**Baystate Franklin Medical Center**
**Community Benefits | Strategic Implementation Plan (SIP)**
**2020 – 2022 WORKPLAN**

1 SOCIAL ENVIRONMENT

| | | |
|---|---|---|
| PRIORITY FOCUS AREA | 1 | **SOCIAL ENVIRONMENT**<br>*A community's social conditions and cultural dynamics, including social networks, social participation, social cohesion, social capital, social support, social inclusion, social integration, discrimination, trust, and norms. When strong, these elements can: provide people with a source of support; protect people from stressors; buffer the effects of stress; connect people with resources; and influence health behaviors. Communities of color and communities of lower socioeconomic status are at a disadvantage with respect to many elements of the social environment, thus contributing to health disparities. Discrimination, which affects shared perceptions, is another element of the social environment. Source: MA DPH.* |
| DESCRIPTION OF NEED (2019 CHNA) | | Please refer to pages 29-22 in the 2019 CHNA |
| PRIORITY POPULATIONS (TO BE ADDRESSED BY STRATEGIES) | | Black and Latino residents of the service area; children who have experienced trauma; gay, lesbian, bisexual, queer, and questioning (GLBQ+) youth; older adults; people re-entering the community after incarceration; low and moderate-income (LMI) people earning below a living wage; transgender, non-binary, and gender nonconforming people.<br><br>White people in positions of power are also a priority population. It is critical this population acknowledge and recognize systems of white dominance in institutions that are named and being used as "remedies" to racial discrimination. |
| GOAL | | Increase strong social environments for all priority populations in the Baystate Franklin service area. |
| OBJECTIVE (SMART) | 1.1 | TBD - DoN RFP Strategies under development |

| OUTCOME/PROCESS INDICATORS | MEASURES OF SUCCESS | | DATA SOURCE |
|---|---|---|---|
| | BASELINE | 2022 TARGET | |
| • TBD | | | |

| | STRATEGIES | STATUS<br>C = Current<br>D = In Development<br>F = Future | HOSPITAL ROLE<br>O = Operational<br>C = Convener<br>P = Partner<br>F = Funder<br>I = Implement | TIMELINE | | | HOSPITAL RESOURCE INPUT(S) | OTHER SOURCE A | PARNTERS |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Y1 | Y2 | Y3 | | | |
| 1.1.1 | Community Action Pioneer Valley Strengthening Perinatal Partnerships Grant | C | F | X | X | | DoN Funding | | CAPV |
| 1.1.2 | Montague Ministries SOAR / MIND Grant | C | F | X | | | DoN Funding | | Montague Ministries |
| 1.1.3 | Understanding the impacts of structural racism: Hospital Administration, CBAC, Grantees. | F | C / I | X | | | DoN Funding | | |
| 1.1.4 | Anchor Mission goal around hiring, purchasing, place based investments. | F | O | X | | | Hospital operations | | FCCDC |

| MONITORING/EVALUATION APPROACHES | POTENTIAL PARTNERS |
|---|---|
| • Quarterly review of strategy indicators by BFMC CBAC | • RFP grantees - TBD |
| • Annual check-in with SIP partners | • Franklin County Community Development Corporation (FCCDC) |
| • Public Health Institute of Western MA contracted for technical assistance and evaluation of each grantee | • |
| • Semi-annual grantee reports | • |
| • Annual presentation to BFMC CBAC | • |

