Mass General Brigham
Salem Hospital

Community Health Implementation Plan 2023

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I. Executive Summary

a. Introduction

Salem Hospital, a member of Mass General Brigham (MGB), has a long-standing commitment to the health and vitality of our North Shore communities. Salem Hospital was founded to serve our neighbors and those in need, a commitment that is just as strong today as it was a century ago. We recognize that access to health care is necessary but not sufficient to achieving good health. Social and economic factors—such as equitable access to employment, healthy food, quality education, and affordable housing—play a critical role in overall health. Access to these resources can also be compounded by significant racial and ethnic inequities. Given the complexities of these issues, hospitals must partner with organizations and sectors of the economy that impact vital resources as a strategy for improving health, reducing cost, and achieving racial and ethnic equity. In 2022, Salem Hospital collaborated with neighboring communities to advance our shared vision of safe, thriving, and healthy neighborhoods by leading a highly participatory 2022 Community Health Needs Assessment and developing a Community Health Implementation Plan to address the priority health needs in our community.

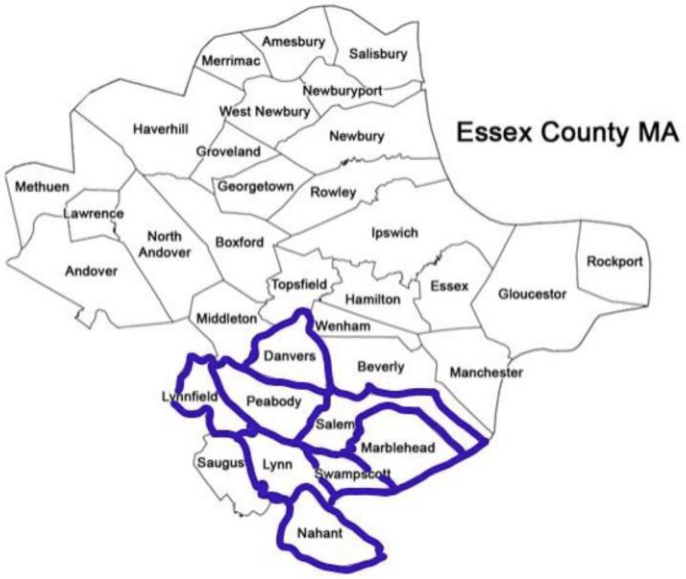
b. Reference to CHNA

The health of the community is integral to quality of life for residents in the region and supporting future social and economic well-being. Salem Hospital regularly engages in a two-part community health planning process to improve the health of residents in its service area: (1) a community health needs assessment (CHNA) to identify health-related needs and strengths of the region; and (2) a community health implementation plan (CHIP) to identify major health priorities, develop goals and objectives, select strategies, and identify partners to address the priority issues across the region. The CHNA and CHIP represent best practices in community health and also fulfill the federal IRS requirements and meet the Massachusetts Attorney General Community Benefit Guidelines.

c. Communities served

In collaboration with community stakeholders, Salem Hospital's Community Benefit Program enhances existing and develops new programs to respond to the health care needs of residents in the hospital's eight priority communities: Danvers, Lynn, Lynnfield, Marblehead, Nahant, Peabody, Salem, and Swampscott (See Figure 1 below).

Figure 1: Salem Hospital priority communities



d. Priority areas determined by CHNA and focus of implementation strategy

Community Assets and Resources: Focus group participants identified the diversity and resiliency of the community, as well as the number of organizations serving the priority communities and collaboration among those organizations as important community assets and resources.

Diversity and Disparities in Lynn: Among the hospital's priority communities, residents of Lynn, Salem, and Peabody are more likely to experience inequities in the social determinants of health and disproportionate risk for health and behavioral health concerns. However, several factors place Lynn residents most at-risk. Lynn has the lowest level of educational attainment and highest rates of unemployment and poverty. Lynn has the lowest home values, lowest proportion of homes with computers and internet access, and highest rates of mortgage and rent-burden. Lynn also had the highest rates of emergency department visits and inpatient discharges for mental health, more hospitalizations for non-fatal overdoses, and the highest rates of substance use treatment admissions. Lynn is the most racially, ethnically, and linguistically diverse of the hospital's priority communities and is home to the greatest proportion of immigrants in the hospital's service area.

