancer (55.2%).
  Across towns in the Emerson Health service area in 2017, the cancer mortality rate was highest in Lincoln (389.0 deaths per 100,000 residents), which was 2.1 times higher than the cancer mortality rate across the State (188.8 deaths per 100,000 residents) and 2.3 times higher than the rate for Middlesex County (165.8 deaths per 100,000 residents).
  In 2012-2014, about 4% of residents in Lincoln (4.4%), Bedford (4.2%), and Concord (4.0%) reported angina or coronary heart disease, which is slightly above the prevalence across Massachusetts (3.9%) and exceeds the prevalence for Middlesex County (3.2%). Each town in the Emerson Health service area had a lower rate of hospitalizations due to cardiovascular disease compared to Massachusetts.
  Across the Emerson Health service area, the percent of adults reporting a diagnosis of diabetes was below the average for Massachusetts (9.0%). Bedford (8.6%) and Hudson (7.6%) had a higher percent of residents reporting diabetes than the average across Middlesex County (7.3%). Concord (5.6%) and Maynard (5.7%) had the lowest percent of adults reporting a diabetes diagnosis. In the survey, diabetes did not come up as a top health concern overall but was a top health concern for Black and South Asian respondents.
  A couple interviewees mentioned physical health, specifically overweight and obesity, as a health concern in the community. Generally, about 1 in 5 adults in the Emerson Health service area reported being obese. Each town in the Emerson Health service area had a lower percent of adults reporting obesity than the prevalence for Massachusetts (25.8%) in 2012-2014
- **COVID-19**
  When Community Survey participants were asked about personal and community health concerns, coronavirus/COVID-19 was a top concern identified for respondents and/or their family (coronavirus/COVID-19: 41.4%) and for their community (coronavirus/COVID-19: 54.7%). Approximately 2 in 5 respondents <65 years of age cited coronavirus/COVID-19 (43.5%) as the top personal health issue. Approximately 2 in 5 respondents 65 years of age and older indicated coronavirus/COVID-19 (40.0%) as a concern. Among providers, nearly 9 in 10 (89.0%) cited coronavirus/COVID-19 as a current health issue. Interviewees and focus group participants indicated that many community needs were exacerbated during the pandemic, and COVID-19 brought about a new awareness around the inequities experienced across the community needs identified.
- **Economic insecurity**, including around food insecurity and the cost of health care/medications.
  Interviewees overwhelmingly described the communities as middle income and well-off, but there was also acknowledgement that this was not universal. In 2015-2019, the median household income in the primary service area ($145,639) and secondary service area ($104,935) were both higher than the median household income in Massachusetts ($81,215) and Middlesex County ($102,603). In 2015-2019, 4.0% of residents in the primary service area and 5.9% in the secondary service area had incomes below the federal poverty level, lower than the poverty rate across the State (10.3%) and for Middlesex County (7.4%).
  From 2019 to 2020, the unemployment rate increased by 200% in the primary service area and by 181% in the secondary service area, which was above the 196% increase across Massachusetts. When community survey respondents were asked about a change in their financial situation due to the COVID-19 pandemic, nearly 1 in 6 (15.4%) respondents reported that their financial circumstances had gotten worse
  Interviewees and focus group participants described food insecurity described as a concern in the community that was exacerbated by COVID-19, as food pantries and other emergency food sources saw

a dramatic rise in individuals and families looking for resources over the past year. In the community survey, availability of supermarkets and affordable healthy food options was a top concern for residents for themselves and the community at large. This was seen as a top concern across age groups. In the secondary service area, approximately 1 in 10 (10.6%) households received food stamps/SNAP benefits, which was just below the proportion for Massachusetts (11.7%), and more than double the proportion of households that received food stamps/SNAP in the primary service area (4.6%).
In the community survey, more than 1 in 10 (14.4%) respondents reported that a member of their household had not received needed medical care due to costs. When asked about the impact of health care systems issues for the community, about 2 out of 3 (68.2%) community respondents cited the cost of care/co-pays as a concern and more than half (56.8%) noted insurance problems as a community issue. About 7 in 10 providers cited cost of care/co-pays (72.2%) or insurance problems (69.8%) as community health care access issues.