**Baystate Franklin Medical Center**
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**2 MENTAL HEALTH AND SUBSTANCE USE**

| | | |
|---|---|---|
| PRIORITY FOCUS AREA | 2 | **MENTAL HEALTH AND SUBSTANCE USE** |
| DESCRIPTION OF NEED (2019 CHNA) | | Please refer to pages 68-77 in the 2019 CHNA |
| PRIORITY POPULATIONS (TO BE ADDRESSED BY STRATEGIES) | | Communities of color (especially Latinos); GLBQ+ youth; older adults; people living unsheltered/homeless; people reentering society after incarceration; people with mental health and/or substance use diagnoses; transgender youth; youth |
| GOAL | | Increase access to prevention, treatment, and recovery supports for priority populations with mental health and/or substance use diagnoses. |
| OBJECTIVE (SMART) | 2.1 | Increase community and provider capacity to advocate for mental health and substance use disorder treatment and prevention through training and coalition building within three years of strategy implementation. |

| OUTCOME/PROCESS INDICATORS | MEASURES OF SUCCESS 2020 BASELINE | MEASURES OF SUCCESS 2022 TARGET | DATA SOURCE |
|---|---|---|---|
| • Number of organizations participating in Opioid Task Force | | | OTF |
| • Number of organizations participating in Franklin County Health Improvement Plan (CHIP) | | | Franklin CHIP |
| • Number of providers trained on mental and behavioral health treatment best practices through CVS Health Grant (FY 2020 only) | 0 | | Baystate Health Foundation |

| | STRATEGIES | STATUS (C = Current, D = In Development, F = Future) | HOSPITAL ROLE (O = Operational, C = Convener, P = Partner, F = Funder, I = Implement) | TIMELINE Y1 | TIMELINE Y2 | TIMELINE Y3 | HOSPITAL RESOURCE INPUT(S) (🕐 \| 🧍 \| $$) | OTHER SOURCES | PARTNERS |
|---|---|---|---|---|---|---|---|---|---|
| 2.1.1 | Franklin County Opioid Task Force (OTF) | C | P | X | X | X | Time, Staff, CBAC | | |
| 2.1.2 | Franklin County Health Improvement Plan (CHIP): | C | F | X | X | | DoN CHI Funding through FY 2021 | | Franklin CHIP Network |
| 2.1.3 | Regional Hospital and Community Provider Training: *best practices in mental and behavioral health treatment* | D | I | X | | | Time, Staff | CVS Health Foundation $27,000 | |

| MONITORING/EVALUATION APPROACHES | POTENTIAL PARTNERS |
|---|---|
| • Quarterly review of strategy indicators by BMC CBAC | • |
| • Annual check-in with SIP partners | • |
| • Annual SIP work plan updates posted on BH website | • |
| • | • |

**Baystate Franklin Medical Center**
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2 **MENTAL HEALTH AND SUBSTANCE USE**

PRIORITY FOCUS AREA: 2 **MENTAL HEALTH AND SUBSTANCE USE**

OBJECTIVE (SMART): 2.2 Increase access to equitable mental health and substance use treatment within three years of strategy implementation.

| OUTCOME/PROCESS INDICATORS | MEASURES OF SUCCESS | | DATA SOURCE |
|---|---|---|---|
| | 2020 BASELINE | 2022 TARGET | |
| • Completion of Baystate Health Behavioral Health Hospital | Incomplete | In Progress/ Complete | Baystate |
| • Number of families served by Empower Power | | | Baystate |
| • Rate of opioid overdose ED visits at BFMC | | | Baystate |

| | STRATEGIES | STATUS C = Current D = In Development F = Future | HOSPITAL ROLE O = Operational C = Convener P = Partner F = Funder I = Implement | TIMELINE Y1 | Y2 | Y3 | HOSPITAL RESOURCE INPUT(S) 🕐 \| 🧍 \| $$ | OTHER SOURCES | PARTNERS |
|---|---|---|---|---|---|---|---|---|---|
| 2.2.1 | Empower Program | C | O / P | X | X | X | Hospital Operations | | Franklin County Perinatal Support Coalition |
| 2.2.2 | Baystate Health Behavioral Health Hospital | F | O | - | - | - | Hospital Operations | | |
| 2.2.3 | BRIDGE | C | O / C / I | X | X | X | Hospital Operations | HRSA - Rural Communities Opioid Response Program (RCORP) | Various community-based organization |
| 2.2.4 | Baystate Family Medicine Residency Program; intensive SUD training | F | P | X | | | CBAC | | |

