Nashoba Valley Health Planning Working Group
Final Report Appendix

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Transportation Subcommittee Report

Transportation Subcommittee

Subcommittee Charge:

From November 2024 – February 2025 the Transportation Subcommittee met to review the current landscape of transportation in the Nashoba Hospital service area to:

(1) Identify short-term action items to mitigate immediate transportation needs in the region related to access to medical care.

(2) Understand what supports, capacity, or technical assistance is needed to create longer-term transportation accessibility for accessing medical care.

(3) Where feasible, work with local and state partners to facilitate action items and identify future supports.

Co-Chairs

- Kirby Lecy, Manager of Healthy Community Initiatives, Division of Community Health Planning and Engagement, Department of Public Health
- Chelsey Patriss, Executive Director, CHNA-9

Members

- Sheri Bean, Montachusett Regional Planning Commission
- Bruno Fisher, Montachusett Regional Transit Authority
- Rachel Fichtenbaum, MassDOT
- Ryan FitzGerald, Chief of Staff, MassDOT
- Kelsey Magnuson, Community Benefits & Events Manager, Emerson Hospital
- Patti Onorato, Deputy Executive Vice Chancellor for Operations, ForHealth
- Patricia Pistone, UMass Memorial Health
- Robert Pontbriand, Ayer Town Manager
- Marian Ryan, Middlesex County District Attorney
- Thomas Schiavone, MassDOT

Summary: Landscape Overview

- Existing **systems and resources are strained,** especially On-Demand services. They were strained before the hospital closure to meet regional needs and build in redundancy.
- **Increased distances and travel times** to reach health care services are reducing the number of trips provided by services like Councils on Aging.
- Local **municipalities and organizations have stepped up** to fill transportation gaps to populations in need. These are **not sustainable long-term**.
- There are **many collaborative partnerships** but most are focused on **one-off needs or projects**.
- Reducing the need to travel to medical services should be supported as well.
- Some populations face **greater inequities accessing transportation** and the systems available can have barriers to navigate.
- There is a data gap on how many people have **transportation insecurity and can't access current services.**
- **Effective public transportation in rural** areas is expensive due to larger geographic areas and lower volume.
- Individual organizations **lack the resources and/or capacity** to support larger scale regional coordination.
- Ensuring additional **burdens do not fall to under resourced municipalities and organizations** was noted by committee members.

Recommendations to Support Immediate Needs

1. SUPPORT A COMMUNICATIONS CAMPAIGN OUTLINING AVAILABLE OPTIONS FOR TRANSPORTATION IN THE REGION.

Residents, providers, and community partners report a lack of knowledge on existing transportation resources and who is eligible for these services.

This communications campaign should include :

- **Creation of a detailed resource** outlining available transportation options that includes,
  - **Services available** across the region, including public and private options.
  - **Eligibility** for use of services such as:
    - PT1 Ride Eligibility
    - Councils on Aging
    - Medicare Advantage Plans
  - Basic **schedule information**. How to schedule rides. Any pre-approvals needed.
  - **Can be updated** as information changes
  - Include information on what transportation options can also be used outside of accessing medical services. (work, shopping, etc.)
- Information and **education for area providers, agencies, EMS/towns, and community connection points** to share resources and support connection/navigation to appropriate resources.
- **A distribution plan** to both broadly share information and ensure target audiences receive information.
  - Coordinate with existing trusted communication mechanisms in the region.
  - Explore potential **use of state partner communication channels** to support outreach to targeted populations through existing mechanisms (Mass Health, Dept. of Transitional Assistance, Mass DoT – Ride Match)
  - A **sustainability plan** that outlines how information will be updated and what ongoing outreach will look like post initial information campaign

Immediate Needs Recommendations, cont.

To Support This Recommendation the Following is Needed:

- **Funding**
  - To support the detailed gathering and organizing of regional information.
  - To keep information and resources updated.
  - To design/print information and resource materials.
  - To support distribution, outreach, and education.
- **Connection Points and Support/Resources from**
  - State partners identified for communications supports (MassHealth, Department of Transitional Assistance)
  - Local organizations providing transportation in the region.
  - Area providers, agencies, and community connectors engaging with those needing transportation support.

2. SUPPORT COORDINATION OF ON-DEMAND SERVICES TO FEED INTO FIXED ROUTE SERVICES

This would help reduce current travel time burdens and restore local capacity to pre-closure levels.

To Support This Recommendation the Following is Needed:

- **Funding** local capacity to support the bi-directional coordination of feeder routes with the regional COAs, demand response, and on-demand services.
- This will include heavier initial coordination to set up the system and process.
- Could be supported longer term by the regional coordinating council (see long term recommendation 1) but to meet immediate needs this should be a stand-alone action taken now.

Immediate Needs Recommendations, cont.

3. FUND A TRANSPORTION SERVICE TO PROVIDE REAL TIME NON-ACUTE MEDICAL TRANSPORTATION UNTIL SEF OPENS.

This would reduce the use of EMS services and support the most prominent gap in medical transportation needs.

- Funding an **interim service to provide medical transportation** for non-acute patients to go to urgent care and the emergency room **will alleviate some pressure from local EMS.**
- Currently **transportation options are less available outside of business hours** and most on-demand services require advanced scheduling. This is leading to the use of EMS for non-acute transportation.
- **Go-Go has established routes in the area** already, funded by UMASS Medical supporting transportation for maternity services. MART also engages with this.
- Services like Go-Go **work with local transportation providers and ride share providers to fulfill requests** in real time. They ensure the ride dispatched is appropriate for the needs of the patient.
- This short-term intervention will need fiscal support– but in comparison to EMS services **would be both a cost savings** and **support local EMS coverage**.
- Setting up this service through MART who could contract with Go-Go and others would ensure for **robust coordination** of available services.
- If funded this should be part of the communications campaign to support outreach and use.

Recommendations for Longer Term Solutions

1. SUPPORT ON-GOING LONG-TERM COORDINATION OF TRANSPORTATION RESOURCES IN THE AREA

This would maximize resources and allow for better planning across under-resourced organizations.

This coordination should support:

The regions future of mobility workgroup has proposed a **Regional Coordinating Council** and there is a **pending funding application** that would stand up this work and fund operations through June 30th of 2026.

- **Alignment of resources** that promotes inter-connectivity of existing services **to maximize access to transportation across the region**.
- **Coordination of technology** and apps being used across the region to support transportation trip scheduling, planning, and dispatching. Supporting more streamlined communications that are accessible and interoperable.
- Data coordination and sharing to **increase the understanding of service uses and needs**, and support decision-making and resource allocation across the region.
- Build out the **workforce and operational resilience** for transportation providers in the region.
- Understand and assess the role of volunteer networks in the region providing transportation supports and how they integrate into the overall transportation work.

