

Baystate Medical Center

Community Benefit | Community Health Needs Assessment

Implementation Strategy 2014-2016

Adopted by the Baystate Health Board of Trustees on September 10, 2013

Introduction

Baystate Medical Center, based in Springfield, Massachusetts is committed to creating healthier communities by working with affiliated providers and community partners to meet the identified health and wellness needs of constituencies and the communities served. In keeping with this commitment to improve health, BMC provides many valuable services, resources, programs and financial support - beyond the walls of the hospital and into the communities and homes of the people we serve.

Baystate Medical Center (the "Hospital") conducted a community health needs assessment (a "CHNA") of the geographic areas served by the Hospital pursuant to the requirements of Section 501(r) of the Internal Revenue Code ("Section 501(r)").¹ The CHNA findings were made available on the Hospital's website in September 2013 (the "2013 CHNA").² This implementation strategy ("Strategy"), also required by Section 501(r), documents the efforts of the Hospital to address and prioritize the community health needs identified in the 2013 CHNA.

The Strategy identifies the means through which the Hospital plans to address a number of the needs that are consistent with the Hospital's charitable mission during 2014 through 2016 as part of its community benefit programs. Beyond the programs discussed in the Strategy, the Hospital is addressing many of these needs simply by providing care to all, every day, regardless of ability to pay.

The Hospital anticipates health needs and available resources may change and therefore, a flexible approach was adopted in the development of its Strategy. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by the Hospital in the Strategy. During 2014 through 2016, other community organizations may address certain needs, indicating that the Hospital's strategies should be refocused on alternative community health needs or assume a different focus on the needs identified in the 2013 CHNA. In addition, changes may be warranted by the publication of final regulations.

The Hospital is a member of the *Coalition of Western Massachusetts Hospitals* ("Coalition"), a partnership between seven (7) not-for-profit hospitals in western Massachusetts that includes: Baystate Medical Center, Baystate Franklin Medical Center, Baystate Mary Lane Hospital, Holyoke Medical Center, Cooley Dickinson Hospital, Mercy Medical Center (a member of Sisters of Providence Health System) and Wing Memorial Hospital and Medical Centers (a member of UMass Memorial Health Care), and Health New England, a local health insurer whose service areas covers the four counties of western Massachusetts.

¹ The Patient Protection and Affordable Care Act (Pub. L. 111-148) added section 501(r) to the Internal Revenue Code, which imposes new requirements on nonprofit hospitals in order to qualify for an exemption under Section 501(c)(3), and adding new reporting requirements for such hospitals under Section 6033(b) of the Internal Revenue Code.

² See the 2013 CHNA at www.baystatehealth.org/

The Coalition, formed in 2012, put competition aside to conduct a regional community health needs assessment while sharing limited resources and enhancing the quality of data collection to benefit the community as a whole. The Coalition engaged Verité Healthcare Consulting to conduct the community health needs assessments that identified the priority health needs of the communities served by Coalition hospitals.

Overview of Implementation Strategy

1. Hospital Mission Statement and Community Benefit Mission Statement
2. The Hospital and Community Served
3. Priority Community Health Needs
4. CHNA Implementation Strategy
5. Needs Beyond the Hospital’s Mission or Community Benefit Program
6. A Broader Commitment to Our Patients and Community Served
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1. Hospital Mission Statement and Community Benefit Mission Statement

As part of Baystate Health (BH), an integrated health care system, the Hospital carries out the Baystate mission “to improve the health of the people in our communities every day with quality and compassion.” It does so by providing a range of community benefits including support groups, financial counseling and assistance and other health and wellness programs. As an integrated delivery system BH provides further benefits to the Hospital’s community by coordinating within and among its various entities.

In addition, the Hospital supports the Baystate Health Community Benefit Mission Statement³ “to reduce health disparities, promote community wellness and improve access to care for vulnerable populations.” At BH, we extend the traditional definition of health to include economic opportunity, affordable housing, education, safe neighborhoods, food security, arts/culture, and racism-free communities – all elements that are needed for individuals, families and communities to thrive.

2. The Hospital and Community Served

The Hospital, located in Springfield, Massachusetts, is an academic, research, and teaching hospital that serves as the western campus of Tufts University School of Medicine. The Hospital is a 716-bed facility with 57 bassinets and is the only Level 1 trauma center in western Massachusetts, treating the most critical and urgent cases in the region. The Hospital is also home to the second-busiest emergency department in Massachusetts. Hospital specialties provided include behavioral health, cancer care, cardiology, critical care, emergency medicine, endocrinology and diabetes, gastroenterology, genetics, infectious disease, maternal fetal medicine, midwifery, neurology, neurosurgery, orthopedics, physical medicine and rehabilitation, plastic surgery, pulmonary medicine, reproductive medicine, senior care, surgery, thoracic surgery, urology and women’s health.

The primary community served by the Hospital is defined based on the geographic origins of the Hospital’s discharges. The Hospital’s primary community is comprised of 51 ZIP codes in 21 cities and towns: Agawam, Blandford, Brimfield, Chester, Chicopee, East Longmeadow, Granville, Hampden, Holland, Holyoke, Longmeadow, Ludlow, Monson, Palmer, Russell, Southwick, Springfield, Wales, West Springfield, Westfield, and Wilbraham. The 51 ZIP codes collectively and essentially are equivalent to Hampden County.

³ Massachusetts Office of the Attorney General’s Community Benefit Principles include that a hospital’s governing body affirms and makes public a community benefit mission statement. Baystate Health’s Board of Trustees adopted a community benefit mission statement on July 13, 2010.

In 2012, about 76 percent of the community's population was White. Non-White populations are expected to grow faster than White populations in the community. The Asian, American Indian, Black, and Other⁴ are expected to have the fastest growth. The growing diversity of the community is important to recognize, given the presence of health disparities. Community input is needed, in order to enhance the cultural competency of Hospital health care providers.

The Hospital is part of Baystate Health, a multi-institutional integrated delivery system that is composed of three hospitals, over 80 physician practices, three (3) community clinics, a visiting nurses association, ambulance services, and reference laboratories. As a tertiary hospital, the Hospital functions as the primary referral center for the region, therefore its community definition extends beyond Hampden County and into the cities and towns in Berkshire, Franklin, Hampshire and parts of Worcester counties.

Figure 1 (below) depicts the primary community served by the Hospital. It also shows the location of the Hospital as well as the other hospitals in the area that are part of the BH system as well as non-BH hospitals that are part of the Coalition.

⁴ Populations that do not identify as White, Black, American Indian, Asian or two or more races.

3. Priority Community Health Needs

Poor health status is due to a complex interaction of challenging social, economic, environmental and behavioral factors, combined with a lack of access to care. Addressing the “root” causes of poor community health can improve quality of life and reduce mortality and morbidity. Figure 2 (below) describes the community health needs identified through the 2013 CHNA as priorities.⁵ Due to limited resources the Hospital is unable to address all access problems and priority health needs. Those needs that the Hospital plans to help address during 2014 through 2016, at least in part, are noted in Figure 2:

Figure 2: List of Priority Community Health Needs

Access to Care	Plan to address
• Lack of Affordable and Accessible Medical Care [◦] •	Yes
• Need for Care Coordination and Culturally Sensitive Care ^Δ	Yes
Dental Health	
• Lack of Access to Dental Care	No
Health Behaviors	
• High Rates of Alcohol, Tobacco, and Drug Use [◦] •	No
• High Rates of Unsafe Sex, Teen Pregnancy, and Chlamydia	No
Maternal and Child Health	
• Prevalent Infant Health Risk Factors ^Δ ◦	Yes
• Pediatric Disability ⁶ ◦•	No
Mental Health	
• Lack of Access to Mental Health Services and Poor Mental Health Status ^Δ ◦•	Yes
Morbidity and Mortality	
• High Rates of Diet and Exercise-Related Diseases and Mortality ^Δ ◦	Yes
• High Rates of Asthma [◦] •	No
• Racial and Ethnic Disparities in Disease Morbidity and Mortality	No
Physical Environment	
• Poor Community Safety	No
• Poor Built Environment and Environmental Quality	No
Social and Economic Factors	
• Basic Needs Insecurity: Financial Hardship, Housing, and Food Access [◦] •	No
• Low Educational Achievement	Yes

Δ = Health need identified by Hospital as a community benefit strategic priority

◦ = Health need that is shared between all BH hospitals

• = Health need shared between all Coalition hospitals

⁵ Priority needs are listed in alphabetical order by health indicator. Additional documentation of the findings presented in this summary is provided in the Appendix of the Hospital’s 2013 CHNA.

