

COMMUNITY HEALTH IMPLEMENTATION PLAN

2021-2024

BERKSHIRE MEDICAL CENTER
BERKSHIRE HEALTH SYSTEMS



EXECUTIVE SUMMARY

INTRODUCTION

A Community Health Implementation Plan (CHIP) is a long-term, systematic effort to address public health problems based on the results of the Community Health Needs Assessment (CHNA), which is conducted every three years. This report is the 2021-2024 CHIP for Berkshire Medical Center.

Berkshire Health Systems CHNA and the Berkshire Medical Center CHIP are developed with community input from engaged community organizations, as well as data collected by other community organizations across Berkshire County. The 2021 Berkshire Health Systems CHNA was abbreviated due to the COVID-19 pandemic. Hospital and community feedback forms were completed and submitted to the Attorney General's Office (AGO).

Nonprofit hospitals are required by government regulators to produce a triennial CHNA and an annually updated CHIP, both of which must be approved by a governing board of the institution. Berkshire Medical Center relied on feedback from the community collected during the CHNA process in developing the CHIP.

THE PRIORITIES

The mission of Berkshire Health Systems is to advance health and wellness for everyone in our community in a welcoming, inclusive, and personalized environment. Our work must be informed by strong principles of diversity, health equity, and inclusion for all populations in the county. In all communities surveyed throughout the assessment process, substance use disorders, behavioral health conditions, suicide prevention, social determinants of health emerged as top priorities, as well as workforce enhancements, and community safety.

The CHNA priorities that have been identified as key to furthering Berkshire Health Systems's mission include:

- Behavioral health, including substance use disorders (SUDs) with an emphasis on youth, whole families, and a holistic approach to care
- Social economic factors related to social determinants of health including housing, nutritious food, and financial stability related employment opportunities, training, and educational pathways, and
- Access to equitable health care, social services, and community resources.

Based on past assessments and historical commitments, Berkshire Health Systems will also continue to address the following priorities:

- Healthy eating, active living, and food insecurity
- Health issues specific to the elderly and aging
- Chronic disease prevention and management
- Community safety

THE COMMUNITIES AND STRATEGIES

Joining with community agencies, Berkshire Health Systems will work collaboratively to address the needs of the Community.

Berkshire Health Systems plans to engage in new initiatives that focus on the needs identified within the CHNA in addressing the health disparities within the community. Berkshire Health Systems will continue its efforts on workforce development, chronic disease management, and improving access to care.

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDERS

Community-wide Approaches

BHS will partner with other community organizations by investing in recruitment, training, and development of behavioral health providers (licensed and non-licensed) that meet the diversity and linguistic needs of the community.

BHS will invest to support improved access to behavioral health services through telemedicine as well as advocate for policies that support parity in care and reduce the stigma for behavioral health and substance use disorders.

SOCIAL ECONOMIC

Community-wide Approaches

BHS is committed to working collaboratively with other community organizations to develop opportunities related to enhancing the workforce both in healthcare and in the community for low to moderate-income residents of Berkshire County. Addressing contributing factors of social and economic determinants of health provides for an opportunity for the improvement of individual well-being by achieving financial stability.

CONCLUSION

We are looking forward to partnering with other community agencies throughout the county to implement this improvement plan over the next three years and together, combining resources and tactics to make positive health improvements.

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDERS

Rationale: As previously expressed in the 2018 CHNA, this 2021 CHNA also identified widespread concern about behavioral health challenges and substance use disorders across the county while identifying the importance of prioritizing a “whole-family, holistic approach.” CHNA respondents report that access to housing and health services for those with substance use and co-occurring mental health issues is limited and recommend finding ways to provide more housing.