- **Mental health**
  The health concern that came up most often among interviewees and was discussed in all of the focus groups was mental health. There were concerns about mental health across age groups, income levels, and racial/ethnic groups. Interviewees also brought up a number of barriers specific to mental health that they found concerning, including: high costs of mental health care even with health insurance; difficulty navigating the mental health services system with or without health insurance; stigma; lack of mental health providers; long waitlists to see a mental health provider, especially for adolescents and individuals with no insurance or with Medicaid; lack of providers who understand the needs of specific patient groups such as domestic violence survivors, people of color, and LGBTQIA+ residents.
  Adult mental health was one of the top five most frequently cited health issues among community respondents (26.9%). Common health concerns indicated by providers included: adult mental health issues (78.2%), alcohol and drug use among adults (63.4%), and mental health issues among youth (63.1%). About 2 in 5 Community Survey respondents prioritized providing more counseling or mental health services (40.5%) or expanding health/medical services for seniors (40.4%). The majority (73.1%) of providers prioritized providing more counseling or mental health services.
- **Transportation options**
  Transportation was a top concern raised in the survey for the community by residents and providers alike. For individuals, it also rose to the third most common concern for residents over 65 responding to the survey. Approximately one-third of respondents prioritized improving public transportation options to health/medical services in the area (34.1%). Many interviewees remarked on the challenge's individuals face accessing services in the community due to lack of transportation infrastructure. Interviewees shared about individual towns or social service agencies trying to create systems for their communities or populations, but they often reported significant limitations such as geographic perimeters and destinations that limit the usability.
- Overarching themes that cut across all topic areas are **systemic racism, racial injustices, and discrimination** which are present in the service area.
  When asked about the Top 5 Social Issues with the Largest Impact on the Community in the Community Survey, addressing systemic racism/racial injustice was the number 2 (57.1%) issue indicated by community members and the number 4 (52.9%) issue indicated by providers.
  The 298 Community Survey participants who reported experiences of discrimination were asked why they were discriminated against. Discrimination on the basis of age (47.8%) and gender (43.7%) were the most frequently cited social identities against which respondents reported experiences of discrimination. Nearly 1 in 3 respondents reported discrimination based on race (32.4%) and nearly 3 in 10 respondents indicated that they experienced discrimination based on their ethnicity, ancestry, or country of origin (29.7%). Discrimination based on physical appearance was reported by approximately 1 in 5 (20.5%) respondents. About 1 in 10 (10.6%) respondents reported discrimination on the basis of their sexual orientation.

Priority Health Issues for the Strategic Implementation Plan

In June 2021, HRiA led a facilitated process with leadership from Emerson Health, members of the Community Benefits Advisory Committee (CBAC), and community stakeholders to identify the priorities for the Strategic Implementation Plan (SIP). During this virtual meeting, HRiA presented the key health issues identified in the 2021 Community Health Needs Assessment (CHNA), including the magnitude and severity of these issues and their impact on the most vulnerable populations. HRiA facilitated a discussion with participants to evaluate possible SIP priorities based on the key criteria outlined in Figure 1.

Figure 1: Criteria for Prioritization

RELEVANCE *How Important Is It?*	**APPROPRIATENESS** *Should We Do It?*	**IMPACT** *What Will We Get Out of It?*	**FEASIBILITY** *Can We do It?*
• Burden (magnitude and severity, economic cost; urgency) of the problem) • Community concern • Focus on equity and accessibility	• Ethical and moral issues • Human rights issues • Legal aspects • Political and social acceptability • Public attitudes and values	• Effectiveness • Coverage • Builds on or enhances current work • Can move the needle and demonstrate measurable outcomes • Proven strategies to address multiple wins	• Community capacity • Technical capacity • Economic capacity • Political capacity/will • Socio-cultural aspects • Ethical aspects • Can identify easy short-term wins

Through thoughtful consideration of the data presented, the prioritization criteria and knowledge of the existing and planned programs already in place, the group identified the four priorities listed below as those that are being addressed by Emerson Health in collaboration with community partners and will be included in the Strategic Implementation Plan. The level of feedback and data from the assessment led the group to also include **systemic racism, racial injustices, and discrimination** as cross-cutting themes to be included in objectives and/or strategies in each of the priority areas.

- Aging Health Concerns
- Economic Insecurity, including around food insecurity and the cost of health care/medications
- Mental Health
- Transportation Options

In July and August 2021, HRiA led a series of virtual SIP planning sessions that included mapping current and emerging programs and initiatives against these needs, as well as decision-making regarding which existing programs and initiatives would be continued and what new programs or initiatives would be developed. Members of the CBAC, Emerson Health staff and community stakeholders comprised the planning work groups. The resulting plan is meant to be reviewed annually and adjusted to accommodate revisions that merit attention.

Vulnerable/Underserved Populations Addressed by this Strategic Implementation Plan

- Individuals over the age of 65
- Youth
- Low-income individuals and families
- Medically underserved individuals
- Individuals managing mental health and/or behavioral health disorders
- Individuals impacted by transportation barriers
- Individuals impacted by food insecurity, the cost of housing, and the cost of health care and medications
- Non-English speaking individuals

Social Determinants of Health Issues Addressed by this Strategic Implementation Plan

- Access to healthy foods

- Access to medical services
- Transportation options
- Affordable and quality housing
- Economic opportunities
- Community safety

Rationale for Priority Community Needs Not Addressed

The following items were identified as community needs through the assessment process. During our collaborative planning efforts, it was determined that our resources and implementation strategies would be best served by addressing the priority areas identified for the Strategic Implementation Plan. The areas listed below represent those community needs not addressed by this SIP.