| MONITORING/EVALUATION APPROACHES | POTENTIAL PARTNERS |
|---|---|
| • Quarterly review of strategy indicators by BMC CBAC | • |
| • Annual check-in with SIP partners | • |
| • Annual SIP work plan updates posted on BH website | • |
| • | • |

| | | |
|---|---|---|
| PRIORITY FOCUS AREA | 2 | **MENTAL HEALTH AND SUBSTANCE USE** |
| OBJECTIVE (SMART) | 2.3 | Increase access to prevention-based initiatives for all individuals within three years of strategy implementation. |

| OUTCOME/PROCESS INDICATORS | MEASURES OF SUCCESS | | DATA SOURCE |
|---|---|---|---|
| | BASELINE | 2022 TARGET | |
| • Weight of medication collected at BFMC kiosk | 0 lbs | | Baystate Health |
| • Weight of sharps collected at BFMC kiosk | 0 lbs | | Baystate Health |

| | STRATEGIES | STATUS C = Current D = In Development F = Future | HOSPITAL ROLE O = Operational C = Convener P = Partner F = Funder I = Implement | TIMELINE Y1 | Y2 | Y3 | HOSPITAL RESOURCE INPUT(S) | OTHER SOURCES | PARTNERS |
|---|---|---|---|---|---|---|---|---|---|
| 2.3.1 | BFMC Medication and Sharps Kiosks | C | O | X | X | X | Hospital Operations | | |
| 2.3.2 | Partnership with Communities That Care and 4SC on three events per year | C | P | X | X | X | In-kind | | |
| 2.3.3 | Communities That Care Coalition Grant | C | F | X | X | | DoN Funding | | |

| MONITORING/EVALUATION APPROACHES | POTENTIAL PARTNERS |
|---|---|
| • Quarterly review of strategy indicators by BMC CBAC | • |
| • Annual check-in with SIP partners | • |
| • Annual SIP work plan updates posted on BH website | • |
| • | • |

| | | |
|---|---|---|
| PRIORITY FOCUS AREA | 3 | **BUILT ENVIRONMENT**<br>*Access to Transportation, Health Care, and Food Security* |
| DESCRIPTION OF NEED (2019 CHNA) | | Please refer to pages 40-45 in the 2019 CHNA |
| PRIORITY POPULATIONS (TO BE ADDRESSED BY STRATEGIES) | | Children and youth; low and moderate-income (LMI) people earning below a living wage; young adults |
| GOAL | | Increase transportation and housing options for residents of Franklin County/North Quabbin. |
| OBJECTIVE (SMART) | 3.1 | Support development of rideshare and micro-transit models appropriate for rural areas within three years of strategy implementation. |

| OUTCOME/PROCESS INDICATORS | MEASURES OF SUCCESS | | DATA SOURCE |
|---|---|---|---|
| | 2020 BASELINE | 2022 TARGET | |
| Participation in FRCOG rideshare pilot | none | Attend 75% of planning meetings | FRCOG |
| Participation in next generation of rideshare service in our region | none | BFMC is core partner | FRCOG/ FRTA |
| Support greater use of FRTA Access program among patients, staff at BFMC and BMP | # trips to BFMC recorded | Triple the number | FRTA |

| | STRATEGIES | STATUS (C = Current, D = In Development, F = Future) | HOSPITAL ROLE (O = Operational, C = Convener, P = Partner, F = Funder, I = Implement) | TIMELINE Y1 | TIMELINE Y2 | TIMELINE Y3 | HOSPITAL RESOURCE INPUT(S) | OTHER SOURCES | PARTNERS |
|---|---|---|---|---|---|---|---|---|---|
| 3.1.1 | FRCOG Rideshare Pilot and Project | D | I | X | X | X | Time, Staff, CBAC | State Budget Earmark | FRCOG |
| 3.1.2 | Support Greater Use of FRTA Access | D | P | X | X | X | Time, Staff, CBAC | FRTA | |

| MONITORING/EVALUATION APPROACHES | POTENTIAL PARTNERS |
|---|---|
| • Quarterly review of strategy indicators by BMC CBAC | • Other human service and healthcare partners |
| • Annual check-in with SIP partners | • |
| • Annual SIP work plan updates posted on BH website | • |
| • | • |