⁶ Pediatric disability is defined by the US Census Bureau as hearing, vision, cognitive, ambulatory, self-care or independent living difficulty.

Hospital Community Benefit Implementation Strategy Task Force

Going into the community benefit implementation strategy process the Hospital did not have an established Community Benefit Advisory Council (“CBAC”). Therefore, a short-term community benefit implementation strategy task force (“Task Force”) was assembled to provide input into the prioritization of health needs and development of the Hospital’s Strategy. The Task Force was charged with reviewing priority health needs, as identified in the Hospital’s 2013 CHNA, and how the needs linked to the hospital’s community benefit mission.

- Task Force Membership included a combination of internal and external stakeholders. The internal (hospital) stakeholders were representative of a broad spectrum of various departments and programs, including Strategic & Program Planning, Diversity & Inclusion, Ambulatory Grants, Finance and Tax, physicians and providers with clinical expertise and public health background and staff responsible for overseeing and coordinating the hospital community benefit program. The external (community) stakeholders included a diverse group of people knowledgeable about the community, a representative of Health New England, and representatives from community groups and priority populations identified in the assessment. The Task Force also included stakeholders with public health expertise and representatives of public health offices. A steering committee (“Steering Committee”) of the Task Force was formed to help drive the planning, priority setting and implementation strategy development processes. Steering committee members also assisted with meeting and small group facilitation. The Hospital intends to evolve this Task Force into a permanent CBAC that will meet quarterly beginning in Fall 2013.
- Task Force Charge was to collect and share information about existing Hospital and community programs/services and other assets; apply expertise to prioritizing health needs; generate approaches to address priority health needs; provide input into the development of a Hospital community benefit implementation strategy; and advise the Hospital in carrying out key aspects of the implementation strategy.

Implementation Strategy Priority Setting Process

The Task Force narrowed the Hospital’s focus through ranking the priority community health needs as identified in the 2013 CHNA. Ranking was critical as the Hospital does not have the capacity or resources to address every need identified in the 2013 CHNA. The ranking process included five phases: 1) Asset mapping, 2) Individual scoring, 3) Group scoring and ranking, 4) Voting exercise (narrowing and focusing) and 5) Program design proposals. To maximize inclusion and diverse perspectives, Task Force members voted by proxy when they could not attend in person. The five phases are described below.

1. Asset Mapping

The Steering Committee grouped the fifteen priority community health needs as identified in the 2013 CHNA into four (4) health focus areas: 1) access to care, 2) health prevention and behaviors, 3) maternal/child health and 4) social determinants of health. Task Force members were assigned to one of the health focus areas to brainstorm answers to the following questions:

- What is the Hospital currently doing to address these health needs?
- What are existing organizations, services, programs, coalitions or initiatives in the community that are addressing these health needs?
- What are future strategic opportunities or program interventions that would address the identified health needs?

After the initial brainstorming session, the groups rotated to the other health focus areas, reviewed what was already listed by previous groups and contributed their ideas. By the end of the exercise, the Task Force had a comprehensive asset map. The asset map is viewed as a working document for the Hospital and will continue to be upgraded by community benefit staff with regular input from the CBAC.

2. Individual Scoring

To begin the prioritization process, the Steering Committee developed a scoring rubric (Appendix B) then asked each task force member to score each health need against the criteria using a four-point Likert scale. The asset map document and a matrix that aligned existing Hospital community benefit programs with the priority health needs (Appendix C) were provided as reference. Each task force member rated the health needs and upon completion had developed their own ranking of health priorities from 1-15.

The scoring criteria were as follows:

- Magnitude: Number of persons affected
- Severity: As indicated by morbidity or mortality rate, economic and/or social impact
- Feasibility: Do we have available expertise and time for planning, implementation and evaluation?
- Potential for Impact: Can we make a measurable impact on vulnerable populations?
- BMC Alignment: Existing programs or hospital resources addressing health need
- Community Alignment: Existing programs and potential for partnerships to address health need
- Strategic Opportunities: Feasibility to build upon existing programs, establish partnerships, seek grants, etc.
- Value: Is there a compelling case and/or subjective measure that indicates importance?

3. Group Scoring & Ranking

Following the individual scoring task force members, were again assigned to a health focus area. For each health focus area the small group members shared their individual scores, discussed their individual scoring rationale and reached consensus for group scores against the criteria for their respective health focus area. The individual and group scores were compared by the Task Force (Appendix D) and helped the large group to reach consensus on an initial group ranking of the priority health needs (Figure 3).

Figure 3: Task Force Group Ranking of Hospital Priority Health Needs

Priority Health Need	Group Score
1. Racial and Ethnic Health Disparities (Morbidity & Mortality)	29
2. Diet & Exercise Related Diseases and Mortality	28
3. Prevalent Infant Health Risk Factors	26
4. Need for Increased Care Coordination/Culturally Sensitive Care	25
5. High Rates of Asthma	25
6. High Rates of Unsafe Sex, Teen Pregnancy and Chlamydia	24
7. Low Educational Achievement	24
8. High Rates of Alcohol, Tobacco and Drug Use	23
9. Lack of Access to Dental Care	23
10. Lack of Access to Mental Health Services/Poor Mental Health Status	23
11. Basic Needs Insecurity: Financial, Housing, Food	21
12. Pediatric Disability	21
13. Poor Community Safety	20
14. Lack of Affordable and Accessible Medical Care	18
15. Poor Built Environment and Environmental Quality	17

4. Voting Exercises to Narrow and Focus Priorities

After reaching consensus on group ranking of the fifteen (15) priority health needs as identified in the 2013 CHNA, the Task Force continued to narrow the Hospital's focus into four (4) strategic priority health needs. The Task Force agreed not to just adopt the top four (4) priorities identified through the group ranking exercise, as this would not consider feasibility, available resources and/or alignment with existing Hospital efforts. Through two separate voting exercises the Task Force narrowed the fifteen (15) health needs to four (4) strategic priority health needs.

During the first exercise, task force members were asked to vote for their top five (5) health needs. Each health need was posted on a piece a paper around the room. Task force members were given five (5) dot stickers to place on the health needs they felt were of greatest priority. From these votes the group narrowed and reached consensus on eight (8) health needs.

Next, the task force was guided through an exercise asking them to view the eight (8) health needs from a different perspective and to categorize them by: 1) issues, 2) causes and 3) outcomes. For example: racial/ethnic health disparities ranked #1 out of the 15 health needs in the individual and group exercises; and again when the health needs were narrowed to eight (8). However, racial/ethnic health disparities is an outcome of lack of affordable/accessible care, financial hardship, low educational achievement, poor community safety, poor built environments, etc. By looking through this different lens, the Task force was able to see with greater clarity, the health needs versus the causes (i.e. social determinants) or outcomes.

For the final voting exercise task force members were asked to vote for three (3) health needs (from the eight (8) in the first voting exercise) and include an explanation or rationale as to why they felt the health need should be in the final four (4). Task force members were asked to vote for the health needs they not only felt were the highest priority but also to consider how they aligned with existing Hospital efforts and community benefit programs, what needs are feasible for the Hospital to address and what health needs could have a measurable impact. **The final four (4) health priorities selected were: 1) need for care coordination and culturally sensitive care 2) prevalent infant health risk factors 3) lack of access to mental health services and poor mental health status and 4) diet and exercise related morbidity and mortality.**

Important note: the Task Force felt strongly that racial and ethnic disparities in morbidity and mortality should remain an important lens through which to realign current community benefit program efforts and to which to focus new program interventions. For example, when developing a program intervention around diet/exercise morbidity/mortality to do so with a specific focus on racial and ethnic disparities.

