Mass General Brigham
Salem Hospital

Salem Hospital

Community Health Needs Assessment

2022

Name of hospital organization operating hospital facility: Salem Hospital
EIN of hospital organization operating hospital facility: 042121376
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Date of CHNA approval: September 28, 2022
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I. EXECUTIVE SUMMARY

a. Introduction and Background

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. Salem Hospital has 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.

Salem Hospital is the North Shore's largest healthcare provider. The hospital offers comprehensive care and a commitment to exceptional quality, safety, and kindness at its main hospital campus, ambulatory care sites and physician offices. While hospital Community Health Needs Assessments are typically conducted every three years, Salem Hospital's 2021 Community Health Needs Assessment (CHNA) informed a one-year Community Health Improvement Plan (CHIP) to: (1) identify and address needs related to pandemic recovery, and (2) allow Salem Hospital to get on the same triennial cycle as the other MGB hospitals. By being on the same schedule, all of the MGB hospitals can work together and leverage resources to help address common concerns across various hospital service areas.

Salem Hospital's 2022 CHNA kicked off on June 7, 2022, when the hospital's Community Affairs and Health Access Committee (CAHAC), the 20-member assembly of clinical and community leaders, reviewed preliminary secondary data and laid out the plan for the 2022 CHNA.

Using multiple data sources, the purpose of a CHNA is to identify the key issues affecting the health of residents within the hospital's primary service area of Danvers, Lynn, Lynnfield, Marblehead, Nahant, Peabody, Salem, and Swampscott. The CAHAC, after reviewing the CHNA findings, is charged with selecting a set of priorities that will become the focus of the CHIP. The CHIP will lay out strategies to address the priority health needs over a three-year period.

b. Regulatory Requirements

The Affordable Care Act requires health care institutions to conduct CHNAs every three years in communities where they have licensed facilities, submit the report to the Internal Revenue Service, and post the report publicly on the hospital website by the last day of the fiscal year in which the CHNA is conducted (September 30 for Mass General Brigham hospitals). The Massachusetts Attorney General

has a similar requirement. A Community Health Improvement Plan (CHIP) detailing how the hospital will engage with the community to address the prioritized issues must be completed and posted by February 15.

While we are required to conduct CHNAs and CHIPs, we are also permitted to prioritize which communities and issues to focus on as long as there is a clear rationale for doing so. Toward this end, we have determined that Salem Hospital will focus on the communities with the greatest health disparities in our primary service area.

c. Methods

The 2022 CHNA was developed using three data sources:

1) Secondary data (e.g., from the hospital and health system, U.S. Census Bureau, Massachusetts Department of Public Health) provided demographic data, as well as information about the health and behavioral health of residents, and the social determinants of health affecting them.
2) Eight focus groups were conducted online with 51 community leaders with experience in/with community health centers; health care advocacy and public health; elder services; youth services; mental health and substance use disorders; immigrant services; housing; and food security. The hour-long groups were conducted via ZOOM and utilized a semi-structured interview guide. The data were analyzed for common and divergent themes and illustrative quotes.
3) A Community Survey was administered between July 28 through August 19 and available in multiple languages: English, Spanish, Portuguese (European and Brazilian), Haitian Creole, Chinese (Mandarin/Cantonese), Arabic, Russian, and Khmer/Cambodian. Data from 686 responses were analyzed using Excel and SPSS (Statistical Package for Social Science).

d. Target Population(s)

Salem Hospital will focus its efforts on the hospital's priority service communities of Danvers, Lynn, Lynnfield, Marblehead, Nahant, Peabody, Salem, and Swampscott. Depending on the priority area, Salem Hospital will concentrate efforts within certain populations or neighborhoods as needed.

e. Key Data

More than 270,000 people call the hospital's primary service communities their home. The diversity and resilience of residents and collaboration and partnership among agencies and organizations were identified as community assets. Providing services to a richly diverse community, however, is challenging. The assessment highlighted communities with lower incomes and greater diversity as the most powerfully and negatively affected within economic and social factors, ultimately impacting health outcomes. Salem Hospital will continue to use a racial and social justice lens in strengthening and developing our strategies to improve the health of our communities and will concentrate efforts within certain populations or communities as needed.

Lynn, the largest of the eight communities, has the youngest and most racially/ethnically diverse population and the highest concentration of foreign-born residents in the region. Of the eight communities, Lynn's educational attainment is lower while unemployment and poverty rates are higher. While Lynn has the lowest home values and lowest proportion of homes with computers and internet access, the city also has the highest rates of mortgage and rent burden. Lynn has also had higher 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.

The 2022 CHNA data suggest that the COVID-19 pandemic exacerbated the already existing needs related to behavioral health and the social determinants of health. Workforce shortages in health care and behavioral health extended already long wait lists and waiting periods for services and served as barriers to care, along with insurance challenges, high costs, and fear and distrust in the health care system. A variety of underserved and vulnerable populations (i.e., seniors, youth, those with hearing impairments or other disabilities, undocumented immigrants, non-English speaking individuals, homeless populations, LGBTQIA and transgender community members, people re-entering the community from jail/prison, and people dealing with mental health and/or substance use disorders) were identified as facing additional barriers to care and requiring outreach and navigation.

f. Mass General Brigham System Priorities

Mass General Brigham Community Health leads the Mass General Brigham system-wide commitment to improve the health and well-being of residents and patients served across the system. In addition to the priorities each hospital identifies which are unique to its communities, Mass General Brigham identified two system-level priorities: cardiometabolic disease and substance use disorder.

These priorities emerged from a review of hospital-level data and prevalent trends in population health statistics that show Black and Hispanic individuals are disproportionately affected by disparities in health outcomes and excess deaths related to these conditions.

Our efforts within these two priorities will aim to reduce racial and ethnic disparities in outcomes, with the goal of improving life expectancy.

g. Themes and Conclusion

Results from our assessment indicated that Lynn, Salem, and Peabody residents are more likely to experience inequities in the social determinants of health and disproportionate risk for health and behavioral health concerns. Social and economic factors have a large impact on the health status of communities, and it is important to focus on both treatment/management of disease along with an upstream focus on those systemic factors. We believe that our collaborations and impending CHIP will enable us to use our collective voice, resources, and strategies to make lasting and positive health impacts.

h. Priorities

The 2022 CHNA affirmed the priorities identified in the 2021 CHNA and addressed in the 2021 CHIP, while introducing new issues related to existing themes and one new community health theme. The 2022 CHNA themes and related issues are as follows.

- ***Behavioral health****,* a priority in the 2021 CHIP, encompasses the issues of mental health, substance use disorders (SUD), gaps in treatment, stigma, and violence (domestic violence, child abuse/neglect, elder abuse/neglect). The 2022 CHNA identified the need for harm reduction conversations in the hospital with active users and those with pain management issues.
- ***Health care access***, also a priority addressed in the 2021 CHIP, involves needs related to the accessibility of services, health insurance and cost, care coordination and navigation, and oral health services. The 2022 CHNA identified opportunities to expand access by enhancing Salem Hospital's partnership with the local community health centers and expanding mobile health services.
- ***Culturally sensitive care*** was defined in the 2021 CHNA and CHIP as 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 addressed in the 2021 CHIP. These needs persist and, for many, have worsened in 2022.
- ***Workforce:*** The 2022 CHNA adds a new theme in understanding the health-related needs in the priority communities. Labor shortages are causing extensive wait lists and times and severely limiting access to health and behavioral health care. Given the demographic make-up of the communities, increasing diversity of the workforce to meet these needs is paramount.

In a September 13, 2022 meeting, the CAHAC reviewed the CHNA findings and MGB's system focus on cardiometabolic disease and SUDS and adopted the five priorities and related issues described above. After reviewing the CHNA results, the CAHAC determined that the 2023-2025 CHIP will continue to focus on its eight priorities communities and develop strategies that will achieve racial and ethnic health equity by addressing the needs of several underserved and vulnerable populations, including 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.

i. Rationale for identified health needs not prioritized by Salem Hospital

Salem Hospital recognizes the importance of the identified health needs that are not within our priorities and, thus, will not be a focus within our health implementation plan. We recognize that we are not experts in any of those areas, but we commit to supporting and working with organizations and groups that are already committed to these efforts.

II. COMMUNITY HEALTH NEEDS ASSESSMENT

a. Purpose and Scope of Community Health Needs Assessment and Community Health Improvement Plan

Salem Hospital, a member of Mass General Brigham (MGB), is the North Shore's largest health care provider. The hospital offers comprehensive care and a commitment to exceptional quality, safety, and kindness at its main hospital campus, ambulatory care sites, and physician offices throughout the service area.

Hospital Community Health Needs Assessments are typically conducted every three years and are used to inform plans that lay out strategies for improving community health over a three-year period. Salem Hospital's 2021 Community Health Needs Assessment (CHNA) was unique in that it informed a one-year Community Health Improvement Plan (CHIP). The reason for a one-year CHIP was two-fold: While communities were still struggling to get through the pandemic, the hospital would likely need to implement some strategies specifically focused on pandemic recovery. Second, the one-year plan enabled Salem Hospital to get on the same triennial cycle as the other hospitals in the MGB system. By being on the same schedule, all of the MGB hospitals can work together and leverage resources to help address concerns that are common across various communities and hospital service areas.

Salem Hospital engaged public health consultant Hope Worden Kenefick, MSW, PhD and Master's in Public Health candidate Julia Schuler to collect and analyze data to develop the 2022 CHNA report. On June 7, 2022, the hospital's Community Affairs and Health Access Committee (CAHAC), the 20-member body of clinical and community leaders, reviewed preliminary secondary data and laid out the plan for the 2022 CHNA.

Like all CHNAs, the 2022 CHNA fulfills the IRS Section H/Form 990 mandate to:

- Identify health-related needs in the community, as well as community strengths and resources;
- Describe issues that affect the community overall, as well as concerns for certain sub-populations; and
- Provide data useful to the hospital and others for planning and developing programs and initiatives.

b. Data and Methods

The 2022 CHNA was developed using three data sources:

(1) **A review of secondary data** from publicly available local, state, and federal sources (e.g., U.S. Census Bureau, Massachusetts Department of Public Health), which provided demographic, health, and behavioral health data on the priority communities. Additionally, all North Shore Physician Group practices have been screening patients for social determinants of health since March of 2018. Data from pre-pandemic screenings between March 2018 – February 1, 2020 (n=30,408) and February 1, 2020 through May 27, 2022 (n=11,006) were available for inclusion in the CHNA.

(2) **Focus Groups** were conducted online with community leaders between July 6 and 29, 2022. In all, 51 leaders participated in eight groups organized around the following services: community health centers; health care advocacy and public health; elder services; youth services; behavioral

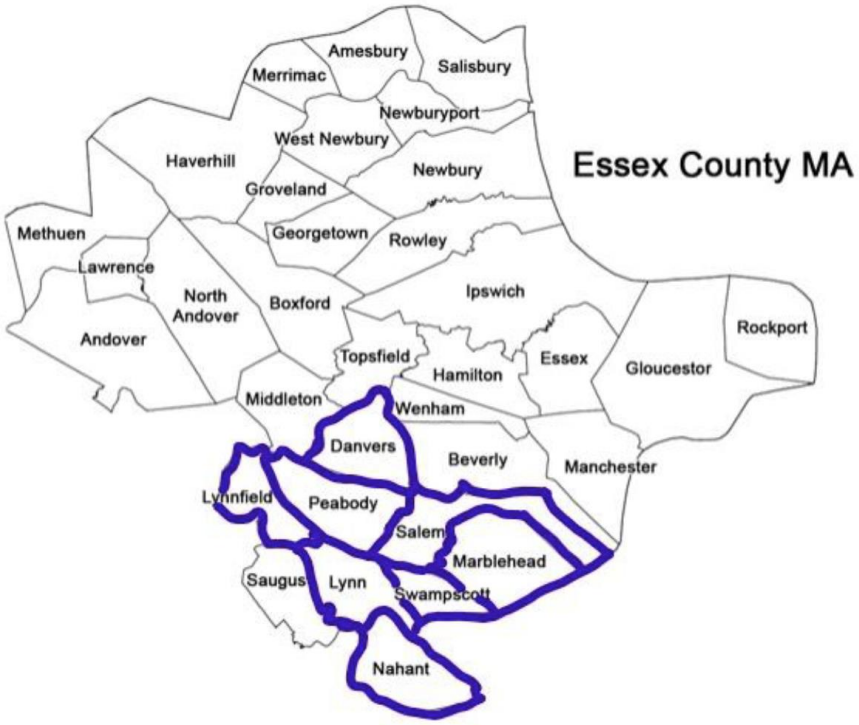
health/mental health/substance use disorders; immigrant services, and two groups on housing and food security. All focus groups were 60 minutes in length and conducted virtually via ZOOM. A focus group facilitator's guide was developed specifically for the CHNA to achieve the following goals: (1) Identify health-related needs and assets in the community; (2) Understand barriers and facilitators to health and wellness and how to address barriers; and (3) Identify opportunities to address identified needs. The focus group participants were assured of anonymity so that they would be comfortable being candid in their responses. The data provided by these leaders were analyzed for common and divergent themes and offer insight into the health concerns and underlying conditions that affect the patients, clients, constituents, and parishioners these leaders serve.

