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

1 EDUCATION

PRIORITY FOCUS AREA	1	**EDUCATION**
DESCRIPTION OF NEED (2019 CHNA)		Please refer to page 41 in the 2019 CHNA
PRIORITY POPULATIONS (TO BE ADDRESSED BY STRATEGIES)		Communities of color (focus on Latinos and Blacks); immigrants and refugees; low- and moderate-income (LMI) families earning below a living wage; people reentering society after incarceration; people with disabilities; people with mental health and/or substance use diagnoses; youth
GOAL		Increase access to educational and workforce opportunities for priority populations.
OBJECTIVE (SMART)	1.1	Increase opportunities to healthcare oriented educational programs within three years of strategy implementation.

OUTCOME/PROCESS INDICATORS	MEASURES OF SUCCESS 2020 BASELINE	MEASURES OF SUCCESS 2022 TARGET	DATA SOURCE
• Number of BSEP graduates hired by Baystate Health (Life to date)			BSEP
• Number of BSEP graduates who attend a two or four year college (Life to date)			BSEP
• Number of unique BSEP scholarship recipients (Life to date)			BSEP
• PURCH indicator	TBD	TBD	PURCH
• TD Bank Baystate Health Bus indicator	TBD	TBD	BHF

	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
1.1.1	Baystate Springfield Educational Partnership (BSEP)	C	O	X	X	X	Hospital Operations		Springfield Public Schools; In Focus Springfield
1.1.2	BSEP Scholarship Awards	C	O	X	X	X	Community Benefits		
1.1.3	TD Bank Baystate Health Bus	D	I	X	X	X	UMMS – Baystate Faculty and Students; Allied Health Students	TD Bank Foundation $750,000	
1.1.4	UMMS – Baystate Population-based Urban Rural Community Health (PURCH) Program	C	O	X	X	X	Hospital Operations		UMMS-Baystate Community Faculty

MONITORING/EVALUATION APPROACHES	POTENTIAL PARTNERS
• Quarterly review of strategy indicators by BMC CBAC	• Urban League of Springfield
• Annual check-in with SIP partners	• PURCH Population-Based Clerkship Host Organizations
• Annual SIP work plan updates posted on BH website	• Springfield Public Schools
•	• In Focus Springfield
•	• TD Bank Foundation
•	•

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1 EDUCATION

PRIORITY FOCUS AREA	1	**EDUCATION**
OBJECTIVE (SMART)	1.2	Increase access to educational resources to build community capacity and awareness within three year of strategy implementation.

ANNUAL OUTCOME/PROCESS INDICATORS	MEASURES OF SUCCESS		DATA SOURCE
	2020 BASELINE	2022 TARGET	
• Number of individuals who have participated in a Baystate-facilitated poverty simulation (Life to date)	420		UMMS-Baystate PURCH
• Number of total community organizations who claim their site on 413Cares	0		PHIWM
• Number of total Baystate Health departments, programs, and service lines who claim their site on 413Cares	0		PHIWM
• Number of PURCH Community Faculty members	25 (FY19)		UMMS-Baystate PURCH
• Number of outreach events completed by community liaison at Mason Square Health Center	33 (FY19)		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	PARNTERS
1.2.1	413Cares Community Resource Database	C	F / P	X	X	X	DoN CHI Funding; CBAC		PHIWM; Live Mutual Project
1.2.2	Baystate-facilitated Poverty Simulations	C	O / C	X	X	X	Hospital Operations		UMMS-Baystate Community Faculty
1.2.3	Mason Square Health Center Community Liaison/Outreach Specialist	C	O	X	X	X	Hospital Operations		
1.2.4	UMMS – Baystate Population-based Urban Rural Community Health (PURCH) Program: Community Faculty	C	O	X	X	X	UMMS-Baystate Faculty		UMMS-Baystate Community Faculty

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	•
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1 EDUCATION

PRIORITY FOCUS AREA	1	**EDUCATION**
OBJECTIVE (SMART)	1.3	TBD (DoN RFP under development)

ANNUAL OUTCOME/PROCESS INDICATORS	MEASURES OF SUCCESS		DATA SOURCE
	2020 BASELINE	2022 TARGET	
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	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
1.3.1									
1.3.2									
1.3.3									
1.3.4									
1.3.5									
1.3.6									

MONITORING/EVALUATION APPROACHES	POTENTIAL PARTNERS
• Quarterly review of strategy indicators by BMC CBAC	•
• Annual check-in with SIP partners	•
• Public Health Institute of Western MA contracted for technical assistance and evaluation of each grantee	•
• Semi-annual grantee reports	•
• Annual presentation to BMC CBAC	•
•	•

PRIORITY FOCUS AREA	2	**MENTAL HEALTH AND SUBSTANCE USE**
DESCRIPTION OF NEED (2019 CHNA)		Please refer to pages 52-59 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		To 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.