Continuing impact of the pandemic: The COVID-19 pandemic exacerbated already existing problems with behavioral health and the social determinants of health in the region. Workforce shortages in health care and behavioral health extended already long wait lists and waiting periods for services and joined insurance challenges, high costs, and fear and

distrust in the health care system as barriers to care. A variety of underserved and vulnerable populations were identified as facing additional barriers to care and requiring outreach and navigation; these include seniors, youth, those with hearing impairments or other disabilities, undocumented immigrants, non-English speaking individuals, homeless populations, LGBTQ and transgender community members, people re-entering the community from jail/prison, and people dealing with mental health and/or substance use disorders. While community collaborations and partnerships in general were strengthened during the pandemic, the CHNA identified that opportunities exist to deepen collaborations to meet community needs.

Social Determinants of Health:

The lack of safe and affordable housing, food insecurity and poor nutrition, transportation challenges, lack of access to broadband and adequate cell service, and lack of affordable and quality childcare were identified as the SDoH that have the greatest impact on the health and wellness of community members.

Housing: The North Shore communities have become increasingly gentrified and housing prices have continued to rise causing major shortages in safe, stable, and affordable housing. Housing problems involve the entire continuum, including emergency/temporary shelter, longer-term/stabilization to permanent housing, and permanent supportive housing. The housing crisis has led to over-crowding, unhealthy and unsafe conditions, instability and frequent relocation, and homelessness, which have exacerbated other social determinants and disrupted care.

Food/nutrition: During the pandemic, significant investments and partnerships provided much needed food to those experiencing food and nutrition insecurity. However, limited program hours, transportation, stigma, lack of understanding about the importance of nutrition to health, poor oral health, and lack of culturally relevant foods affect use of such programs. Further, due to housing conditions/status, many people continue to have limited or no storage or cooking facilities. There is also concern that gains made during the pandemic related to the provision of healthy, nutritious foods to the community could be lost.

Transportation: Lack of reliable transportation poses a major challenge in the priority communities. Transportation affects access to medical appointments and preventive services, continuity of care, and appropriate use of emergency and ambulance services.

Broadband and Cell Service: The pandemic escalated the need for cell phone and internet services to access school, work, health care, and other resources. At the same time, the significant inequities in access to services that enable remote access became clear. Unlimited cell plans and internet service are expensive. While resources that expanded access to both during the pandemic have been reduced, the need for remote access remains high.

Childcare: Prior to the pandemic, there were too few childcare slots available in the community, especially for lower paid health and social service workers. The staffing challenges affecting many sectors of the workforce have particularly affected the availability of childcare services. While many residents worked and learned from home during the pandemic, the return to in-person work and school attendance has escalated the need for quality and affordable childcare.

Identified Health Issues:

The 2021 CHIP identified three health concerns affecting the community: COVID-19, oral health, and behavioral health. While COVID-19 is still a factor and oral health remains a significant need, the 2022 CHNA showed that problems related to behavioral health have continued to grow.

COVID-19: COVID-related unemployment and social distancing exacerbated economic disparities, isolation, and behavioral health issues for many residents, especially immigrants, seniors, and those with existing behavioral health issues. While testing and vaccinations have contributed to lower infection rates and better outcomes, continued efforts to ensure equitable access to testing and vaccines and understanding of the importance of both are important.

Oral health: Oral health services are expensive, particularly for restorative care. Too few dentists are available in the service area and fewer still accept Medicaid. Poor oral health has a significant impact on the ability to consume nutritious foods and affect health more broadly.