5. Program Design Proposals

The final phase involved gathering additional information to assist in future planning around potential program interventions to address the top four (4) health priorities. At the time this implementation strategy was being developed the Hospital did not allocate funding for new program interventions. However, the Hospital has a successful history of securing leveraged resources (grants). Task Force members self-selected to one (1) of the four (4) strategic priority health needs. The goal for each workgroup was to take a closer look at what the Hospital may already be doing to address each priority, and identify a possible program intervention that could build upon, grow or enhance existing Hospital efforts to address each of the four (4) priority needs. The Task Force also discussed possible internal "champions" to spearhead particular programs. With the establishment of a permanent CBAC in the Fall of 2013, the CBAC will review the four program design proposals and work with internal champions to secure leveraged resources to implement the proposals.

4. CHNA Implementation Strategy

The Hospital has a strong tradition of meeting community health needs through its ongoing community benefit programs and services. The Hospital will continue this commitment through the strategic health priorities set forth below that focus primarily on four (4) high-priority health needs as well as other selected priority health needs as identified in the 2013 CHNA.

Not all programs provided by the Hospital that benefit the health of patients in the Hospital's primary service area are discussed in the Strategy. Further, given evolving changes in health care, the strategies may change, and new programs may be added or programs may be eliminated during the 2014 – 2016 period.⁶ The Strategy laid out in this document has two major parts – identifying priority needs, and then implementing programs to address those needs through community benefits and Determination of Need community health initiatives. More detail is provided below on these parts.

A. Identify Strategic Priority Health Needs

For the period of 2014-2016, the Hospital, in partnership with its Implementation Strategy Task Force has identified four (4) high-priority health needs that will be the focus of future Hospital grant-funded community benefit and in-kind resources. These strategic priority health needs, as identified through the 2013 CHNA and subsequent prioritization process are:

1. **NEED FOR CARE COORDINATION/CULTURALLY SENSITIVE CARE**

The region has a great need for better coordination between patients, the Hospital, and primary and specialty care providers. In addition, the Hospital recognizes with the growing diversity of the community and the prevalence of health disparities there is a need to enhance cultural competency of health care providers.

2. **LACK OF ACCESS TO MENTAL HEALTH SERVICES AND POOR MENTAL HEALTH STATUS**

The Hospital recognizes an urgent need for improved access to mental health services and increased resources for improving mental health status in the Hospital's service area.

3. **PREVALENT INFANT HEALTH RISK FACTORS**

The Hospital recognizes an urgent need for improved maternal/child health. A healthy mother leads to healthy children, healthy children make healthy families, and healthy families make healthy communities.

4. **HIGH RATES OF DIET AND EXERCISE-RELATED DISEASES AND MORTALITY**

The Hospital recognizes the importance of committing resources to reduce the high rates of diet and exercise-related diseases and mortality in the Hospital's service area.

⁶ This implementation strategy is primarily focused on hospital-specific programs. However, the Hospital as part of the BH system, may participate in additional programs and services through system wide initiatives which may also be highlighted in the implementation strategy.

Through implementing evidence-based strategies to address these four (4) priority needs, the Hospital anticipates the following positive impact and improvements in community health:

- Reduction of racial and ethnic health disparities in morbidity and mortality
- Increased care coordination and culturally sensitive care
- Reduction of infant mortality and improved infant health.
- Increased access to mental health services and improved mental health status
- Reduction of diet and exercise related morbidity and mortality

B. Address Priority Health Needs through Hospital’s Existing and New Community Benefit Programs

The Hospital plans to provide community benefit programs responsive to the health needs identified in the 2013 CHNA. These may include, but are not limited to, health education programs, screenings, support groups and other community health improvement services and access to care through the Hospital’s financial assistance program.

Listed below are the identified priority health needs, including the Hospital’s strategic priority health needs (Section 4A), the Hospital has capacity and resources to address through DoN funding and specific community benefit programs and/or strategies that will address the need.

1. Coordination of Care/Culturally Sensitive Care (strategic priority health need)

- New Project: build upon the existing and successful Medical Home Work Group (“MHWG”) for Children with Special Needs model. The MHWG is a community of parents, providers, physicians, and community agencies that meet monthly to discuss care options for children with special healthcare needs. The group’s goal is to seek regular community input from families of children with special needs to provide valuable insight that primary care physicians may otherwise not realize. Families, healthcare providers, and community agencies can learn from each other as they discuss issues and challenges they face in meeting the many needs of children and families. Expand this model to focus on chronic diseases and/or vulnerable populations for improved health management and offer regular culturally sensitive training to work group participants. In addition, align current Hospital community benefit programs to better address care coordination and culturally sensitive care.
- Pioneer Valley Health Information Exchange (PVIX): is a regional health information organization that seeks to improve the exchange of health information among clinicians and healthcare organizations throughout the Pioneer Valley. PVIX is focused on supporting care coordination by offering providers a “One Patient, One Record” approach to health information regardless of where a patient presents.
- Hampden County House of Corrections HIV Services: through a HRSA grant the Hospital is enhancing linkages to HIV primary care and services in the jail setting at the Hampden County Correctional Center. The program promotes continuity of care for inmates and releases by using dually-based physicians and case managers working at the jail and at community health centers in Hampden County. The model emphasizes five elements: early detection, effective treatment, education, prevention, and continuity of care. NOTE: this program is part of the community health center’s ambulatory grants program) - section B5).
- Community School Health Center: located in Brightwood Elementary School in the North End of Springfield, is a satellite for the Baystate Brightwood Health Center. This office is maintained by a Baystate Community Program Manager that creates and supports capacity building infrastructure for a healthier community. Programs and services are focused on the health needs of the

community and aligned with movements throughout the region. The Community Manager works collaboratively with city teams, state staff, regional managers and other initiative partners to integrate and improve the health of the population. The health center is also a hub for a broad range of services through an integrated, collaborative framework to ensure cohesive health care for school aged children and the broader community.

2. **Prevalent Infant Health Risk Factors (strategic priority health need)**

- New Project: 1,000 days + 1 is a long-term (10 year) comprehensive strategy to create a coordinated, collaborative, continuum of care from preconception until the child is three years old. The initiative will capitalize on current Hospital supported programs by forming a collaboration between the Postpartum Depression Taskforce, the Springfield Pregnant & Parenting Teen Project, and Project Baby. In addition, the collaboration will expand partnerships to include additional community based organizations and strategic partners who can enhance services, address policy change, establish a shared measurement system and implement best practices. The initiative will target vulnerable populations that are disproportionately impacted by adverse maternal child infant health outcomes with a primary focus on African American and Hispanic women, their partners and their children.
- Safe Kids of Western MA: strives to prevent accidental childhood injuries and death through public awareness, safety education and distribution of safety devices. Program activities include car seat safety education and inspections, bicycle safety workshops and parent seminars.
- Postpartum Support Groups: based in two of the three community health centers and soon-to-be at the Hospital-based Wesson Women's Clinic, these support groups address postpartum depression and anxiety and support the mental and physical health of women, especially women of color and immigrant mothers. Data shows that 10-25% of mothers will experience ppd/ppa and rates are higher in disempowered and disadvantages communities due to linguistic, cultural, academia and financial limitations. The groups are facilitated by Hospital staff who been trained in the MotherWoman model.

3. **Lack of Access to Mental Health Services and Poor Mental Health Status (strategic priority health need)**

- New project: build upon the existing and successful Brightwood Behavioral Health Initiative (see below) and expand implementation to the other Hospital community health centers.
- Baystate Family Advocacy Center ("BFAC"): a nationally accredited Child Advocacy Center serving children, families and communities of Western Massachusetts affected by child abuse, domestic violence and/or homicide. As child abuse, domestic violence and homicide are community problems the BFAC coordinates services with various community partners.
- Brightwood Behavioral Health Initiative: a team-based clinical approach at one of the Hospital's community-based clinics that centralizes care management while supporting individuals as they work towards self-management goals. This method integrates primary and behavioral healthcare, building care management/behavioral health consultant and consulting psychiatry into the Medical Home Model. The goal of this initiative is to identify primary health care risks during primary care appointments. Patients are then referred to a social worker and clinic case manager during the same visit and matched to a behavioral health specialist. Participating providers currently specialize in the following areas: post partum depression, early intervention, elder care, pediatrics, schizophrenia/psychosis, adolescent/school, substance abuse, post incarceration, domestic violence, gender identity/GLBT, criminal justice, uninsured/pro-bono). The clinic collaborates with outside providers by establishing an Memorandum of Understanding (MOU) to provide space in

the Hospital clinic that ensures a minimum of three clinicians on site each day to provide critical mental health services.