PRIORITY FOCUS AREA 3 **BUILT ENVIRONMENT**
*Access to Transportation, Health Care, and Food Security*

OBJECTIVE (SMART) 3.2 Improve housing options for young people who have experienced trauma within three years of strategy implementation.

| OUTCOME/PROCESS INDICATORS | MEASURES OF SUCCESS | | DATA SOURCE |
|---|---|---|---|
| | 2020 BASELINE | 2022 TARGET | |
| • Number of total youth supported by DIAL/SELF | | | DIAL/SELF |

| | STRATEGIES | STATUS C = Current D = In Development F = Future | HOSPITAL ROLE O = Operational C = Convener P = Partner F = Funder I = Implement | TIMELINE Y1 | Y2 | Y3 | HOSPITAL RESOURCE INPUT(S) 🧍 \| 🕐 \| $$ | OTHER SOURCES | PARTNERS |
|---|---|---|---|---|---|---|---|---|---|
| 3.2.1 | DIAL/SELF | C | F | X | X | X | DoN CHI Funding | | |
| 3.2.2 | | | | | | | | | |

| MONITORING/EVALUATION APPROACHES | POTENTIAL PARTNERS |
|---|---|
| • Bi-annual reports from DIAL/SELF | • Franklin County Community Development Corporation (FCCDC) |
| • Quarterly review of strategy indicators by BMC CBAC | • |
| • Annual check-in with SIP partners | • |
| • Annual SIP work plan updates posted on BH website | • |
| • | • |

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3 BUILT ENVIRONMENT

PRIORITY FOCUS AREA 3 **BUILT ENVIRONMENT**
*Access to Transportation, Health Care, and Food Security*

OBJECTIVE (SMART) 3.3 Increase access to care for residents of Franklin County/North Quabbin, with a special emphasis on improving access for members of priority populations.

| OUTCOME/PROCESS INDICATORS | MEASURES OF SUCCESS | | DATA SOURCE |
|---|---|---|---|
| | 2020 BASELINE | 2022 TARGET | |
| • Number of MassHealth, Health Safety Net and Financial Assistance Program applications completed | | | Baystate |
| • Number of patients assisted by financial counselors | | | Baystate |
| • Expansion of CHCFC on-site Dental Clinic and increased collaboration with clinic | Current size | Two additional rooms | Baystate |
| • Telehealth capacity development - TBD | TBD | TBD | |

| | STRATEGIES | STATUS C = Current D = In Development F = Future | HOSPITAL ROLE O = Operational C = Convener P = Partner F = Funder I = Implement | TIMELINE Y1 | Y2 | Y3 | HOSPITAL RESOURCE INPUT(S) 🧍 \| 🕐 \| $$ | OTHER SOURCES | PARTNERS |
|---|---|---|---|---|---|---|---|---|---|
| 3.2.1 | Baystate Financial Assistance Program (FAP) | C | O | X | X | X | Hospital Operations | | |
| 3.2.2 | Baystate Financial Counseling | C | O | X | X | X | Hospital Operations | | |
| 3.2.3 | CHCFC BFMC On-site Dental Clinic | C | O | X | X | | Hospital space | | CHCFC |
| 3.2.4 | Telehealth capacity development and deployment in rural areas | D | P / I | | X | X | Bridge Team | U.S. Department of Health and Human Services (HHS) Grant | |

| MONITORING/EVALUATION APPROACHES | POTENTIAL PARTNERS |
|---|---|
| • Annual check-in with SIP partners | • Center for New Americans (CfNA) |
| • Quarterly review of strategy indicators by BMC CBAC | • Community Action Pioneer Valley (CAPV) |
| • Annual SIP work plan updates posted on BH website | • Franklin Regional Council of Governments (FRCOG) |
| • | • Interfaith Council |
| • | • Tapestry Health |
| • | • The Literacy Project |