- **Availability and affordability of housing**, *specifically around low-income individuals, and households: While this community need was not selected as a priority area for the SIP, housing is incorporated in the Economic Insecurity priority area as part of Objective 3.3: Increase efforts to address the cost of living and the growing inequality in the area by 2024.*

- **Chronic health conditions**, *including high blood pressure, overweight/obesity, cancer, and diabetes: While chronic health conditions were highlighted in some of the data as areas of concern for community members there was less urgency in the need to address. There were also resources – from Emerson and others – that address these issues, so additional resources were perceived as not as needed in this area. Emerson will continue work in cancer through education and prevention efforts.*

- **COVID-19**: *COVID-19 and its impacts on the communities served by Emerson Health were raised as concerns across all data gathering methods. While this important issue was not selected as a specific priority to be addressed as part of Emerson's Community Benefits Program, Emerson Health continues to provide care to patients with COVID-19 and conducts a COVID Recovery Program as part of ongoing services. As noted in the CHNA, many community needs were exacerbated during the pandemic, and COVID-19 brought about a new awareness around the inequities experienced across the community needs identified. Planning participants took lessons learned during the pandemic into consideration during planning and incorporated these learnings into some strategies of the SIP.*

Emerson Health Community Benefits Advisory Committee (CBAC)

Name	Title	Representation	Town
Lauren Barretta	COA Asst. Director	Social Services-Older Adults	Concord
Dawn Bentley	Vice President of Education & Head of School The Dr. Franklin Perkins School	Education	Lancaster
Jill Block	Corporator	Community member	Concord
Amy Caggiano	Auxiliary Liaison Officer and Run~Walk Coordinator	Emerson staff	Carlisle/Concord
Adam Duchesneau	Director of Planning and Town Development	Transportation/municipal staff	Sudbury
Christine Gallery	Senior VP Planning and Chief Strategy Officer	Emerson staff	Emerson
Roseann Giordano	Board Member	Board member	Acton
Tami Gouveia	MA State Representative 14th District	Elected Official	Acton
Sandra Hinds	Adjunct Professor, Quinsigamond Community College	Community member	Acton
Rick Lefferts	Chair, Maynard Affordable Housing Trust	Housing	Maynard
Kelsey Magnuson	Community Benefits	Emerson staff	Concord
Jack McKeen	Corporator	Community member	Maynard
Susan Rask	Public Health Director	Town Public Health	Concord

Liz Rust	Director-Regional Housing Services Office	Housing	Concord
Bill Ryan	Board Member	Board member	Maynard
Cheryl Serpe	Bank Manager	Business Community-private sector	Westford
James Street, MD	Board Member	Board member	Concord
Jill Stansky	Board Member	Board member	Sudbury
Teresa Symula	Corporator	Community member	Harvard
Deb Van Walsum	Auxiliary	Community member	Carlisle
Pat Worsley	Emerson PHO-Community Health Worker	Emerson staff	Emerson

Emerson Health Strategic Implementation Plan (SIP) Participants

CBAC members as well as Emerson Health staff and key community stakeholders participated in the CHNA Findings/Prioritization Process Meeting in late June, and then formed priority area working groups for the SIP Planning Sessions held in July and early August.

1. Mental Health

Dawn Bentley, CBAC
Tami Gouveia, CBAC
Adrienne Principe, Exec Director, Turning Life On
Susan Rask, CBAC
Bill Ryan, CBAC
Jill Stansky, CBAC
Teresa Symula, CBAC
Deb Van Walsum, CBAC
Pat Worsley, CBAC

2. Aging Health Concerns

Lauren Barretta, CBAC
Jennifer Claro, Director, Westford Council on Aging
Nancy Douglass, Director of Financial Planning and Decision Support, Emerson Health
Terrie Enis, Director of Rehabilitation, Emerson Health
Rose Ann Giordano, CBAC
Rick Lefferts, CBAC

3. Economic Insecurity

Jill Block, CBAC
Amy Caggiano, CBAC
Griet Dehandschutter, Executive Director Acton-Boxborough United Way
Sandra Hinds, CBAC
Ziola Ricciardi, Community Member
Liz Rust, CBAC

4. Transportation Options

Jacquelin Apsler, Executive Director, Domestic Violence Services Network (DVSN)
Adam Duchesneau, CBAC
Christine Gallery, CBAC
Jack McKeen, CBAC
Cheryl Serpe, CBAC
James Street, MD, CBAC

