August 2024

Emerson Health

2024-2027 Strategic Implementation Plan

Submitted to:

Contents

Introduction 3
About Emerson Health 3
Emerson's Vision Statement 3
Emerson's Values 3
Emerson's Mission & Commitment 3
Community Benefits Mission Statement 3
Emerson Health Community Benefits 3
Community Health Needs Assessment and Strategic Implementation Plan 4
Methods 4
CHNA Key Findings 5
Priority Health Issues for the Strategic Implementation Plan 6
Populations Most Impacted 7
Social Determinants of Health Issues Addressed by this Plan 8
Rationale for Priority Community Needs Not Addressed 8
Emerson Health Strategic Implementation Plan (SIP) Participants 9
Emerson Health Strategic Implementation Plan Snapshot 10
Emerson Health Strategic Implementation Plan 11
Priority Area 1: Mental Health 11
Priority Area 2: Healthcare Access 17
Priority Area 3: Financial Stability 21

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

Introduction

About Emerson Health

Emerson Health provides advanced medical services to more than 300,000 people in 21 towns. Our core mission is to deliver exceptional patient-centered care that is highly reliable, safe, compassionate, equitable, efficient, and coordinated. We make high-quality healthcare more accessible to those who live and work in our community at Emerson Hospital in Concord, health centers in Bedford, Westford, Groton, Sudbury, and Concord, as well as urgent care centers in Hudson, Maynard, and Littleton.

Emerson's Vision Statement

Emerson Health strives to be a trusted healthcare provider, valued community partner, and creator of positive change in our region. We aim to help all people achieve their full potential for health and wellness throughout their lives.

Emerson's Values

Excellence, Compassion, Empathy, Inclusion, Integrity, Respect, Safety, Dignity, Innovation, and Teamwork

Emerson's Mission & Commitment

Emerson Health's mission is to deliver exceptional patient-centered care that is highly reliable, safe, compassionate, and equitable. We are committed to a culture of belonging, inclusivity, diversity and equity. We value and appreciate individuality and diversity of thought, experience, and perspective.

Emerson Health believes that all patients have the right to care regardless of race, color, creed, religion, national origin, age, disability, sex, sexual orientation, gender identity or expression, marital status, veteran status, ability to pay, membership or activity in a local commission, political affiliation, or place of residence. We support a culture where every person is respected and treated fairly.

Emerson Health is committed to health equity and works within our organization and our community to ensure that everyone has a fair and just opportunity to attain their highest level of health and well-being.

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 Hospital community by undertaking a Community Health Needs Assessment, developing a Strategic Implementation Plan, and offering funding for initiatives through the Christine Gallery 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 improvement process to improve the health of residents in 21 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 recognized that numerous factors at multiple levels impact a community's health. The goal of the CHNA was to gain a greater understanding of the issues that community residents face, how those issues are currently being addressed, and where there are gaps and opportunities to address these issues in the future. 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:

- Engagement of the Community Benefits Advisory Committee (CBAC)
  - Assisting with community engagement for data collection
  - Review and comment on draft documents
  - Participating in prioritization process
  - Disseminate findings
- Review of Secondary Data
  - Including U.S. Census Bureau, Census Bureau's American Community Survey, MA Department of Elementary and Secondary Education, School and District Profiles, MA Population Health Information Tool, Youth Risk Behavioral Survey, Tufts Health Plan, Massachusetts Healthy Aging Collaborative, Federal Bureau of Investigation Uniform Crime Reports, Bureau of Labor Statistics, Local Area Unemployment Statistics, and MA Department of Public Health
- 6 Key Informant Interviews
  - Subject matter experts and community leaders representing various segments
- 4 Focus Groups
  - Food pantry recipients
  - Adults involved in community mental health initiatives
  - Youth
  - Patient Family Advisory Council (PFAC)
- Community Health Survey - DPH Community Health Equity Survey (CHES)
  - Conducted primarily online in the summer and fall of 2023
  - Purpose was to understand the most pressing health-related needs facing Massachusetts residents, including their social circumstances, economic situations, and resource needs
  - Open to all people 14 or older living in MA
  - CHNA includes 8016 responses from the 21 communities that Emerson serves

Qualitative data were coded and analyzed thematically, where data analysis identified themes that emerged across sources. Selected quotes—without personal identifying information—are presented in the report to further illustrate points within topic areas.