# 4 CARE COORDINATION

| | | |
|---|---|---|
| PRIORITY FOCUS AREA | 4 | **CARE COORDINATION** |
| DESCRIPTION OF NEED (2019 CHNA) | | Please refer to pages 62-63 in the 2019 CHNA |
| PRIORITY POPULATIONS (TO BE ADDRESSED BY STRATEGIES) | | People reentering society after incarceration; people with mental health and/or substance use disorders; GLBQ+ and transgender individuals |
| GOAL | | Improve care coordination systems in Franklin County/North Quabbin. |
| OBJECTIVE (SMART) | 4.1 | Increase access to local community resource information for hospital staff, community organizations and residents within three years of strategy implementation. |

| OUTCOME/PROCESS INDICATORS | MEASURES OF SUCCESS: 2020 BASELINE | MEASURES OF SUCCESS: 2022 TARGET | DATA SOURCE |
|---|---|---|---|
| • Number of meetings held to promote Look4Help internal to Baystate Franklin providers | | | CAPV data |
| • Creation of billing structure for Look4Help | Incomplete | Complete | CAPV data |
| • Use of Look4Help by hospital employees | | Increased use | CAPV survey data |
| • Use of Look4Help by community organizations | | Increased use | CAPV survey data |

| | STRATEGIES | STATUS (C = Current, D = In Development, F = Future) | HOSPITAL ROLE (O = Operational, C = Convener, P = Partner, F = Funder, I = Implement) | TIMELINE Y1 | TIMELINE Y2 | TIMELINE Y3 | HOSPITAL RESOURCE INPUT(S) | OTHER SOURCES | PARTNERS |
|---|---|---|---|---|---|---|---|---|---|
| 4.1.1 | Look4Help – utilization and promotion | C | P | X | X | X | CBAC; Hospital Staff | | CAPV |
| 4.1.2 | Look4Help – sustainability | F | F | - | - | - | TBD; *Previous funding provided FY16-19* | CAPV | CAPV |

| MONITORING/EVALUATION APPROACHES | POTENTIAL PARTNERS |
|---|---|
| • Quarterly review of strategy indicators by BMC CBAC | • |
| • Annual check-in with SIP partners | • |
| • Annual SIP work plan updates posted on BH website | • |
| • | • |

# 4 CARE COORDINATION

PRIORITY FOCUS AREA 4 **CARE COORDINATION**

OBJECTIVE (SMART) 4.2 Increase utilization and capacity of community health workers, recovery coaches, and health navigators within three years of strategy implementation.

| ANNUAL OUTCOME/PROCESS INDICATORS | MEASURES OF SUCCESS | | DATA SOURCE |
|---|---|---|---|
| | 2020 BASELINE | 2022 TARGET | |
| • Number of grants that include component for community health workers, recovery coaches, and/or health navigators | 1 grant | 3 grants | BFMC |
| • Number of meetings convened for community health workers, recovery coaches, and health navigators | None | Annual meeting | BFMC |
| • Advocate with state legislature and DPH to increase ability to bill the time of these peer navigator roles. | n/a | Testimony | Baystate |

| | STRATEGIES | STATUS (C = Current, D = In Development, F = Future) | HOSPITAL ROLE (O = Operational, C = Convener, P = Partner, F = Funder, I = Implement) | TIMELINE Y1 | TIMELINE Y2 | TIMELINE Y3 | HOSPITAL RESOURCE INPUT(S) | OTHER SOURCES | PARTNERS |
|---|---|---|---|---|---|---|---|---|---|
| 4.2.1 | Consider including CHWs/RCs in all appropriate grants written | F | I | - | - | - | BFMC Bridge Clinic; CBAC | | |
| 4.2.2 | Convene annual meeting with community health workers, recovery coaches, and health navigators | F | I | - | - | - | Time; CBAC; Staff | | |
| 4.2.3 | Legislative Advocacy - *with state legislature and DPH to increase ability to bill the time of these peer navigator roles.* | D | I, C | x | x | x | BH Office of Government | | |

| MONITORING/EVALUATION APPROACHES | POTENTIAL PARTNERS |
|---|---|
| • Quarterly review of strategy indicators by BMC CBAC | • |
| • Annual check-in with SIP partners | • |
| • Annual SIP work plan updates posted on BH website | • |
| • | • |