Recommendations for Longer Term Solutions, cont.

2. BOLSTER EXISTING TRANSIT OFFERINGS THROUGH INCREASED RESOURCES AND CAPACITY.

More robust transportation support .

This coordination should support:

The regions future of mobility workgroup has proposed a **Regional Coordinating Council** and there is a **pending funding application** that would stand up this work and fund operations through June 30th of 2026.

- **Alignment of resources** that promotes inter-connectivity of existing services **to maximize access to transportation across the region**.
- **Coordination of technology** and apps being used across the region to support transportation trip scheduling, planning, and dispatching. Supporting more streamlined communications that are accessible and interoperable.
- Data coordination and sharing to **increase the understanding of service uses and needs**, and support decision-making and resource allocation across the region.
- Build out the **workforce and operational resilience** for transportation providers in the region.
- Understand and assess the role of volunteer networks in the region providing transportation supports and how they integrate into the overall transportation work.

Emergency Medical Services Subcommittee Report

Emergency Medical Services Subcommittee Report

The Emergency Medical Services (EMS) Subcommittee was charged to review status of emergency medical response services in terms of transport times and distances to provide emergency response services in the Nashoba Valley Region due to the closure of the Nashoba Valley Medical Center. The Subcommittee will look to provide information and opportunities to the Working Group regarding strengthening the Nashoba Valley Region's emergency medical response services in terms of specific resources needed to maintain the emergency medical response system of the Nashoba Valley Region as well as potential operational or programmatic changes (both among the EMS agencies and/or in concert with the receiving hospitals).

Chair

- Aaron Gettinger, Office of Preparedness and Emergency Management, Department of Public Health

Members

- Chief Arthur "Art" Cheeks, Groton
- Chief Brian L. Borneman, Pepperell
- Chief Robert A. Sideleau II, Leominster
- Chief Steele McCurdy, Littleton
- Chief Timothy Johnston, Ayer

EMS Subcommittee Report

- With the closure of Nashoba Valley Medical Center (NVMC), specifically its Emergency Department, local licensed ambulance services had to travel further to other receiving facilities. The eight licensed ambulance services who predominantly utilized NVMC are municipal combination fire department, meaning they provide both fire suppression and emergency medical services. Needing to travel further to transport patients to definitive care means longer times when ambulances are unavailable for simultaneous emergencies (either fire or medical in nature). This also had an impact on the ambulance services who utilized other hospitals who were now receiving higher volume. This, in turn, created a delay for the availability of vehicles and crews as well.
- The EMS subcommittee is comprised of fire chiefs from Groton, Ayer, Littleton, and Leominster, who bring knowledge and insight from their communities and other communities. This model allows for effective communication as there are duplicative meetings where area chiefs meet outside of this work and discussed challenges in a variety of settings.
- Prior to the subcommittee's formation, the Commonwealth, through its Department of Public Health (DPH), provided $2 million grant funding to eight towns for capital infrastructure improvements due to the longer transport times. This work continued and was a focus.

EMS Subcommittee Report Discussion

The group discussed the following impacted areas and opportunities for improvement:

Workforce

There is a shortage of an EMS workforce across the nation. It is a long-term problem that has been building for many years, now additionally impacted from pandemic burnout.[1] These impacts are felt in communities across the Commonwealth[2] in urban[3] and suburban areas[4]. Many of the EMS agencies in the Nashoba Valley Region voiced challenges hiring or recruiting staff. This was across varies types of agencies, from full-time paid, to call/volunteer, or a mix. Studies have been done in other states[5] [6], which show the underlying issues are complex without simple fixes but needing a supportive pathway for new staff entering the industry.

Operations

Operational Funding – In calendar year 2024 prior to closing, NVMC was receiving an average of 10-15 ambulances daily[9]. These ambulances now have further distances to transport. This increases the transport time, return to service time, and possibly the at-hospital time depending on volume. These increases mean a community now have to call back or hold staff for overtime, or rely on neighboring ambulances more (i.e., mutual aid), who may have to use overtime and call back to cover their own communities. The municipal agencies who provide fire and EMS voiced this unexpected increase in staffing need comes with a significant cost. While not every community will have the same impacts or costs, this ripple effect could impact communities outside the original eight who predominately transported to NVMC.

Capital Infrastructure Funding – Prior to NVMC closing, utilizing a geospatial analysis of drive time to hospitals (with and without NVMC) in the Northern Middlesex/Worcester County/Southern NH, it was determined that eight communities would have further distances to drive for care. Further analysis was done with data from the Massachusetts Ambulance Trip Record Informatic System (MATRIS), which supported the eight communities were also the ones who used NVMC the most, with significant portion coming from Ayer and Groton[9]. **$250,000 per community was provided through DPH** to support impacts to physical infrastructure (i.e., wear and tear on ambulances) and other capital improvements (i.e., purchasing additional equipment or vehicles due to the longer transport times)[10].

Future

Shared Services – Each town has their own EMS agency to serve their citizens, there are models elsewhere in Massachusetts, New England, and across the nation where communities share these services. This is done for operational efficiency, in both ensuring the shortest response time with the most appropriate resource for those in need and for the cost savings economies of scale can bring.

EMS Subcommittee Report Opportunity

The group discussed the following impacted areas and opportunities for improvement:

Workforce

Area for Opportunity – Work with local community colleges to bring training and other educational opportunities into the impacted areas. This will support creating an EMS pipeline. Community colleges already have "*a special responsibility for workforce development and through partnerships with business and industry, provide job training, retraining, certification, and skills improvement*"[7] which makes them well suited for this gap in workforce. Many community colleges (including Mount Wachusett Community College[8], which services part of the Nashoba Valley) have existing accredited EMS training programs. Exploration of partnerships between the EMS agencies and the community colleges could bring training programs to the area fire departments and expand the number of potential EMS staff already in the area.

Operations

Operational Funding Area for Opportunity – Utilizing available data to identify those communities impacted the most by longer transport times and delays, explore if short term funding could be made available while long-term solutions are put in place for the effected area.

Capital Infrastructure Funding Action Progress – All eight communities have received the funding and have begun purchases. This includes, but is not limited to, quick response SUVs which will bring advanced medical staff and equipment to call which otherwise may not receive this care, replacement or additional ambulances, additional equipment due to the need to care for patients longer, or other items such as bringing the ability to refuel ambulances in-town vs staying out of town and unavailable longer.

Future

Shared Services Area for Opportunity – Moving to a shared service model would require additional exploration and study. The subcommittee recognizes the work this would need and recommends considering funding for a consultant.