CHNA Key Findings

The key health issues that emerged as areas of potential concern in the CHNA were raised in the community health 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 Key Findings Presentation for additional data and more detailed information pertaining to race/ethnicity breakdowns on each of these issues):

Economic Stability (originally described as High Cost of Living)

The percent of individuals living below the poverty line is lower in the service areas than the state or Middlesex County overall, but there is a range – in Sudbury just 1.5% of individuals live below the poverty line while it is 8.3% of individuals in Maynard.

- Unemployment peaked in 2020, but rates in the service areas returned to pre-COVID levels by 2022. Current unemployment is 2.7% in the primary service area and 3.0% in the secondary.
- Interviewees and focus group participants noted that the cost of living has been increasing.
- While lower than the state overall, still almost a quarter (23.2%) of CHES respondents in the Emerson service area reported trouble paying for basic needs, it was about double that for those with less than a bachelor's degree (45.0%) and with any disability (44.7%).
- CHES respondents in the Emerson service area reported not having enough money at the end of the month more than the state overall (22.6% vs. 16.5%).
- Housing and food came up as two areas of concern around affordability.
- As with the state overall, nearly half of households in many towns in the Emerson service area spend more than 30% of their income on housing.
- Fewer households receive SNAP in the service area, but food costs came up as a concern for those receiving and not receiving benefits.

Healthcare Access

- More than a third (38.4%) of CHES respondents reported an unmet need for short-term illness care and a little under a third (30.6%) reported an unmet need for ongoing health conditions.
- Language access: Key informant interviewees noted that some clinics do not provide translation or interpretation services and that doctors often do not send reminders or information in someone's native language.
- Cost: Even with health insurance, key informant interviewees and focus groups participants noted the cost with co-pays can still be a barrier to accessing services.
- Transportation: Some key informant interviewees noted the difficulty in accessing services because of limited or unreliable transportation options.

Mental Health

- The health concern that came up the most across interviewees and focus groups was mental health. Among focus group participants, there was a focus on anxiety, depression, and isolation.
- Almost a quarter (22.1%) of adults from the CHES reported having a mental health condition.
- Some interviewees noted the intertwined nature of mental health and social determinants of health.
- Interviewees and focus group participants identified youth as a community that is particularly impacted by mental health issues, citing school pressures and high expectations, along with social media and COVID-19 as leading factors. Youth experiencing depression, self-injury, and suicide decreased from 2022 to 2024.
- Many of the key informant interviews highlighted the difficulties of reaching medical appointments when patients do not have access to a vehicle, with one mentioning that there is no bus route to get to Emerson.

- A range of barriers were identified in relation to mental healthcare including a lack of practitioners, inadequate insurance coverage, long waitlists, and lack of hospital beds.
- Substance use was described as something that may not always be visible but still existed in the area.
- Some interviewees and focus group participants noted that the stigma surrounding substance use discouraged people from openly acknowledging what's going on or seeking resources / help.
- Alcohol related emergency room visits increased significantly from July 2018-June 2019 to July 2022-June 2023, more than doubling for Massachusetts, Middlesex County, and the majority of the towns in the Primary Service Area.

Transportation

Transportation was mentioned as a challenge in each of the key informant interviews and focus groups. It was noted that a lack of transportation impacted people's abilities to reach medical appointments, food pantries, jobs, social activities, and the courthouse.

- Many of the key informant interviews highlighted the difficulties of reaching medical appointments when patients do not have access to a vehicle, with one mentioning that there is no bus route to get to Emerson.
- Seniors were especially heightened as a group that may be isolated due to not being able to drive or not having access to transit.

Diversity, Equity, and Community Cohesion

Institutional racism, economic inequality, discriminatory policies, and historical oppression of specific groups are a few of the factors that drive health inequities in the U.S. Barriers to opportunities to services, supports, and resources may be disproportionately concentrated among certain populations, such as communities of color, low-income populations, persons with disabilities, and the lesbian, gay, bisexual, transgender, intersex, and asexual (LGBTQIA+) community. Issues of racism and discrimination still exist within the service area and can impact individuals' mental health, well-being, and sense of belonging.

- Diversity of residents has increased over time and participants noted that change as well. In the Primary Service Area, the White, non-Hispanic population decreased from 78.9% in 2015-2019 to 76.9% in 2018-2022; in the Secondary Service Area, the same population decreased from 86.0% in 2015-2019 to 80.8.0% in 2018-2022.
- Among CHES respondents, more than one in ten (13.1%) reported experiencing discrimination in the past year - those who identified as a person of color (28.7%) and with any disability (23.8%) reported higher percents of experiencing discrimination.
- The main strength noted by interviewees and participants was a strong sense of community and support throughout the area, while some commented that it can be hard to build social connections, especially after the COVID-19 pandemic.