GOAL: Provide comprehensive services and resources for individuals of all ages with behavioral health conditions and substance use disorders	
Objective 1: Improve MAT access to treatment and access to behavioral health services	
	Strategy 1
	<i>Sustain and expand access to medication-assisted treatment in both inpatient and outpatient settings; identify ways to encourage practitioners to seek waivers to administer buprenorphine to treat patients with opioid use disorder</i>
<i>Population</i>	People experiencing substance use disorders
<i>Current Initiatives</i>	Substance Use Treatment Clinic Clinical Stabilization Services for Substance Abuse NP Team Leader for Substance Use and Pain Support Team
<i>Collaborations</i>	Alternative Living, Berkshire Clinical Stabilization Services for Substance Abuse, Berkshire Faculty Services, Berkshire Fallon ACO, Berkshire Medical Center, Keenan House, McGee Recovery Center, The Brien Center, ServiceNet , Harm Reduction Program
<i>Expected Outcomes</i>	<ul style="list-style-type: none"> • Decreased addiction severity • Reduction in length of stay and 30-day readmission to the hospital • Reduction in ED utilization
<i>Data Source</i>	Program data

GOAL:

Provide comprehensive services and resources for individuals of all ages with behavioral health conditions and substance use disorders

Objective 2: Expand service collaborations to support reducing the stigma of people with substance use disorders while providing education and resources for infectious disease prevention and chronic disease management

	Strategy 1	Strategy 2
	Expand the Harm Reduction Program to populations identified as high risk for infectious disease, and overdose, provide harm reduction services, and refer people with SUD who desire more information to MAT providers	Expand outreach to rural communities in Berkshire County
<i>Population</i>	Gay and bisexual men and other men who have sex with men (MSM), Persons who inject drugs (PWID), Non-US born individuals, inclusive of persons born in Puerto Rico and additional US Territories (NUB/UST), Transgender men and women (TG)	High-risk populations in the rural communities of northern and southern Berkshire county including Sheffield, Tyringham, and Washington, MA
<i>Potential New Resources</i>		Grant Funding
<i>Current Initiatives</i>	Harm Reduction Program in North County, Central County, and South County. Narcan Education SUT program	Mobile Harm Reduction Program Underway in 2022
<i>Collaborations</i>	HFHC SUT Program, Berkshire Overdose Addiction Prevention Collaborative, Emergency Medical Services, BCHC, McGee & CSS, Spectrum Health, Williamstown Medical, Tapestry, Alternative Living Center (ALC), Pittsfield Library, Keenan House, Rural Recovery Resources	Local Boards of Health, Hillcrest Family Health Center SUT Program, Berkshire Overdose Addiction Prevention Collaborative, Emergency Medical Services, BCHC, McGee & CSS, Spectrum Health, Williamstown Medical, Tapestry, Alternative Living Center (ALC), Pittsfield Library, Keenan House, Rural Recovery Resources
<i>Expected Outcomes</i>	<ul style="list-style-type: none"> reducing the impact of HIV, HCV, syphilis/chlamydia/gonorrhea, and latent TB infection among residents Berkshire County Lower mortality from opioid overdose More engaged in treatment Harm reduction results in fewer medical complications of addiction 	<ul style="list-style-type: none"> reducing the impact of HIV, HCV, syphilis/chlamydia/gonorrhea, and latent TB infection among residents Berkshire County Lower mortality from opioid overdose More engaged in treatment Harm reduction results in fewer medical complications of addiction
<i>Data Source</i>	Program Data	Program Data, City & State Overdose Data

GOAL:

Provide comprehensive services and resources for individuals of all ages with behavioral health conditions and substance use disorders

Objective 3: Develop partnerships with community organizations to facilitate wrap-around services to care for pregnant women with opioid use disorder