(3) **A Community Survey** was adapted from an existing MGB tool designed to understand community members' beliefs of the most pressing needs affecting community health, identify needs related to their own health and any barriers to care that they face, and to understand where they receive health care and which services, if any, they would be interested in accessing from a mobile health van. The survey was administered in multiple languages: English, Spanish, Portuguese (European and Brazilian), Haitian Creole, Chinese (Mandarin/Cantonese), Arabic, Russian, and Khmer/Cambodian. The survey was administered between July 28 through August 19. Community partners were instrumental in engaging, and in some cases assisting, community residents in completing the survey. In total, 686 responses were included in data analysis,[1] which was conducted using Excel and SPSS.

[1] At the time the survey was officially closed, there were 2,750 responses. The evaluator conducted a comprehensive review of each submission to determine which were completed by residents in the hospital service area and which were the product of hacking. Ultimately, 686 were identified that are believed to be legitimate submission by community members.

c. Target Population

The 2022 CHNA focused on Salem Hospital's priority communities, namely Danvers, Lynn, Lynnfield, Marblehead, Nahant, Peabody, Salem, and Swampscott (See Figure below).



Population size of MA, Essex County, and Salem Hospital's priority communities (2016-2020)

MA	Essex	Danvers	Lynn	Lynnfield	Marblehead	Nahant	Peabody	Salem	Swampscott
6,873,003	787,038	27,549	94,201	12,968	20,530	3,512	53,004	43,350	15,184

Source: 2020 American Community Survey 5-year estimates

According to the 2020 American Community Survey (ACS) 5-year estimates, the total population of the priority communities is 270,298 (34.3% of the population of Essex County). The largest of the nine communities is Lynn at 94,201 and the smallest is Nahant at 3,512

d. Population Characteristics

1. Sex:

Women comprise a greater percentage of the population than men in MA, Essex County, and in all of the priority communities except for Lynn, where the proportion of men is slightly higher than women (50.3% versus 49.7%, respectively).

Percent of population by sex in MA, Essex County, and Salem Hospital's priority communities (2016-2020)

	MA	Essex	Danvers	Lynn	Lynnfield	Marblehead	Nahant	Peabody	Salem	Swampscott
Female	51.5	51.8	53.3	49.7	53.8	54.3	56.3	53.1	56.0	54.3
Male	48.5	48.2	46.7	50.3	46.2	45.7	43.7	46.9	44.0	45.7

Source: 2020 American Community Survey 5-year estimates

2. Age:

Five communities (Danvers, Marblehead, Nahant, Peabody, and Swampscott) have a higher proportion of seniors (65+) than the state and Essex County overall (See table below). Four communities (Lynn, Lynnfield, Marblehead, and Swampscott) have a higher percentage of people under age 18. Lynn and Salem have the largest proportion of residents under age 65 (at 87.7% and 83.6%) among the nine priority communities and greater than in Massachusetts and Essex County.

Percent of population by age for MA, Essex County, and Salem Hospital's priority communities (2016-2020)

Age	MA	Essex County	Danvers	Lynn	Lynn-field	Marble-head	Nahant	Peabody	Salem	Swamp-scott
< 18	19.8	21.3	18.4	24.0	27.0	23.0	13.1	18.3	15.6	20.7
18-20	4.5	3.9	4.0	4.3	3.2	3.2	3.3	3.0	4.6	2.3
21-24	5.6	5.2	5.1	5.7	4.5	2.1	3.2	5.5	7.9	4.4
25-34	14.3	12.4	13.0	15.6	9.0	4.3	4.0	11.7	17.7	10.1
35-44	12.3	12.0	10.0	13.5	12.3	11.9	8.9	10.0	12.1	12.8
45-54	13.4	13.8	13.3	13.6	15.4	16.6	16.0	13.6	13.0	16.2
55-64	13.6	14.3	14.7	11.0	12.0	17.5	23.2	15.3	12.6	14.3
65+	16.5	17.1	21.6	12.3	16.7	21.4	28.3	22.6	16.4	19.2

Source: 2020 American Community Survey 5-year estimates

3. Race/ethnicity

The percentage of White residents within all but two of the priority communities is greater than in Essex County and Massachusetts. The White population in Salem (at 70.6%) is proportionately larger than in Essex County and slightly smaller than statewide. However, in Lynn, the percentage of White residents is substantially lower than statewide, in the county, and in all other priority communities. In Lynn, the largest racial/ethnic groups are Hispanics/Latinos (43%), Blacks/African Americans (11.1%), and Asians (6%).

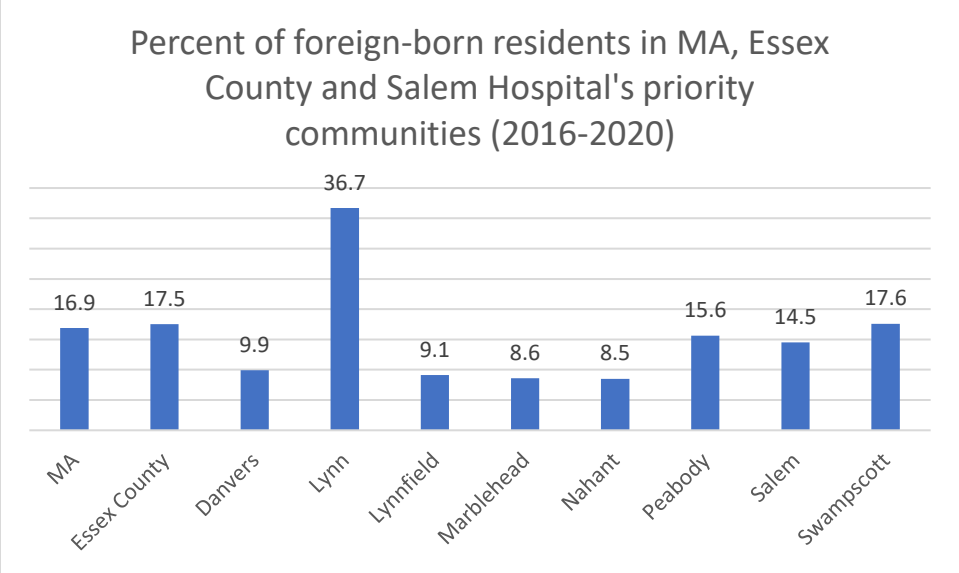
Percent of population of different races and Hispanic/Latino ethnicity in MA, Essex County, and priority communities (2016-2020)

Race/ethnicity	MA	Essex	Danvers	Lynn	Lynn-field	Marble-head	Nahant	Peabody	Salem	Swamp-scott
White	70.8	69.5	87.7	36.3	88.1	91.9	92.5	81.9	70.6	90.3
Black/African	6.8	3.2	1.8	11.1	2.0	0.4	1.5	3.1	4.8	1.5
Asian	6.7	3.4	2.1	6.0	4.1	1.6	2.7	1.3	2.6	2.4
American Indian/ Alaskan Native	0.1	0.1	0.16	0.2	0	0	0	0.2	0.1	0
Other	0.03	0.02	0	0.1	0	0	0	0	0	0
Two or More Races	2.7	2.1	2.2	2.8	4.6	1.3	1.9	1.8	3.2	0.7
Hispanic or Latino	12.1	21.4	5.8	43.0	1.2	4.4	1.1	11.6	18.3	5.0

Source: 2020 American Community Survey 5-year estimates

4. Foreign born

According to the 2020 ACS 5-year estimates, foreign-born residents make up more than one-third (36.7%) of the population of Lynn, a far greater proportion than in any other priority community, Essex County, or MA overall.



Source: 2020 American Community Survey 5-year estimates

5. Education

The percentage of residents in the priority communities with at least some college or a bachelor's degree is higher or comparable to the state and county. However, in Peabody and Lynn, 61% and 44.8%, respectively, have some college or a bachelor's degree, the lowest percentages among the priority communities and lower than statewide and Essex County. Among the priority communities, Lynn had the lowest percentage of residents with at least a high school diploma (at 76.6%) and the lowest percentage of residents with at least a bachelor's degree (19.5%). Peabody had the second

lowest rates of these two indicators at 90.9% with at least a high school degree and 34.6% with at least a bachelor's degree.

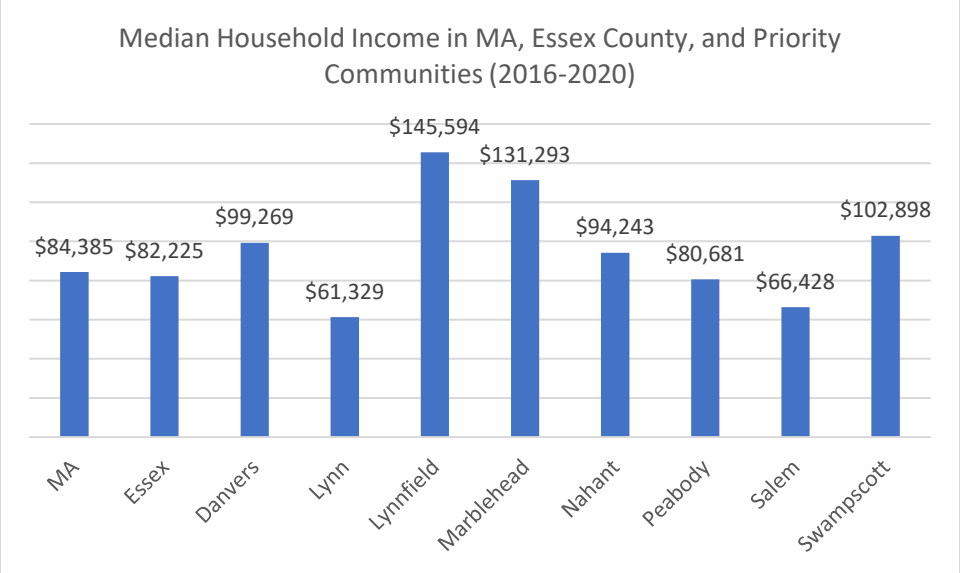
Percentage of residents in MA, Essex County, and priority communities at various levels of educational attainment (2016-2020)

Educational attainment	MA	Essex	Danvers	Lynn	Lynn-field	Marble-head	Nahant	Peabody	Salem	Swamp-scott
Less than HS Diploma	8.9	10.3	6.5	23.5	2.7	1.4	2.5	9.2	8.6	2.6
HS Diploma and No College	23.5	24.5	24.0	31.8	17.7	10.0	17.3	29.9	23.0	16.9
GED or Alternative Credential	2.8	2.7	1.9	4.5	1.3	0.9	1.1	2.2	2.2	0.5
At Least HS Diploma	91.1	89.7	93.5	76.6	97.3	98.6	97.5	90.9	91.4	97.4
Some College or Associate's Degree	23.0	24.5	24.8	25.3	20.2	15.1	17.8	26.4	23.2	21.4
At Least Bachelor's Degree	44.5	40.7	44.7	19.5	59.5	73.4	62.4	34.6	45.1	59.2

Source: 2020 American Community Survey 5-year estimates

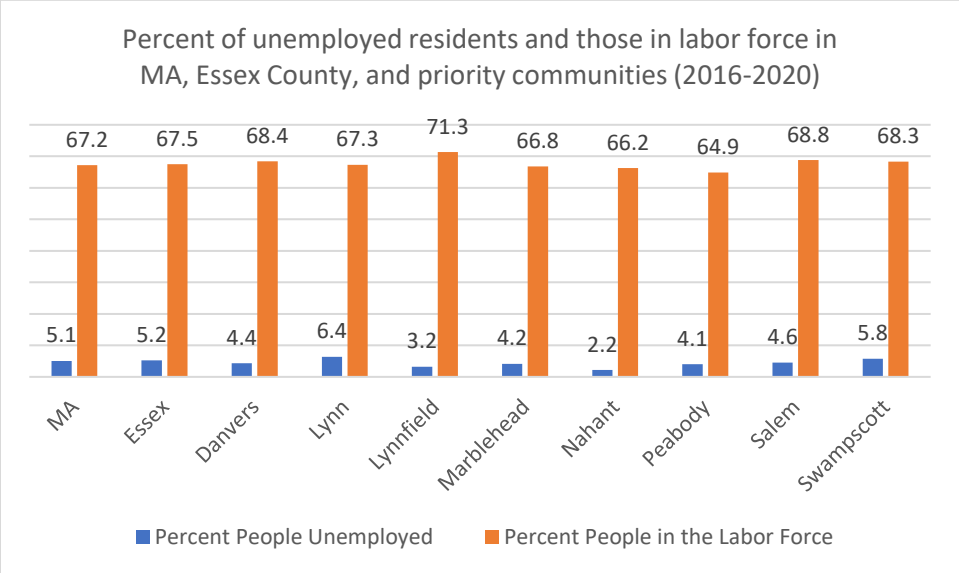
6. Income and Unemployment

In three of the priority communities, median household incomes are lower than in MA and Essex County. While median income in Peabody is only slightly lower than statewide and in Essex County, median incomes in Lynn ($61,329) and Salem ($66,428) are substantially lower than in MA and the county.