EMS Subcommittee Report Footnotes

[1] https://www.naemt.org/resources/workforce-development

[2] https://www.bostonglobe.com/2024/12/05/metro/when-winthrop-toddler-stopped-breathing-where-were-all-ambulances/

[3] https://www.wgbh.org/news/local/2023-09-18/boston-tries-to-address-its-emt-shortage

[4] https://www.cbsnews.com/boston/news/staffing-pepperell-fire-station-empty-one-night/

[5] https://naemt.org/docs/default-source/initiatives/workforce-development/scems-workforce-survey-2018.pdf

[6] https://nycremsco.org/2024-update-on-the-ems-workforce-shortage/

[7] https://www.mass.gov/guides/about-the-public-higher-education-system#-mission-of-the-community-colleges-

[8] http://catalog.mwcc.edu/associatedegreesandcertificatelistandotheroptions/paramedictechnology/#overviewtext

[9] RHIVR – Not Publicly Posted. https://prod-useast-b.online.tableau.com/t/eohhsdph/views/MATRISEMSDashboard/Runsbytownhospitalservice/caf8892f-172d-47d2-9463-0dc010553622/27360fde-e9d6-44b5-9bb7-3768498e0e60

[10] https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-25-1031-OFFIC-OPEM-107605&external=true&parentUrl=bid

Emergency, Outpatient, and Healthcare Services Subcommittee Report

Emergency, Outpatient, and Healthcare Services Subcommittee

Subcommittee Charge:

To investigate, study and propose viable options which will:

(1) Sustainably address the lack of critical services in the Nashoba Valley region, including emergency, outpatient, and related healthcare services

(2) Explore and report on potential funding sources from the Nashoba Valley Region for the establishment and sustainability of proposed viable options

Co-Chairs

- Robert Pontbriand, Ayer Town Manager
- Representative Margaret Scarsdale

Members

- Shane Blundell, Legislative Affairs, EOHHS
- Stephany Godfrey, DO, Family Medicine Physician
- Sarah Graham, EOHHS
- Amjad Husain, MD, Pulmonologist
- Chief Timothy Johnston, Ayer Fire Department
- Chief Steele McCurdy, Littleton Fire Department
- Audra Sprague, Massachusetts Nurses Association
- Maria Syrniotis, Legislative Affairs, Congresswoman Lori Trahan's Office

Emergency, Outpatient, and Healthcare Services Opportunities

Actions by subcommittee include:

- Met 10 times since creation of subcommittee on December 13, 2024
- Heard presentations by subject matter experts related to healthcare operations on numerous occasions
- Discussed issues to be addressed to establish services in the region and solutions including but not limited to operators, location, and financing
- Provided feedback to UMMH related to proposal for SEF, communicating critical information
- Discussed potential funding solutions for establishment and viability of options

Emergency, Outpatient, & Healthcare Services Subcommittee

The subcommittee recommend **re-establishment of essential services in a tiered approach** as soon as possible, to reduce overall and long-lasting negative health impacts in this region:

Tier 1

- Emergency department, including critical ancillary services: Lab/x-ray/CT/etc.
- Cardiac lab
- Echocardiogram
- Endoscopy, with a GI physician on call 24/7

Tier 2

- Cardiac Rehab
- Infusion clinic
- Oncology
- Mammography
- Pain clinic
- Endocrinology
- OT/PT/Speech/Audiology

Tier 3

- Geriatric psychiatric services and support

Not Fully Explored

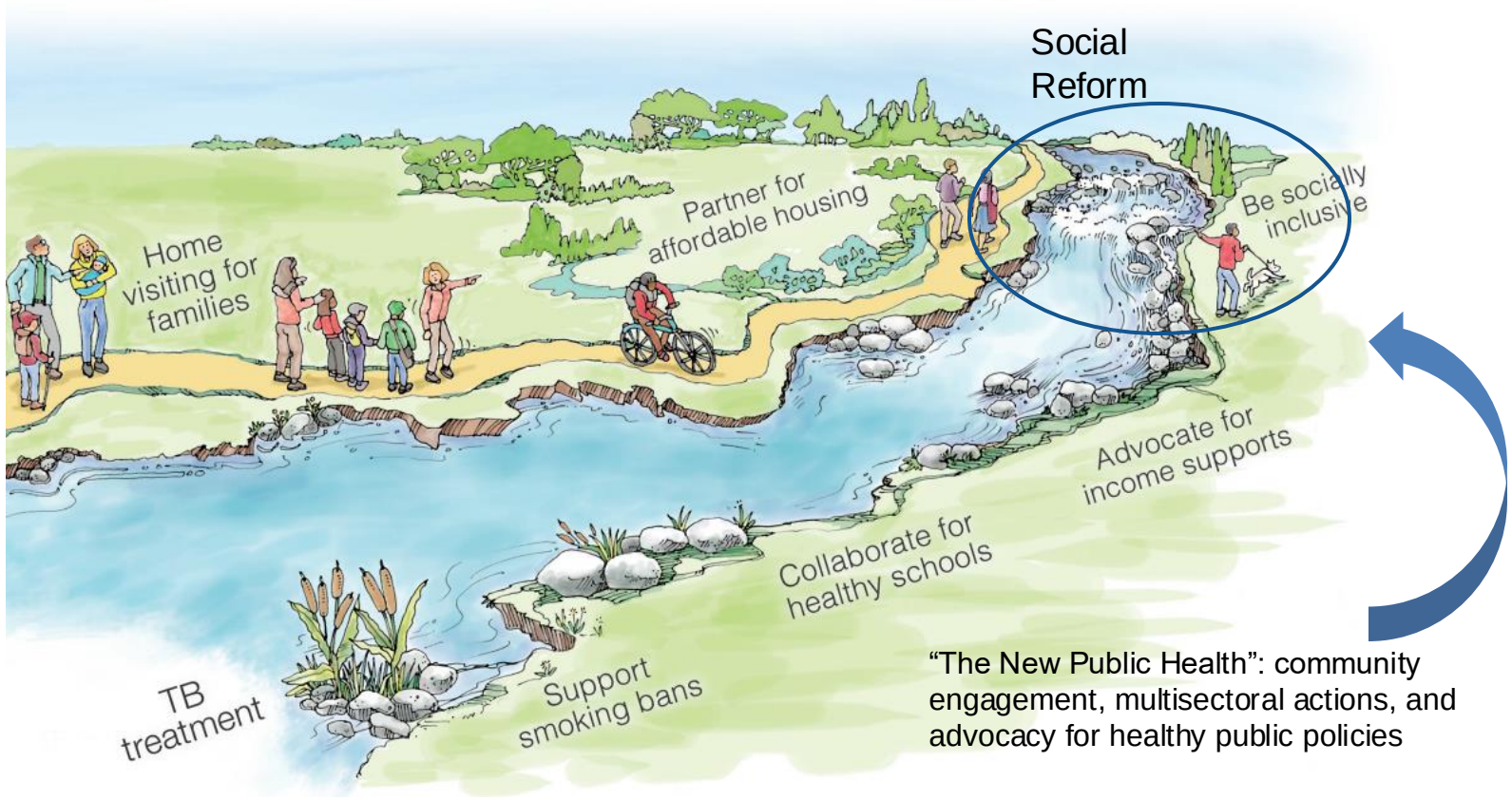
- Urgent care centers
- Community health center