- Transgender Support Group: in partnership with UNITY of Pioneer Valley, this support group is a peer lead and psychosocial support group for Transgender individuals, their allies and all GLBTs. The confidentiality of the meetings in a Hospital facility provides a safe environment in which to address issues related to transition, such as relationships, family, health care, spirituality and the workplace.

4. **High Rates of Diet and Exercise-Related Diseases and Mortality (strategic priority health need)**

- New project: *Exercise is Medicine*, is an evidence-based initiative of the American College of Sports Medicine and the American Medical Association that encourages health care providers to include exercise as part of a patient's treatment plan. *Exercise is Medicine* perceives physical activity as an integral part of the prevention and treatment of chronic disease. This 16-week program would be piloted at Baystate Mason Square Neighborhood Health Center and Baystate High Street Clinic in partnership with the YMCA of Greater Springfield and Dunbar YMCA as well as Health New England. There is potential for a Baystate Brightwood Health Center/Pioneer Valley Riverfront Club partnership. Community Health Workers, based in the clinics would be essential to the success and implementation of the program by regularly checking in with patients, identifying and helping resolve barriers, improving cultural competence, etc.
- Brightwood Walking School Bus: a nationally recognized, multi-focal, low cost and sustainable program that encompasses exercise, safety, increasing school attendance and learning capacity, improving environmental air quality and increasing community engagement. This program also helped form the Springfield Safe Routes to School Alliance: a consortium of local, state and national organizations with a focus on safety, health and wellness, physical activity or the environment as it pertains to children, families and the surrounding school districts.
- MIGHTY (Moving, Improving and Gaining Health Together at the Y): a community-based multidisciplinary pediatric obesity treatment program that is held at the Springfield YMCA and includes 14 - 2 hour sessions which include physical activity, nutrition and behavior modification. It targets children and adolescents age 5-21. Sessions are augmented by weekly phone calls, monthly group activities, cooking classes and a gardening experience. In addition, participants and their families are given a free 6 month long membership to their local YMCA. Ongoing monthly maintenance groups are available to all previous program participants. This program enrolls approximately 300 children per year.

5. **Lack of Affordable and Accessible Medical Care**

- Community Health Centers: the Hospital invests significant resources into three Springfield-based community health centers including Baystate Brightwood Health Center, Baystate High Street Health Center (Adult and Pediatric Medicine) and Baystate Mason Square Neighborhood Health Center. Our health centers are comprehensive primary care medical practices that offer Adult and Pediatric Ambulatory Services, staffed by physicians, nurse practitioners, nurse-midwives, and many other health care professionals. The health centers serve as community training sites for our Medical Residency Program and in FY12, provided continuity of care for over 26,442 patients for a total of 122,238 encounters. To enhance primary medical care services, the following grant-funded programs are offered:
 - Emergency Preparedness: provides free flu services and information to patients and community residents about potential health threats (i.e. H1N1 flu epidemic), natural and

man-made disasters, how to prepare for such events, and available resources in the community (i.e. emergency shelter, etc.)

- HIV/AIDS Prevention (PICSAR-T): offers free integrated preventive testing, counseling, referral and treatment for HIV, STI, and Hepatitis at Baystate Mason Square & Brightwood Health Centers. Rapid HIV testing is provided at the Emergency Department.
- ICD-10 Coding: provides training to appropriate staff within the health system on changes in medical coding to capture proper diagnoses for 3rd party billing. **Impacts** affordable/accessible medical care.
- Medical Case Management/Hep Treatment: provides intensive case management of HIV+ individuals to insure patients are retained in care, adherent to medical treatment/protocols and medication regimens. Provides support (i.e. taxi vouchers/bus tokens) to increase access to other needed services and medical appointments, etc.
- Migrant Farmworkers Primary Care: provides outreach & primary medical care to migrant and seasonal farmworkers and their families at farm sites in CT and MA and follow-up care at the Baystate Brightwood Health Center.
- Office-based Opioid Treatment (OBOT): provides a nurse case manager to work with patients maintaining or starting on an office based opioid treatment program. Referrals are from primary care physicians, substance abuse counselors, family members or self referrals. Addresses: affordable/access to care, health behaviors/prevention, substance abuse, mental health, and racial ethnic health disparities (morbidity & mortality).
- Ryan White HIV + Primary Care: sub-contract with Holyoke Health Center (HRSA funded Ryan White Care Act) to provide medical care/treatment, support services (housing, food, utility payments, etc) for HIV+ individuals
- Yale-Naltrexone: sub-contract with Yale (NIH research grant) to implement double-blind placebo controlled study of the effectiveness of Naltrexone in treatment of alcoholism.
- Financial Counseling: the Hospital provides financial counseling services to inpatient and outpatient individuals who have concerns about how to pay for care. Financial Counselors are dedicated to identifying and assisting patients who are unable to pay their estimated care prior to treatments or who have large existing balances. This assistance includes linking patients to available funding sources such as Medicaid and Medicare and determining whether they are eligible for charity care or for Baystate's Financial Assistance Program.
- Hospital Financial Assistance Program: the Hospital is committed to ensuring that the community has access to quality health care services provided with fairness and respect and without regard to a patients' ability to pay. The Hospital not only offers free and reduced cost care to the financially needy as required by law, but has also voluntarily established discount and financial assistance programs that provide additional free and reduced cost care to additional patients residing within the communities served by the Hospital. The Hospital also makes payment plans available based on household size and income.
- Indigent Pharmacy Program: a prescription drug assistance program for uninsured patients. Program staff assist low-income patients access free prescription medications who might not otherwise have access to necessary medications.
- Regional Tuberculosis Clinic: provides access to TB diagnosis and treatment for patients throughout Western Massachusetts. It has been providing services for over 25 years. The majority of patients served are non-English speaking immigrants who have been referred for examination and treatment after receiving a positive PPD test or with a history of TB exposure in their native country. It serves both adult and pediatric patients.

6. **Low Educational Achievement**

- Annual Backpack Giveaway: annually each August, the Hospital donates 1,200 school backpacks for children from Springfield's North End who attend various public schools throughout the city. Hospital employees volunteer to distribute the backpacks at a Back-to-School Picnic, hosted by New North Citizens' Council.
- Baystate Springfield Educational Partnership ("BSEP"): offers a variety of hospital-based learning experiences for students, 9th through 12th grade, to participate in programming activities that expose them to varied careers in the health field, requirements for employment and skills to enhance their employability. Program outcomes include improved health outcomes for Springfield minority populations and improvement of social determinant of health of the local population.

7. **Basic Needs Insecurity: Financial Hardship, Housing, and Food Access**

- Baystate Mason Square Community Outreach: a Hospital outreach worker helps to identify unmet community health needs and provide outreach to underserved residents of the Mason Square community via the coordination of health education focus groups, community health forums and fairs. They also help connect vulnerable patients and community residents to food (via Project Bread), financial counseling, and other basic health needs. Baystate High Street Clinic – Pediatrics and Baystate Brightwood Clinic now have a staff person working in a similar outreach capacity.
- Project Bread: through a grant from ProjectBread.org the Hospital's Community Health Center's purchase gift cards for distribution to food-insecure patients at all three community health centers. NOTE: this program is part of the community health center's ambulatory grants program) - section B5).

8. **Poor Community Safety**

- Trauma and Injury Prevention: trauma centers have an important role in reducing the impact of injury by participating in prevention efforts. These efforts are based on identification of specific injuries and risk factors in patients, families and the community. For many injuries, prevention is often the only, if not the best, means of dealing with this health care problem. Examples of our programs include; Brains at Risk, The Balancing Act, AARP Drivers Safety Program, and Drowsy Driving Campaign. Currently there are several programs that are in development. Radiantly, the Trauma and Injury Prevention Coordinator participates in ROCA and the annual county Gun Buy Back Program.