Source: 2020 American Community Survey 5-year estimates

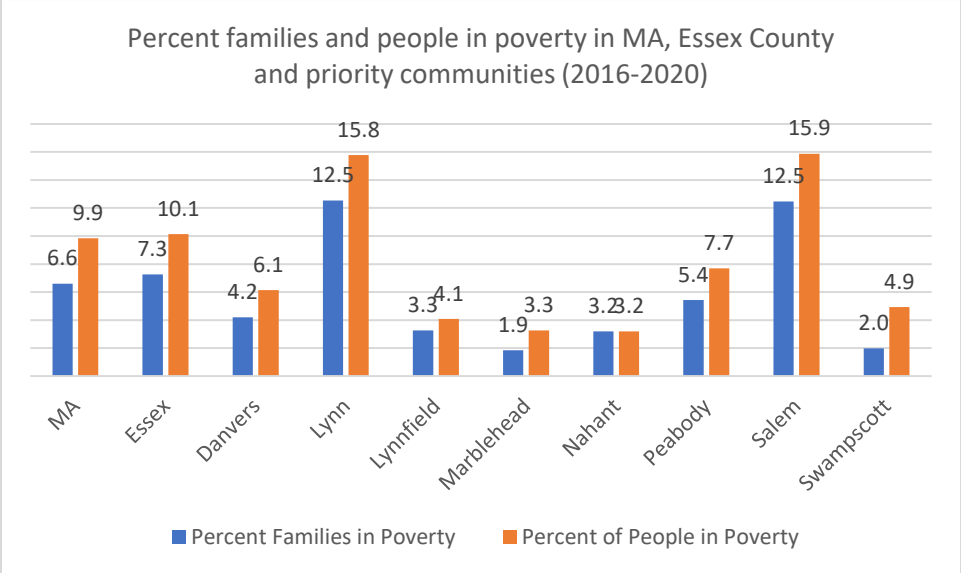
According to the 2020 ACS 5-year estimates, unemployment was higher in Lynn (6.4%) and Swampscott (5.8%) than in MA, Essex County, and the other priority communities. Labor force participation is higher in four of the priority communities than in MA; Marblehead, Nahant, and Peabody were the exceptions with labor force participation rates of 66.8%, 66.2%, and 64.9%, respectively.



Source: 2020 American Community Survey 5-year estimates

7. Poverty

In Lynn and Salem, the percentage of families (12.5% each) and people living in poverty (15.8% and 15.9%, respectively) exceed the percentages in Massachusetts, Essex County, and in the other priority communities.



Source: 2020 American Community Survey 5-year estimates

e. Social and Physical Environment

Multiple data sources, including the hospital's screening for the social determinants of health, the public health and Census data, community survey, and focus groups demonstrated multiple needs within the priority communities, particularly in Lynn, Salem, and Peabody. Most focus group participants and the hospital's screening suggest that SDOH needs have worsened throughout the pandemic. Some of the focus group participants recognized that now, more than ever, residents need a single location for accessing the range of resources available to them on the North Shore.

> *"We are seeing people we wouldn't normally see seeking social services and they are so ashamed. We need a central location, a portal."*

> *"There is no one stop shop, so people have to search and find services unless they are already plugged into proactive organizations. There are big gaps and people are struggling."*

The sections below provide details about specific SDOH needs in the priority communities.

1. Housing

According to the 2020 ACS 5-year estimates, there were 110,019 housing units total in the priority communities, which account for 35% of the 313,956 housing units in Essex County and 4% of the 2.91 million statewide. Among the priority communities, the largest number of housing units were in Lynn followed by Salem; these communities had 31.4% and 20.7%, respectively, of the housing units in the priority communities.

Housing units in the priority communities (2016-2020)

Danvers	10,990	10.0%
Lynn	34,524	31.4%
Lynnfield	4,683	4.3%
Marblehead	8,727	7.9%
Nahant	1,900	1.7%
Peabody	22,766	20.7%
Salem	20,069	18.2%
Swampscott	6,360	5.8%

Source: 2020 American Community Survey 5-year estimates

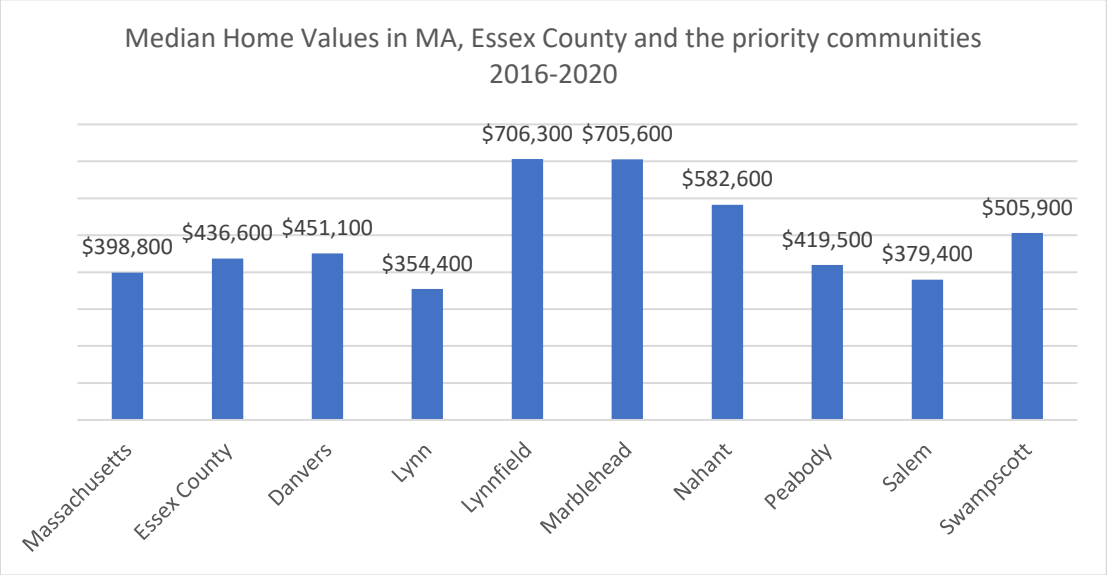
According to the 2020 ACS 5-year estimates, there were 105,486 households in the priority communities with the number of inhabitants per household ranging between a low of two in Nahant to a high of 2.9 in Lynnfield. The average household size in Lynn (at 2.8) and Lynnfield (2.9) exceeds the averages statewide, in Essex County, and in the other priority communities.

Number of households and average household size in Massachusetts, Essex County, and the priority communities (2016-2020)

	# of Households	Average household size
Massachusetts	2,646.980	2.5
Essex County	297,254	2.6
Danvers	10,652	2.5
Lynn	33,261	2.8
Lynnfield	4,520	2.9
Marblehead	8,126	2.5
Nahant	1,723	2.0
Peabody	22,049	2.4
Salem	19,094	2.2
Swampscott	6,061	2.5

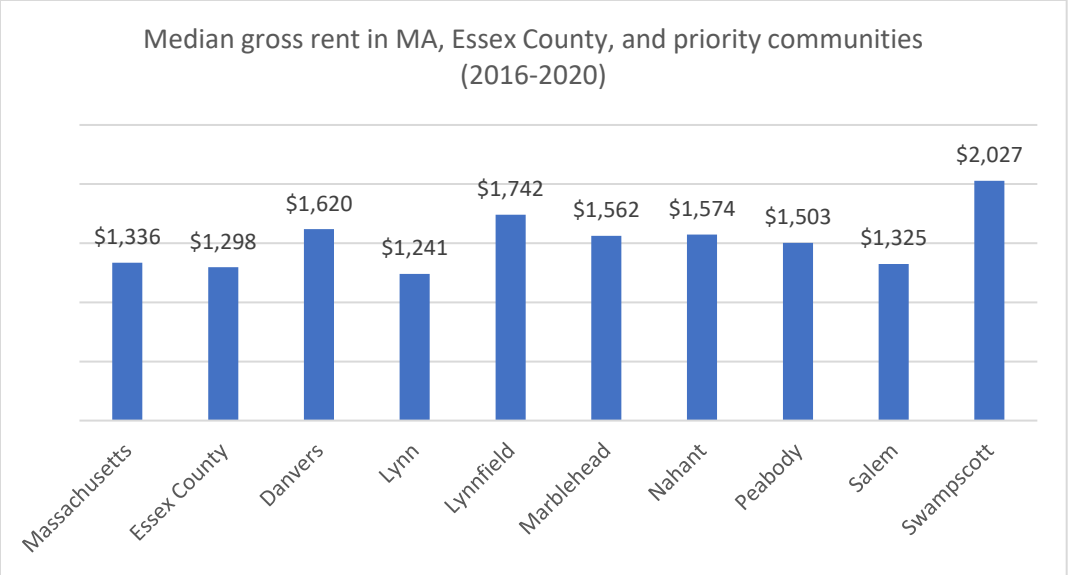
Source: 2020 American Community Survey 5-year estimates

The 2020 ACS 5-year estimates reported median home values in Lynn, Salem, and Peabody that were lower than in Essex County. Lynn and Salem also had lower median home values than statewide. Among the priority communities, Lynn's median home value of $354,400 was the lowest among the priority communities and roughly half the median home values of in Lynnfield and Marblehead.



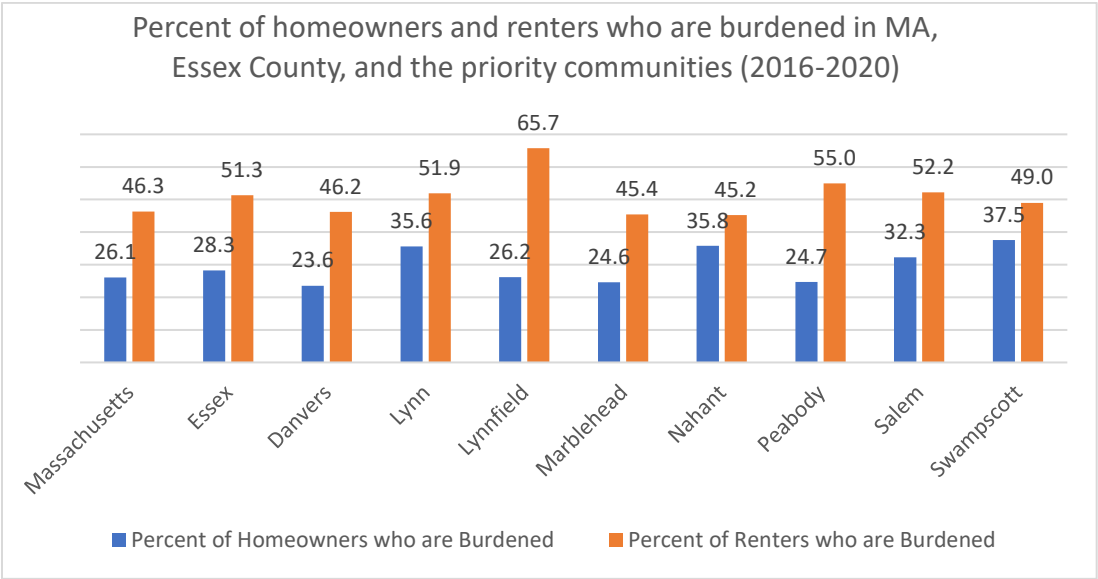
Source: 2020 American Community Survey 5-year estimates

With the exception of Salem and Lynn, the median gross rent in the priority communities was greater than the median gross rent in Massachusetts. Lynn had the lowest median gross rent at $1,241 per month followed by Salem at $1,325.



Source: 2020 American Community Survey 5-year estimates

According to the U.S. Census, "homeowner burden" occurs when 35% or more of a homeowner's monthly household income is spent on mortgage payments, utility bills, real estate taxes, property insurance, and any required condominium or mobile home fees. The U.S. Department of Housing and Urban Development defines renter burden as those who spend 30% or more of their monthly income on rent. According to the 2020 ACS 5-year estimates, Lynn, Nahant, Salem, and Swampscott were home to a greater percentage of mortgaged burdened homeowners than in both Massachusetts and Essex County. The percentage of those who were rent burdened was higher in Lynn, Lynnfield, Peabody, and Salem than in both the state overall and in Essex County.



Source: 2020 American Community Survey 5-year estimates

Prior to the pandemic (March 2018 – February 1, 2020), 5.6% of patients screened for SDOH by their health care providers in North Shore Physician Group practices indicated that they had challenges

related to housing. During the pandemic (February 1, 2020-May 27, 2022), the percentage of patient who screened positive for housing needs was 10.8%.