ANNUAL OUTCOME/PROCESS INDICATORS	MEASURES OF SUCCESS 2020 BASELINE	MEASURES OF SUCCESS 2022 TARGET	DATA SOURCE
• Number of city/towns participating in Hampden County Municipal First Responder Narcan Initiative	14	23	Baystate
• Number of organizations participating in Hampden County Addition Task Force (HCAT)	100		HCAT
• Number of organizations participating in Hampden County Health Improvement Plan (HCHIP)	60		HCHIP
• Number of providers trained on mental and behavioral health treatment best practices through CVS Health Grant (FY 2020 only)	0		BHF

	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
2.1.1	Hampden County Addiction Task Force (HCAT)	C	P	X	X	X	Time, Staff		Hampden County DA's Office; Sheriff's Department
2.1.2	Hampden County Health Improvement Plan (HCHIP): *Behavioral Health Domain*	C	P / F	X	X	X	DoN CHI Funding through FY 2021	MA DPH System-wide CHI - *TBD*	HCHIP Network
2.1.3	Hampden County Municipal First Responder Narcan Initiative	C	F / P / I	X			Community Benefits	Hampden County DA's Office	CHD; Mercy Medical Center
2.1.4	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	•
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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 patients on medically assisted treatment (MAT) regimen at Brightwood Health Center (life to date)	309		Baystate
• Rate of opioid overdose ED visits at BMC			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	Baystate Health Behavioral Health Hospital	F	O	-	-	-	Hospital Operations		
2.2.2	BMC Emergency Department Buprenorphine Protocol *(offers low threshold medication for patients presenting with Opioid Use Disorder)*	C	O	X	X	X	Hospital Operations		
2.2.3	Continue administration of medically assisted treatment (MAT) at Brightwood Health Center	C	O	X	X	X	Hospital Operations	State OBOT-B Grant	
2.2.4	Rooming In Program *(for infants impacted by maternal OUD)*	C	O	X	X	X	Hospital Operations		

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: 2020 BASELINE	MEASURES OF SUCCESS: 2022 TARGET	DATA SOURCE
• Number of Narcan pop ups conducted	0		Baystate
• Number of people trained in Baystate Health-Facilitated Youth Mental Health First Aid			BSEP
• Weight of medication collected at BMC kiosk	1,147 lbs (FY19)		Baystate
• Weight of sharps collected at BMC kiosk	1,233 lbs (FY19)		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
2.3.1	Baystate Health-Facilitated Youth Mental Health First Aid	C	O	X			BSEP; Office of Continuing Education		
2.3.2	BMC Medication and Sharps Kiosks	C	O	X	X	X	Hospital Operations		
2.3.3	Narcan Pop Ups *(trainings and Narcan distribution)*	F	P / F	-	-	-	Time, Staff		Tapestry Health, Hampden County DA's Office

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

PRIORITY FOCUS AREA	3	**BUILT ENVIRONMENT** *Transportation, Healthcare Access, Food*
DESCRIPTION OF NEED (2019 CHNA)		Please refer to pages 33-35 and 46-51 in the 2019 CHNA
PRIORITY POPULATIONS (TO BE ADDRESSED BY STRATEGIES)		Communities of color (focus on Latinos and Blacks); Older adults; parents of children with disabilities; low- and moderate-income (LMI) people earning below a living wage; people with disabilities; people with mental health and/or substance use diagnoses; transgender patients; youth
GOAL		Enhance equitable access to transportation, healthcare and food for priority populations.
OBJECTIVE (SMART)	3.1	Increase coordination of, and access to, alternative transportation resources over three years after strategy implementation.