Emerson Health Strategic Implementation Plan

Priority Areas		Goals	Objectives	
1	**Mental Health**	Raise awareness and support the mental health needs in our communities.	1.1	Create a map of mental health gaps and underserved populations in the communities we serve by 2024.
			1.2	Identify existing mental health resources and partnerships available to our communities by 2024.
			1.3	Establish community partnerships to improve mental health system framework by 2024.
			1.4	Implement 6 educational events to raise mental health awareness and reduce stigma by 2024.
2	**Aging Health Concerns**	Improve access to, coordination and understanding of available resources and services to help elderly stay healthy and connected to their community with feelings of safety and belonging.	2.1	Increase awareness of strategies and resources to improve the physical and mental health status of older adults and their caregivers by 2024.
			2.2	Increase the comfort level in the use of technology for older adults by 2024.
			2.3	Increase awareness and availability of programs addressing the social determinants of health for the aging population by 2024.
3	**Economic Insecurity**	Increase economic security by providing an integrated and collaborative approach to new or existing community services while reducing barriers to access and by empowering individuals.	3.1	Expand the identification of individuals or households experiencing or at risk of food insecurity, and share information with programs and agencies that can help respond to the identified need by 2024.
			3.2	Increase collaborations and support for community agencies in an effort to address the cost of living and the growing inequality in the area by 2024.
			3.3	Increase vulnerable individuals' access to financial support, training and resources, by 2024.
4	**Transportation Options**	Collaborate with community partners to expand accessible, affordable, and flexible transportation to essential services.	4.1	Develop and implement a plan to address priority areas of unmet transportation needs for essential services by 2024.
			4.2	Increase awareness of currently available transportation options for essential services by 2024.
			4.3	Improve ongoing advocacy at state and local levels for transportation needs or services by 2024.

Priority 1: Mental Health

Priority Area 1: Mental Health **Goal 1: Raise awareness and support the mental health needs in our communities.**				
Objective 1.1: Create a map of mental health gaps and underserved populations in the communities we serve by 2024				
Outcome Indicators			**Baseline**	**Target**
• Receiving information on available services and resources			Receive information	Compile complete information
• Completed key informant interviews			0	5 interviews
• Identify gaps and underserved populations			Current gaps	Complete list with gaps by community
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
1.1.1: Develop an inventory of available services and resources.	CB Staff	Y1	Financial Support	Contracted Service
1.1.2: Meet with key informants to address how to outreach to those that may not have the ability to access mental health services easily.	CB Staff	Y2	Staff Time	
1.1.3: Examine ER discharge, addiction services and community benefits data.	CB Staff	Y2	Staff Time	Contracted Service
1.1.4: Implement the Youth Risk Behavior Survey (YRBS) every two years and disseminate findings, specifically around the behavioral health of youth.	CB Staff	Y1, Y3	Staff Time	Contracted Service
Monitoring/Evaluation Approach				
• Platform to capture information gathered • Updates to the Community Benefits Advisory Committee (CBAC)				
Potential Partners				
• Boys and Girls Clubs • Case Collaborative • Community Benefits Advisory Committee (CBAC) • Corporators • Councils on Aging • Department of Mental Health • Emerson Behavioral Health Department • Faith-based organizations			• Key Informants • National Association of Mental Illness (NAMI) • Population-specific community-based organization • Private mental health providers • School collaborative on mental health • Schools • Town social workers • William James College (MSPP) Interface	

Priority Area 1: Mental Health **Goal 1: Raise awareness and support the mental health needs in our communities.**				
Objective 1.2: Identify existing mental health resources and partnerships available to our communities by 2024.				
Outcome Indicators			**Baseline**	**Target**
• Completion of key stakeholder interviews			0	5 interviews
• Compile resources			0	Creation of resource guide (online and paper)
• Disseminate resources				Disseminate resources through PHO and Care Management
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
1.2.1: Collaborate with town key stakeholders, including schools, to identify accessible mental health resources.	CB Staff	Y1-Y2	Staff Time	Community Partnerships
1.2.2: Establish a dissemination plan for available mental health resources to distribute to communities and schools.	CB Staff	Y1-Y2	Staff Time	Community Partnerships
1.2.3: Identify partnerships and strategies for improving telehealth access for underserved populations	CB Staff	Y2	Staff Time	Vendor Partnerships
1.2.4: Increase patient knowledge of mental health resources by providing information in discharge paperwork	CB Staff	Y1-Y2	Staff Time	

Monitoring/Evaluation Approach

- Platform to capture information gathered
- Updates to the Community Benefits Advisory Committee (CBAC)

Potential Partners

- Advocates organization
- Assabet Valley Collaborative
- Boys and Girls Clubs
- Case Collaborative
- Community Benefits Advisory Committee (CBAC)
- Corporators
- Councils on Aging
- Department of Mental Health
- Emerson Behavioral Health Department
- Employment Options
- Faith-based organizations
- Home visiting organizations
- Key Informants
- Local Foundations
- Mental Health organization
- National Association of Mental Illness (NAMI)
- OUT MetroWest
- Population-specific community-based organization
- Private boarding schools
- Private mental health providers
- Schools – Adjustment Counselors, Social Workers, etc.
- Senior Living organization
- Telehealth Organizations
- Town social workers
- William James College (MSPP) Interface

Priority Area 1: Mental Health
Goal 1: Raise awareness and support the mental health needs in our communities.
Objective 1.3: Establish community partnerships to improve mental health system framework by 2024.