Among respondents to the Salem Hospital Community Survey, 20.8% selected housing stability and homeowners among the top three issues they believe hospitals should address to improve community health. That was the sixth most commonly selected issue by survey participants. Just under 20% (19.7%) of survey respondents indicated that housing is a challenge in their own life. Additionally, 31.6% of community survey respondents reported that they experience challenges paying for utilities, rent, and other supplies.

Focus group participants described housing as fundamental to one's health and reported that housing instability and homelessness are growing concerns on the North Shore. There was recognition that overcrowded housing contributed to the spread of COVID-19 because people were unable to isolate. The pandemic further exacerbated the housing crisis, and along with the increasing costs of housing and taxes, the lack of affordable housing, and displacement of individuals and families due to gentrification the housing situation has become a "three alarm fire."

> *"I think housing is the most fundamental thing, because without housing, everything is secondary. We all need a place to sleep and eat and rest, so without housing, I think a lot of other things go by the wayside."*

Participants would like to see the hospital and MGB advocate for more affordable housing on the North Shore and, in the meantime, help seed a fund to provide financial support to people who have fallen behind, so they don't also become displaced from their homes and risk losing access to other community resources such as schools and local services.

2. Food/nutrition security

According to the Feeding American food insecurity[2] projections, Massachusetts experienced the greatest percentage increase in food insecurity in the country due to the pandemic at 59%. According to the Greater Boston Food Bank (GBFB), the surge in its service area of Eastern Massachusetts was even greater, a projected 66% increase in the number of people struggling with access to healthy food. The problem has been even worse for children. The coronavirus caused food insecurity among children to rise 117% in Eastern Massachusetts. The spikes in food insecurity were the highest for any food bank service area in the country. The GBFB estimated that in 2020, 1 in 7 adults and 1 in 5 children were food insecure.

Focus group participants acknowledged that a great deal has been accomplished on the North Shore to address food insecurity and several people expressed gratitude for the investment that MGB and Salem have made in addressing the problem. However, food and nutrition insecurity continue to affect residents in the priority communities, according to focus group participants. Participants indicated that good nutrition is not only an access problem, but also a problem of proper food storage and preparation. They explained that some people may be sharing living space with multiple people and lack their own space for storing foods. They may also have incomplete kitchens (e.g., no stove or

[2] Food insecurity is defined as a household not being able to provide enough food for every person to live an active, healthy life. in Massachusetts versus the rest of the country during the pandemic at a 59% increase. Source: https://www.gbfb.org/2021/01/19/food-insecurity-across-eastern-massachusetts-at-an-all-time-high/

refrigerator). They stated that, with the rising costs of living, people are having to make difficult choices about how they use their money and purchasing nutritious food may become secondary to something else (e.g., medication, rent).

> *"We need more food models like the gardens behind the North Shore Physicians' Group, like a greenhouse to grow things year-round would be great or hydroponics."*

Prior to the pandemic, 7.5% of patients screened for SDOH reported that they faced challenges in accessing food. During the pandemic, the percentage of patients screening positive for food-related challenges increased to 18.5%.

On the community survey, 19.1% of respondents listed food as one of the top three things hospitals should address to improve community health (the seventh most commonly selected issue), and 11.8% indicated that they face their own challenges in accessing food.

3. Transportation

Prior to the pandemic, 3.7% of patients screened for SDOH reported that they faced transportation-related challenges (the ninth most commonly selected issue). During the pandemic, the percentage of patients screening positive for transportation challenges increased to 6.9%.

Among community survey respondents, 8% indicated that they face transportation challenges and 15.9% selected transportation as one of the top three things hospitals should address to improve community health. Of the 525 community survey respondents who indicated that they face challenges in accessing health care, 18.5% said transportation was a barrier to care.

Focus group participants explained that transportation difficulties continue to hinder access to services. The participants added that lack of transportation contributes to missed medical appointments, particularly for seniors, and that people often spend long periods of time at the hospital after being discharged because they are waiting for transportation to take them home. The focus group participants explained that taxis, Lyft, and Uber are far less available now than before the pandemic; they believe, driver shortages account for the decreased availability of these services.

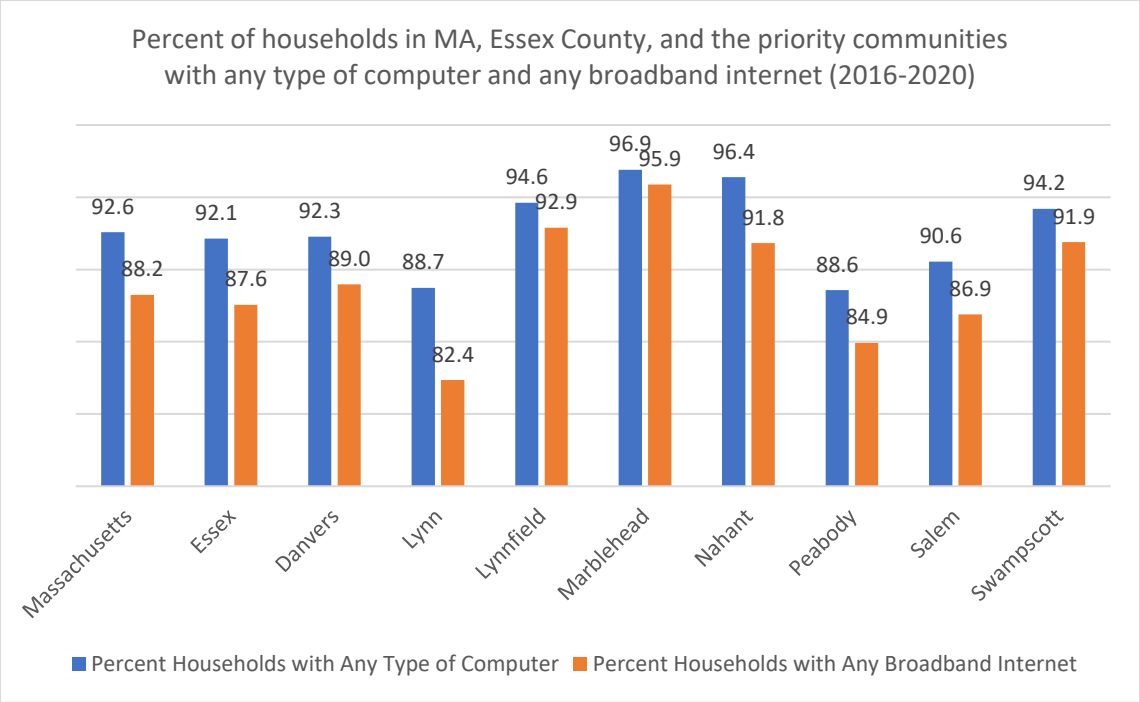
4. Utilities, Internet, and Cell Services

Prior to the pandemic, 4.9% of patients screened for SDOH reported that they had difficulty paying for utilities. During the pandemic, the percentage of patients screening positive for utility payment challenges increased to 11.6%.

As noted earlier, 31.6% of community survey respondents reported that they experience challenges paying for utilities, rent, and other supplies.

On the community survey, 12.6% of respondents selected affordable and reliable cell phone service and 11.4% selected affordable and reliable internet among the top three things they believe hospitals should address to improve community health (the 10th and 12th most commonly selected issues, respectively). Roughly 10% reported problems related to cell phone coverage/access (10.2%) and broadband/internet/computer (9.8%).

According to the 2020 ACS 5-year estimates, compared to both the statewide rates and rates in Essex County, three priority communities (i.e., Lynn, Peabody, and Salem) had a lower percentage of households with any type of computer, as well as a lower percentage of households with any broadband internet.



Source: 2020 American Community Survey 5-year estimates

Several focus group participants described the "digital divide" that exists within the priority communities, particularly for low-income and communities of color. Given its increasing importance as both a communication tool and the way people access information and services, lack of access to the internet was described by some as a major inequity.

> *"In 20 years, the way that you will know a person is poor is what kind of broadband access they have and what instrument they are using to access it; that's going to be the true new poverty."*

Participants also described how the reliance on online services creates inequities for seniors. Participants also explained that advancements in telehealth expanded access to health care for many. However, virtual appointments often don't work well for seniors, who may lack comfort and experience with technology and are more likely to experience vision and hearing impairments.

5. Childcare

Among Salem Hospital patients screened for SDOH before the pandemic, 1.8% reported that they had challenges related to family/childcare. Of those screened during the pandemic, 4.4% screened positive for family/childcare issues.

In the focus groups, there was acknowledgement that difficulties finding affordable childcare contributes to workforce issues. As one person explained,

"Workers in long-term care are so passionate. They'd like a career, but they need childcare plus tuition support."

In the community survey, 25.7% of respondents selected affordable childcare as one of the top three things hospitals should address to improve community health (the fourth most commonly selected issue).

6. Education

Prior to the pandemic, 8.5% of Salem patients screened for SDOH indicated that they faced challenges related to education. During the pandemic, the proportion of patients screening positive for education challenges increased substantially, to 23.4%.

Education was not a theme arising out of the focus groups. However, on the community survey, 12.5% of respondents selected education supports and activities for youth as one of the top three things they believe hospitals should address to improve community health, whereas 19% selected career training for quality jobs; these were the 11th and 8th most commonly selected, respectively.

As noted in section IIIb5 above, among the priority communities, Lynn had the lowest percentage of residents with at least a high school diploma (at 76.6%) and the lowest percentage of residents with at least a bachelor's degree (19.5%) followed by Peabody (which had 90.9% with at least a high school degree and 34.6% with at least a bachelor's degree).

f. Community Health Issues and Outcomes

1. Behavioral health

Behavioral health was a frequently recurring theme throughout the focus group discussions and was identified as having a significant negative impact on the priority communities. Participants primarily discussed struggles with mental health, behavioral issues, and substance use disorders. The survey and secondary data also demonstrate the need to address behavioral health issues.

a. Mental health

Among the community survey respondents, 29.2% indicated that they are experiencing challenges with social isolation/mental and emotional wellbeing (29.2%) and spiritual well-being (16.8%). The top issue respondents believe hospitals should address to improve community health was mental health service (prioritized by 52.6% of respondents).

The available data from 2016 to 2019 on utilization of hospital services for mental health demonstrate the link between health care and mental health and need for such services in the priority communities.

Between 2016 and 2019, rates of Emergency Department visits for mental health in Lynn and Salem were higher than the statewide rate overall and for White residents. Danvers, Peabody, and Salem had rates higher for one or both populations of color for which data were available.

2016-2019 age-adjusted rates per 100,000 Emergency Department visits for mental health not ending in admission or outpatient stay

	All	White	Black	Asian
MA	2,808	1,597	2,756	369
DANVERS	2,046	1,419	6,097	477
LYNN	3,839	2,272	1,424	268
LYNNFIELD	1,355	914	228	
MARBLEHEAD	1,346	685	2,430	
NAHANT	1,818	1,011		
PEABODY	2,491	1,402	3,385	1,490
SALEM	3,904	1,867	1,691	509
SWAMPSCOTT	1,454	590		

Data Source: Hospitalizations - MA Inpatient Hospital Discharge Database, Center for Health Information and Analysis (CHIA).

Also, between 2016 and 2019, rates of inpatient discharges related to mental health in Danvers, Lynn, Peabody, and Salem were higher than statewide for all, Whites, Blacks and Asians. Rates for the Black population in Swampscott and Asians in Marblehead were higher than statewide rates.

2016-2019 age-adjusted rates per 100,000 of inpatient discharges related to mental health

	All	White	Black	Asian
MASSACHUSETTS	990	740	861	168
DANVERS	1,134	926	3,269	555
LYNN	1,398	1,651	1,036	278
LYNNFIELD	464	455		
MARBLEHEAD	538	556		309
NAHANT	613	552		
PEABODY	1,039	819	1,070	533
SALEM	1,565	1,281	1,003	587
SWAMPSCOTT	590	507	7,071	

Data Source: Hospitalizations - MA Inpatient Hospital Discharge Database, Center for Health Information and Analysis (CHIA).

Between 2016 and 2019, none of the priority communities had higher rates of outpatient observation for mental health than the state. However, Lynn, Danvers, and Salem had higher rates of inpatient discharges plus outpatient observations overall and for Whites. Peabody had a higher rate for Whites than statewide. Data for other races were not available by town.

2016-2019 age-adjusted rates per 100,000 for outpatient observation for mental health and inpatient discharge plus outpatient observation for mental health

	Outpatient observations for MH		Inpatient discharge AND outpatient observation for MH	
	All	White	All	White
MASSACHUSETTS	176	74	1,166	813
DANVERS	39	29	1,173	955
LYNN	74	66	1,472	1,717
LYNNFIELD	34	28	498	483
MARBLEHEAD	32	34	570	590
NAHANT	NA	NA	NA	NA
PEABODY	56	36	1,095	855
SALEM	53	35	1,617	1,316
SWAMPSCOTT	36	23	626	530

Data Source: Hospitalizations - MA Inpatient Hospital Discharge Database, Center for Health Information and Analysis (CHIA).