Behavioral health: Existing behavioral health problems intensified during the pandemic, including isolation, depression, anxiety, and substance use. Along with persistent opioid concerns, stimulant use is on the rise. There are long waiting lists and too few behavioral health providers, especially those who speak languages other than English, who accept Medicaid, and for pediatric patients. While statewide there are too few detox beds, too few options for the uninsured and those with MassHealth, and too few post-detox services, the needs are especially acute on the North Shore. Lack of transportation to services outside of the immediate area presents an additional barrier to access. When medication assisted treatment (MAT) is provided in Emergency Rooms, it is sometimes difficult to schedule follow-up appointments with primary care providers to ensure that patients can continue with MAT. The window of opportunity for getting people into detox, treatment, and on MAT is narrow and the aforementioned barriers often mean the window is missed. Additionally, patients are sometimes discharged from hospitals without medications for mental health issues or SUDs, which increases the likelihood patients will go without medications and conditions will be exacerbated. While the opening of a new state-funded on-demand behavioral health clinic on the North Shore will offer critically important services, there is concern about what the new facility will mean for the already lean staffing resources available elsewhere in the community.

Barriers to care and service delivery and coordination:

The previous CHNA identified several systemic barriers that affect access to care and effective service delivery and coordination; these issues persist in 2023. The closure of Union Hospital increased utilization of the Salem Hospital emergency department. With primary care appointments so hard to get, ED use for non-urgent issues has increased. Such demand on the ED resulted in long wait times. Workforce challenges at all levels have further complicated service delivery and lead to burnout of health and behavioral health providers. Hospital staff experience difficulty reaching providers in the community and encounter barriers referring patients due to different EMR systems. At the hospital, screening, referrals, and consultations often happen too late to problem-solve effectively with community providers. North Shore Community Health center patients don't have access to prenatal services on site at the health center and, when referred to the hospital, experience delays and difficulty navigating the system. Several vulnerable populations (identified below) have a particularly difficult time accessing care and/or navigating the health system.

Needs of Vulnerable populations:

In the previous CHIP, the needs of seniors, youth, and immigrants (with or without documentation)/residents with limited English proficiency and/or health literacy were identified as vulnerable population. The 2022 CHNA affirmed the vulnerability of these groups while also identifying additional populations who may face barriers to care and/or inequities in the SDoH. These additional groups include those with hearing impairments and other disabilities, homeless populations, the transgender community, people re-entering the community from jail/prison, and people dealing with mental health concerns and substance use disorders. Often, these groups are not mutually exclusive. Vulnerability likely increases for those identifying with more than one group (e.g., homeless seniors, transgender youth, undocumented individuals with disabilities).

Seniors: Behavioral health and the SDoH pose particular threats to seniors in the target communities. Increased isolation has worsened behavioral health issues among senior residents in the hospital's priority communities. Too few providers are comfortable and equipped to address the specific care needs of geriatric patients, which may mean end-of-life decisions are not discussed and patients are denied choice about their health care. The combination of mental health and dementia (and sometimes SUDs too) among seniors is not well-understood or appropriately treated in health care generally; to ensure the safety of such patients, collaborative planning between hospital and community partners is essential. When seniors are admitted to long-term care without ensuring they and their families understand their conditions and prognosis, it puts the facilities and community providers in a difficult position. Home-health shortages, especially caregivers who speak languages other than English, cause long delays and inconsistent care and endanger homebound seniors. Far too little transportation, particularly chair cars, exist to transport seniors to/from health care and other services. Too few affordable housing units exist for seniors and many live in unmaintained housing, and unsanitary and unsafe conditions, including infestations. Seniors often go without resources that would keep them safe and out of the

hospital (i.e., air conditioning, grab bars, chair lifts, hospital beds) because insurance won't pay for them. Healthy, easy to prepare and easy to eat foods are not always available, which affects blood pressure, blood sugar, and the overall health of seniors.

Youth: Behavioral health and the SDoH also pose particular challenges to the health and wellness of young people in the priority communities. Too few behavioral health resources existed for youth before the pandemic. During the pandemic, social isolation, anxiety and depression, and SUDs increased among youth. Education was disrupted for many youth who got jobs to contribute to household incomes and/or cared for younger siblings so their parents could work. Shelter space for unaccompanied youth (under 18) is extremely limited. Transportation issues limit youth access to school and youth programs. Unaccompanied youth and LGBTQ youth are hard to identify (unless they self-identify) and engage in services. Many youth services providers don't feel adequately prepared to talk to youth about mental health concerns, assess risk, and make referrals.