Additional recommendations supported by the subcommittee

- SEF with complementary services such as lab (including cardiac), imaging, echocardiogram, endoscopy, etc.
- Preferably restore services at the current NVMC site, exhausting all efforts to secure the site
- Demonstrated ancillary health needs brought online as quickly as possible
- Ensure subcommittee continues supporting these priorities beyond the work of the NVHPWG
- Legislative advocacy to support the region

Upstream Efforts &
Public Health Subcommittee Report

Moving Upstream



Source: NCCDH Let's Talk Moving Upstream

Upstream Efforts & Public Health Subcommittee – Full Report

Subcommittee Charge:

This subcommittee will discuss upstream interventions that can address public health and social determinants of health to:

(1) Ensure that discussion of constellation of services needed to ensure the health of Nashoba Valley residents

(2) Review work that has already been done in this space (i.e., CHNA9's Community Health Improvement Plan & HCFA visioning session results)

(3) Ensure these efforts are included in final report

Goals of Subcommittee:

- Reduce hospitalizations and acute care needs
- Improve people's ability to comply with medical advice
- Improve people's understanding of healthy decisions
- Increase access and options so that healthy choices are reasonable

Chair:

- Chelsey Patriss – Health Equity Partnership of North Central MA
- Eliza Lake – Executive Office of Health and Human Services

Members:

- Jason Main – Massachusetts Veteran Service Officers
- Cari Medina – SEIU
- Jenna Montgomery – Nashoba Associated Boards of Health
- Patricia Pistone – UMass Memorial Health
- Lori Richardson – Aging Services of North Central Massachusetts
- Marian Ryan – Middlesex County District Attorney
- Jamila Xible – Health Care for All

Framework for Subcommittee Report

Context for Report:

- Health Equity Partnership of North Central MA has led community health planning since 2016.
- Their existing Community Health Improvement Plan (CHIP) 2028 helped identify key health challenges and priorities that align with the subcommittee's findings.
- The CHIP domains provided a framework for the subcommittee to contextualize recommendations, ensuring alignment with broader regional health priorities.
- CHIP emphasizes equity, system change, and collaboration which complement the Nashoba Valley Health Planning Working Group's goals.

Report & Resources

- For additional information regarding the work of CHNA-9 and to view the CHIP 2028 report, please use the links below:
  - View CHNA Website
  - View CHIP Report

Upstream Strategies – Gaps and Challenges

Subcommittee assessed areas of alignment between the findings of the NVMC Community Visioning top concerns and the regional Community Health Improvement Plan.

- Need ongoing organization and community coordination to continue these efforts – Health Equity Partnership and local social service organizations are resource-constrained
- Lack of inpatient care capacity
- Distance to and shortage of specialty care
- Nutrition-related chronic disease – poorly managed diabetes and cardiovascular disease
- Lack of support for aging in place and lack of homes with appropriate accommodations/support
- Healthcare services difficult for patients to navigate
- Little access to addiction/mental and behavioral health, and DV services, increasing burden on police, fire, EMS

Upstream Strategies – Regional Context/Existing Efforts

Subcommittee assessed areas of alignment between the findings of the NVMC Community Visioning top concerns and the regional Community Health Improvement Plan.

- Health Equity Partnership is starting a Regional Coordinating Council and planning to start 5-7 resident-led, HEP-supported micro-coalitions to build a hub and spoke model for the region.
  - Micro-coalitions will identify local opportunities to implement CHIP strategies and spread community awareness of regional efforts.
- Advocacy for CHWs, digital equity, and other policies and funding that support public health. Legislative events engage community members with legislators.
- Supporting Local Food Works, a collaborative building an equitable food system for farmers, large buyers, and consumers. Supporting Food Is Medicine and home delivery CSA programs to address food insecurity and nutrition-related chronic disease
- Pursuing AARP Age-Friendly Region designation and associated coordination of municipal plans
- Elevating diverse voices through intentional recruitment to boards, committees, and working groups. Providing the supports to ensure people are capable, confident, and heard.
- Facilitating collaboration among community stakeholders for coordinated/collective impact (aka “multi-solving”) initiatives
- Leading regional Future of Mobility efforts, including a regional 5-Year Mobility Master Plan, a Regional Coordinating Council, and a planned Transportation Management Association

Upstream Strategies – Recommendations

Subcommittee assessed areas of alignment between the findings of the NVMC Community Visioning top concerns and the regional Community Health Improvement Plan.

- Create a structure for continued engagement and strategic planning/implementation
  - Start a resident-led, Health Equity Partnership-supported micro-coalition to continue this work and carry out these opportunities, as well as plug into regional CHIP initiatives
- Pilot a full spectrum of home-based healthcare options, from Hospital at Home to telehealth and home visits.
- Digital equity support – access/affordability, literacy, training, equipment
- Expand Food Is Medicine and home delivery CSA programs to address food insecurity and nutrition-related chronic disease
- Improve home health and safety to keep people safe and living independently longer
  - Retro-fit or modify for mobility
  - Test and mitigate for water and air quality
  - Evaluate for mental and behavioral health and implement supports (Aging Services of NCMA)
- Healthcare navigator support embedded in NABH
- Identify funding to implement mobile harm reduction program
- Support COIN Collaborative and strengthen/add mental health clinician support and DV advocates embedded in police departments

CHIP Domain: Access to Healthcare

NVMC Community-Identified Priority: Emergency Care/Access to Specialty Care

Gaps	Current Efforts	Areas of Action
Lack of inpatient care capacity. Distance to and shortage of specialty care.	Working with multiple healthcare providers to mitigate a wave of service losses and closures, including with transportation and exploring home/tele-services.	Pilot a full spectrum of home-based healthcare options, from Hospital at Home to telehealth and home visits.
Loss of geri-psych beds Lack of support for aging in place and lack of homes with appropriate accommodations/support	Pursuing AARP Age-Friendly Region designation and associated coordination of municipal plans	Improve home health and safety to keep people safe and living independently longer: - Retro-fit or modify homes for mobility - Test and mitigate for water and air quality - Evaluate for mental and behavioral health and implement supports (Aging Services of NCMA and others need funding to implement)
Little access to addiction/mental and behavioral health, and DV services, increasing burden on police, fire, EMS	Promoting mental health co-response programs such as COIN/Advocates and providing technical assistance and convening/education. Promoting police-embedded DV advocates. Identified provider able to bring Syringe Service Program/mobile harm reduction to the region.	Funding needed for DV advocates, additional hours for co-response clinicians. DMH funding for SSP ran out – need to identify funding and promote the benefits of the program to each Board of Health/Select Board.