ANNUAL OUTCOME/PROCESS INDICATORS	MEASURES OF SUCCESS		DATA SOURCE
	2020 BASELINE	2022 TARGET	
• BeHealthy ACO medical appointment no show rate at health centers			BeHealthy ACO
• Number of residents with Valley Bike memberships			Valley Bike
• Number of miles traveled on Valley bikes			Valley Bike

	STRATEGIES	STATUS C = Current D = In Development F = Future	HOSPITAL ROLE O = Operational C = Convener P = Partner F = Funder I = Implement	TIMELINE			HOSPITAL RESOURCE INPUT(S) 🕐 | 🧍 | $$	OTHER SOURCES	PARTNERS
				Y1	Y2	Y3			
3.1.1	RideCare	D	C / P / I	X			BeHealthy Partnership ACO; Baystate CHCs	Federal Transit Authority (FTA) Grant	PVTA; Caring Health Center
3.1.2	Valley Bike Stations *BMC Chestnut/Pratt St.* *BMC Main St. North End,* *Plainfield St.*	C	P / F/ I	X	X		Promotional and How To Video		Valley Bike

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	•
•	•

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3 BUILT ENVIRONMENT

PRIORITY FOCUS AREA: 3 — **BUILT ENVIRONMENT**
Transportation, Healthcare Access, Food

OBJECTIVE (SMART): 3.2 — Increase use and promotion of BMC coordinated care services.

OUTCOME/PROCESS INDICATORS	MEASURES OF SUCCESS		DATA SOURCE
	2020 BASELINE	2022 TARGET	
• BeHealthy ACO medical appointment no show rate at health centers			BeHealthy ACO
• ED Utilization Rates for Adult Patients enrolled in ACO			BeHealthy ACO
• ED Utilization Rates for Pediatric Patients enrolled in ACO			BeHealthy ACO
• Number of Dispatch Health care episodes	4,000 (FY19)		Dispatch Health
• Number of ED visits avoided due to Dispatch Health	2,000 (FY19)		Dispatch Health
• Number of patients seen by Baystate Community Health Centers	98,574 (FY18)		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
3.2.1	Baystate Community Health Centers • Baystate Mason Square Neighborhood Health Center • Baystate Brightwood Health Center • Baystate High Street Health Center • Baystate General Pediatrics at High Street	C	O	X	X	X	Hospital Operations		
3.2.2	BEHealthy Partnership Accountable Care Organization (ACO)	C	O	X	X	X	Hospital Operations		Health New England Caring Health Center
3.2.3	Dispatch Health	C	O	X	X	X	Hospital Operations		

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	•
•	•

3 BUILT ENVIRONMENT

PRIORITY FOCUS AREA	3	**BUILT ENVIRONMENT** *Transportation, Healthcare Access, Food*
OBJECTIVE (SMART)	3.3	Increase access to physical activity and healthy eating curricula for residents within three years of strategy implementation

ANNUAL OUTCOME/PROCESS INDICATORS	MEASURES OF SUCCESS		DATA SOURCE
	2020 BASELINE	2022 TARGET	
• 75% of participating elders report increased consumption of fresh fruit and vegetables	n/a	75% or more (FY20)	GTC
• 75% of participating low income families report increased consumption of fresh fruit and vegetables	n/a	75% or more (FY20)	GTC
• Establishment of a winter farmer's market site in Indian Orchard/Boston Rd/Pine Point neighborhoods	Incomplete	Complete (FY20)	WCC
• Number of people served by winter farmer's market	n/a	50 (FY20)	WCC
• Number of youth enrolled in MIGHTY program	118 (FY19)		MIGHTY

	STRATEGIES	STATUS C = Current D = In Development F = Future	HOSPITAL ROLE O = Operational C = Convener P = Partner F = Funder I = Implement	TIMELINE			HOSPITAL RESOURCE INPUT(S)	OTHER SOURCES	PARTNERS
				Y1	Y2	Y3			
3.3.1	Gardening the Community (GTC)	C	F	X			Community Benefits Mini Grant		GTC
3.3.2	GoFresh Mobile Farmer's Market	C	F	X			Community Benefits Mini Grant		PHIWM
3.3.3	MIGHTY (Moving, Improving, Getting Health Together at the YMCA)	C	O / I	X	X	X	Baystate Pediatric Weight Management Staff	Kohls Cares Grant	YMCA of Greater Springfield
3.3.4	Wellspring Cooperative Corporation (WCC) Harvest Food Access Scholarship	C	F	X			Community Benefits Mini Grant		WCC