9. **Broader Health Needs Being Addressed by Hospital Community Benefit Programs**

- Baystate Continuing Education: Baystate Health is a nationally accredited provider of continuing education for health care professionals on staff and in the community. Our mission is to provide high-quality, evidence based continuing education to maintain and enhance the knowledge, expertise, and performance of health care professionals, to improve the health of the people in our communities every day, with quality and compassion. In 2012, Baystate Health ran 65 courses for a total of 1,143 hours of continuing education activities. A total of 14,173 health care professionals attended these live activities. All courses and sessions were attended by both employees and non employees. Our educational activities are a service to the community.
- Community Board Involvement: various Hospital leaders and employees volunteer, on behalf of the Hospital, on local community boards, committees and coalitions. In these roles employees are serving as liaisons between the Hospitals, its community partners and the community served.

- Community Sponsorships: the Hospital supports various community organizations and community health events that align with the Hospital's mission and/or CHNA priority health needs.
- Consumer Health Library: established in 1998, the Consumer Health Library ("Library"), located at 3300 Main Street in Springfield was designed to offer free and reliable library resources and services to patients and their families. Open Monday-Friday from 12:00-5:00pm, the Library is staffed by a librarian or trained library assistant to handle requests for information about health topics. The library has standard drug and medical reference books, current newsletters from Harvard, Mayo Clinic, Johns Hopkins, and UC Berkeley and free pamphlets on general health topics. Visitors have access to subscription databases through the use of two PCs and a wireless connection. Visitors look at anatomical models and medical images to gain greater understanding about anatomy and physiology. The Hospital Outreach Librarian is also available by appointment during morning, evening and Saturday hours.
- Health Professions Education: Baystate Medical Center is recognized as a leading academic medical center. As the Western Campus of Tufts University School of Medicine since 1974, BMC offers clinical training and undergraduate and graduate medical student education across all specialties. In addition to BMC, Medical Residents and Fellows rotate through the Baystate Franklin Medical Center and Baystate Mary Lane Hospital.
- Library Community Outreach - Reliable Health Information Classes: beginning in March 2010, the Outreach Librarian met with several community groups to explore possibilities of teaching classes on how to find reliable online health information. The librarian offers their knowledge, expertise and skills and (in some cases) use of the library's computer lab. The community partners are the contacts to populations facing chronic disease and racial/ethnic disparities. The teaching is a collaborative effort of the Outreach Librarian and Hospital community partners.
- Partners for a Healthier Community ("PHC"): founded as a not-for-profit organization in 1996 by Baystate Health, the City of Springfield and other key local stakeholders, PHC has partnered with over 100 organizations in various community benefit projects since its creation. The Hospital supports the core infrastructure of the PHC by donating \$250,000 annually plus additional in-kind services. PHC's mission is to build measurably healthy communities for all with equitable opportunities and resources through civic leadership, collaborative partnerships and policy advocacy. PHC is committed to improving the public's health by fostering innovation, leveraging resources, and building partnerships across sectors, including government agencies, communities, the health care delivery system, media, and academia organized to create a measurably healthier community using collaborative programming to solve pressing community health issues. PHC does not provide direct services; rather it takes the role of neutral facilitator to promote community collaborations. In this role, PHC provides multipurpose support including, convening and partnering, health policy development, population based health program delivery and research and evaluation.
 - BEST Oral Health: Bringing early Education, Screening, and Treatment ("BEST"): to prevent dental decay among preschool-aged children. BEST is a collaborative effort to mobilize constituents in the design and implementation of community-based, prevention-focused programs and policy advocacy that address local oral health issues.
 - Live Well Springfield Eat Smart. Stay Fit: a comprehensive, collaborative, functioning coalition that promotes city-wide campaigns to increase daily physical activity and healthy eating through programming, physical infrastructure improvements, and policy work – targeting all people who live, work and play in Springfield.

- Farm to Preschool & Families (F2P): an innovative initiative to link Springfield families to locally grown food by providing fresh, local produce to preschool children and their families and exposing them to healthy eating habits.
- Pioneer Valley Asthma Coalition (“PVAC”): a coalition of health professionals & institutions, community groups and residents, public health organizations, municipal and state agencies, academic institutions, schools, day care, housing and environmental groups committed to improving asthma and environmental conditions that affect health in Western Massachusetts.
- YEAH! Network: the Youth Empowerment Adolescent Network consists of diverse community stakeholders who work together to create a proactive, comprehensive response to adverse adolescent sexual health and adolescent sexuality. Priorities include the Springfield Pregnant and Parenting Teen Project and the Teen Leadership Training on adolescent reproductive health.
- Research: as an academic teaching hospital and the Western Campus of Tufts University School of Medicine, the Hospital is a center for research. Strong partnerships with other research organizations allow the Hospital to further its institutional commitment to the Advancement of Knowledge. Collaborations enable the Hospital to better support the innovative research of its investigators and to improve the lives of the people in the communities served. The Hospital is an active participant in the research communities of Massachusetts and a member institution of the state and regional organizations that also promote the goals of biomedical research. Its faculty and research staff are engaged in basic, clinical and biomedical research across a broad spectrum of medical and surgical specialties, with nationally-recognized research programs in quality of care and diabetes and metabolism. The Hospital serves as a regional resource for specialty medical care while providing comprehensive primary medical services to its community. The Hospital is also a research partner with University of Massachusetts through the Pioneer Valley Life Sciences Institute. Formed in 2003, PVLSI is a research institution which applies its translational research efforts in the areas of cancer, diabetes, obesity, and wound healing. Its scientists and technicians are committed to improving human health and reducing suffering from disease through creative strategies for early detection and preventive interventions.
- Voluntary Financial Contribution to the City of Springfield: in 2006 the Hospital made a commitment to the City of Springfield and residents of Springfield by making a voluntary contribution. The City must use the funds only for its public health activities and initiatives to ensure that Springfield residents continue to be able to access quality public health services.

C. Address Health Needs through Hospital Determination of Need (DoN) Community Health Initiatives

The Massachusetts Executive Office of Health and Human Services administers a Determination of Need (“DoN”) Program. Health care institutions planning a substantial capital expenditure and/or substantial change in services must submit a DoN proposal to the Massachusetts Department of Public Health. If the application is approved, the applicant facility then provides the equivalent of 5% of the capital outlay to support community health and prevention needs. The purpose of DoN program is to help monitor the availability and accessibility of cost-effective, quality health care services and foster collaborations among hospitals and community-based partners as well as to improve the health status of vulnerable populations.

Hospitals are also required by the IRS and the Office of the Attorney General of Massachusetts to provide community benefit programs and to provide and report annually on benefits to the communities that they

serve. DoN funds distributed for community health initiatives may qualify as community benefits, but it is important to distinguish these funds from ongoing, required hospital run community benefit programs. Our goal in this document is to establish a strategy towards implementing Hospital community benefit programs independent of current and subsequent DoN community health initiatives.

As part of a capital expansion project, the Hospital invested \$9.6 million (spent over seven years, beginning in 2008) in Springfield area community health initiatives. This funding, a condition of the Hospital's DoN application was specifically for Springfield's North End and Mason Square communities where citizens devised, planned and lead ground-level initiatives to diminish health disparities and improve the lives of their families, friends and neighbors in these communities. The Hospital made an additional investment of \$2 million (spent over three years, beginning in 2012) for community health initiatives tied to the Hospital's new Emergency Department.

Appendix A describes the Hospital's various DoN community health initiatives funded through its two capital expansion projects. To date, the Hospital's total DoN investment in the community is \$11.6 million over nine years (beginning in 2008).