Aging Population

- The Primary and Secondary Service Areas have larger older (65+) populations than the state.
- Participants discussed the unique challenges that older adults face in many of the key themes that emerged: accessibility and stigma around food pantries, transportation to reach medical appointments as well as daily activities, and isolation and loneliness.

Priority Health Issues for the Strategic Implementation Plan

In May 2024, 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 2024 Community Health Needs Assessment (CHNA), including the magnitude and

severity of these issues and their impact on the most vulnerable populations. As part of discussion on the key themes, participants were asked whether the findings were consistent with their experience or understanding of the community, and whether there was important information that they felt was missing. Participants raised two additional key themes that they wished to have considered as potential priorities for the SIP: Substance Use and Child Care. Following the finalization of potential priority areas for consideration, HRiA facilitated a prioritization process with participants to evaluate possible SIP priorities based on the criteria outlined in Figure 1.

Figure 1: Prioritization Criteria

RELEVANCE *How Important Is It?*	**APPROPRIATENESS** *Should We Do It?*	**IMPACT** *What Will We Get Out of It?*	**FEASIBILITY** *Can We do It?*
• Burden • Significance to Community • Equity	• Collective Responsibility • Community Attitudes and Values	• Collaboration/ Critical Mass • Effectiveness • Best-Practices/ Evidence-Based	• Achievable • Short- and Long-Term Change • Funding

Through thoughtful consideration of the data presented and knowledge of the existing programs already in place, participants used a rating and ranking worksheet to evaluate the potential priorities against the prioritization criteria, then indicated their selections through online polling. As a result, three priorities were identified to be addressed by Emerson Health in collaboration with community partners:

Priority 1: Mental Health
Priority 2: Healthcare Access
Priority 3: Economic Stability

In June 2024, HRiA facilitated a series of three virtual SIP planning sessions. Members of the CBAC, Emerson Health staff, and community stakeholders participated in work groups by priority area and were provided opportunities to provide feedback on the other priority areas between planning sessions. Each work group developed objectives, considered current programs and initiatives in the priority areas that should continue, and suggested additional strategies and initiatives to achieve each objective.

The resulting plan is meant to be reviewed during implementation efforts and adjusted to accommodate revisions that merit attention.

Populations Most Impacted

The following populations are those most impacted across the Priority Areas Addressed by this Strategic Implementation Plan:

Lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+)
Low-income households
Migrant populations
Older adults
People of color
People with disabilities
Young families
Youth

Social Determinants of Health Issues Addressed by this Plan

Economic Stability - including Housing and Food Security
Health Care Access - including Transportation
Neighborhood and Built Environment - including Housing
Social and Community Context - including Food Security and Health Literacy

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 resources and implementation strategies would be best served by addressing the priority areas identified for the Strategic Implementation Plan.

- **Diversity, Equity, and Community Cohesion**
  While this community need was not selected as a priority area for the SIP, these issues have been addressed in the SIP as follows:
  - *Diversity and equity are addressed across the plan through strategies to help the most impacted populations in each priority area.*
  - *Community Cohesion was the main strength noted by interviewees and participants - - a strong sense of community and support throughout the area. Others commented that it could be hard to build social connections, especially after the COVID-19 pandemic. Isolations is addressed in Priority 1 Mental Health through Objective 1.3: Enhance collaborations with community-based organizations to improve social connection and address populations at risk of social isolation by 2027.*
- **Transportation**
  While this community need was not selected as a priority area for the SIP, transportation has been addressed under Priority 2 Healthcare Access through Objective 2.3: Increase knowledge of existing transportation resources within the Emerson Health service area by 2027.
- **Aging Population**
  While this community need was not selected as a priority area for the SIP, the aging population is one of the populations most impacted under the Mental Health and Economic Stability priority areas.

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 May, and then formed priority area working groups for the SIP Planning Sessions held in June.

1. Mental Health

Melanie Dineen, Concord, and Lincoln Board of Health, CBAC
Sandra Hinds, CBAC
Lori Krinsky, Central Middlesex NAMI, CBAC
Nicole Laviolette,
Kelsey Magnuson, Emerson Health, CBAC
Jean Maguire, Maynard Public Library
Brittany Nash, North West Public Health Coalition
Heidi Porter, HHS Director, Bedford, CBAC
Nicole Saia, Social Services Supervisor, Concord Council on Aging, CBAC
Sara Wilson, Corporator and Foundation board member, also Carlisle school committee chair Carlisle school, CBAC
Patricia Worsley, Community Health Worker, Emerson Health Physicians-Hospital Organization, CBAC