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	•
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4 FINANCIAL HEALTH

PRIORITY FOCUS AREA	4	**FINANCIAL HEALTH** Economic dignity and wealth creation for low- and moderate-income families. Examples include savings, homeownership, and financial literacy.
DESCRIPTION OF NEED (2019 CHNA)		Refer to pages 39-40 in the 2019 CHNA
PRIORITY POPULATIONS (TO BE ADDRESSED BY STRATEGIES)		Cultural and linguistic diverse (CALD)[1] populations and communities, particularly Black and LatinX populations, young adults (ages 16 -24yrs), and low- and moderate-income (LMI) families earning below a living wage.
GOAL		To advance the economic dignity of LMI populations so that they are better able to provide for their own and their families care and needs and increase opportunities to build financial wellness and stability for priority populations.
OBJECTIVE (SMART)	4.1	To provide financial programs and services to **LMI workers, particularly workers in low-income families with children**, which improve their financial capabilities (e.g., budgeting, credit rating, savings, etc.) so they become more financially self-sufficient.

OUTCOME/PROCESS INDICATORS	MEASURES OF SUCCESS: 2020 BASELINE	MEASURES OF SUCCESS: 2022 TARGET	DATA SOURCE
• Number of LMI patients completing MassHealth, Health Safety Net and Financial Assistance Program applications who are linked to either internal or external financial programs and services	TBD		Baystate
• Number of LMI employees who reside in low-income neighborhoods surrounding BMC facilities who are linked to either internal or external financial programs and services and also file for EITC/CTC benefits	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	PARTNERS
4.1.1	Baystate Financial Assistance Program (FAP)	C	O	X	X	X	BMC Hospital Operations		
4.1.2	Baystate Financial Counseling	C	O	X	X	X	BMC Hospital Operations		
4.1.3	Financial Empowerment Programs and Services	F	P	X	X	X	Baystate	Community-based Organizations	SPCA VOC

MONITORING/EVALUATION APPROACHES	POTENTIAL PARTNERS
• Quarterly review of strategy indicators by BMC CBAC	• Springfield Partners for Community Action (SPCA
• Annual check-in with SIP partners	• Valley Opportunity Council (VOC)
• Annual SIP work plan updates posted on BH website	•
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[1] CALD refers to persons who have a cultural heritage different from that of the majority of people from the dominant (Anglo) American culture according to birthplace, ancestry, religion, race, ethnicity or language. Other terms are used in the literature to denote CALD populations, including terms such as_ "minority", "underserved", "underrepresented", "multicultural", "migrant", "refugee" and from a non-English speaking background.

4 FINANCIAL HEALTH

PRIORITY FOCUS AREA	4	**FINANCIAL HEALTH** Economic dignity and wealth creation for low- and moderate-income families. Examples include savings, homeownership, and financial literacy.
OBJECTIVE (SMART)	4.2	To provide financial programs to **NE residents (particularly BHP members, BMC patients, and other low-income families)** in partnership with others' community-based wealth creation strategies (e.g., jobs and skills training, small business development and expansion and home ownership) and improve one's financial capabilities (e.g., budgeting, credit rating, savings, etc.) so that residents become more financially self-sufficient.

OUTCOME/PROCESS INDICATORS	MEASURES OF SUCCESS		DATA SOURCE
	2020 BASELINE	2022 TARGET	
• Number of homes served by North End GreenNFit	n/a		Revitalize CDC
• Total value of home improvements conducted by North End GreenNFit	n/a		Revitalize CDC
• Institutional purchasing directed towards local neighborhood businesses	TBD		Baystate
• Local hires from NE neighborhoods	TBD		Baystate
• Number of Springfield homes purchased by Baystate employees through the Tolosky Baystate Neighbors Program	3	10	Baystate

	STRATEGIES	STATUS C = Current D = In Development F = Future	HOSPITAL ROLE O = Operational C = Convener P = Partner F = Funder I = Implement	TIMELINE			HOSPITAL RESOURCE INPUT(S)	OTHER SOURCES	PARTNERS
				Y1	Y2	Y3			
4.2.1	Advancing Cities Grant	D / F	P / I	-	-	-		JP Morgan and Chase	
4.2.2	Community Health Innovation Fund (CHIF)	C	P / F	X	X	X	DoN CHI Funding; CBAC	Common Capital; MA State $200,000 Funding Match	Common Capital
4.2.4	Mass Mutual Live Mutual Project: North End Action Tank, Financial Resources & Placemaking	C	P / F	X	X		DoN CHI Funding	MassMutual Foundation	NNCC
4.2.5	Revitalize CDC: North End GreenNFit	D	P	X			CBAC	Mercy	Revitalize CDC NNCC
4.2.6	Tolosky Baystate Neighbors Programs	C	O	X	X	X	Hospital Operations		City of Springfield