Immigrants/residents with limited English proficiency and/or health literacy: Newer immigrants often lack experience with, trust in, and understanding of health care, including why it's important and how to access it. Lack of understanding about the health system leads to increased ED use for non-urgent issues. The ability to navigate and utilize health system among those with limited English is hindered by language. Many immigrants without residency-status fear being turned in to immigration services by health care and other service providers. Immigrants often live in over-crowded housing and have less access to services due to language barriers, lack of insurance, and fear and mistrust.

Transgender individuals: Transgender individuals are at increased risk of violence and discrimination, which limits their access to resources and services. However, unintentional bias and lack of awareness can also pose barriers to care. Transgender individuals need providers who understand their needs and who can offer specialized health care. Lack of understanding and inadequate care tend to lead to mistrust in the health care system.

Homeless communities: Individuals and families who lack safe, stable housing face multiple obstacles to health, including possible exposure to the elements, discrimination, and violence. Those without adequate housing generally lack basic resources to store and cook healthy foods. Not having a permanent address can affect one's ability to access work and other resources. The stress associated with all of these factors can have a detrimental effect on one's health and wellbeing.

People re-entering the community post-incarceration: Those re-entering the community following jail or prison often lack support systems and adequate resources to ensure re-integration into the community. They may face discrimination that limits or prevents access to employment, housing, and other resources. They likely lack a primary care provider. Without work, most lack insurance and the ability to pay for health care. Many have histories of trauma. Those with histories of substance abuse may face challenges to sobriety and increased risk of overdose due to diminished tolerance while incarcerated.

People with hearing impairments and/or other disabilities: The experiences of those with disabilities can differ in many ways, based on their disability and other factors, including the SDoH. Depending upon the particular disability, an individual may have greater health care needs and yet, because of limits in communication or actual physical navigation, have difficulty accessing the care they need. Within the health and social service systems, they may encounter those who don't understand their particular needs and limited institutional resources to facilitate communication. They may encounter implicit bias or discrimination and, because of all of these factors, grow to distrust the systems that house the supports and services they need.

People with mental health and/or substance use disorders: Individuals who live with mental health and/or substance use disorders are at increased risk of violence and incarceration, are more likely to be unemployed, homeless, isolated, and in poor health, and to have low health literacy and difficulty navigating the health system. They often encounter obstacles to care, including too few behavioral health providers in the community, especially those who speak a language other than English and/or who are uninsured. They may experience discrimination, understaffed and busy service environments, or staff who not trained to understand the patient's specific diagnosis and needs. Fear and distrust may be associated with a particular diagnosis and/or developed through negative experiences with systems of care.

Priority Health Issues for the CHIP:

In a September 13, 2022 meeting, the CAHAC reviewed the CHNA findings and adopted five priorities for the 2023-2025 CHIP. These priorities and related issues are described below; the first four were also priorities in the previous CHIP, whereas the fifth (Workforce) is new.

- ***Behavioral health*** encompasses the issues of mental health, substance use disorders, gaps in treatment, stigma, and violence (domestic violence, child abuse/neglect, elder abuse/neglect). The 2022 CHNA also identified the need for harm reduction conversations in the hospital with active users and those with pain management issues.
- ***Health care access*** involves needs related to the accessibility of services, health insurance and cost, oral health services, and care coordination and navigation, especially for vulnerable populations. The 2022 CHNA identified opportunities to expand access by partnering with health centers and expanding mobile health services.
- ***Culturally sensitive care*** (referred to as "Health care environment and trust" in the previous CHIP) is the delivery of culturally sensitive care and services in multiple languages. These continuing needs call for further investment in outreach to and engagement of diverse communities and vulnerable populations.
- ***Social determinants of health***, including inequities related to housing, food/nutrition, transportation, broadband and cell service, childcare, and education, were included in the previous CHIP. These needs persist and, for many, have worsened in 2022.
- ***Workforce*** was introduced as a theme in the 2022 CHNA because labor shortages are causing extensive wait lists and wait times and severely limiting access to health and behavioral health care. Given the demographic make-up of the communities, it is also critical to increase the diversity of the workforce.