Focus group participants identified that mental health issues were exacerbated during the pandemic for many populations, including children and adults. They explained that there are heightened levels of stress, strained family units, and a continued fear of COVID-19. Participants also expressed that the mental health programs are struggling to keep up with the influx of patients dealing with mental health issues. They also noted that a negative stigma surrounding mental health needs inhibits certain populations from seeking help.

> *"I think the need for behavioral health has grown even more acute."*
>
> *"We're seeing more and more mental health issues…"*
>
> *"Yes, our collaborations are working better because of what we had to go through together, but it's also laid bare a lot of really icky wounds, like the behavioral health needs of our people."*

Focus group participants explained that the rise of stress, anxiety, and fear is affecting all populations, but children have been particularly affected. They indicated that there has been an increase in behavioral concerns among children coming out of COVID-19 and while struggling to transition back into school and society. Some participants reported that violence and bullying are increasing among young people and that they are seeing increased "school phobia," which many believe is related to media coverage of recent school shootings.

> *"We see a lot more anxiety, not only with students particularly in the younger grades, but with adults as well. Parents are, they're struggling as well."*

On the community survey, neighborhood safety and violence were selected by 10.9% of participants as one of the top three issues they believe hospitals should address to improve community health; this was the 13th most commonly selected issue.

Focus group participants also explained that the number of inpatient psychiatric beds is insufficient for the number of people who need them. Likewise, there are too few mental health clinicians. Given how workforce shortages are affecting the availability of behavioral health providers, some focus group participants recognized a need to "get creative" in thinking about staffing models for behavioral health.

b. Substance use disorders

The secondary data related to substance use disorders (SUDs) also illustrate a history of hospital service utilization for SUDs and SUDs-related needs in the priority communities. Between 2016 and 2019, the rate of hospitalization for non-fatal unintentional overdoses in Danvers, Lynn, Peabody, and Salem were higher than statewide and Lynn had the highest rate across all of the hospital's priority communities.

Hospitalizations of Non-fatal Unintentional Poisonings/Overdoses (2016-2019)

Town	**Count**	**Rate per 100,000**
STATEWIDE	12,991	46.9
DANVERS	62	54.5
LYNN	292	73.3
LYNNFIELD	12	25.8
MARBLEHEAD	16	20.8
NAHANT	<11	--
PEABODY	119	53.7
SALEM	108	60.4
SWAMPSCOTT	22	40.1

Source: Hospitalizations - MA Inpatient Hospital Discharge Database, Center for Health Information and Analysis

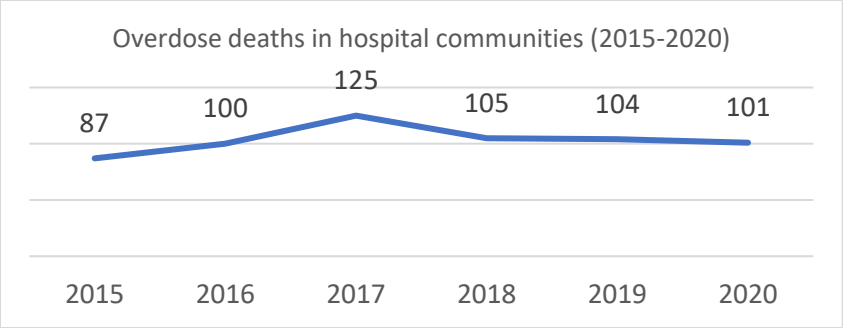
Heroin and alcohol accounted for the majority of 2020 SUDs treatment admissions in the priority communities. The number of SUDs-related admissions for all substances were higher in Lynn than in the other priority communities.

Substance Use Treatment Admissions (2020)

	Alcohol	Crack/Cocaine	Marijuana	Heroin	Other
Danvers	36	NA	NA	33	NA
Lynn	293	57	24	375	52
Lynnfield	6+	0	0	NA	NA
Marblehead	18	NA	NA	NA	NA
Nahant	0	0	0	NA	0
Peabody	82	12	8	108	25
Salem	122	13	NA	98	32
Swampscott	7	NA	NA	NA	NA
Total	558	82	32	614	109

Source: Hospitalizations - MA Inpatient Hospital Discharge Database, Center for Health Information and Analysis

Between 2015 and 2020, overdose deaths in the hospital communities peaked in 2017.



Source: Massachusetts Department of Public Health, Registry of Vital Records and Statistics

Each year between 2015 and 2020, overdose death in Lynn made up roughly half of all overdose deaths in the priority communities.

Overdose deaths in the priority communities (2015-2020)

Geography	2015	2016	2017	2018	2019	2020
Danvers	7	4	9	8	5	9
Lynn	47	56	63	51	57	49
Lynnfield	3	1	2	5	4	1
Nahant	1	2	0	0	2	0
Peabody	11	11	23	14	18	18
Marblehead	0	4	5	3	0	1
Salem	16	18	21	20	15	23
Swampscott	2	4	2	4	3	0

Source: Massachusetts Department of Public Health, Registry of Vital Records and Statistics

Among the community survey respondents, the second most commonly reported issue respondents believe hospitals should address to improve community health was substance misuse and the opioid crisis (prioritized by 30.6% of respondents).

Focus group participants shared the concern about SUDs, explaining that they have seen a rise in overdoses in the past year and believe the hospital, health centers, and community agencies need a new way of working together to ensure people get the services they need in a timely way.

2. COVID-19 and related issues

The top issue community survey participants reported as a challenge in their own lives was fitness and physical wellbeing (43.1%). The pandemic, focus group participants explained, restricted many, particularly seniors, from getting regular physical activity. They also reported that most people did not access routine care during the pandemic, and it has had a detrimental impact on their health.

> *"COVID caused people to delay care and now they are much sicker. We are seeing more advanced disease progression and more stress for families and it's still hard to get PCP visits."*

Lasting fear about COVID exposure continues and, according to focus group participants, is disproportionately affecting communities of color. The focus group participants believe that efforts made during the pandemic to educate the diverse communities about the dangers of COVID-19 are

having an impact on labor force participation now. They explained that fear, particularly among those at high risk for COVD-related illness, is preventing many members from diverse communities from returning to the workforce, which has an impact on their economic well-being.

The fifth most commonly selected issue (by 22.4%) that survey respondents believe hospitals should address to improve community health was the COVID-19 pandemic (testing, vaccinations, information, supplies, etc.). Of 525 survey respondents who indicated that they face barriers to health care, 16.4% said concern about COVID exposure was a problem. Just under a third (31.5%) of survey respondents indicated that they would be willing to access supplies such as face masks and hand sanitizer from a mobile health van.

3. Obstetrics

Data from 2019 showed that, while the birth rate in Lynn was higher than statewide, the rate in Lynn was substantially higher. Likewise, the percent of people using a public payer to cover prenatal care was higher in Lynn than statewide.

Birth rate per 1,000 and those with public payers in MA, Lynn, and Salem (2019)

Birth rate per 1,000	Massachusetts	7.1
	Lynn	23.7
	Salem	7.7
Public Pay Prenatal Care	Massachusetts	38%
	Lynn	70%
	Salem	36%

Source: Massachusetts Department of Public Health, Registry of Vital Records and Statistics

Salem and Lynn also had a higher percent of low birth weight and very low birthweight infants than statewide.

Birthweight data for MA, Lynn, and Salem (2019)

Percent Infants Low Birthweight	Massachusetts	7.7
	Lynn	8.6
	Salem	9.6
Percent Infants Very Low Birthweight	Massachusetts	1.1
	Lynn	1.8
	Salem	1.4

Source: Massachusetts Department of Public Health, Registry of Vital Records and Statistics

Some focus group participants believe more is required to address obstetrical needs on the North Shore. They reported the need for more obstetricians and called for better coordination of care.

> *"When over 20% of patients are getting into prenatal care late, we need a system, one place they can call."*

4. Health care access and barriers to care

The majority of community survey respondents get their routine health care from a doctor's office (60.3%) followed by a public health clinic or community health center (27.8%). Only 1.6% reported that they do not have a usual source of care, however, 4.7% rely on the emergency room and 5.4% on urgent care as their primary source of care.

Where do you primarily receive your routine health care? (n=645)

	#	%
A doctor's office	389	60.3%
A public health clinic or CHC	179	27.8%
A hospital emergency room	30	4.7%
No usual place	10	1.6%
Other	2	0.3%
Urgent care provider	35	5.4%

Source: 2022 Salem Hospital Community Survey

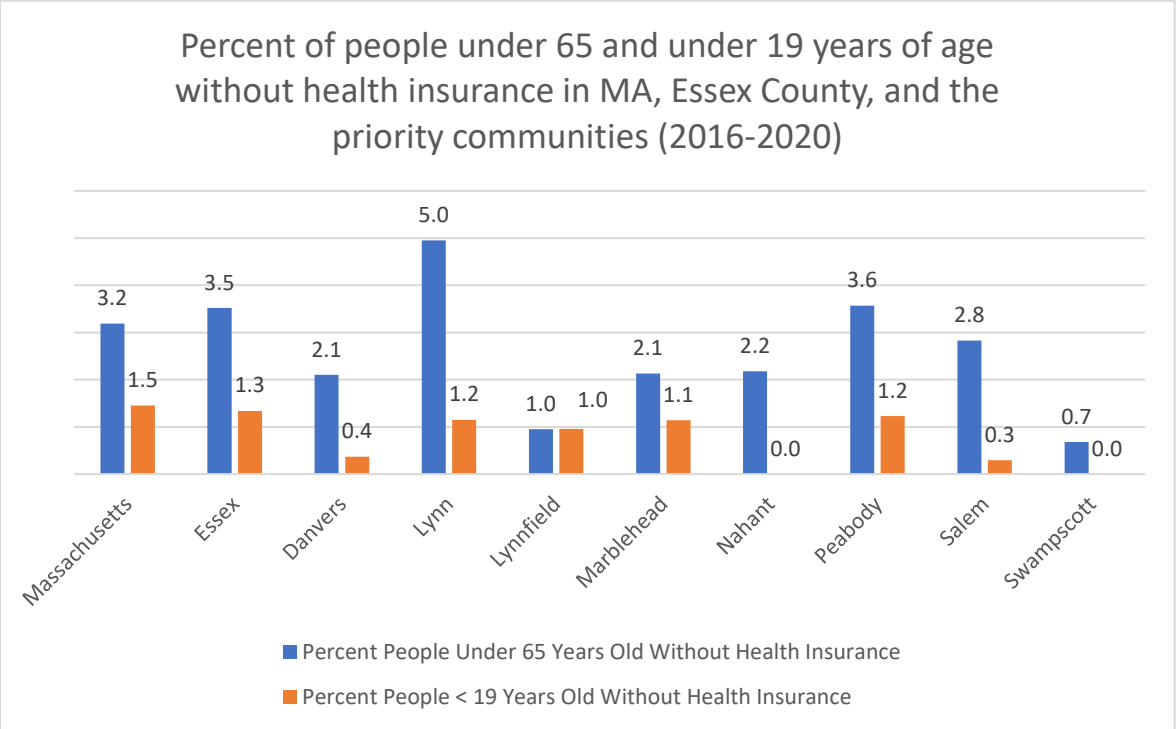
While most survey participants have a usual source of health care, most (76.5%) reported that they experience barriers to care. Of the 525 who experience barriers, the most commonly reported were that they did not have time to access care (39.2%) and that they could not get appointments with providers (30.7%).

What barriers, if any, prevent you from getting needed health care? (n=686)

	#	%
I don't face any barriers	**161**	**23.5%**
I face one or more barriers	**525**	**76.5%**
	Of those facing barriers n=525	
Not enough time	206	39.2%
Can't get an appointment	161	30.7%
Insurance issues	143	27.2%
Cost	118	22.5%
Fear or distrust of health care system	106	20.2%
Transportation	97	18.5%

Source: 2022 Salem Hospital Community Survey

Among community survey respondents who face barriers to health care, 27.2% reported issues with insurance and 22.5% face problems related to the cost of care. According to the 2020 ACS 5-year estimates, two of the priority communities (Lynn at 5% and Peabody at 3.6%) have a greater proportion of residents under 65 who are uninsured than the state overall and Essex County. The percentage of uninsured people under 19 years of age was lower in all of the priority communities than in Essex County and the state overall.



Source: 2020 American Community Survey 5-year estimates

Health insurance and health care costs were described as barriers to care in several focus groups, specifically that, despite universal health coverage in Massachusetts, there are still many people in the

community who are either uninsured or underinsured and cannot afford health care services. This is especially true, participants explained, for undocumented immigrants.