MONITORING/EVALUATION APPROACHES	POTENTIAL PARTNERS
• Quarterly review of strategy indicators by BMC CBAC	• Common Capital
• Annual check-in with SIP partners	• MassMutual Foundation
• Annual SIP work plan updates posted on BH website	• Revitalize CDC
•	• City of Springfield
•	•

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5 VIOLENCE AND TRAUMA

PRIORITY FOCUS AREA	5	**VIOLENCE AND TRAUMA**
DESCRIPTION OF NEED (2019 CHNA)		Please refer to pages 42-44 in the 2019 CHNA
PRIORITY POPULATIONS (TO BE ADDRESSED BY STRATEGIES)		Youth (especially GLBQ+, and transgender individuals); communities of color (focus on Latinos and Blacks)
GOAL		Decrease the prevalence of violent incidents and increase trauma informed care ability among community residents and providers.
OBJECTIVE (SMART)	5.1	Increase access to violence prevention-based initiatives within three years of strategy implementation.

ANNUAL OUTCOME/PROCESS INDICATORS	MEASURES OF SUCCESS		DATA SOURCE
	2020 BASELINE	2022 TARGET	
• Development of violence intervention protocol at BMC	Incomplete	Complete	BMC TIP
• Number of Baystate workshops offered to at risk mothers and fathers enrolled in ROCA	0		BMC TIP
• Number of firearms collected during gun buy back	0		Hampden County DA's Office

	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
5.1.1	Hampden County Gun Buy Back Day	C	P / F / I	X	X	X	Community Benefits		Hampden County DA's Office; MA State Police
5.1.2	Successful & Safe Youth Initiative (SSYI)	C	P	X			BMC Social Work; Trauma and Injury Prevention (TIP) Coordinator	Grants: Peer to Peer facilitator and Nurse educator	Executive Office of Health and Human Services/ Governor's Office
5.1.3	ROCA Gun Violence Grant: *Baystate Workshop Series*	C	P / I	X	X		BMC Social Work; Trauma and Injury Prevention (TIP) Coordinator	MDPH	ROCA
5.1.4	BMC Hospital-based Violence Intervention Program – *Protocol Development*	D / F	O / P / I	X	X	X	BMC Workgroup		

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 VIOLENCE AND TRAUMA

PRIORITY FOCUS AREA: 5 **VIOLENCE AND TRAUMA**

OBJECTIVE (SMART): 5.2 Increase community and provider capacity to advocate for violence prevention/trauma informed care 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 Baystate Family Advocacy Center (BFAC) visits	5,137 (FY2018)		Baystate
• Number of Baystate-facilitated Trauma Informed Care trainings			Baystate
• Number of car seats given away at BMC Pediatric ED	28		Baystate
• Number of Human Trafficking trainings completed by BFAC			Baystate
• Number of people who attend Baystate-Facilitated Stop the Bleed trainings (since October 2018)	4,821		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
5.2.1	Baystate Family Advocacy Center (BFAC): *Homicide Bereavement* *Suicide Bereavement*	C	O / P / I	X			BFAC Staff	New York Life Insurance Company (BHF)	VOCA
5.2.2	Baystate-Facilitated Stop the Bleed Trainings	C	O / I	X			Trauma and Injury Prevention (TIP) Coordinator		
5.2.3	BMC Pediatric Emergency Department Car Seat Checks and Give Away (post MVA)	C	O / I	X			Baystate Children's Hospital		
5.2.4	BMC Trauma and Injury Prevention Program (TIP)	C	O	X	X	X	Hospital Operations		
5.2.5	Businesses Against Human Trafficking Pledge / Human Trafficking Trainings by BFAC	C	P / I	X			BFAC Staff; IT		
5.2.6	Car Seat Safety Messaging (Flyer/ Registry of Motor Vehicles (RMV) Statewide)	C		X			Injury Prevention Coordinator		MA RMV

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	•
•	•