2. HealthCare Access

Amy Caggiano, Emerson Health, CBAC
Thalita Campelo, Regional Health Communications Specialist, MetroWest Shared Public Health Services (and Hudson Health Dept),
Jaqueline Clancy, Emerson Health, CBAC
Rae Dick, Westford Health Director
Rose Ann Giordano, Board of Directors Emerson Health, CBAC
Christine Kielar, Director of Corporator and Community Engagement, Emerson Health
Jack MacKeen, Emerson CBAC
James Street, MD, Member of the EH Board, Chair of the Community Benefits Committee, former President of the Emerson Medical Staff EH Board, CBAC
Anna Winter Rasmussen, Emerson Hospital Board, CBAC

3. Financial Stability

Lauren Antonelli, Director, Public & Community Health, Town of Hudson
Christopher Bang, Community Social Worker
Jill Block, public health consultant Concord Corporation, CBAC
Melissa DeMarino, Emerson Home Care Social Worker, Emerson Health Physicians-Hospital Organization
Debra Galloway, Sudbury COA
Myriam JeanPierre, Health Coordinator MOC
Rick Lefferts, Chair Maynard Affordable Housing Trust, CBAC
Katie Neville, Acton-Boxborough United Way
Susan Rask, Public Health Consultant, Emerson Corporator, CBAC

Emerson Health Strategic Implementation Plan Snapshot

Priority Areas		Objectives	
1	Mental Health	1.1	Increase the awareness of both clinical and non-clinical mental health and substance use support services by 2027.
		1.2	Decrease stigma that serves as a barrier to seeking mental health and substance use services by 2027.
		1.3	Enhance collaborations with community-based organizations to improve social connection and address populations at risk of social isolation by 2027.
		1.4	Enhance understanding, education, and support for the mental health needs of youth by 2027.
2	Healthcare Access	2.1	Reduce barriers to health care access by raising awareness and utilization of Emerson Health language services by 2027.
		2.2	Enhance community members' ability to navigate the Emerson Health care system by 2027.
		2.3	Increase knowledge of existing transportation resources within the Emerson Health service area by 2027.
		2.4	Increase health and wellness related education to the Emerson Health service area by 2027.
3	Financial Stability	3.1	Increase connections of those experiencing or at risk of food insecurity to programs and agencies that can help improve food access by 2027.
		3.2	Increase collaborations with and support community-based organizations who assist people at risk of losing housing, who are in substandard housing, and people in need of housing by 2027.
		3.3	Increase access to resources, training, and education that address financial stability by 2027.

Emerson Health Strategic Implementation Plan

Priority Area 1: Mental Health

Priority Area 1: Mental Health				
Objective 1.1: Increase the awareness of both clinical and non-clinical mental health and substance use support services by 2027.				
Outcome Indicators			**Baseline**	**Target**
• Number of people attending awareness events or workshops			0	10 people per event
• Number of new partnerships addressing mental health and substance use			0	3 new community partners
• Number of translated materials			0	5 resource materials
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
1.1.1: Increase language access and translation of existing behavioral health resources.	CB Staff	Y1, Y2, Y3	Financial Contribution/Staff time	Contracted Service
1.1.2: Share and promote Behavior Health Resource List, Behavioral Health Helpline (e.g., multimedia campaign, social media, partner with schools/religious organizations/community centers, work with news media to share messaging about services available).	CB Staff, NAMI Central Middlesex, Mental Health Work Group	Y1, Y2, Y3	Staff time	
1.1.3: Support and collaborate with community events and workshops that share information and presentations by local support service providers.	CB Staff, Community Partners	Y1, Y2, Y3	Staff time/Grant funding	
1.1.4: Promote substance use awareness, education, and resources (e.g., highlight alcohol use from the Community Health Assessment (CHA), sober-friendly events/activities, partner with communications team to share mocktail recipes and promote nonalcoholic drinks, identifying local sober homes or AA or NA meetings, Narcan availability, mass.gov community naloxone program locator, address marijuana use in seniors).	CB Staff, Community Partners	Y1, Y2, Y3	Staff time	

Priority Area 1: Mental Health				
1.1.5: Identify and support existing efforts to address substance use and mental health and collaborate with partners to better coordinate efforts to ensure no duplication (e.g., Opioid Project, Opioid Take Force).	CB Staff, Mental Health Work Group	Y1, Y2, Y3	Staff time/Grant funding	
Monitoring/Evaluation Approach				
• Survey to use of clinical/non-clinical supports • Attendance at events/workshops • Monitor website traffic				
Potential Partners				
• Acton/Boxborough United Way (ABUW) • Local sober homes • National Alliance on Mental Illness (NAMI) Central Middlesex • Opioid Project • Opioid Task Force • Religious organizations • Schools				