> *"A lot of people are either uninsured or, you know, underinsured and they just can't afford the care that they need."*

> *"We need to expand partnerships to enroll people in MassHealth and the Connector. Online enrollment doesn't work for everyone. In-person enrollment at a place like the food pantry would be helpful."*

> *"Those above the MassHealth threshold, we try to help but two-thirds of their money goes to health care costs. Those with just a little more in assets are suffering and go without oral health, prescriptions, and glasses just to survive."*

Throughout the focus groups, participants referred to closure of Union Hospital as having a negative effect on the accessibility of health care services. Participants explained that accessing appointments with primary care providers and specialists was increasingly difficult and involved long wait times. They added that too few providers exist who speak languages other than English or who represent the communities of color that live in the priority communities.

Focus group participants identified barriers to care such as health insurance/cost and gaps in coordination and navigation and said these barriers are most problematic for underserved and vulnerable populations (i.e., seniors, youth, those with hearing impairments and other disabilities, undocumented immigrants, non-English speaking individuals, homeless populations, the transgender community, people reentering the community from jail/prison, those with mental health concerns).

Access issues extend beyond the limited number of providers; among community survey respondents, 13.7% indicated that access to medications is a challenge they face in their own lives.

According to focus group participants, underserved and vulnerable populations continue to face problems once they are able to access health care services. They described gaps in navigation within the health system and coordination of services across the health system and other programs and services in the community. They argued that the hospital should have more navigators on staff to ensure that these populations are getting what they need and that they don't "fall through the cracks."

Several focus group participants talked specifically about the populations they serve and shared some of the experiences clients and constituents have had at the hospital. Among seniors, for example, focus group participants shared that transportation and wait times were particularly problematic. They also shared a sense that hospital staff are at times reluctant to have "end of life" discussions with seniors and their families, which can then result in unrealistic expectations among seniors and families once patients are discharged to the community. They added that patients sometimes show up in nursing homes without advanced directives and health care proxies.

Several focus group participants noted the success of the mobile health van in delivering services in the community and can see other ways in which mobile services could be used to impact community health problems on the North Shore.

> *"There should be a van providing behavioral health and SUDs to the homeless population."*

Community survey respondents were asked to indicate which, if any, services they would be willing to seek from a mobile health van in their community. While 19% said they would not access any services from a van, many survey respondents indicated that they would be willing to access services such as blood pressure checks (36.0%), mental health services (33.5%) and supplies such as face masks and hand sanitizer (31.5%) among others. The data suggest that, for some portion of the community, mobile health vans offer an opportunity to improve access to some health-related services and resources.

What types of health care services or resources would you seek for yourself or your family on a mobile health van in your community? (n=686)

	#	%
Blood pressure checks	253	36.9%
Mental health services	230	33.5%
Supplies, such as face masks and hand sanitizer	216	31.5%
Cancer screenings	199	29.0%
Food assistance, including SNAP enrollment	188	27.4%
Housing resources and support	164	23.9%
Substance use counseling	139	20.3%
Other	21	3.1%
I wouldn't seek any health services	130	19.0%

Source: 2022 Salem Hospital Community Survey

Several focus group participants described that community health centers are trusted institutions in the community but recognized how staffing vacancies have impacted their ability to offer the hours and range of services they previously could. Some explained how important the health centers are to providing care, particularly to new residents.

> *"The health centers should be seeing new patients, not just their own. They are an important source of care for new populations and an access point for the health system."*

The health centers indicated that they could benefit from some of the staff training Salem Hospital extends to its employees and see it as one way to build capacity at the health centers. Those working in and closely with the community health centers would like to see enhanced collaboration between the hospital and the health centers. The participants see opportunities for "new programs and innovations" to jointly address the need for a range of services in the community, including for substance use disorders and mental health, obstetrics, and specialty care (e.g., dermatology, Gastrointestinal care, cardiology). They also see opportunity to collaborate around urgent care to reduce emergency room wait times at the hospital.

> *"I'd love to talk about, is there a way to get a system of behavioral health care…joint work on the North Shore to pilot a something that would benefit all."*

> *"Community health centers can do more with relationships and resources."*

5. Culturally sensitive care

Focus group participants believe that there is still room to improve the trust between the hospital and community. Focus group participants believe that cultural barriers and differing levels of health literacy play a significant role in the trust diverse communities have in the health system and their understanding of it. They reported that the North Shore, and Lynn in particular, are home to several immigrant communities. The availability and quality of health care services with which immigrants have experience varies dramatically around the world. Based on one's experience in their country of origin, one may not understand how the health system works in the U.S. and/or may view it with skepticism or mistrust. In some circumstances, focus group participants explained that it is critical for health care institutions to reach out to communities via trusted individuals, like community health workers who come from these diverse communities, to inform resource development and to build health literacy and trust.

> *"Proactiveness from community health partners [is needed] to reach out to communities when resources are put in place and talk to them before rolling something out to build trust and ownership."*

The focus group participants also explained that it important to recognize how racial inequities and the history of mistreatment communities of color have experienced in the health system still affect trust today. Several focus group participants explained that it is crucial for hospitals to employ more people who come from diverse communities, who share similar backgrounds and experiences, to increase representation of and trust from these groups in the health care system.

> *"Translation is not enough, there are cultural connections that are extremely important to engaging people, and I think it's really important for the hospital to be looking at ways that they can be more inclusive of the diverse populations, you know we have a lot of diversity in Salem and they're not feeling heard."*

> *"Getting more representation of folks that look like you has been really instrumental in bridging language, cultural divides, and trust."*

> *"Really talking about culturally relevant access to resources that are really important, but also how do we get the resources to the communities that are most vulnerable that may have anxiety or fear of interacting with certain agencies, because of their [residency/legal] status."*

A few focus group participants described increasing attacks on the LGBTQ community and fear, particularly among youth, related to seeking out services. For transgender individuals, there is an added challenge of providers who may not understand how to communicate about gender identity or offer appropriate care. The participants explained how important it is for the health system to be "intentional" about wanting to treat this population and to offer trans-sensitive care.

6. Workforce

The focus group participants identified the inability to hire enough providers and staff as a major impediment to increasing access to health care and adding racial/ethnic diversity to the health care workforce. They noted that the problem is not unique to health care; nearly every organization represented in the focus groups seems to be experiencing labor shortages of their own or confronts

staffing-related capacity issues when referring their clients to other agencies. Within health care specifically, they reported vacancies at all staffing levels, from administrators to all types of providers and care givers to support staff. Long wait lists and wait times to see a primary care provider or specialist (sometimes several months long) have become the norm. The lack of providers has driven more people to seek care through the hospital emergency department. The increase in emergency room patients coupled with staffing shortages there have resulted in longer wait times. Focus group participants explained that the long wait lists and waiting times discourage people from either going to see a health care provider to address a problem or cause them to discontinue care before a problem is fully addressed.

Organizations are not only struggling to hire staff, but also to retain them. Focus group participants explained that many organizations are offering higher wages to attract workers and that most non-profits cannot compete. And, as mentioned earlier, some community members, particularly those at high risk for COVID-related illness, are nervous about returning to the workforce.

> *"Labor shortages are affecting everything that we're dealing with in health care."*
>
> *"Our patients are suffering and also our workforce is suffering, so it is a perfect storm for more community health issues."*
>
> *"More needs to be done to build the pipeline of workers, particularly in diverse communities."*
>
> *"We can't increase the pay structure [in health care] unless the government [Medicaid] increases reimbursement rates…Costs are going up and our employees are suffering with costs too."*

Focus group participants described a number of collaborative initiatives that are necessary to address workforce needs, including advocacy to increase Medicaid rates so organizations can offering livable and competitive wages, working with the state to expedite the licensing/credentialing process for various provider types, increasing the availability of affordable and quality child care, exposing high school students to health and human service career opportunities, and offering scholarship and tuition support for those who want to enter into or advance in their careers in health and human services.

g. Key Themes and Conclusions

More than 270,000 people call the hospital's primary service communities their home. The diversity and resilience of residents and collaboration and partnership among agencies and organizations were identified as community assets. Providing services to a richly diverse community, however, is challenging. The assessment highlighted communities with lower incomes and greater diversity as the most powerfully and negatively affected within economic and social factors, ultimately impacting health outcomes. Salem Hospital will continue to use a racial and social justice lens in strengthening and developing our strategies to improve the health of our communities and will concentrate efforts within certain populations or communities as needed.

Results from our assessment indicated that Lynn, Salem, and Peabody residents are more likely to experience inequities in the social determinants of health and disproportionate risk for health and

behavioral health concerns. Social and economic factors have a large impact of the health status of communities, and it is important to focus on both treatment/management of disease along with an upstream focus on those systemic factors. We believe that our collaborations and impending CHIP will enable us to use our collective voice, resources, and strategies to make lasting and positive health impacts.

Lynn, the largest of the eight communities, has the youngest and most racially/ethnically diverse population and the highest concentration of foreign-born residents in the region. Of the eight communities, Lynn's educational attainment is lower while unemployment and poverty rates are higher. While Lynn has the lowest home values and lowest proportion of homes with computers and internet access, the city also has the highest rates of mortgage and rent burden. Lynn has also had higher 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.

The COVID-19 pandemic exacerbated already existing problems with behavioral health and the social determinants of health. Workforce shortages in health care and behavioral health extended already long wait lists and waiting periods for services and join 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, LGBTQIA and transgender community members, people re-entering the community from jail/prison, and people dealing with mental health and/or substance use disorders.

Community collaborations and partnerships in general were strengthened during the pandemic. As demonstrated in the 2022 CHNA, opportunities exist to deepen collaboration with community partners and, in particular, community health centers to strengthen the network of available services. Opportunity also exists to expand access through resource and service delivery via a mobile health van.

h. Priorities

As illustrated below, the 2022 CHNA affirmed the priorities identified in the 2021 CHNA and addressed in the 2021 CHIP, while introducing new issues related to existing themes and one new theme.

Focus group themes (relationship to 2021 CHNA and CHIP)	**Related issues**
Behavioral Health (Existing)	From 2021: Mental health, Substance Use Disorders, gaps in treatment, stigma, violence (domestic violence, child abuse/neglect, elder abuse/neglect) NEW: Need for harm reduction conversations in the hospital with active users and those with pain management issues
Health Care Access (Existing)	From 2021: Accessibility, health insurance and cost, care coordination and navigation, oral health services New: Expand access by partnering with health centers and expanding mobile health services
Culturally sensitive care (Existing)	From 2021: Culturally sensitive care delivery and services in multiple languages New: Expand upon outreach to and engagement of diverse communities to increase health literacy and trust in the health system
Social Determinants of Health (Existing)	From 2021: Housing, food/nutrition, transportation, broadband and cell service, childcare, and education
Workforce (New)	NEW: Labor shortages causing extensive wait lists/times; increase diversity of workforce to meet community needs

i. Rationale for identified health needs not prioritized by Salem Hospital

Salem Hospital recognizes the importance of the identified health needs that are not within our priorities and, thus, will not be a focus within our health implementation plan. We recognize that we are not experts in any of those areas, but we commit to supporting and working with organizations and groups that are already committed to these efforts.

III. MASS GENERAL BRIGHAM SYSTEM PRIORITIES

a. Context and Priorities

Mass General Brigham Community Health leads the Mass General Brigham system-wide commitment to improve the health and well-being of residents in our priority communities most impacted by health inequities. Mass General Brigham's commitment to the community is part of a $30 million pledge to fund programs aimed at dismantling racism and other forms of inequity through a comprehensive range of approaches involving our health care delivery system and community health initiatives.

While not required to conduct a CHNA under current regulations, Mass General Brigham's belief in the critical importance of system-wide, population-level approaches resulted in our decision to have every hospital conduct a 2022 CHNA. Having all our hospitals on the same three-year cycle will prove invaluable in our efforts to eliminate health inequities by identifying system-wide priorities that require system-level efforts.