Outcome Indicators	Baseline	Target
• Identified community partners	0	5 active partners
• Convening of partners		2-3 meetings/ year
• Implementation plan to coordinate services		Plan is being activated

Strategies/Initiatives	Person(s) Responsible	Timeline (Y1, Y2, Y3)	Hospital Contribution	Other Source
1.3.1: Provide continuing education to community liaisons. (Ex: Non-profit organization, town social workers, CHW's, etc.).	CB Staff	Y1-Y2	Community or Vendor Partner	
1.3.2: Convene community partners to improve communication systems.	CB Staff	Y1-Y2	Staff Time	
1.3.3: Establish a framework/implementation plan for coordinating services.	CB Staff	Y3		Community or Vendor Partner
1.3.4 Strengthen relationships with state and local politicians to learn, inform, and advocate on the needs of the community. See also 3.2.2	CB Staff	Y2, Y3	Staff Time	Community or Vendor Partner

Monitoring/Evaluation Approach

- Report back on successes and challenges

Potential Partners

- Advocates organization
- Assabet Valley Collaborative
- Auxiliary/Corporator Collaborative
- Boys and Girls Clubs
- Case Collaborative
- Community Benefits Advisory Committee (CBAC)
- Corporators
- Councils on Aging
- Department of Mental Health
- Emerson Behavioral Health Department
- Employment Options
- Faith-based organizations
- Home visiting organizations
- Key Informants
- Local Foundations
- Mental Health organization
- OUT MetroWest
- National Association of Mental Illness (NAMI)
- Population-specific community-based organization
- Primary Care practices
- Private boarding schools
- Private mental health providers
- Schools – Adjustment Counselors, Social Workers, etc.
- Senior Living organization
- Telehealth Organizations
- Town social workers
- William James College (MSPP) Interface

Priority Area 1: Mental Health **Goal 1: Raise awareness and support the mental health needs in our communities.**				
Objective 1.4: Implement 6 educational events to raise mental health awareness and reduce stigma by 2024.				
Outcome Indicators			**Baseline**	**Target**
• Attendance at educational events (and future online viewing)				At least 10 attendees per event
• Evaluation of educational events				Evaluation complete
• Development and Delivery of educational events				At least 6 educational events
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
1.4.1: Collaborate to train parents and guardians on appropriate stress management tools and strategies to implement with their children.	CB Staff	Y1-Y3	Grant Funds	Community Partner/ Awardee
1.4.2: Outreach to target populations to determine the best implementation platforms for educational events.	CB Staff	Y1-Y2	Staff Time	Community Partner
1.4.3: Collaborate with various Emerson departments to produce events on addressing mental health awareness	CB Staff	Y1-Y3	Grant Funds and Staff Time	NAMI and Other Agencies
1.4.4: Collaborate with and support community based organizations in their efforts to address mental health stigma and education.	CB Staff	Y1, Y2, Y3	Grant Funds	Community Awardee
Monitoring/Evaluation Approach				
• Pre and Post event evaluations • Survey key stakeholders among populations identified to see if the events developed meet the needs identified				
Potential Partners				
• Advocates organization • Assabet Valley Collaborative • Auxiliary/Corporator Collaborative • Boys and Girls Clubs • Case Collaborative • Center for Parents and Teachers • Community Benefits Advisory Committee (CBAC) • Corporators • Councils on Aging • Department of Mental Health	• Emerson Behavioral Health Department • Employment Options • Faith-based organizations • Home visiting organizations • Key Informants • Libraries • Local Foundations • Local media • Mental Health organization • OUT MetroWest	• Population-specific community-based organization • Primary Care practices • Private boarding schools • Private mental health providers • Schools – Adjustment Counselors, Social Workers, etc. • Senior Living organization • Telehealth Organizations • Town social workers • William James College (MSPP) Interface		

Priority 2: Aging Health Concerns

Priority Area 2:	**Aging Health Concerns**
Goal 2:	**Improve access to, coordination and understanding of available resources to help older adults stay healthy, safe and connected to their community.**
Objective 2.1:	**Increase awareness of strategies and resources to improve the physical and mental health status of older adults and their caregivers by 2024.**