Priority Area 1: Mental Health				
Objective 1.2: Decrease stigma that serves as a barrier to seeking mental health and substance use services by 2027.				
Outcome Indicators			**Baseline**	**Target**
• Number of participants in stigma reduction workshops and events			0	10 participants per event
• Number of new partnerships			0	3 new community partners
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
1.2.1: Identify and support community-based organizations that work with migrant/immigrant/refugee populations to address stigma and encourage mental health conversation.	CB Staff, Mental Health Work Group	Y1, Y2	Staff time	
1.2.2: Share positivity-focused messaging such as success stories, statistics, and testimonials from individuals who have benefited from mental health and substance use services.	CB Staff	Y2	Staff time	
1.2.3: Explore community-based partners who are working with vulnerable populations such as veterans, older adults, and LGBTQ+.	CB Staff, Mental Health Work Group	Y1, Y2	Staff time	
1.2.4: Host and promote educational events focused on mental health to normalize discussion of mental health concerns.	CB Staff, Community Partners	Y1, Y2, Y3	Staff time/Grant funding	
1.2.5: Collaborate with community partners to implement Yellow Tulip Project initiatives (e.g., storytelling, hope garden).	CB Staff, AB Cares	Y1, Y2, Y3	Financial contribution/Staff time	
Monitoring/Evaluation Approach				
• Survey on self-reported positive attitudes towards mental health and substance use services • Attendance at workshops/events • Monitor social media engagement				
Potential Partners				
• In Our Voice and Sharing Our Stories (both NAMI programs) • First Connections, https://www.youtube.com/channel/UCjSVKzSiszXLHzKVSEG7nMg, https://iine.org/migrants-immigrants-refugees-asylum-seekers-parolees-understanding-the-key-differences/ • Making Opportunities Count (MOC) • Acton/Boxborough United Way (ABUW) • Massachusetts Organization for Addiction Recovery (MOAR) • Community libraries, youth groups • School groups for LGBTQ+ youth • Concord Adult and Family Education Network				

<table>
<tr><th colspan="5">Priority Area 1: Mental Health</th></tr>
<tr><th colspan="5">Objective 1.3: Enhance collaborations with community-based organizations to improve social connection and address populations at risk of social isolation by 2027.</th></tr>
<tr><th colspan="3">Outcome Indicators</th><th>Baseline</th><th>Target</th></tr>
<tr><td colspan="3">• Grants awarded to support addressing social isolation</td><td>0</td><td>3 grantees</td></tr>
<tr><td colspan="3">• Number of community partners focused on decreasing social isolation</td><td>3</td><td>5 community partners</td></tr>
<tr><th>Strategies/Initiatives</th><th>Person(s) Responsible</th><th>Timeline (Y1, Y2, Y3)</th><th>Hospital Contribution</th><th>Other Source</th></tr>
<tr><td>1.3.1: Provide resources to support the programs and services at local community-based organizations (e.g., grants, speakers, space, tools, cross-promotion).</td><td>CB Staff</td><td>Y1, Y2, Y3</td><td>Staff time, Grant funding</td><td></td></tr>
<tr><td>1.3.2: Collaborate with existing community-based organizations (charity organizations) who can offer volunteers on ongoing basis to provide companionship (friendly visitor program through Councils on Aging).</td><td>CB Staff, Community Partners</td><td>Y2, Y3</td><td>Staff time</td><td></td></tr>
<tr><td>1.3.3: Investigate, share, and promote innovative programs that build community, increase social connections, and reduce social isolation, such as MA Association to Build Community and End Loneliness, English Minister of Isolation, Friends of Indian Senior Citizens Organization (FISCO), Action Health, Concord Housing Authority, and Minuteman Senior Services.</td><td>CB Staff, Mental Health Work Group</td><td>Y1</td><td>Staff time</td><td></td></tr>
<tr><th colspan="5">Monitoring/Evaluation Approach</th></tr>
<tr><td colspan="5">• Attendance numbers from senior centers
• Grants awarded
• Monitor number of volunteers</td></tr>
<tr><th colspan="5">Potential Partners</th></tr>
<tr><td colspan="5">• Massachusetts Association to Build Community and End Loneliness
• State Office of Aging and Independence
• Aging Service Access points
• Councils on Aging (COAs) for companion care programs
• Emerson Health Works and Emerson Auxiliary</td></tr>
</table>