In addition to adopting the priorities and related issues above, the CAHAC determined that the 2023-2025 CHIP will continue to focus on its eight priority communities and develop strategies to address the needs of the underserved and vulnerable populations of seniors, youth, those with hearing impairments and other disabilities, undocumented immigrants, non-English speaking individuals, homeless populations, the transgender community, people re-entering the community from jail/prison, and people dealing with mental health concerns and substance use disorders. Given the challenges these vulnerable populations face regarding access to and navigation of health care, the CAHAC acknowledged that CHIP strategies must consider the needs of these specific populations as well as those that address needs within the priority communities more broadly.

e. CHIP Planning Process

On November 29, 2022, the CAHAC met to review the five priorities, review and refine the goals and objectives associated with the existing four priorities, and to develop a goal and objectives for the new workforce priority. The group also had an initial discussion about strategies to accomplish the objectives over the next three years. Thereafter, two small group meetings (on December 5 and 7, 2022) and a survey with CAHAC members were used to elicit additional ideas about strategies for the CHIP. On January 17, 2023, the CAHAC met again to review the list of strategies and prioritize those it believed to be most needed, most likely to advance the plan's objectives and address needs within the priority communities and vulnerable populations, and feasible over the next three years.

II. Priority Area Goals, Objectives, Strategies, Community Collaborations, and Metrics

The tables below provide the goal and objectives for each priority area, the planned strategies for achieving the objectives, and the community partners with whom Salem Hospital will partner to carryout strategies associated with the priority area over the next three years. The 2023-2025 CHIP includes new strategies, as well as many of those included in the one-year CHIP Salem Hospital implemented in 2022 so that it could get on the same community health implementation planning cycle as the other MGB hospitals. The CAHAC acknowledged when selecting strategies for the 2022 CHIP that many would take several years to implement and thus would likely continue to be CHIP strategies in the next planning cycle.

a. Behavioral Health

Goal: Enhance community awareness of and access to high quality behavioral health services
Objectives: • Decrease the morbidity and mortality for community members who have mental health needs and substance use disorders • Reduce gaps in access to and quality of behavioral health treatments • Improve community awareness that mental health is part of physical health and wellness
Strategies added in 2023:
1. Collaborate with Community Behavioral Health Centers (i.e., Eliot) to provide patients with on-demand/urgent care services
2. Expand SUD harm reduction strategies with active substance users and individuals struggling with pain management
3. Collaborate with MGB SUD leadership and other community leaders to assess possibility of expanding services to patients with Stimulant Use Disorders on the North Shore
4. Assess innovative models for providing behavioral health care (e.g., peer to peer, group work, new therapeutic settings, others)
5. Explore expanding local detox services (e.g., pilot detox at home model with Lynn Community Health Center) and outpatient psychiatric services at Salem Hospital
Strategies ongoing from 2022 CHIP:
6. Expand North Shore SUD Bridge Clinic
7. Increase screening for SUDs in primary care settings
8. Continue to identify opportunities to engage in efforts to reduce mental and behavioral health stigma
9. Improve coordination and communication between hospital and community providers
10. Continue to provide advocacy and support to patients and community members who experience domestic violence
11. Expand stress reduction and mindfulness training for providers
12. Continue Trauma Informed Care education, awareness and training for providers and staff
13. Provide technical support to Lynn Community Health Center for SUD mobile van
14. Continue to provide Sexual Assault Nurse Examiner services locally
Potential Partners: Local DPH departments, local public-school systems, Lynn Community Health Center, North Shore Community Health, MGH Haven, Healing Abuse Working for Change (HAWC), Healthy Streets, Eliot, protective services agencies, homeless shelters, local police departments, DPH SANE