Outcome Indicators	**Baseline**	**Target**
• Older adults have an increased awareness of strategies and resources to improve their physical and mental health	Measure current awareness	Increase awareness
• Caregivers for older adults have an increased awareness of strategies and resources to improve physical and mental health	Measure current awareness	Increase awareness
• Older adults use strategies and resources	Measure utilization	Increase utilization
• Caregivers use strategies and resources	Measure utilization	Increase utilization

Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
2.1.1: Research, prioritize and publicize the information on events that impact the physical and mental health status of older adults and their caregivers.	CB staff	Y1, Y2, Y3	Staff Time	Contract
2.1.2: Connect with existing relevant programs and services at local CBOs.	CB staff	Y1, Y2, Y3	Staff Time	Community Partners
2.1.3: Provide resources to support the programs and services at local CBOs (e.g., speakers, space, tools, cross-promotion).	CB staff	Y1, Y2, Y3	Grant Funding and Staff Time	Community Awardees
2.1.4: Promote the replication and/or expansion of impactful programs.	CB staff	Y2-Y3	Grant Funding and Staff Time	Community Awardees
2.1.5: Support community based organizations in their efforts to address aging health concerns.	CB Staff	Y1-Y3	Grant Funding	Community Awardees

Monitoring/Evaluation Approach

- Administration of community health survey or coordination with partners on questions in their local assessments
- Tracking of activities
- Training/education program participant counts and pre/post-test or end of session feedback forms
- Google, or similar, analytics for reach of online postings

Potential Partners

- Councils on Aging/Senior Centers
- Long-term Care Facilities
- Minute Man Senior Services
- Other CBOs
- Topic experts

Priority Area 2:	**Aging Health Concerns**
Goal 2:	**Improve access to, coordination and understanding of available resources to help older adults stay healthy, safe and connected to their community.**

Objective 2.2: Increase the comfort level in the use of technology for older adults by 2024.

Outcome Indicators	**Baseline**	**Target**
• Older adults have an increased comfort level in the use of technology	Measure current efficacy	Increase efficacy
• Older adults use technology to stay healthy, safe and connected to their communities	Measure current efficacy	Increase efficacy
• Caregivers have an increased comfort level in the use of technology	Measure current efficacy	Increase efficacy
• Caregivers use technology to assist older adults in staying healthy, safe and connected to their communities	Measure current efficacy	Increase efficacy

Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
2.2.1: Collaborate with local Councils on Aging (COA) and other community based organizations on training and education programs in the use of technology	CB Staff	Y2-Y3	Grant Funding and Staff Time	Community Awardees
2.2.2: Partner with local youth programs or other CBOs or partners to provide education and set up/install technology	CB Staff	Y2-Y3	Grant Funding and Staff Time	Community Awardees
2.2.3: Promote replication and/or expansion of impactful programs. See also 2.4.1	CB Staff	Y2-Y3	Grant Funding and Staff Time	Community Awardees

Monitoring/Evaluation Approach

- Administration of community health survey or coordination with partners on questions in their local assessments
- Tracking of activities
- Training/education program participant counts and pre/post-test or end of session feedback forms
- Google, or similar, analytics for reach of online postings

Potential Partners

- Boy Scouts/Girl Scouts
- Councils on Aging (COA)/Senior Centers
- Libraries
- Minute Man Senior Services
- Other CBOs
- STEM education programs
- Tech companies (Ring, Nest, other Tech, Google/Alexa)

Priority Area 2:	**Aging Health Concerns**
Goal 2:	**Improve access to, coordination and understanding of available resources to help older adults stay healthy, safe and connected to their community.**
Objective 2.3:	**Increase awareness and availability of programs addressing the social determinants of health for the aging population by 2024.**

Outcome Indicators	**Baseline**	**Target**
• Older adults have an increased awareness and understanding of issues related to aging	Measure Awareness	Increase Awareness
• Caregivers have an increased awareness and understanding of the need for aging related planning	Measure Awareness	Increase Awareness

Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
2.3.1: Promote replication and/or expansion of impactful programs. See also 2.1.4	CB Staff	Y2-Y3	Grant Funding and Staff Time	Community Awardees
2.3.2: Curate, promote, and maintain access to community resources.	CB Staff	Y2	Staff Time	Vendor Partner
2.3.3: Support community based organizations in their efforts to address SDOH in aging population.	CB Staff	Y1, Y2, Y3	Grant Funding	Community Awardees

Monitoring/Evaluation Approach

- Tracking of activities
- Training/education program participant counts and pre/post-test or end of session feedback forms
- Google, or similar, analytics for reach of online postings

Potential Partners

- Councils on Aging (COA)/Senior Centers
- Elder law attorneys
- Long term care facilities
- Minute Man Senior Services
- Senior Housing
- Topic experts