In addition to the priorities each hospital identifies that are unique to its communities, Mass General Brigham identified two system-level priorities: cardiometabolic disease and substance use disorder. These priorities emerged from a review of hospital-level data and prevalent trends in population health statistics. Our efforts within these priorities will aim to reduce racial and ethnic disparities in outcomes, with the goal of improving life expectancy.

b. Key Findings

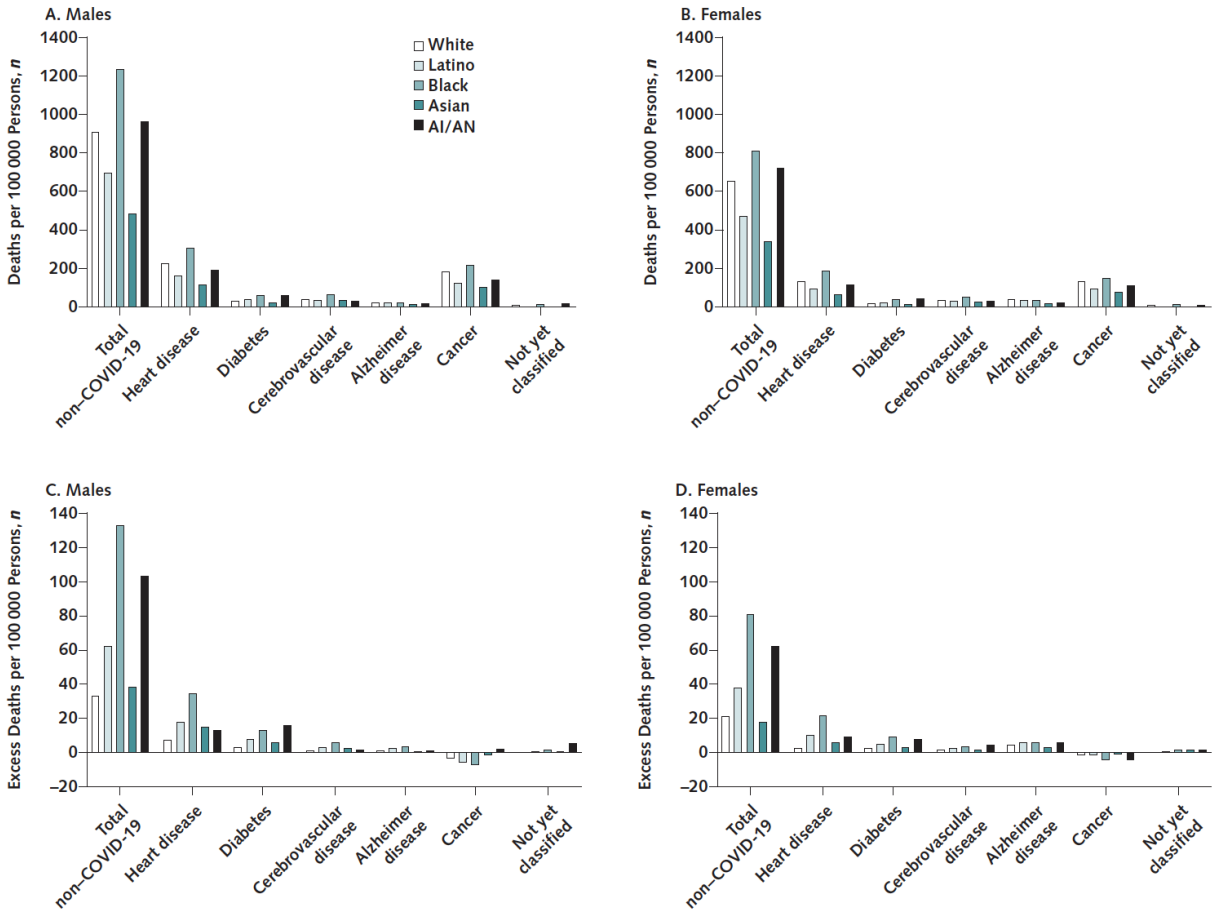
In a national study of deaths during the first wave of the COVID-19 pandemic (March to December 2020), researchers explored non-COVID deaths and excess deaths, defined as the difference between the number of observed and number of expected deaths.

Nationally, non-COVID deaths disproportionately affected Black, American Indian/Alaska Native, and Latinx persons (A. and B.) (Graphic 1)[3]. Moreover, when looking at excess deaths, the inequities worsened (C. and D.). The greatest disparities are seen for heart disease and diabetes. Inequities also exist for all cancer deaths but not excess cancer deaths.

[3] `Sheils et al. Racial and Ethnic Disparities in Excess Deaths During the COVID-19 Pandemic, March to December 2020. Annals of Internal Medicine, Vol 174 No. 12. December 2021. 1693-1699

Graphic 1: Racial and Ethnic Disparities in Excess Deaths During the COVID-19 Pandemic, March to December 2020, Annals of Internal Medicine

Age-standardized non–COVID-19 cause-specific deaths per 100 000 persons in the United States in March to December 2020 among males (*A*) and females (*B*) and age-standardized non–COVID-19 excess cause-specific deaths per 100 000 persons among males (*C*) and females (*D*), by race/ethnicity.



AI/AN = American Indian/Alaska Native.

Massachusetts mortality data for 2019 reveal that heart disease and unintentional injuries, which include drug overdoses, account for the second and third highest causes of death. As shown in Graphic 2, the highest number of deaths among individuals from birth to age 44 were the result of unintentional injuries. However, among those 45 years of age and older, heart disease accounts for the highest or second highest cause of death across age group.

Graphic 2: Top Ten Leading Underlying Causes of Death by Age, MA 2019

	Age Groups (number of deaths)								
Rank	<1 year	1-14 years	15-24 years	25-44 years	45-64 years	65-74 years	75-84 years	85+ years	All
1	Short gestation and LBW[1] (57)	Unintentional Injuries[3] (20)	Unintentional Injuries[3] (186)	Unintentional Injuries[3] (1319)	Cancer (2781)	Cancer (3446)	Cancer (3430)	Heart Disease (5622)	**Cancer (12584)**
2	Congenital malformations (56)	Cancer (17)	Suicide (67)	Cancer (241)	Heart Disease (1585)	Heart Disease (1786)	Heart Disease (2581)	Cancer (2641)	**Heart Disease (11779)**
3	SIDS[2] (21)	Congenital malform (9)	Homicide (43)	Suicide (202)	Unintentional Injuries[3] (1138)	Chronic Lower Respiratory Disease[5] (632)	Chronic Lower Respiratory Disease[5] (893)	Stroke (1260)	**Unintentional Injuries[3] (4094)**
4	Complications of placenta (19)	Other infect (8)	Cancer (27)	Heart Disease (193)	Chronic liver disease (383)	Unintentional Injuries[3] (340)	Stroke (629)	Alzheimer's Disease (1128)	**Chronic Lower Respiratory Disease[5] (2842)**
5	Pregnancy Complications (13)	Homicide (8)	Heart Disease (7)	Homicide (77)	Chronic Lower Respiratory Disease[5] (350)	Stroke (331)	Alzheimer's Disease (415)	Chronic Lower Respiratory Disease[5] (941)	**Stroke (2463)**
6	Respiratory distress (8)	Ill-defined conditions-signs and symptoms[4] (7)	Injuries of Undetermined Intent[3] (7)	Chronic liver disease (62)	Diabetes (312)	Diabetes (300)	Unintentional Injuries[3] (381)	Unintentional Injuries[3] (709)	**Alzheimer's Disease (1662)**
7	Bacterial sepsis of newborn (7)	Influenza & Pneumonia (4)	Diabetes (6)	Ill-defined conditions-signs and symptoms[4] (37)	Suicide (281)	Nephritis (221)	Diabetes (358)	Influenza & Pneumonia (612)	**Diabetes (1386)**
8	Necrotizing entercolitis (6)	Suicide (3)	Influenza & Pneumonia (4)	Diabetes (29)	Stroke (212)	Septicemia (181)	Nephritis (339)	Nephritis (553)	**Nephritis (1280)**
9	Circulatory System (5)	Septicemia (2)	Ill-defined conditions-signs and symptoms[4] (4)	Stroke (29)	Septicemia (171)	Chronic liver disease (180)	Parkinsons (285)	Diabetes (381)	**Influenza & Pneumonia (1217)**
10	Intrauterine Hypoxia (4)	In situ neoplasms (2)	Chronic Lower Respiratory Disease[5] (2)	Injuries of Undetermined Intent[3] (26)	Nephritis (150)	Influenza & Pneumonia (179)	Influenza & Pneumonia (276)	Ill-defined conditions-signs and symptoms[4] (355)	**Septicemia (942)**
All Causes	**255**	**106**	**389**	**2,646**	**9,417**	**9,974**	**13,570**	**22,303**	**58,660**

Note: Ranking based on number of deaths. The number of deaths is shown in parentheses.

1. LBW: Low birthweight. 2. SIDS: Sudden Infant Death Syndrome. 3. Injuries are subdivided into 4 separate categories by intent: unintentional, homicide, suicide, and injuries of undetermined intent (deaths where investigation has not determined whether injuries were accidental or purposely inflicted). 4. Ill-Defined Conditions: Includes ICD-10 codes R00-R99. 5. The title of this cause of death has changed between ICD-10 and ICD-9. Chronic Lower Respiratory Disease (ICD-10 title) corresponds to Chronic Obstructive Pulmonary Disease (COPD) (ICD-9 title).

In Boston, heart disease mortality for Black and Hispanic residents was second only to COVID-19 in 2020.

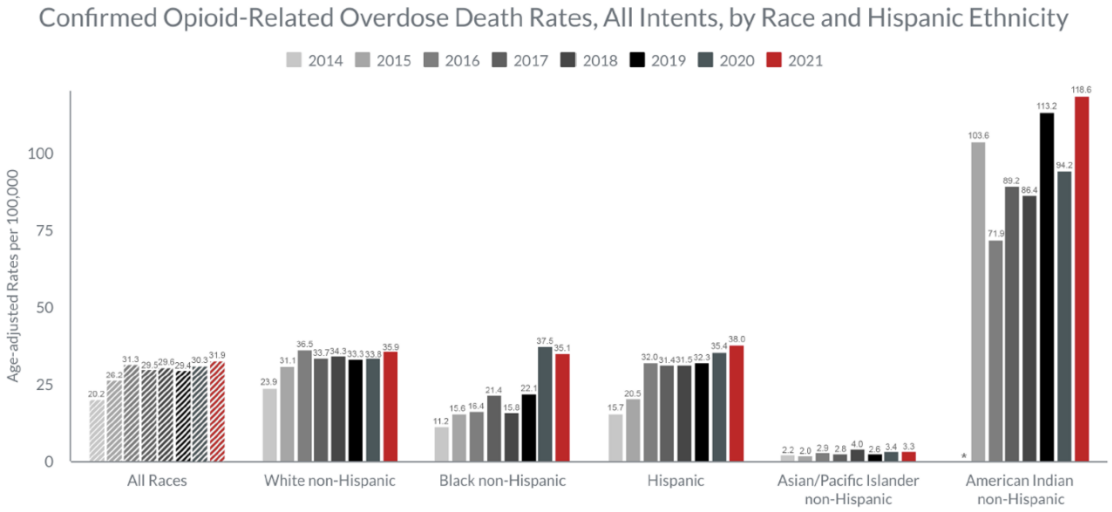
Graphic 3: Leading Causes of Mortality, by Boston and Race/Ethnicity, Age-Adjusted Rate per 100,000

	Boston	Asian	Black	Latino	White
1	COVID-19 138.4	COVID-19 95.1	COVID-19 238.1	COVID-19 143.5	Cancer 117.6
2	Cancer 117.4	Cancer 92.8	Heart Disease 183.6	Heart Disease 86.1	Heart Disease 113.1
3	Heart Disease 114.9	Heart Disease 55.4	Cancer 166.7	Cancer 78.8	COVID-19 103.5
4	Accidents 53.7	Cerebrovascular Diseases 22.2 †	Accidents 82.7	Accidents 59.5	Accidents 53.2
5	Cerebrovascular Diseases 27.4	Accidents 17.1 †	Cerebrovascular Diseases 52.8	Diabetes 27.4	Chronic Lower Respiratory Diseases 24.7

DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Deaths, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Please be advised that 2020-2022 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Massachusetts Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events; Dagger (†) denotes where rates are based on 20 or fewer deaths and may be unstable

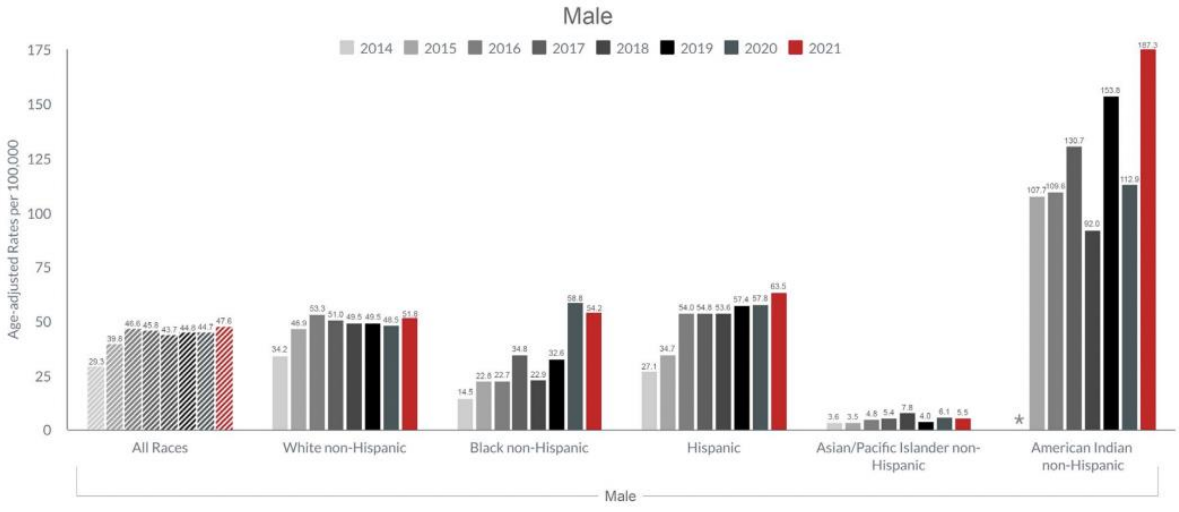
From 2014 to 2021, opioid-related overdose deaths in Massachusetts increased dramatically for Black and Hispanic residents. Death rates for American Indian residents have consistently and significantly outpaced deaths rates for all other races.