Priority Area 1: Mental Health				
Objective 1.4: Enhance understanding, education, and support for the mental health needs of youth by 2027.				
Outcome Indicators			**Baseline**	**Target**
• Number of partners YRBS data is shared with			10 partners	30 partners
• Number of participants in educational workshops and events			0	10 people per event
• Number of partners crisis information is shared with			10 partners	30 partners
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
1.4.1: Implement the Youth Risk Behavior Survey (YRBS) in 2026.	CB Staff	Y2	Financial contribution/Staff time	Contracted Services
1.4.2: Disseminate Youth Risk Behavior Survey (YRBS) results through presentations and online media, including identifying new community partners who would benefit from YRBS results.	CB Staff	Y1, Y3	Staff time	
1.4.3: Collaborate with community partners to increase training and education to address youth mental health.	CB Staff, Community Partners	Y1, Y2, Y3	Grant funding	
1.4.4: Identify and support programs that empower youth to take leadership roles in promoting mental health awareness and reducing stigma among their peers (e.g., partners with youth advisory councils). (Cross-reference 1.2)	CB Staff, Community Partners	Y1, Y2, Y3	Staff time/Grant funding	
1.4.5: Offer education and activities and share resources for families on supporting their children's mental health and promoting open communication and mental well-being (e.g., social media usage, NAMI family support groups, and NAMI family classes).	CB Staff, Community Partners	Y1, Y2, Y3	Staff time/Grant funding	
1.4.6: Share resources with school clinicians/guidance office explaining what happens when young person goes to hospital for mental health support/in mental health crisis.	CB Staff	Y1	Financial contribution/Staff time	
Monitoring/Evaluation Approach				
• Track who the Youth Risk Behavior Survey (YRBS) is shared with • Monitor educational programs • Survey/YRBS				

Priority Area 1: Mental Health
Potential Partners
• The NAN Project • Speaking of Hope (via Department of Mental Health (DMH)) • Pediatric Intervention (PIT) team at Emerson • program at Westford Academy • Nashoba Regional Technical Academy • Home school groups • Danny's Place • Boys and Girls Clubs • NAMI Central Middlesex family support groups and basics classes • The Shift | Start the Conversation. Stop the Stigma.

Priority Area 2: Healthcare Access

Priority Area 2: Healthcare Access				
Objective 2.1: Reduce barriers to health care access by raising awareness and utilization of Emerson Health language services by 2027.				
Outcome Indicators			**Baseline**	**Target**
• Maintain and work to increase utilization of language services annually			7,000	7,000
• Number of translated promotional materials			English materials	3 languages
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
2.1.1: Research existing channels and tools and explore additional options to educate the community.	CB Staff	Y1	Staff time	
2.1.2: Assess staff understanding and usage of Emerson Health language services.	CB Staff,	Y1	Staff time	
2.1.3: Promote Emerson Health language capabilities.	CB Staff	Y1, Y2, Y3	Staff time	
Monitoring/Evaluation Approach				
•				
Potential Partners				
• Emerson staff • Local organizations that serve non-native English speakers such as Chinese American Club				

Priority Area 2: Healthcare Access				
Objective 2.2: Enhance community members' ability to navigate the Emerson Health care system by 2027.				
Outcome Indicators			**Baseline**	**Target**
• Website usage, patients searching for providers			0	Increase by 10%
• Utilization of telehealth services				Increase by 10%
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
2.2.1: Enhance Emerson Health community education on how, when, and where to access health care: – Build a new Emerson Health website – Explore potential for direct mail – Expand Community lecture series – Continue communication strategies through social, web and email.	CB Staff	Y1, Y2, Y3	Financial contribution/staff time	Contracted services
2.2.2: Outreach to populations most impacted (low-income households, people with disabilities, seniors).	CB Staff	Y1, Y2, Y3	Staff time	Contracted services
2.2.3: Provide education to the community on telehealth and how to access and utilize it.	CB Staff	Y1, Y2, Y3	Staff time	
Monitoring/Evaluation Approach				
• New Web Traffic • Track total individuals reached both patients/non-patients • Lecture series participants				
Potential Partners				
• Minuteman Senior • Minute Man ARC (MMARC) • Emerson Marketing • Councils on Aging (COAs), Community Health Agents, Cultural organizations, food pantries, community newsletters • Emerson website designers • Shelters • Schools • Towns				