CHIP Domain: Racial and Social Justice / Access to Healthcare

NVMC Community-Identified Priority: Care Navigation

Gaps	Current Efforts	Areas of Action
Healthcare services are confusing, time-consuming, and frustrating for patients to navigate.	Hospital-based and insurance-based navigators serving their existing patients.	Healthcare navigator support embedded in NABH, capable of intensive support across all coverages and providers.
Vulnerable populations are not seeking services or engaging with institutions (education, health, etc.).	Supporting institutional DEIB policies. Promoting ESL, licensure/certification waivers, and other efforts to value and increase workplace diversity.	Recruit navigators who have cultural credibility with vulnerable populations. Increase trauma-informed care training for navigators and providers. Support “Know Your Rights” awareness campaigns to promote accurate information to vulnerable populations
Veterans and other populations (non-English speakers, older adults) have “given up” on systems and stopped seeking routine and preventive care due to lack of trust and past failures of the systems.	Community engagement to elevate diverse voices through intentional recruitment to boards, committees, and working groups. Providing the supports to ensure people are capable, confident, and heard. Supporting community leadership – civic engagement toolkit, Youth Advisory Council, Spanish-speaking Ambassadors	Start a resident-led, HEP-supported micro-coalition as a spoke under the regional hub of the Health Equity Partnership. Micro-coalition will identify local opportunities to implement CHIP strategies and spread community awareness of regional efforts.

CHIP Domain: Healthy Food Access / Transportation, Housing, & Built Environment

NVMC Community-Identified Priority: Community-based Programs and Prevention

Gaps	Current Efforts	Areas of Action
Nutrition-related chronic disease – poorly managed diabetes and cardiovascular disease. Loss of NVMC nutrition counseling services.	Equitable CSA home delivery program accepts SNAP/HIP. Successful Food Is Medicine program in HealthAlliance implemented in partnership with Growing Places.	Expand CSA home delivery program to cover all eligible NVMC community members. Expand Food Is Medicine program, including medically tailored and patient-preferred meals as well as nutrition and food-preparation counseling.
Digital equity gap makes accessing social and medical services challenging and increases isolation.	Some digital literacy training available in the region. Promoting programs that make internet access and equipment more affordable.	Comprehensive digital equity hub, including digital literacy training, equipment, and technical assistance.
Social services can be fragmented and siloed, often under-resourced and not always well-known and understood in the community.	Integrating food delivery with social service navigation for maternal/neonatal populations. Inter-agency working group tasked with increasing the capacity and connectedness of critical needs access programs	Integrate CHW services in food pantries and critical needs services. Create a resource hub and spoke model – one stop shops for multiple SS needs with experts doing rounds at spoke locations.
Transportation	*Addressed in Transportation Subcommittee Report*	*Addressed in Transportation Subcommittee Report*

CHIP Domain: Racial and Social Justice

NVMC Community-Identified Priority: Systems and Policy Change

Gaps	Current Efforts	Areas of Action
Lack of trust in systems. Increasing cultural and linguistic diversity of patients without resources in the healthcare system. Providers/staff not representative of the diversity of the patient population.	Anchor Collaborative: supporting local, inclusive employment – institutional DEIB policy, childcare policy, transportation. Promote ESL, licensure/certification waivers, and other efforts to value and increase workplace diversity	Policies that fast-track reciprocity licensure, limited licensure, and waivers. Pay differentials for bilingual or cultural broker staff.
Chronically underfunded and under-resourced region.	Advocating to advance the MA Rural Policy Plan and strengthening voices for Rural Health Policy Providing annual mini-grants to support discrete local projects/programs	Increase Health Equity Partnership's ability to provide mini-grants, technical assistance, and convene stakeholders to maximize resources and implement collective impact projects. Include community coalitions as eligible entities to receive Public Health Excellence funds.
Residents feel disempowered and uninformed about civic engagement at all levels.	Community trainings on civic engagement, annual Legislative Breakfast/Event	Start resident-led, HEP-supported micro-coalition. (Recommended above)
Healthcare business/funding models are unsustainable, especially in high public-payer communities.	Advocating for increased accountability and transparency, as well as better reimbursement rates for hospitals in high-need and rural communities.	Engage hospitals, insurers, community members, and legislators in negotiating fair and transparent solutions.

Additional Healthcare Model Details

Health Care Models Presented

There are several different options for the NVMC Workforce to consider researching further, which include:

- Federally Qualified Health Center (FQHC)
- Hospital Outpatient Department (HOPD)
- Hospital-based Satellite Emergency Facility (SEF)
- Rural Health Clinic (RHC) - more research must be done regarding the HPSA status

Currently, the NVMC facility does not meet the criteria to be utilized as any of the following options unless there are changes to regulatory criteria

- Rural Emergency Hospital (REH)
- Critical Access Hospital (CAH)
- Independent Freestanding Emergency Department (FSED)

**Based on presentation by Stroudwater Associates, a consulting firm specializing in rural healthcare*

Important Considerations: Rural Designation

Stroudwater Associates, a consulting firm with expertise in rural & community healthcare, presented a feasibility report around federal and state designations open to the NVMC-specifically. Findings included:

The former NVMC facility met a state definition of rural hospital which allowed it to participate in the Small Rural Hospital Improvement Program (SHIP) grant for several years

The former NVMC facility is in a Metropolitan Statistical Area (not rural) and is not currently in a Healthcare Professional Shortage Area (HPSA)

Based on Rural Information Hub, the NVMC facility is in a “rural” area for the purpose of the Rural Health Clinic (RHC) program but still does not currently meet the HPSA requirement

Potential for HPSA designation and/or reclassification of the area as rural could be explored in future, as appropriate