# 4 CARE COORDINATION

PRIORITY FOCUS AREA: 4 **CARE COORDINATION**

OBJECTIVE (SMART): 4.3 Increase support of improved care coordination through hospital-led regional collaboratives.

| OUTCOME/PROCESS INDICATORS | MEASURES OF SUCCESS: 2020 BASELINE | MEASURES OF SUCCESS: 2022 TARGET | DATA SOURCE |
|---|---|---|---|
| • Number of Baystate Franklin staff serving on Franklin County Perinatal Support Coalition (FCPSC) | | | FCPSC |
| • Readmission Collaborative - TBD | TBD | TBD | Baystate Health |

| | STRATEGIES | STATUS (C = Current, D = In Development, F = Future) | HOSPITAL ROLE (O = Operational, C = Convener, P = Partner, F = Funder, I = Implement) | TIMELINE Y1 | TIMELINE Y2 | TIMELINE Y3 | HOSPITAL RESOURCE INPUT(S) | OTHER SOURCES | PARTNERS |
|---|---|---|---|---|---|---|---|---|---|
| 4.3.1 | Franklin County Perinatal Support Coalition | C | P / C | X | X | X | Staff; Time | | Community Based Organizations serving on FCPSC |
| 4.3.2 | Readmission Collaborative Membership Expansion | D | C / I | X | X | X | Staff; Time | | Community Based Organizations |

| MONITORING/EVALUATION APPROACHES | POTENTIAL PARTNERS |
|---|---|
| • Quarterly review of strategy indicators by BMC CBAC | • |
| • Annual check-in with SIP partners | • |
| • Annual SIP work plan updates posted on BH website | • |
| • | • |

# 5 CHRONIC DISEASE

| | | |
|---|---|---|
| PRIORITY FOCUS AREA | 5 | **CHRONIC DISEASE** |
| IDENTIFIED NEEDS (2019 CHNA) | | Please refer to pages 77-86 in the 2019 CHNA |
| PRIORITY POPULATIONS (TO BE ADDRESSED BY STRATEGIES) | | Children; Older adults; People of color (focus on Blacks) |
| GOAL | | Reduce the burden of chronic disease in the Baystate Franklin service area. |
| OBJECTIVE (SMART) | 5.1 | Increase support for evidence-based programming to reduce the development and management of diabetes within three years of strategy implementation. |

| OUTCOME/PROCESS INDICATORS | MEASURES OF SUCCESS | | DATA SOURCE |
|---|---|---|---|
| | 2020 BASELINE | 2022 TARGET | |
| • Number of participants who successfully complete the Stanford Chronic Disease Self-Management Program (CDSMP) | | | LifePath |
| • Number of participants who successfully complete the Diabetes Prevention Program (DPP) | | | YMCA of Athol, Greenfield |
| • Pre-diabetic screenings for patients at hospital and BMP - TBD | TBD | TBD | Baystate |

| | STRATEGIES | STATUS (C = Current, D = In Development, F = Future) | HOSPITAL ROLE (O = Operational, C = Convener, P = Partner, F = Funder, I = Implement) | TIMELINE Y1 | TIMELINE Y2 | TIMELINE Y3 | HOSPITAL RESOURCE INPUT(S) 🕐 \| 🧍 \| $$ | OTHER SOURCES | PARTNRES |
|---|---|---|---|---|---|---|---|---|---|
| 5.1.1 | YMCA Diabetes Prevention Program | C | P | X | X | X | CBAC | | YMCA of Athol and Greenfield |
| 5.1.2 | Stanford Chronic Disease Self-Management Program (CDSMP) | C | P | X | X | X | CBAC | | LifePath |