Priority 3: Economic Insecurity

Priority Area 3:	**Economic Insecurity**			
Goal 3:	**Increase economic security by providing an integrated and collaborative approach to new or existing community services while reducing barriers to access and by empowering individuals.**			
Objective 3.1:	**Expand the identification of individuals or households experiencing or at risk of food insecurity, and share information with programs and agencies that can help respond to the identified need by 2024.**			
Outcome Indicators			**Baseline**	**Target**
• Number of individuals screened/identified as food insecure by EH departments				Creation of screening process and reporting tools
• Number of food drives held at Emerson Health/amount of food donated				2 per year
• Number of collaborative partners Emerson works with and supports				3
• Number of educational opportunities promoted through Emerson				2 per year
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
3.1.1: Engage various Emerson Health departments to identify individuals and families experiencing or at risk of food insecurity.	CB Staff	Y2, Y3	Staff Time	None
3.1.2: Understand and identify the network of programs and agencies to provide information on individuals and households in need of food assistance.	CB Staff	Y1-Y3	Staff Time	Contract
3.1.3: Leverage Emerson Health nutrition services wellness instructors for healthy cooking and educational classes across different platforms.	CB Staff	Y1, Y2, Y3	Staff Time	Wellness Instructors
3.1.4: Continue support for local food pantry/providers in service area through collaboration and innovative strategies	CB Staff	Y1, Y2, Y3	Grant Funding and Staff Time	Community Awardees
3.1.5: Reduce stigma around food insecurity by increasing awareness and education	CB Staff	Y1, Y2, Y3	Staff Time	Community Partnerships
Monitoring/Evaluation Approach				
• List of programs and agencies that can provide resources to individuals and households in need of assistance • Annual reporting on patients screened and identified • Annual reporting on food drives and financial support to local food pantries				

Priority Area 3:	**Economic Insecurity**
Goal 3:	**Increase economic security by providing an integrated and collaborative approach to new or existing community services while reducing barriers to access and by empowering individuals.**

Potential Partners

- Emerson Health Home Health Care Team
- Emerson Health Nutrition Services department
- Greater Boston Food Bank
- Open Table
- Bedford Food Bank
- Other local food pantries

Priority Area 3:	**Economic Insecurity**			
Goal 3:	**Increase economic security by providing an integrated and collaborative approach to new or existing community services while reducing barriers to access and by empowering individuals.**			
Objective 3.2:	**Increase collaborations and support for community agencies in an effort to address the cost of living and the growing inequality in the area by 2024.**			
Outcome Indicators			**Baseline**	**Target**
• Increased awareness around inequalities			Measure Awareness	Increase awareness
• Number of collaborative partners Emerson works with and supports				3
• Number of educational opportunities promoted through Emerson				2
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
3.2.1: Understand and Identify resources and agencies in the area that exist around housing and utilities support.	CB Staff	Y1, Y2, Y3	Staff Time	
3.2.2 Promote resources and agencies through traditional communication platforms and Find Help				
3.2.3 Continue support for local housing/utility providers in service area through collaboration and innovative strategies				
3.2.4: Reduce stigma around housing insecurity by increasing awareness and education				
3.2.5: Strengthen relationships with state and local politicians to learn, inform, and advocate on the needs of the community. See also 1.3.4	CB Staff	Y1, Y2, Y3	Staff Time	Community Partnerships
Monitoring/Evaluation Approach				
• Emerson Health meeting attendance at CHNAs/collaborative – Number of actions Emerson Health takes from those meetings • Number of meetings with state and local representatives to share information and strategies around cost of living in the area				
Potential Partners				
• CHNAs for Emerson Health service area • State and local politicians				

Priority Area 3: Economic Insecurity **Goal 3: Increase economic security by providing an integrated and collaborative approach to new or existing community services while reducing barriers to access and by empowering individuals.**				
Objective 3.3: Increase vulnerable individuals' access to financial support, training and resources by 2024.				
Outcome Indicators			**Baseline**	**Target**
• Staff training on Find Help and other DEI initiatives				
• Number of collaborative partners Emerson works with and supports				3
• Free/low cost care opportunities				3
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
3.3.1: Provide training and education to Emerson staff and providers to connect individuals to resources in a culturally sensitive way.	CB Staff	Y1, Y2, Y3	Staff time	Contract
3.3.2: Identify, collaborate, and partner with programs to connect individuals to sources of support	CB Staff	Y1, Y2, Y3	Staff time	
3.3.3 Reduce barriers to healthcare through promotion of resources and no cost care opportunities	CB Staff	Y1-Y3	Staff time and grant funding	Community Partners
Monitoring/Evaluation Approach				
• Annual reporting on number of trainings provided to Emerson staff, number of participants, number of referrals made, number of collaborations				
Potential Partners				
• Chamber of Commerce • Emerson Health HR department • International Institute of New England • Other job training programs in the area				