D. Collaborate with Community Partners to Address Health Needs

The Strategy will be implemented in collaboration with other entities including, but not limited to:

- AIDS Foundation of Western MA
- American Foundation of Suicide Prevention
- Baystate Child Protection Team
- Baystate Medical Center Behavior Health/Neuropsychology Department
- Baystate Office of Diversity and Inclusion
- Baystate Postpartum Depression Taskforce
- BMC HealthNet
- BMP Medical Practices
- Community Outreach Worker Networking Organization
- Dunbar Y Family and Community Center
- Dunbar YMCA
- Elms College RN to BSN Program
- Gardening the Community
- Hampden County Child Fatality Review Team
- Hampden County District Attorney's Office
- HCS Head Start
- Health New England
- Healthcare for the Homeless
- Holyoke Fire Department
- Local Boards of Health (Springfield, West Springfield, Agawam, Holyoke, Chicopee, Amherst, Northampton)
- MA Prevent Injuries Now Network
- Martin Luther King, Jr. Family Services
- Mason Square Health Task Force
- Massachusetts Association of Community Health Workers
- Massachusetts Department of Children and Families - Western Regional Office
- Massachusetts Dept of Public Health - TB Division
- Medical Home Work Group for Children with Special Needs

- New North Citizens Council
- North End Campus Coalition
- Partners for a Healthier Community
- Project Baby
- Puerto Rican Cultural Center
- ROCA
- Springfield City Library
- Springfield Dept of Health and Human Services
- Springfield Fire Department
- Springfield Girls' Club Family Center
- Springfield Police Department
- Springfield Pregnant & Parenting Teen Project
- Springfield Public Schools
- Supplemental Nutrition Application Program (SNAP)
- UNITY of Pioneer Valley
- Westfield Police Department
- YMCA of Greater Springfield

Other non-profit agencies, schools, preschools, farmers, state associations and departments, city government, oral health professionals, faith-based institutions and higher education.

5. Needs Beyond the Hospital’s Mission or Community Benefit Program

No community hospital facility can address all of the health needs present in its community. The Hospital is committed to adhering to its Mission and remaining financially healthy so that it can continue to enhance its clinical excellence and to provide a wide range of community benefits. The Strategy does not address the following community health needs identified in the 2013 CHNA due to no new funding or resources, other hospitals or community organizations within service area are already addressing the need or the need falls outside of the Hospitals’ mission or capacity.

- **Racial and Ethnic Disparities in Disease Morbidity and Mortality:** the Hospital understands the connection between institutional racism and ethnic and racial health disparities and has committed DoN resources (see Section C and Appendix A) to fund local undoing racism education and training.
- **Lack of Access to Dental Care:** pediatric dental access is being addressed through Partners for a Healthier Community’s BEST Oral Health Initiative (see Section 4b).
- **High Rates of Alcohol, Tobacco, and Drug Use:** a variety of existing community-based non-profits and agencies are addressing these needs, including, but not limited to: Behavioral Health Net, Center for Human Development, City of Springfield Tobacco Program, Gandara, and the Mason Square Drug Free Task Force.
- **High Rates of Unsafe Sex, Teen Pregnancy, and Chlamydia:** Teen pregnancy is being addressed through the efforts of the YEAH! Network and the Springfield Pregnant and Parenting Teens Collaborative (see Section 4b) as well as the City of Springfield’s Springfield Adolescent Sexual Health Advisory Committee and the Community Health Network Area #4’s Springfield Adolescent Health Project.

- **Pediatric Disability:** Hospital clinicians and staff co-lead and participate in the Medical Home Workgroup for Children with Special Needs. As part of its regular service line, the Hospital has a new Developmental and Behavioral Pediatrics Department (see section 6).
- **High Rates of Asthma:** being addressed through Partners for a Healthier Community and the Pioneer Valley Asthma Coalition (see Section 4b).
- **Poor Built Environment and Environmental Quality:** being addressed through Partners for a Healthier Community's Live Well Springfield and Healthy Environment, Healthy Springfield Initiatives (see Section 4b).

6. A Broader Commitment to Our Patients and Community Served

The Hospital, through its affiliation with Baystate Health, is able to provide other programs and services to patients and the communities served that may not qualify as community benefits, yet these programs and services are addressing community health needs. In addition, the Hospital participates in community partnerships that work collaboratively to address health needs.

- Annual "In the Spirit of Giving" Toy Drive: each December, the Hospital delivers over 3,000 toys that are collected through an annual employee holiday toy drive. The toys are donated to community partners including Martin Luther King Jr. Family Services, Dunbar Community Center, New North Citizens' Council, Puerto Rican Cultural Center, Margaret C. Ells School, Baystate Mason Square Neighborhood Health Center, Baystate High Street Health Center and Baystate Brightwood Health Center. 2013 CHNA priority health need(s) being addressed: broader health needs.
- Baystate Developmental & Behavioral Pediatrics: provides developmental evaluations and some intervention for children with developmental delays, learning disabilities, and special health care needs. They are an interdisciplinary team, which means regular communication amongst the medical team, the family, the child's health professionals and educators. 2013 CHNA priority health need(s) being addressed: pediatric disability
- Baystate Neighbors Program: Beginning in 1999, this program was established to help employee first-time homebuyers purchase a home and to promote homeownership in neighborhoods around BH's three hospital entities. Employees are granted forgivable loans in the amount of \$7,500 that may be used towards a down payment or closing costs. In the past 13 years, the Baystate Neighbors Program has awarded a total of 124 loans to help employees become homeowners, helping to stabilize housing in the Towns of Greenfield (seven loans) and Ware (ten loans) and the City of Springfield (107 loans). H2013 CHNA priority health need(s) being addressed: basic needs: housing.
- Integrated Behavioral Health: Baystate Behavioral Health and the Department of Psychiatry have partnered with Baystate Medical Practices' Patient Centered Medical Homes (PCMH) to develop the creation of Integrated Behavioral Health (IBH). The goal of IBH is to address the unmet mental health needs of patients by improving the recognition and treatment of psychiatric and behavioral health problems within the primary care setting; to address behavioral health factors contributing to excess morbidity and mortality for patients with chronic medical conditions; to address behavioral factors contributing to risks of physical health problems; and improve the coordination between community mental health resources and each PCMH within BMP. In 2013, Behavioral Health Clinicians have been hired and integrated within two of the ten PCMHs at Baystate Health. In 2014 and 2015, BH intends to integrate clinicians within the remainder of the PCMHs. In addition to providing behavioral health clinicians to each of these practices, psychiatric consultations will also be offered to the primary care providers. Monthly consultations are currently offered to 5 of the 10 practices and plans are to grow

the program to offer these much needed services to all ten practices. IBH currently has a Medical Director, Practice Manager and Clinical Supervisor. 2013 CHNA priority health need(s) being addressed: lack of mental health services, care coordination.

- Massachusetts Child Psychiatry Access Project (MCPAP): the Hospital, the first MCPAP site established in 2004, covers the entire western MA region (Berkshire, Franklin, Hampshire and Hampden Counties) with 1.0 FTE Child Psychiatrist, 1.0 FTE Clinical Social Worker, 1.0 FTE Care Coordinator, .2 FTE Medical Director and .1 FTE Program Manager. MCPAP is a system of regional children's mental health consultation teams designed to help primary care providers (PCPs) meet the needs of children with psychiatric problems. MCPAP goals include improving access to treatment for children with psychiatric illness, promoting the inclusion of child psychiatry within the scope of the practice of primary care, restoring a functional primary care/specialist relationship between PCPs and child psychiatrist and promoting the rational utilization of scarce specialty resources for the most complex and high-risk children. 2013 CHNA priority health need(s) being addressed: pediatric disability, lack of access to mental health services/poor mental health status.
- Office of Diversity and Inclusion: the Hospital is committed to fostering an environment of diversity, inclusion and cultural competence where all employees are appreciated, fully engaged and motivated to improve the health of the people in our communities every day, with quality and compassion. The Diversity and Inclusion strategic plan includes the following strategic priorities:
 - Education and Awareness: employees at all levels understand the meaning of diversity and inclusion and its importance to Baystate Health.
 - Closing the Gap: close the gaps identified in the organizational assessment to increase inclusion.
 - Leadership Diversity: increase the number of people of color in the leadership of the organization.

The Office of Diversity and Inclusions offers a variety of programs, learning tools and development opportunities to provide Hospital employees with the knowledge, skills and abilities to ensure that our workforce is engaged and culturally complement. In addition, the Hospital's leadership team provides strategic direction and approval of the Diversity & Inclusion strategic plan. The Baystate Health Diversity Council leads the overall integration of diversity, inclusion and cultural competence across the organization. Employee Resource Groups (ERG's) are open to all employees, support Diversity and Inclusion initiatives and further the Hospital mission. Employees are empowered to do the work of diversity and inclusion in their own departments.

In alignment with its business goals, development goals and in support of our community the Hospital offered the first annual Baystate Health Diversity & Inclusion Conference in September 2013, a conference offering the region's diversity champions and leaders inspiration and direction to build and support a business imperative of diversity and inclusion. The event provides a unique opportunity to collaborate, share best practices, and collectively define what diversity and inclusion means for our region. 2013 CHNA priority health need(s) being addressed: culturally sensitive care.