b. Health Care Access

Goal: Efficiently and effectively meet the unique healthcare needs of diverse population
Objectives: • Identify and reduce barriers to accessing health care within North Shore Health System • Ensure that all individuals have access to care regardless of their ability to pay • Enhance communication and coordination between Salem Hospital and organizations within our community
Strategies added in 2023:
1. Expand Community Care Van services and collaborative outreach to provide easier access to education, prevention, screening, and chronic disease management in priority communities
2. Continue clinical collaborations with local community health centers aimed at reducing health disparities and addressing chronic diseases that disproportionately impact people of color and contribute to premature mortality (e.g., heart disease, cancer, diabetes)
3. Work with the local community health centers and North Shore Physicians Group to explore models for improving access to primary care to lessen wait times and take pressure off urgent care centers/emergency departments
4. Improve Patient Gateway enrollment, internet access, interpreter access, and other resources to support patient/provider communication particularly for non-English speaking patients and those with hearing impairment
5. Expand digital chronic disease management programs
Strategies ongoing from 2022 CHIP:
6. Renew affiliation agreements with Lynn Community Health Center and North Shore Community Health
7. Support and expand ongoing specialty care collaboration between NSPG and local community health centers
8. Continue Salem Hospital financial assistance transportation program
9. Assess best practices to improve access and provide oral health services especially for Medicaid patients
10. Continue to streamline processes for enrollment in state medical assistance programs
11. Ensure full compliance with MGB's financial assistance policy
12. Collaborate with local homeless shelters to improve communication and coordination of care
Potential Partners: Lynn Community Health Center, North Shore Community Health, Salem Skipper, Lyft, MassHealth, Medicare, Commercial Insurance Providers, local homeless shelters, GLSS, Lynn YMCA, Salem YMCA, Salem Pantry

c. Culturally Sensitive Care

Goal: Be accepted and trusted by the community as a culturally diverse and culturally sensitive hospital that is responsive to and reflective of the community's priorities and needs
Objectives: • Increase patients' level of feeling understood, welcomed, and respected when they seek care • Increase community members' access to multilingual services offered • Decrease disparities in healthcare within our communities
Strategies added in 2023:
1. Work with community partners to increase outreach, engagement, and navigation for diverse populations by growing a collaborative team of Community Health Workers and patient navigators across community organizations
2. Work with the cities, towns and larger service provider organizations to increase peer and community-based outreach support services for refugee, immigrant, and non-English speaking communities
3. Advocate for reimbursement for Community Health Workers
4. Increase expression of appreciation for various cultures by employees and leadership in their daily interactions with public and co-workers and in the design of facilities
5. Assess opportunities to make the MGB Healthcare Center in Lynn more welcoming, accessible, and culturally appropriate
Strategies ongoing from 2022 CHIP:
6. Explore including culturally competent care training as part of onboarding process for new staff and annual training requirements for existing staff (include customer service component to improve patient experience among those who are low-income)
7. Assess process for community providers to file complaints on behalf of their patients
8. Identify ways of tracking socio-economic status (or proxy measure) as part of patient complaints so that trends can be identified
9. Continue existing SH/NSPG youth and adult workforce development programs
10. Improve accuracy of race, ethnicity, and language patient data
11. Improve diversity in governance, leadership, and workforce
12. Increase racism training and awareness of incident reporting system
Potential Partners: Lynn Public Schools, Salem Public Schools, Peabody Public Schools, Wellspring, Lynn Community Health Center, North Shore Community Health, City of Lynn, City of Salem, City of Peabody

d. Social Determinants of Health

Goal: Reduce inequities related to the social determinants of health
Objectives: • Improve access to quality affordable housing • Improve access to nutritious foods • Improve access to reliable and affordable transportation • Improve access to reliable and affordable broadband and cell service
Strategies added in 2023:
1. Expand Social Determinants of health screening and connect patients to community resources
2. Collaborate with MGB leadership and community leaders to advocate for more affordable housing funding, appropriate housing options for patients upon discharge, and additional resources to support financial assistance programs
3. Support efforts to increase resources to construct, preserve, and manage affordable housing for residents, including health care staff
4. Explore opportunities to increase resources for homeless children and families on the North Shore
5. Support programs designed to reduce food insecurity, promote healthy eating and increase physical activity
6. Collaborate with community partners to increase SNAP and WIC enrollment
7. Explore expansion of transportation options on the North Shore to facilitate access to care and other services
Strategies ongoing from 2022 CHIP:
8. Increase engagement with Salem and Lynn Housing Authorities to improve communication and coordination
9. Continue to partner with community organizations to support a holistic approach to create a sustainable nutrition security plan
10. Advocate for “Food as Medicine” public policy
11. Provide financial support to the Phoenix Food Hub in Lynn
12. Advocate for better broadband/cell coverage on the North Shore and for low-income/at-risk populations.
13. Explore “wrap around” services for Salem Hospital staff that are available at other MGB facilities as a way of supporting retention and job satisfaction (such as onsite childcare)
Potential Partners: Lynn Housing Authority, Salem Housing Authority, Lynn Community Health Center, North Shore Community Health, Salem Food Pantry, My Brother’s Table, Citizen’s Inn, City of Lynn, Greater GLSS, senior services organizations, local transportation companies