ED, SEF & Urgent Care Comparison

	Full-Service ED	SEF	Urgent Care
Open 24/7	Yes	Yes	Usually 8-16 hrs./day
Physician Staffing – 24/7, 365	Yes	Yes	May have*
Board prepared by ABEM or ABOEM	Required	Required	Not Required
Provide 25% of total hours worked per year in full-service ED	Not Required	Required	Not Required
Nurses, Nurse Practitioner, and Physicians Assistants			
ACLS, APLS, or PALS certified	Required	Required	Not Required
Provide 25% of total worked hours per year in full-service ED	Required	Required	Not Required
Min. 3 years experience in full-service ED	Not Required	Required	Not Required
Services On-Site			
X-ray	Always	Always	May have
Ultrasound	Always	Always	May have
Computed Tomography (CT)	Always	Always	No
Lab	Always	Always	Limited
IV Meds	Always	Always	May have
Narcotic Availability	Always	Always	May have
Must follow EMTALA	Yes	Yes	No

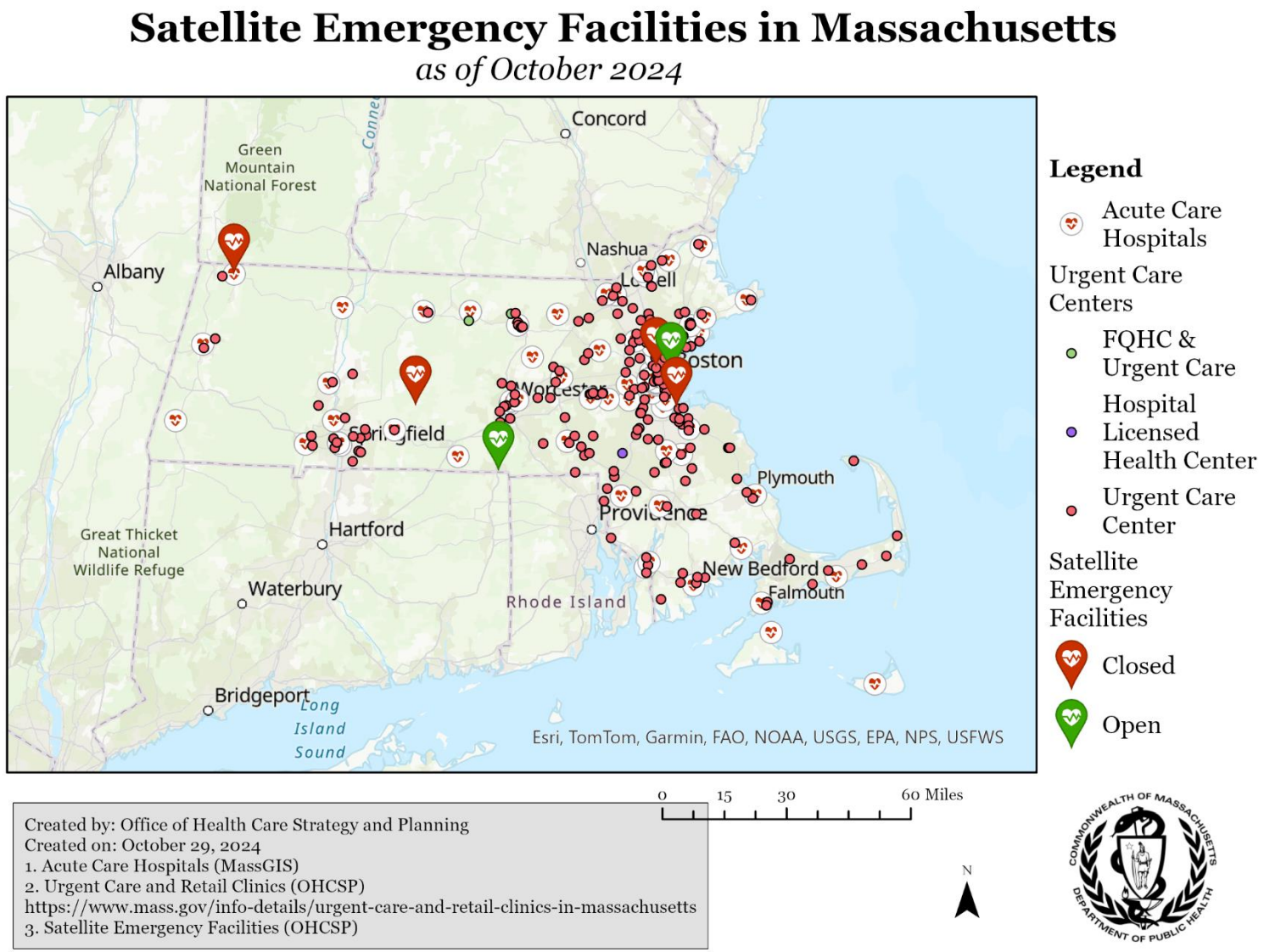
Satellite Emergency Facility Licensure

- Prior to DPH approval for the addition of a hospital Satellite Emergency Facility (SEF), the SEF must full-service all applicable state and federal regulations. The following areas of state and hospital regulation must be addressed to obtain approval to operate:
- The Hospital must develop and implement a public education plan;
- The SEF must be full-service with at least one Physician.
  - All physicians must be board prepared in emergency medicine by ABEM or ABOEM.
  - All physician staff must provide traditional clinical emergency services at a full-service hospital-based ED for at least 25% of their total hours per year.
- Nurse practitioners and physician assistants must be Advanced Cardiac Life Support (ACLS), Advanced Pediatric Life Support (APLS), or Pediatric Advanced Life Support (PALS) certified, minimum 3 yrs experience at full-service hospital ED, and must provide traditional clinical emergency services at a full-service, full-service ED for at least 25% of their working hours per year.
- Registered Nurse employees at SEF must be ACLS, APLS, or PALS and Certified Emergency Nurse (CEN) certified, minimum 3 yrs experience at full-service hospital ED, and must provide traditional clinical emergency services at a full-service hospital-based ED for at least 25% of their working hours per year.
- Policies must ensure all radio communication between SEF and pre-hospital providers are in compliance with applicable statewide emergency communication plans.

Satellite Emergency Facility Licensure (cont.)

- **SEF must provide:**
  - 24 hr. basic diagnostic radiology services;
  - Basic lab testing services w/results in less than 1hr;
  - 24 hr. lab services capable of performing blood gas analysis and routine hematology and chemistry;
  - Radiology services including CT scans and ultrasound with clinically appropriate turnaround time;
  - 24 hr. plain film radiology with techs available.
- **SEF has:**
  - Monitored and unmonitored beds in sufficient quality to meet projected patient volume
  - Pediatric and adult code carts and other standard
  - Surgical or other emergency consultative services available, on site or at an appropriate full-service hospital, within 30 minutes of a decision that said services are warranted;
  - Written policies that assure all transfers from the SEF are carried out in accord with all applicable state and federal laws and the Massachusetts Statewide Interfacility Transfer Guidelines;
  - A written list of the medical conditions and problems that are appropriate and inappropriate for ambulance transport to the SEF based on the capability of the SEF and regional point of entry plans.