- Reduction of Early Labor Inductions: births that are performed early without a medical reason lead to increased risk of maternal and infant complications, including risk of maternal and neonatal morbidity and longer hospital stays for both mothers and newborns. The Hospital has created a policy to eliminate elective induction of labor before 41 weeks.
- Skin to Skin Contact: when babies are born at the Hospital their first embrace is with mom immediately following delivery. Weight and measurements occur later. Mom's have skin-to-skin contact by holding their baby against their chest. A blanket is placed over them and their baby to create a warm, calm place for their baby to relax. Babies learn through touch, sight, sound, smell and taste which is

enhanced by this skin-to-skin contact. This is also a good way to begin breastfeeding. Snuggling on mom's chest for an hour or two, baby is able to bond with mom, settle into the perfect temperature, and breastfeed naturally at the right time. 2013 CHNA priority health need(s) being addressed: prevalent infant health risk factors.

- Tdap Vaccine: according to the Massachusetts Department of Public Health, pertussis rates in Massachusetts (and nationally) remain elevated. Pertussis, also known as whooping cough, is a very serious disease and can be life-threatening for infants, small children, and the elderly. The pertussis vaccine (also known as Tdap, which is an abbreviation for Tetanus, Diphtheria, and acellular pertussis) continues to be the best way to protect ourselves from Pertussis and its complications. The Hospital, through its women's clinic, ob/gyn and midwifery practices is offering to administer a dose of Tdap during each pregnancy irrespective of the patient's prior history of receiving Tdap. Transplacental transfer of maternal pertussis antibodies from mother to infant may provide protection against pertussis in early life, before beginning the primary DTaP series. A woman vaccinated with Tdap vaccine during pregnancy will also herself be protected at time of delivery and will be less likely to transmit pertussis to her newborn infant.
- United Way: The United Way develops and supports programs that directly improve the lives of people in our communities, a mission proudly shared by Baystate Health. Baystate Health is a strong supporter of the United Way, and a major contributor to the organization with three workforce campaigns and thousands of employee donors and volunteers. Baystate Health's contributions help the United Way serve our families, friends, colleagues and others who seek help in different ways and at different times in their lives. Three community campaigns are held annually: Springfield workplace to support the United Way of Pioneer Valley, Greenfield workplace to support the United Way of Franklin County and Ware workplace to support the United Way of Hampshire County. 2013 CHNA priority health need(s) being addressed: broader health needs.

7. Implementation Strategy Development Partners

In developing this implementation strategy, the Hospital partnered with the following internal and external stakeholders:

- Baystate Adult/Child Behavioral Services
- Baystate Ambulatory Grants
- Baystate Community Health Center's
- Baystate Department of Strategic and Program Planning
- Baystate Department of Taxation
- Baystate Family Advocacy Center
- Baystate Health Sciences Library
- Baystate Office of Diversity and Inclusion and Diversity Council
- Baystate Office of Government and Community Relations
- Baystate Springfield Educational Partnership
- Health New England
- La Esperanza
- MA Department of Public Health
- Mason Square Health Task Force
- MotherWoman
- Partners for a Healthier Community
- Springfield Department of Health and Human Services
- Springfield Public Schools
- YEAH! Network

Appendix A. Hospital DoN Community Health Initiatives

Community Health Initiatives	Description	Community Partner(s)	Priority Health Needs Being Addressed by Initiative
Mason Square Health Task Force	The Mason Square Health Task Force (MSHTF) is a community coalition working to eliminate racial health disparities in Mason Square through information sharing, capacity building & policy change, with a focus on nutrition and healthy food access, diabetes & chronic heart disease.	Dunbar YMCA & Family Community Center; Broader Mason Square Community	Diet & Exercise Related Morbidity and Mortality, Racial and Ethnic Disparities, Basis Needs: Food Access
North End Campus Coalition	The North End Campus Coalition seeks to increase community involvement and encouraging partnerships between local organizations and individuals. It is a health initiative concerned with promoting active, healthy lifestyles and preventative care while encouraging and supporting active community involvement. Through education, partnerships, and effective programming, the coalition seeks to foster citizen involvement within the North End Community to improve the quality of life of its residents.	New North Citizens Council, Project Coach	Community Safety, Low Education Achievement, Diet/Exercise Related Disease and Morbidity
North End Housing Initiative	This initiative seeks to increase the quantity, quality and healthy habitability of owner-occupied housing in the North End of Springfield.	City of Springfield, New North Citizens' Council	Community Safety, Basic Needs: Housing
Springfield Homelessness Initiative	For the purpose of implementation of the "Springfield Homelessness Initiative" and development of the Worthington House Campus Project and the new Homeless Resource Center that includes medical, dental and assessment services for homeless individuals, a new shelter for homeless women and 32 efficiency apartments for homeless individuals.	Friends of the Homeless and City of Springfield	Basic Needs: Housing
Francis Hubbard Social Change Program	Address key health priorities, including sexually transmitted infections and teen pregnancy prevention.	Community Health Network Agency #4, Springfield Adolescent Health Project	Low educational achievement, racial and ethnic disparities,
Higher Education Scholarship Program	Address racial and ethnic disparities in the composition of Springfield's health-care workforce. Help maintain the city's population and expand economic opportunity by helping people from underserved communities obtain college degrees and achieve jobs in the health-care workforce.	Springfield Public Schools, Baystate Springfield Educational Partnership	Low Educational Achievement, Racial and ethnic disparities
Baystate Mary Lane Hospital	BMLH, in partnership with its Community Benefit Advisory Council will be allocate its DoN funding via a request for proposal ("RFP") process that will solicit community program and projects that specifically address the hospital's three priorities as identified in its CHNA.	TBD	Lack of Access to Mental Health Services and Poor Mental Health Status, High Rates of Alcohol, Tobacco, and Drug Use, and Need for Additional Treatment, High Rates of Diet and Exercise-Related Diseases and Mortality
Baystate Franklin Medical Center	BFMC, in partnership with its Community Benefit Advisory Council allocated its DoN funding via a request for proposal ("RFP") process that will solicited community program and projects that specifically address the hospital's health needs identified in its CHNA.	The Literacy Project Cooperative Public Health Service at the Franklin Regional Council of Governments	Lack of Access to Mental Health Services and Poor Mental Health Status, High Rates of Alcohol, Tobacco, and Drug Use, and Need for Additional Treatment, Need for increased care coordination
Develop Springfield	Funding to support multi-year efforts that addresses public health and education needs of tornado impacted neighborhoods in Springfield	Develop Springfield	Low educational achievement, Basic needs: Financial, Housing, Food
Dunbar YMCA Health Initiative	Organizational backbone support for projects such as MOCHA (e.g., Men of Color Health Awareness, ACHIEVE) to extend these programs to the Mason Square community and locate other community-based wellness and fitness programs in Mason Square.	YMCA of Greater Springfield, Dunbar Y Family and Community Center	Diet and exercise related morbidity and mortality, Low Educational Achievement, Racial and ethnic disparities
Martin Luther King, Jr. Family Services	To provide health and wellness education, obesity related disease prevention, capacity building and population based supports to the greater Mason Square community of 45,000 residents of Springfield.	Martin Luther King, Jr. Family Services	Diet and exercise related morbidity and mortality, Low Educational Achievement, Racial and ethnic disparities
Massachusetts Public	Funding to support and strengthen Act FRESH, a statewide initiative	Massachusetts Public	Built environment, Basic