e. Workforce

Goal: Improve staff recruitment and retention
Objectives: • Expand and diversify healthcare workforce pipeline • Improve employee wellbeing and job satisfaction
Strategies- all new in 2023
1. Work with state and local education and training providers to promote career exposure and advancement and educational attainment for North Shore residents
2. Increase awareness of pathways, incentives, and supports for individuals from communities of color to join the behavioral health workforce
3. Partner with local high schools and other organizations around pipeline initiatives (e.g., shadowing, speaker sessions) to encourage young people and other members of diverse communities to pursue health careers, including as MDs
4. Explore how to remove barriers to increasing internships at the hospital, including compensation and/or other recognition for internship supervisors
5. Partner with academic institutions (local colleges/universities and nursing programs) to develop and enhance new professional relationships
6. Extend hospital trainings to other organizations (e.g., CHCs) to strengthen workforce skills
7. Promote workforce mental health and wellness resources
8. Continue to recognize staff achievements
9. Continue salary equity initiatives
10. Foster discussions among leadership at various health organizations about how to address common workforce issues

f. Potential Evaluation Metrics

The table below provides the proposed outcome measures for monitoring progress toward the CHIP objectives. In the coming months, Salem Hospital's CAHAC will develop a process for evaluating successful implementation of the CHIP strategies, tracking improvements related to the outcome measures, and implementing changes (if needed) to our strategies to ensure the desired outcomes are achieved.

Priority	Process Measures	Outcome Measures
Behavioral Health	• Number of people receiving mental health support • Number of people receiving SUDs treatment services • Number of patients engaged in Bridge Clinic • Number of patients supported by Recovery Coaches • Number of patients who receive IPV services • Number of counseling sessions provided to those experiencing intimate partner/domestic violence	• Increase in engagement in mental health services in the community, particularly youth • Increase in engagement in SUDs services in the community • Increase in patients and community members reporting feeling safe • Reductions in hospitalizations
Health Care Access	• Average daily visit volume to Mobile Care Van • Number of patients enrolled in MassHealth • Number of patients accessing urgent care services by location	• Reduction in non-emergency ED visits • Reduction in ED wait times • Increase in primary care engagement • Reduction in wait times following hospital discharge • Increase volume of telehealth visits
Culturally Sensitive Care	• Number of patients using Salem Hospital interpreter services • Number of patient encounters with CHWs • Number of BIPOC and Lynn residents using MGB Healthcare Center in Lynn	• Reduction in racial disparities in health outcomes, particularly for hypertension, cardiometabolic disease, and SUDs • Increase in CHW workforce • Number of bills or policies supported/adopted related to reimbursement for CHW services

Priority	Process Measures	Outcome Measures
Social Determinants of Health	• Number of patients screened for SDOH • Number of referrals made to housing support services • Number of community-based organizations funded to support housing stabilization efforts • Dollars distributed to community-based organizations to support housing stabilization • Number of food assistance referrals and SNAP applications completed • Number of community-based organizations funded to support food security efforts • Dollars distributed to community-based organizations to support food security efforts • Number of patients assisted with transportation to or from the hospital	• Increased SNAP/WIC enrollment • Increased food pantry utilization • Number of bills or policies supported/adopted related to affordable housing • Improved access to affordable broadband service on the North Shore
Workforce	• Number of school and community events exposing students and residents to health care career opportunities • Number of interns hosted at Salem Hospital • Number of employee appreciation events	• Increase in BIPOC mental health and health care providers and staff • Retention rate of behavioral health and health care providers and staff (for BIPOC providers in particular)