SEFs in Massachusetts

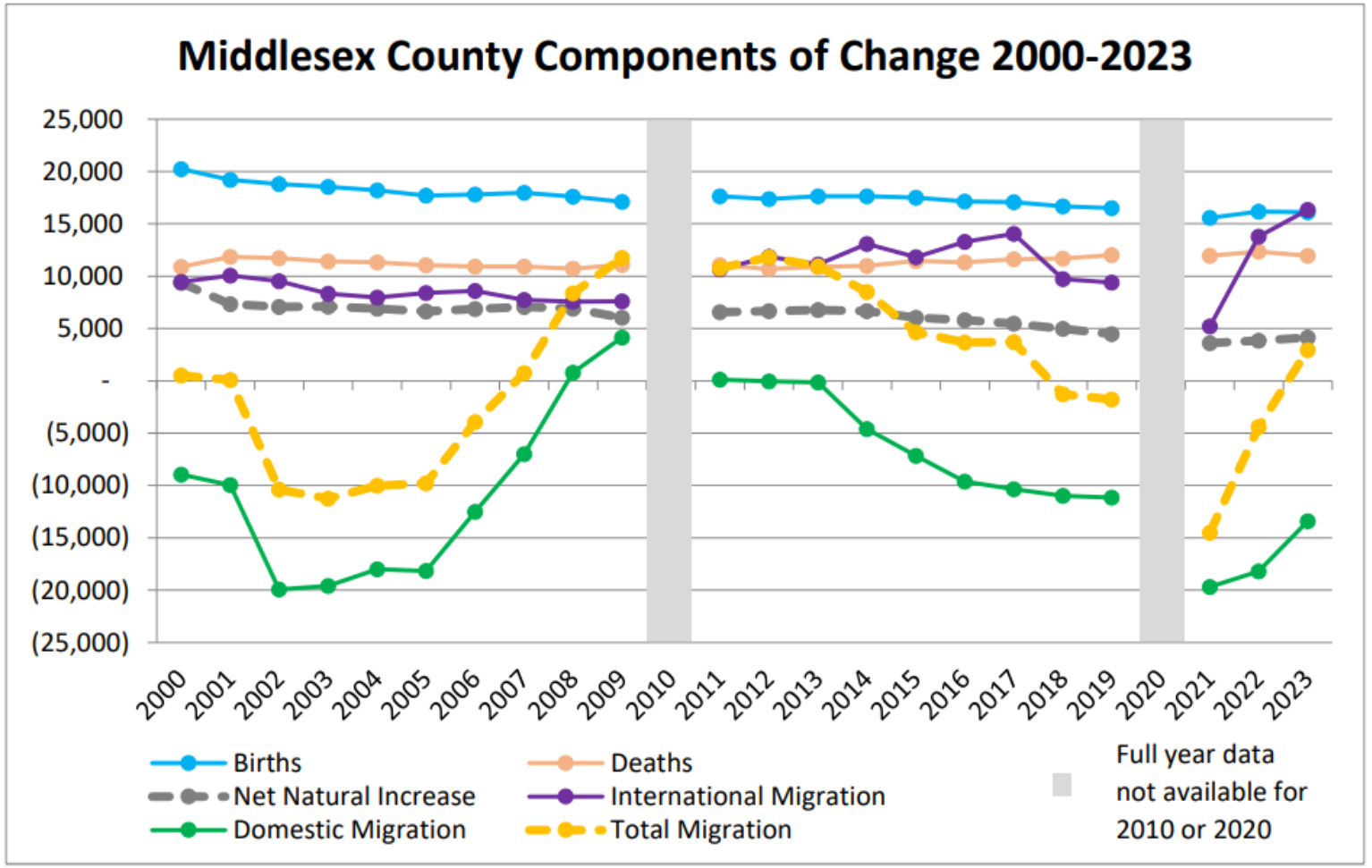


- East Boston Neighborhood Health Center
- UMass Harrington at Webster
- CHA Somerville Hospital – converted to urgent care
- Quincy Hospital – closed, converted to apartments
- North Adams Campus of Berkshire Medical Center – converted to critical access hospital
- Lawrence Memorial Hospital SEF – closed in 2019
- Baystate Mary Lane SEF – closed in 2021

Nashoba Valley Data

Population Changes

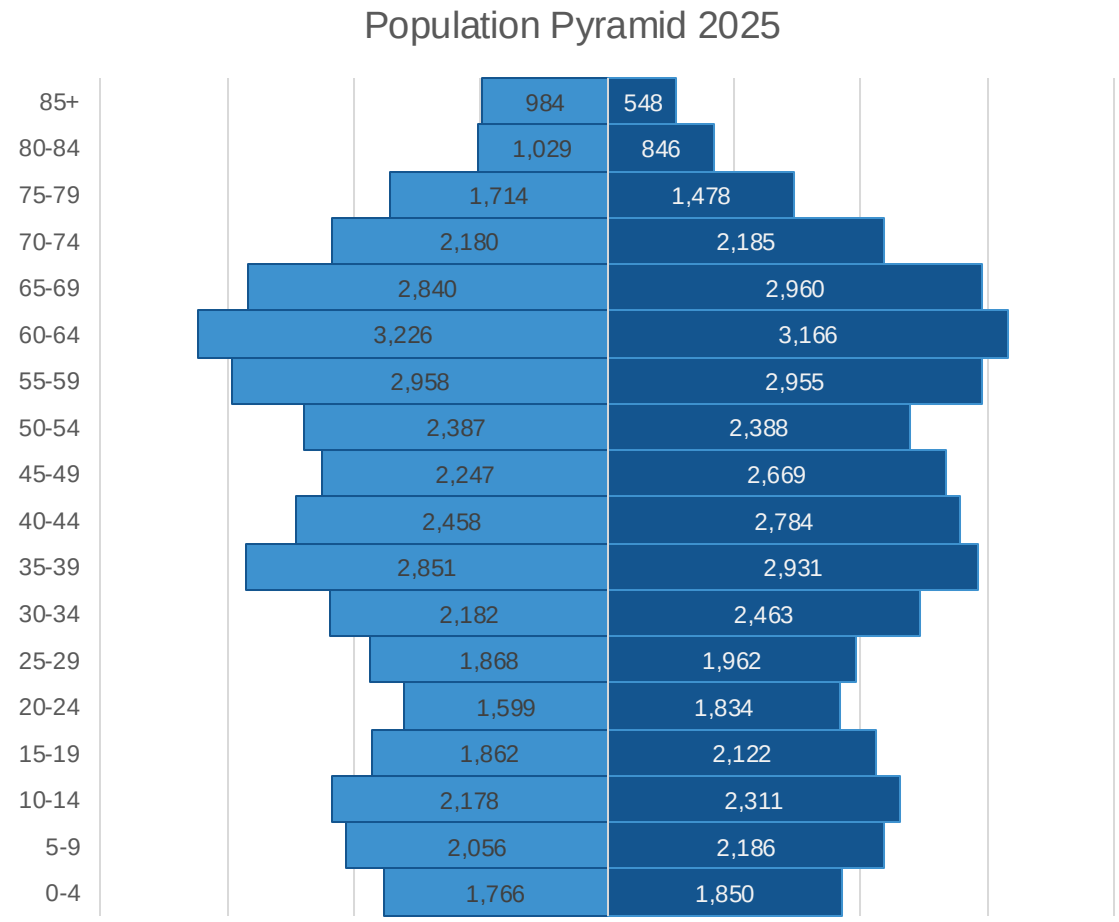
Middlesex County Recent Rapid Growth MA 2000 - 2023