Community Health Initiatives	Description	Community Partner(s)	Priority Health Needs Being Addressed by Initiative
Health Association	working to change state laws and policies so that every community has access to healthy, affordable food and safe, public space for physical activity.	Health Association	needs, financial, housing, food, Diet and exercise related morbidity and mortality
MotherWoman	Support to expand their community-based perinatal support model into Hampden County, creating a safety net of resources and referrals for mothers with post-partum emotional complications.	MotherWoman	Lack of Access to Mental Health Services and Poor Mental Health Status, Prevalent Infant Health Risk Factors, Need for increased care coordination
Partners for a Healthier Community (Farm to Preschool)	Supports a “movement” to organize and advance a Farm to Preschool and Families projects including farmers, schools, parents, community groups, and school food service staff to assure fresh produce is available everyday	Local schools, daycare centers, preschools and farms	Basic needs: food, Diet and exercise related morbidity and mortality
Springfield Early Education Reading Competency Initiative	A citywide initiative to ensure that all Springfield children develop reading competency by the fourth grade.	Davis Foundation	Low educational achievement, racial and ethnic disparities
Undoing Racism	Recognizing that “undoing racism” and embracing cultural diversity are keys to eliminating persistent health disparities in the city of Springfield, this program helps set up a multi-faceted initiative to address racism.	Davis Foundation	racial and ethnic disparities
Well Spring Initiative Economic Development Cooperatives in Springfield	Support the intersection of community development and health to increase access to resources, and create entry-level jobs in low-income neighborhoods to ultimately improve residents’ health.	Well Spring	Basic needs: Financial, Housing, Food, racial/ethnic disparities,
YEAH Network	To support county-wide teen pregnancy prevention coalition activity leading to the development and implementation of innovations and related policy change for social impact.	City of Springfield, YEAH! Network	Prevalent Infant Health Risk Factors, Low Educational Achievement
YMCA of Greater Springfield	Funding for a Liberty Crossing Case Manager to work with individuals at risk of homelessness; connects individuals with needed services and supports their accessing needed services.	YMCA of Greater Springfield	Basic needs: Financial, Housing, Food

Appendix B: Priority Health Needs – Scoring by Criteria

PRIORITY HEALTH NEEDS - SCORING BY CRITERIA

Score the following health needs based on each stated criteria using a 1-4 scale, with “1” indicating LOW, “2” MEDIUM, “3” HIGH and “4” VERY HIGH

*shared need with BMC and BMLH 4 = VERY HIGH 3 = HIGH 2 = MEDIUM 1 = LOW	Access to Care				Health Behaviors/Prevention				Maternal/Child Health		Social Determinants of Health						
	Dental Care	Mental Health Services/ Poor Mental Health Status*	Affordable/ Accessible Medical Care*	Increased Care Coordination/ Culturally Sensitive Care	Alcohol, and Tobacco, and Drug Use*	Asthma*	Diet & Exercise-Related Diseases and Mortality*	Unsafe Sex, Teen Pregnancy, and Chlamydia	Pediatric Disability*	Infant Health Risk Factors/ Mortality	Financial Hardship, Housing, and Food Access*	Low Educational Achievement	Poor Built Environment & Environmental Quality	Poor Community Safety	Racial and ethnic morbidity /mortality disparities		
1. Magnitude <i>Number of persons affected (incidence and/or prevalence)</i>																	
2. Severity <i>As indicated by morbidity or mortality rate, economic and/or social impact</i>																	
3. Feasibility <i>Do we have available expertise and time for planning, implementation, & evaluation</i>																	
4. Potential for Impact <i>Can we make a measurable impact on vulnerable populations</i>																	
5. BMC Alignment <i>Existing programs or hospital resources addressing health need</i>																	
6. Community Alignment <i>Existing programs and potential partnerships to address health need</i>																	
7. Strategic Opportunities <i>Feasibility to build upon existing programs, establish partnerships, seek grants, etc.</i>																	
8. Value <i>Is there a compelling case and/or subjective measure that indicates importance</i>																	
TOTAL SCORE: (Maximum of 32)																	

CRITERIA

Appendix C Existing Hospital Community Benefit Programs Aligned with 2013 CHNA Priority Health Needs

BMC COMMUNITY BENEFIT PROGRAMS VS. PRIORITY HEALTH NEEDS

	Access to Care				Health Behaviors/Prevention				Maternal/Child Health		Social Determinants of Health				
	Dental Care	Mental Health Services/ Poor Mental Health Status*	Affordable/ Accessible Medical Care*	Increased Care Coordination/ Culturally Sensitive Care	Alcohol, and Tobacco, and Drug Use*	Asthma*	Diet & Exercise-Related Diseases and Mortality*	Unsafe Sex, Teen Pregnancy, and Chlamydia	Pediatric Disability*	Infant Health Risk Factors/ Mortality	Financial Hardship, Housing, and Food Access*	Low Educational Achievement	Poor Built Environment & Environmental Quality	Poor Community Safety	Racial and ethnic morbidity /mortality disparities
*shared need with BFMC and BMLH															
Community Health Centers		•	•	•					•	•	•				•
Ambulatory Grants @ Health Centers															
Ryan White - HIV + primary care			•	•	•										
MCM – HIV access to care/coordination			•	•	•										
PICSR-T (HIV/SI/HEP)															
free rapid HIV/ STI/HEP screening & referral															
YALE-NAL TREXONE															
<i>Research - treatment of alcoholism</i>															
<i>Hampton County House of Corrections HIV SERVICES</i>		•		•	•										
OBOT		•			•										
Opioid treatment															
PROJECT BREAD															
<i>food gift cards for food-insecure patients</i>															
FARMWORKERS			•	•											•
primary care to migrant and seasonal farm workers															
EMERGENCY PREP			•	•											
<i>enhance emergency preparedness</i>			•	•											
O2Action			•	•											•
Retain primary care physicians /hypertensive patients			•	•											
ICD-10 Coding- Staff Training			•	•											
Health Care Infrastructure & Capacity <i>Enhance primary medical care</i>			•	•											
Baystate Mason Square Community Outreach					•	•									•
Baystate Springfield Educational Partnership (BSEP)															
Brightwood Community School Satellite Clinic		•	•	•	•	•									•
Collaborative & Consumer Health Classes/Consumer Health Library					•	•									•
Family Advocacy Center (FAC)		•													
Financial Assistance & Counseling			•							•					
Indigent Pharmacy Program @ Brightwood Health Center			•												
MIGHTY (Pediatric Weight Mgmt)										•					
Partners for a Healthier Community (PHC)	•					•									
Safe Kids of Western MA															•
Somos Mujeres Poderosas (Latina Postpartum Support Group – MotherWoman)		•		•											
Trauma and Injury Prevention															•
Tuberculosis Regional Clinic			•												•
UNITY Support Group		•													•

Appendix D: Individual and Group Scores of Priority Health Needs

Individual and Group Scores of Priority Health Needs

Individual Participant Scores	Access to Care				Health Behaviors/Prevention				Maternal/Child Health		Social Determinants of Health				
	Dental Care	Mental Health Services/ Poor Mental Health Status*	Affordable/ Accessible Medical Care*	Increased Care Coordination /Culturally Sensitive Care	Alcohol, Tobacco, and Drug Use*	Asthma*	Diet & Exercise- Related Diseases and Mortality*	Unsafe Sex, Teen Pregnancy, and Chlamydia	Pediatric Disability*	Infant Health Risk Factors/ Mortality	Financial Hardship, Housing, and Food Access*	Low Educational Achievement	Poor Built Environment & Environmental Quality	Poor Community Safety	Racial and ethnic morbidity/ mortality disparities
Totals	460	521	480	532	473	530	568	507	441	493	456	473	425	440	516
Mean	23	26	24	27	24	27	28	25	22	25	23	24	21	22	26

Small Group Scores	Access to Care				Health Behaviors/Prevention				Maternal/Child Health		Social Determinants of Health				
	Dental Care	Mental Health Services/ Poor Mental Health Status*	Affordable/ Accessible Medical Care*	Increased Care Coordination /Culturally Sensitive Care	Alcohol, Tobacco, and Drug Use*	Asthma*	Diet & Exercise- Related Diseases and Mortality*	Unsafe Sex, Teen Pregnancy, and Chlamydia	Pediatric Disability*	Infant Health Risk Factors/ Mortality	Financial Hardship, Housing, and Food Access*	Low Educational Achievement	Poor Built Environment & Environmental Quality	Poor Community Safety	Racial and ethnic morbidity/ mortality disparities
Orange										21		24	17	20	29
Blue	23	23	18	25											
Yellow					23	25	28	24							
Green									21						
Totals	23	23	18	25	23	25	28	24	21	26	21	24	17	20	29

Variance	0	-3	-6	-2	-1	-2	0	-1	-1	1	-2	0	-4	-2	3
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