Priority Area 2: Healthcare Access				
Objective 2.3: Increase knowledge of existing transportation resources within the Emerson Health service area by 2027.				
Outcome Indicators			**Baseline**	**Target**
• Number of people using FindHelp website for transportation services			5 per month	15 per month
• Number of patients supported with transportation resources			300 patients	400 patients
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
2.3.1: Review web resource page and update annually	CB Staff	Y1, Y2, Y3	Staff time	Contracted services
2.3.2: Collaborate with community-based organizations in their efforts to address unmet transportation needs.	CB Staff	Y1, Y2, Y3	Staff time	
2.3.3: Support patients by promoting community transit options upon discharge.	CB Staff	Y1, Y2, Y3	Financial contributions/staff time	
Monitoring/Evaluation Approach				
• Website traffic (Emerson and FindHelp) • Total number of individuals supported with transportation help through Emerson year over year?				
Potential Partners				
• Community-based organizations • Local towns • Council on Aging • Transportation Providers (ex. Cross town connect) • Churches				

Priority Area 2: Healthcare Access				
Objective 2.4: Increase health and wellness related education to the Emerson Health service area by 2027.				
Outcome Indicators			**Baseline**	**Target**
• Number of health and wellness related education events			1 event per year	2 events per year
• Support provided to community organizations to conduct health and wellness education			2 educational presentations per year	3 educational presentations per year
• Number of individuals participating in wellness education events, classes, or programs				10 people per event
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
2.4.1: Use Emerson platforms to educate the community (possible topics to include): – Digestive Health – Heart health – Women's Health – Stroke Prevention – Cancer Prevention: Sunscreen dispensers in the community – Caregiver education	CB Staff, CBAC	Y1, Y2, Y3	Financial contributions, staff time	Contracted services
2.4.2: Raise awareness of the wellness programs available to the community.	CB Staff, CBAC	Y1, Y2, Y3	Staff time	
2.4.3: Provide resources to support the programs and services at local community-based organizations (e.g., grants, speakers, space, tools, cross-promotion).	CB Staff	Y1, Y2, Y3	Staff time, Grant funding	
Monitoring/Evaluation Approach				
• Website traffic • Event participation • Class registration				
Potential Partners				
• Councils on Aging (COAs) • Emerson Auxiliary • Impact Melanoma (sunscreen dispensers) • Emerson providers/clinicians • Libraries				

Priority Area 3: Financial Stability

Priority Area 3: Financial Stability				
Objective 3.1: Increase connections of those experiencing or at risk of food insecurity to programs and agencies that can help improve food access by 2027.				
Outcome Indicators			**Baseline**	**Target**
• Number of people using FindHelp for food resources			10 per month	20 per month
• Number of physicians engaged in food pantry prescriptions			0	2
• Number of grants provided to food security partners			1 grant per year	1 grant per year
• Number of nutritional articles/presentations to the community			10 articles per year	20 articles per year
• Number of new community partners addressing food insecurity			0	3 new community partners
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
3.1.1: Explore building relationships with Emerson physicians and other local health providers to expand use of food pantry prescriptions.	CB Staff	Y1, Y2, Y3	Staff time	
3.1.2: Reduce barriers to food insecurity by partnering with local food providers to address cultural preferences.	CB Staff and community partners	Y1, Y2, Y3	Staff time/Grant funding	
3.1.3: Leverage Emerson Health nutrition services wellness instructors for healthy cooking and educational content.	Emerson Staff	Y1, Y2, Y3	Staff time	
3.1.4: Continue support for local food pantry/providers in the service area. (See also 3.3).	CB Staff	Y1, Y2, Y3	Staff time/Grant funding	
3.1.5: Expand partnerships and provide support for food rescue organizations (e.g., Spoonfuls),	CB Staff, Financial Stability Work Group, Community Partners	Y1, Y2, Y3	Financial contributions/Staff time	
3.1.6: Investigate, share, and promote innovative programs that improve access to healthy food (e.g., Hudson Health Dept. SNAP coordinator).	CB Staff and Financial Stability Work Group	Y1, Y2, Y3	Staff time/Grant funding	
3.1.7: Support and advocate for the expansion of food delivery services (e.g., Meal on Wheels, Heart to Home, Mom's Meals) and mobile food pantries (see Hudson Mobile Food Pantry- partnership with Open Table) and locations for food pick up where people already gather (e.g., senior centers).	CB Staff and Financial Stability Work Group	Y1, Y2, Y3	Staff time/Grant funding	

Priority Area 3: Financial Stability				
3.1.8: Collaborate with local food policy councils (e.g., the MetroWest Food Collaborative https://www.metrowestfoodcollaborative.org/).	CB Staff	Y1, Y2, Y3	Staff time	