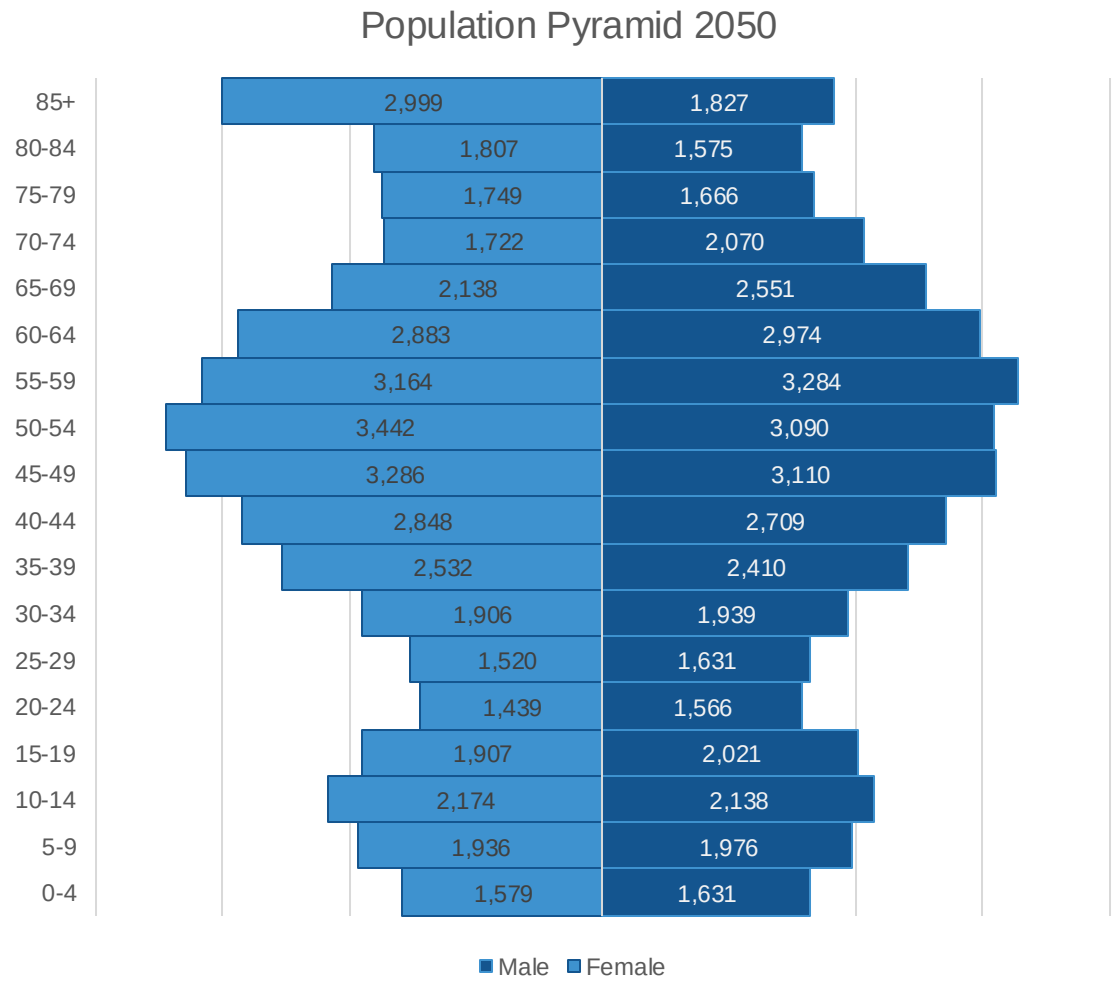


Data source: UMASS Donahue Institute (https://donahue.umass.edu/business-groups/economic-public-policy-research/massachusetts-population-estimates-program/population-estimates-by-massachusetts-geography/by-county)

Population Changes

Selected Communities: 2025-2050





Data source: UMASS Donahue Institute

(https://donahue.umass.edu/business-groups/economic-public-policy-research/massachusetts-population-estimates-program/population-projections)

Licensed Hospital Services and Bed Count

Acute Care Hospital	Med/Surg	ICU + CCU	Pediatrics	Maternal Newborn	Psych	Trauma
Health Alliance Clinton Hospital – Leominster	87	10				
Health Alliance Clinton Hospital – Clinton	21				20	
Emerson Hospital	70	14	11	24	31	
Lowell General Hospital (2 campuses)	181 + 120	23	20 + 20	26		Level III Adult
St Joseph's Hospital	131 adult inpatient beds					Level III Adult + Pediatric
Southern New Hampshire Health	152 adult inpatient beds					Level III Adult + Pediatric
Regional total	*479*	*47*	*51*	*50*	*51*	

Data source: Division of Health Care Facility Licensure and Certification, DPH

Geri-Psych at NVMC

From January 2, 2024, to January 7, 2025, number of licensed geriatric psych beds decreased from 440 to 423 (net decrease of 17) throughout MA

Breakdown of changes since January 2, 2024, below:

Geriatric Psych Facility	Date of Change	Licensed Bed Change	Staffed Bed Count*
Valley Springs BH	1/22/24	6 beds opened	24 beds total
	3/20/24	4 beds opened	
Nashoba Valley Medical Center	8/31/24	20 beds closed	
Carney Hospital	8/31/24	16 beds closed	
St. Elizabeth	8/31/24	15 beds closed	
Good Samaritan MC	10/28/24	16 beds opened	10 beds total

**As of 1/7/2025*

Current Status of Statewide Geri-Psych Beds

Geri-psych bed status statewide as of January 28, 2025. Importantly, number of licensed beds is not necessarily reflective of availability