Priority 4: Transportation Options

Priority Area 4:	**Transportation Options**			
Goal 4:	**Collaborate with community partners to expand accessible, affordable, and flexible transportation to essential services.**			
Objective 4.1:	**Develop and implement a plan to address priority areas of unmet transportation needs for essential services by 2024.**			
Outcome Indicators			**Baseline**	**Target**
• Identified unmet needs in transportation options to/from essential services (process)				Develop inventory of current services
• Number of identified unmet needs that were addressed			Review gaps	Identify full list of unmet needs
• Identify additional indicators as needed based on the prioritized unmet needs			Review gaps	
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
4.1.1: **Define "essential services"** and the transportation associated with them.	CB Staff	Y1	Staff Time	Community Partners
4.1.2: Emerson staff, with input from others, will **conduct a gap analysis** to identify current transportation options available, lessons learned, strengths, gaps in transportation, etc.	CB Staff	Y1	Staff Time	Vendor Partner
4.1.3: **Prioritize unmet needs** for defined essential services based on an agreed upon set of criteria.	CB Staff	Y1	Staff Time	Vendor Partner
4.1.4: Utilize the Transportation Work Group, to define Emerson's role in supporting strategies to address top priority needs.	CB Staff	Y1, Y2, Y3	Staff Time	Community Partnership
4.1.5: Support community based organizations and municipalities in their efforts to address unmet transportation needs	CB Staff	Y1, Y2, Y3	Grant Funding	Community Awardees
Monitoring/Evaluation Approach				
• Monitoring the number of unmet needs. • Identify additional approaches based on the prioritized unmet needs				
Potential Partners				
• 495 Metrowest Initiative • Community Benefits Advisory Committee (CBAC) • Chambers of Commerce • Crosstown Connect • Faith-based organizations		• Local Council on Aging (COA) offices • Local Health Departments (LHD) • Regional Transit Authorities (RTA) • Town administration - including town planning directors		

Priority Area 4: Transportation Options **Goal 4: Collaborate with community partners to expand accessible, affordable, and flexible transportation to essential services.**				
Objective 4.2: Increase awareness of currently available transportation options for essential services by 2024.				
Outcome Indicators			**Baseline**	**Target**
• Increase in utilization of existing transportation options			Measure current utilization	Increase utilization
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
4.2.1: Identify the vehicles/channels for messaging (e.g., podcasts, videos, texts, Health Works magazine, public service announcements (PSA), email, flyers, town websites, notices in local newspapers, social media posts, YouTube channels, etc.).	CB Staff	Y1, Y2, Y3	Staff Time	
4.2.2: Collaborate with partners and stakeholders to disseminate messaging at regular intervals. FY23 Goal: • Brainstorm list of partners and stakeholders to support sharing of information	CB Staff	Y1, Y2, Y3	Staff Time	Community Partnerships
4.2.3: Support communication between communities and organizations around transportation options and strategies	CB Staff	Y1, Y2, Y3	Staff Time	Community Partnerships
Monitoring/Evaluation Approach				
• Review utilization data for each currently available transportation option, at least semi-annually				
Potential Partners				
• 495 Metrowest Initiative • Community Benefits Advisory Committee (CBAC) • Chambers of Commerce • Corporators (hospital ambassadors) • Crosstown Connect • Faith-based organizations • Local cable channels/Local access channel			• Local Council on Aging (COA) offices • Local Health Departments (LHD) • Local reporters • Regional Transit Authorities (RTA) • State legislators • Town administration - including town planning directors	

Priority Area 4: Transportation Options **Goal 4: Collaborate with community partners to expand accessible, affordable, and flexible transportation to essential services.**				
Objective 4.3: Improve ongoing advocacy at state and local levels for transportation needs or services by 2024.				
Outcome Indicators			**Baseline**	**Target**
• Increase in funding for new transportation programs			Current funding	Increase funding
• Maintain or increase existing funding for current transportation programs			Current funding	Maintain funding
• Increase in the number of individuals and organizations advocating for transportation needs or services			Current advocacy	Increase advocacy
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
4.3.1: Identify community organizations that are already doing advocacy at local or state levels	CB Staff	Y1	Staff Time	Community Partnership
4.3.2: Establish a list of champions and/or key points of contact for advocacy efforts	CB Staff	Y1, Y2, Y3	Staff Time	
4.3.3: Develop advocacy platform and specific "asks".	CB Staff	Y2, Y3	Staff Time	Vendor Partner
Monitoring/Evaluation Approach				
• Identify expected reports and to whom • Existing state report on community transportation funding (is there one?) • Town reports/budgets				
Potential Partners				
• Community Representatives • CrossTown Connect • Economic Development Organizations/Committees • Key influencers • Making the Connections • Regional Transit Authorities (RTA) • State Legislators • Town officials				