Monitoring/Evaluation Approach

- Look into what is/can be tracked when SDOH responses are flagged
- Annual Reporting

Potential Partners

- Open Table and other local food pantries
- Greater Boston Food Bank
- Boston Gleaners (Stonefield Farm in South Acton)
- Spoonfuls and similar organization
- MetroWest Food Collaborative (https://www.metrowestfoodcollaborative.org/)
- Emerson Ambulatory
- Care Grant Writers

Priority Area 3: Financial Stability				
Objective 3.2: Increase collaborations with and support community-based organizations who assist people at risk of losing housing, who are in substandard housing, and people in need of housing by 2027.				
Outcome Indicators			**Baseline**	**Target**
• FindHelp data on number of times housing resources were sought			15 per month	30 per month
• Number of community partners addressing safe housing			3 Community Partners	5 Community Partners
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
3.2.1: Promote and support programs that assist in maintaining safe housing (e.g., Clear Path, Matter of Balance, Habitat for Humanity, share information and raise awareness about various towns' efforts to establish Hoarding/At Risk Task Forces).	CB Staff and community partners	Y1, Y2, Y3	Grant funding	
3.2.2: Investigate share and promote information on innovative programs that address or improve access to housing (e.g., Hudson Health Dept housing navigator position using funding with ARPA funding).	CB Staff and Financial Stability Work Group	Y2, Y3	Staff time/Grant funding	
3.2.3: Investigate, support, and promote programs that assist with household utilities and housing resources through FindHelp website (e.g., South Middlesex Opportunity Council, Community Team Works, and Making Opportunity Count).	CB Staff and Financial Stability Work Group	Y1, Y2, Y3	Financial contribution/Staff time	Contracted services

Monitoring/Evaluation Approach

- Look into what is and can be tracked when SDOH responses are flagged
- Does Epic have a query function?
- Annual Reporting

Potential Partners

- Metropolitan Community Development Corporation (MCDC)
- Local Public Health Coalitions
- Councils on Aging (COAs)
- Fire Departments
- Police Departments
- Non-profit community development corporations
- Regional Housing Service Organization (RHSO)
- Clear Path
- South Middlesex Opportunity Council
- Community Team Works
- Making Opportunity Count
- Habitat for Humanity

Priority Area 3: Financial Stability				
Objective 3.3: Increase access to resources, training, and education that address financial stability by 2027.				
Outcome Indicators			**Baseline**	**Target**
• FindHelp website searches on Money, Education, Work and Legal support			15 per month	30 per month
• Number of ELL and high school equivalency classes supported			1	3 total
• Number of financial literacy classes supported			1	1 per year
• Number of patients referred to free legal services through Metrowest Legal Services			40 referrals	60 referrals
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**
3.3.1: Collect information from food pantries and other community agencies to ask what their greatest needs are (e.g., diapers, feminine hygiene products) to better understand how to target grant funding. – Invite to meetings – Surveys – Talk with community members utilizing the services	CB Staff, Financial Stability Work Group	Y1, Y2, Y3	Staff time	
3.3.2: Partner with agencies and organizations to offer classes in multiple languages on financial literacy, how to avoid being scammed, payday loans, credit cards, and/or gambling addictions (e.g., Banks, Rotary Club).	CB Staff	Y1, Y2, Y3	Staff time, Grant funding	
3.3.3: Support and promote adult ELL and high school equivalency classes.	CB Staff and community partners	Y1, Y2, Y3	Grant funding	
3.3.4: Promote and support FindHelp as a resource in multiple languages.	CB Staff	Y1, Y2, Y3	Financial contribution	Contracted Service
3.3.5: Promote and support access to free legal services (e.g., Metrowest Legal Services).	CB Staff	Y1, Y2, Y3	Financial contribution	Contracted Service
3.3.6: Investigate, share, and promote information on innovative programs, which help people access resources, training, and education to address financial stability (e.g., Acton/Boxborough Resource Center of the United Way).	CB Staff, Financial Stability Work Group	Y1, Y2, Y3	Staff time	
Monitoring/Evaluation Approach				
• Tracking by Emerson Health • Data collected by others who conduct training and education • Annual Reporting				

Priority Area 3: Financial Stability
Potential Partners
• Banks • Rotary Club • Police Departments • Technical High schools (e.g., Minuteman, Assabet) • Community colleges • Acton/Boxborough Resource Center of the United Way • Metrowest Legal Services • Organizations who offer language and financial literacy courses • Hudson/Maynard Adult Learning Center • Concord/Carlise Adult Ed • Libraries