Graphic 4: Massachusetts Opioid-Related Deaths, All



Data Source: MA Department of Public Health. https://www.mass.gov/doc/opioid-related-overdose-deaths-demographics-june-2022/download

Graphic 5: Massachusetts Opioid-Related Deaths, Males



c. Focus Areas

As Mass General Brigham develops and implements programming and supports that will reduce disparities in health outcomes for the two system priorities, our efforts will focus on the highest need communities across our hospital priority neighborhoods. We will also continue to support locally identified priorities at the hospital level.

IV. CONCLUSION

The Salem Hospital Community Affairs and Health Access Committee met on September 13, 2022 to review the CHNA results and select its vulnerable populations and priorities for the next community health improvement plan. The details of their decisions are provided below.

a. Summary of under resourced populations in the community

After reviewing the CHNA results, the CAHAC determined that the upcoming CHIP will continue to focus on its eight priorities communities of Danvers, Lynn, Lynnfield, Marblehead, Nahant, Peabody, Salem, and Swampscott. Within these communities, the CHNA identified several underserved and vulnerable populations, including 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. While the upcoming CHIP will include strategies to improve community health overall, it will focus specifically on ways to improve conditions for these underserved and vulnerable populations in particular.

b. Priorities identified and how they address the needs of the community

The CAHAC decided to retain the priorities identified in the 2021 CHNA and addressed in the 2021 CHIP (i.e., Behavioral Health, Health Care Access, Culturally Sensitive Care, and Social Determinants of Health) and add a new, fifth priority of Workforce. The table below shows the five priorities selected for the 2022 CHIP as well as the issues related to each priority. The issues from the 2021 CHNA and CHIP were also retained for the 2022 CHIP with a few additions (see in italics below).

Key Themes:	Related Issues:
1) Behavioral Health	Mental health, substance use disorders, gaps in treatment, stigma, violence (domestic violence, child abuse/neglect, elder abuse/neglect), *harm reduction, pain management*
2) Health Care Access	Accessibility, health insurance and cost, care coordination and navigation, oral health services, *partnership with local Community Health Centers, mobile services*
3) Culturally sensitive care	Culturally sensitive care delivery and services in multiple languages, *Outreach to and engagement of diverse communities to increase health literacy and trust in the health system*
4) Social Determinants of Health	Housing, food/nutrition, transportation, broadband and cell service, childcare, and education
5) Workforce	*Labor shortages, diversity of workforce*

These priorities and issues will serve as the focus for planning the next CHIP.

c. Next steps and considerations toward implementation plan

Salem Hospital's CHIP must be completed by the 15th day of the fifth month after the end of the taxable year (February 15). The plan will include goals, objectives, and strategies to address the identified priorities and issues. Once the CAHAC has completed its work, hospital leadership must review and approve the CHIP before it is finalized. Once approved, Salem Hospital and its community partners will begin implementation of the CHIP, reviewing progress each of the three years and amending, as necessary, to achieve improvements in community health.

V. APPENDICES

a. Community Advisory Board Members

1) Margaret Brennan (President and CEO of North Shore Community Health),
2) Robyn Burns (Executive Director of the Salem Food Pantry),
3) Gargi Cooper, NP (Lynn Community Health Center),
4) Joseph C. Correnti, Esq. (Serafini, Darling & Correnti, LLP),
5) Emily Herzig (Lynn Health Task Force),
6) Molly Hogan-Fowler (Salem State University)
7) Dianne Kuzia-Hills (Executive Director of My Brother's Table, Lynn Health Task Force),
8) Charity Lezama (Executive Director Salem YMCA),
9) Terrence McGinnis, Esq. (Co-Chair),
10) Jay McManus, Esq. (Children's Law Center of MA),
11) Philip Rice, M.D. (Salem Hospital),
12) Linda Saris (Leap for Education),
13) Mark Schechter, M.D. (Co-Chair, Salem Hospital),
14) Deidra Smith-Horton (North Shore Physicians Group),
15) Christine Valdes, MD (SH/NSPG Medical Director of Diversity, Equity and Inclusion),
16) Candace Waldron (North Shore Elder Services),
17) Mary Wheeler (Healthy Streets, Lynn Health Task Force),
18) Nelson Woodfork (Lynn Community Health Center Board of Directors)
19) Tina McLoughlin, Manager of Community Benefits, Salem Hospital
20) Dr. Mitch Rein, Chief Medical Officer, Salem Hospital

b. Survey Respondent Characteristics

Salem Hospital Community Survey Results for all respondents (n=686)

Community you most identify with (n=685)

Town	#	%
Danvers	32	4.7%
Lynn	248	36.2%
Lynnfield	16	2.3%
Marblehead	44	6.4%
Nahant	18	2.6%
Peabody	70	10.2%
Salem	161	23.5%
Saugus	14	2.0%
Swampscott	27	3.9%
Other	55	8.0%

Which best describes your relationship to the community? (n=679)

	#	%
I live in this community	317	46.7%
I work in this community	157	23.1%
I live and work in this community	205	30.2%

Select the top 3 things that hospitals should focus on to make community healthier (n=686)*

Top concerns:	#	%
Mental health services	361	52.6%
Substance misuse and the opioid crisis	210	30.6%
Improved care for medical conditions such as heart disease, cancer, diabetes, etc.	202	29.4%
Affordable childcare	176	25.7%
COVID-19 pandemic (testing, vaccinations, information, suppliers, etc.)	154	22.4%
Housing stability and homeownership	143	20.8%
Food insecurity	131	19.1%
Career training for quality jobs	130	19.0%
Transportation	109	15.9%
Affordable/reliable cell service	88	12.8%
Education supports and activities for youth	86	12.5%
Affordable/reliable internet	78	11.4%
Neighborhood safety and violence	75	10.9%
Other	20	2.9%
Small business support	9	1.3%

What are the main challenges you are experiencing in your own life? (n=686)*

	#	%
Fitness and physical wellbeing	296	43.1%
Paying for utilities, rent, other supplies	217	31.6%
Social isolation/mental and emotional wellbeing	200	29.2%
Housing	135	19.7%
Educational opportunities	132	19.2%
Spiritual wellbeing	115	16.8%
Access to medication	94	13.7%
Safety	81	11.8%
Access to food	81	11.8%
Cell phone coverage/access	70	10.2%
Broadband/internet or computer	67	9.8%
Transportation	55	8.0%
Other	50	7.3%
Unemployment	21	3.1%

Where do you primarily receive your routine health care? (n=645)

	#	%
A doctor's office	389	60.3%
A public health clinic or CHC	179	27.8%
A hospital emergency room	30	4.7%
No usual place	10	1.6%
Other	2	0.3%
Urgent care provider	35	5.4%

What barriers, if any, prevent you from getting needed health care? (n=686)*

	#	%
I don't face any barriers	**161**	**23.5%**
I face one or more barriers	**525**	**76.5%**
	Of those facing barriers n=525	
Not enough time	206	39.2%
Can't get an appointment	161	30.7%
Insurance issues	143	27.2%
Cost	118	22.5%
Fear or distrust of health care system	106	20.2%
Transportation	97	18.5%
Concern about COVID exposure	86	16.4%
No providers or staff speak my language	48	9.1%
Other	18	3.4%

What types of health care services or resources would you seek for yourself or family on a mobile health van in your community? (n=686)*

	#	%
Blood pressure checks	253	36.9%
Cancer screenings	199	29.0%
Food assistance, including SNAP enrollment	188	27.4%
Housing resources and support	164	23.9%
Mental health services	230	33.5%
Substance use counseling	139	20.3%
Supplies, such as face masks and hand sanitizer	216	31.5%
Other	21	3.1%
I wouldn't seek any health services	130	19.0%

Age (n=612)

Mean	42.2
Median	38
Youngest	20
Oldest	85

Gender identity (n=629)

	#	%
Woman	431	68.5%
Man	186	29.6%
Gender queer or gender non-confirming	6	1.0%
Transgender	5	0.8%
Prefer to self-describe	1	0.2%

Race/ethnicity (n=686)*

	#	%
White	449	65.5%
Hispanic/Latino	103	15.0%
Black or African American	52	7.6%
American Indian or Alaska Native	32	4.7%
Asian	22	3.2%
Other	14	2.0%
Native Hawaiian or other Pacific Islander	7	1.0%

Language (n=628)

	#	%
English	557	88.7%
Spanish	51	8.1%
Other	6	1.0%
Russian	5	0.8%
Chinese (including Cantonese and Mandarin)	4	0.6%
Cambodian (including Mon-Khmer)	2	0.3%
Portuguese	1	0.2%
French	1	0.2%
French Creole	1	0.2%
Italian	0	0.0%
Vietnamese	0	0.0%
Greek	0	0.0%
Arabic	0	0.0%

Employment status (n=633)

	#	%
Employed, self-employed full-time	482	76.1%
Employed part-time or seasonal work	78	12.3%
Currently out of work	16	2.5%
Unable to work for health reasons	21	3.3%
A stay at home parent or caregiver	7	1.1%
A student (full or part-time)	1	0.2%
Retired	18	2.8%
Other	10	1.6%

c. Focus Group Participant Characteristics

Local Community Health Centers and North Shore Physicians Group	
Organization	Name
North Shore Community Health	Maggie Brennan (CEO)
North Shore Community Health	Damian Archer, MD (co-CMO)
North Shore Community Health	Laura Holland, MD (co-CMO)
Lynn Community Health Center	Kiame Mahaniah, MD (President)
Lynn Community Health Center	Geoff Pechinsky, MD (CMO)
North Shore Physicians Group	Christine Valdes, MD (Medical Director of DE&I)

Health Care Advocacy Organizations	
Organization	Name
Lynn Health Task Force	Laura Gallant
Lynn Health Task Force	Emily Herzig
New Lynn Coalition	Tish Mukala (President)
New Lynn Coalition	Jacquelyn Fitzhugh (Vice President)
Deaf, Inc	Matt Castiglione
Health Department Peabody	Sharon Cameron
Salem Food for All	Kerry Murphy
Public health Director City of Lynn	Michele Desmarais
City of Salem	David Greenbaum

Food and housing (2 groups)	
Organization	Name
Lynn Grows	John Wang (Director)
City of Salem	Kerry Murphy (Health and Wellness Coordinator)
My Brother's Table	Dianne Kuzia Hills (Executive Director)
Lynn Community Health Center	Emily Johnson
NSCAP	Laura MacNeil
Executive Director of Mass Senior Action Council	Pam Edwards
Lynn Housing Authority	Adelle Abdallah
Care Dimensions	Patricia Ramsden
Northshore Community Action Programs	Derek LePard
Northshore Community Action Programs	Laura Meisenhelter
LEO Inc.	Lilian Romero
Salem Food Pantry	Robyn Burns (Executive Director)
Lynn United for Change	Isaac Simon Hodes

Youth services	
Organization	Name
NAGLY	James Giessler (Executive Director)
Girls Inc	Deb Ansourlian (Executive Director)
Salem YMCA	Charity Lezama (Executive Director)
Leap for Education	Linda Saris (Executive Director)
Salem Public Schools	Stephen Zrike (Superintendent)
Lynn Schools	Deborah Tanzer
Lynn Schools	Jackie Westrin
Peabody Assistant Superintendent	Mark Higgins

Elder services	
Organization	Name
North Shore Physicians Group	Larissa Lucas, MD
Greater Lynn Senior Services	Kathryn Burns (CEO)
City of Lynn Council on Aging	Christopher Gomez Farewell
	Joanna Duby

BH/MH/SUD	
Organization	Name
Lynn Community Health Center	Sarah Eilers
CFFS/JRI	Dalene Badsen
Salem Hospital	Bob Caggiano (Ex. Director Psychiatry)
Healthy Streets	Mary Wheeler (Executive Director)
Lynn Community Health Center	Ryan Griffin
Director of BH & Prevention Programs Lynn	Wendy Kent
Greater North Shore (Filling in for Chris Sadkowski)	Thea Galley Jackson

Faith-Based Leaders/Immigration/DE&I	
Organization	Name
Immaculate Conception Church (Salem)	Pastor Robert Murray
Iglesia de Dios (Lynn)	Eduardo Caceres
Case Manager (NAAM)	Paola Colunga
Lynn Diversity Equity Inclusion Officer	Faustina Cuevas