| MONITORING/EVALUATION APPROACHES | POTENTIAL PARTNERS |
|---|---|
| • Quarterly review of strategy indicators by BMC CBAC | • Elm Terrace |
| • Annual check-in with SIP partners | • Greenfield Gardens |
| • Annual SIP work plan updates posted on BH website | • Highland Village |
| • | • Leyden Woods |
| • | • Montague Catholic Social Ministries |
| • | • Powertown Apartments |

PRIORITY FOCUS AREA: 5 **CHRONIC DISEASE**

OBJECTIVE (SMART): 5.2 Reduce the prevalence of childhood obesity in the region within three years of strategy implementation.

| OUTCOME/PROCESS INDICATORS | MEASURES OF SUCCESS | | DATA SOURCE |
|---|---|---|---|
| | 2020 BASELINE | 2022 TARGET | |
| • Number of youth enrolled in MIGHTY program | 35 | | MIGHTY |

| | STRATEGIES | STATUS (C = Current, D = In Development, F = Future) | HOSPITAL ROLE (O = Operational, C = Convener, P = Partner, F = Funder, I = Implement) | TIMELINE Y1 | TIMELINE Y2 | TIMELINE Y3 | HOSPITAL RESOURCE INPUT(S) | OTHER SOURCES | PARTNERS |
|---|---|---|---|---|---|---|---|---|---|
| 5.2.1 | MIGHTY (Moving, Improving, Getting Health Together at the YMCA) | C | O / I | X | X | X | Baystate Pediatric Weight Management Staff | Kohls Cares Grant | YMCA in Greenfield |

| MONITORING/EVALUATION APPROACHES | POTENTIAL PARTNERS |
|---|---|
| • Quarterly review of strategy indicators by BMC CBAC | • |
| • Annual check-in with SIP partners | • |
| • Annual SIP work plan updates posted on BH website | • |
| • | • |

# 5 CHRONIC DISEASE

PRIORITY FOCUS AREA: 5 **CHRONIC DISEASE**

OBJECTIVE (SMART): 5.3 Improve services for older adults living with chronic disease within three years of strategy implementation.

| OUTCOME/PROCESS INDICATORS | MEASURES OF SUCCESS: 2020 BASELINE | MEASURES OF SUCCESS: 2022 TARGET | DATA SOURCE |
|---|---|---|---|
| • Number of towns with Age Friendly Community Policies | 1 - Deerfield | 4 | MA Healthy Aging Collaborative |
| • Number of town Age-Friendly Community Planning process that BFMC staff participate in | 0 | 2 | Life Path, FRCOG |
| • Number of towns whose Age Friendly Action Plans include better services for elders with chronic diseases | 0 | 2 | Life Path, FRCOG |

| | STRATEGIES | STATUS (C = Current, D = In Development, F = Future) | HOSPITAL ROLE (O = Operational, C = Convener, P = Partner, F = Funder, I = Implement) | TIMELINE Y1 | TIMELINE Y2 | TIMELINE Y3 | HOSPITAL RESOURCE INPUT(S) | OTHER SOURCES | PARTNERS |
|---|---|---|---|---|---|---|---|---|---|
| 5.3.1 | BFMC staff participation in Age-Friendly Community planning processes | F | P | X | X | X | Time, Staff, CBAC | | Life Path |

| MONITORING/EVALUATION APPROACHES | POTENTIAL PARTNERS |
|---|---|
| • Quarterly review of strategy indicators by BMC CBAC | • Public Health Nurses from Greenfield, Rowe, Heath, FRCOG, and Local Councils on Aging and Senior Centers |
| • Annual check-in with SIP partners | • |
| • Annual SIP work plan updates posted on BH website | • |
| • | • |