	Strategy 1	Strategy 2	Strategy 2
	<p>Develop and implement the wrap-around service program including:</p> <ul style="list-style-type: none"> • Building capacity and pilot testing of protocol • Educating providers and patients about the program 	<p>Increase the enrollment capacity of the program to respond to the needs of pregnant women with OUD, their children, and their families to support a culture of recovery and health</p>	<p>Enroll 70 dyads over a 2-year period, following Substance Exposed Newborns through 12 months of age</p>
<i>Population</i>	Perinatal women with OUD, their newborns, and their families	Perinatal women with OUD, their newborns, and their families	Perinatal women with OUD, their newborns, and their families
<i>Potential New Resources</i>	HPC-funded wrap-around program	HPC-funded wrap-around program	HPC-funded wrap-around program
<i>Current Initiatives</i>	The Berkshire Connections	The Berkshire Connections	The Berkshire Connections
<i>Collaborations</i>	MAT providers including Spectrum and the Brien Center, First Steps Together, 18 Degrees, Berkshire Perinatal Opioid Collaborative, Early Intervention Providers, Pediatricians	MAT providers including Spectrum and the Brien Center, First Steps Together, 18 Degrees, Berkshire Perinatal Opioid Collaborative, Early Intervention Providers, Pediatricians	MAT providers including Spectrum and the Brien Center, First Steps Together, 18 Degrees, Berkshire Perinatal Opioid Collaborative, Early Intervention Providers, Pediatricians
<i>Expected Outcomes</i>	<ul style="list-style-type: none"> • Reduced perinatal relapse rates (through 12 months post-partum) • Increased breast-feeding rates • Reduced maternal separation through DCF 	<ul style="list-style-type: none"> • Reduced perinatal relapse rates (through 12 months post-partum) • Increased breast-feeding rates • Reduced maternal separation through DCF 	<ul style="list-style-type: none"> • Reduced perinatal relapse rates (through 12 months post-partum) • Increased breast-feeding rates • Reduced maternal separation through DCF
<i>Data Source</i>	Program Data	Program Data	Program Data

GOAL: Provide comprehensive services and resources for individuals of all ages with behavioral health conditions and substance use disorders		
Objective 4: Expand education and access to care for youth and families		
	Strategy 1	Strategy 2
	Partner with school systems and community health programs to provide education on resiliency, behavioral health support, and the risks of marijuana, vape, alcohol, and opioid use.	Develop clinical support programs and resources to increase treatment options and access for youth
<i>Population</i>	Berkshire County School Systems students, parents, and faculty	Berkshire County residents between the ages of 12 and 17
<i>Potential New Resources</i>	BHS Investment Philanthropy	BHS investment
<i>Current Initiatives</i>	Providing education focusing on harm reduction and opioid overdose prevention to those struggling with addiction, families, and medical providers. Provide education to youth and families around marijuana, vaping, alcohol, and opioids.	Youth Intensive Outpatient that provides strength-based and trauma-informed care emphasizing skill-building, interpersonal connection, psychological safety, and growth. The program operates during after-school hours so youth can maintain regular routines.
<i>Collaborations</i>	Public Schools Community organizations Brien Center Northern Berkshire Community Coalition	Public Schools Community organizations Brien Center Northern Berkshire Community Coalition
<i>Expected Outcomes</i>	<ul style="list-style-type: none"> • Improved access to care • Increased resilient communities 	<ul style="list-style-type: none"> • Improved access to care • Increased resilient communities
<i>Data Source</i>	Youth Risk Behavior Survey	Youth Risk Behavior Survey, program data

GOAL:

Provide comprehensive services and resources for individuals of all ages with behavioral health conditions and substance use disorders

Objective 5: Strengthen the county-wide network of care for individuals with behavioral health conditions, depression, and suicide by recruiting culturally appropriate behavioral health workers (licensed and community-based) and increasing services in traditional and non-traditional settings.

	Strategy 1	Strategy 2
	Develop incentive/scholarship program for racially, ethnically & linguistically diverse students to obtain education and training for behavioral health roles and recruit behavioral health clinicians who reflect the diversity of the community.	Conduct research and develop a framework for creating a recovery-friendly workforce program that could support those recovering from behavioral health conditions or SUDs with employed positions in the healthcare field.
<i>Population</i>	Culturally and linguistically diverse students seeking behavioral health careers	Recovering behavioral health and SUD patients
<i>Potential New Resources</i>	BHS investment Philanthropy Government funding/grants	BHS investment Philanthropy Government funding/grants
<i>Current Initiatives</i>	CHW training and certification program Recovery Coach Training Programs	
<i>Collaborations</i>	Local Colleges Community Organizations Brien Center	Local Colleges Community Organizations Brien Center
<i>Expected Outcomes</i>	<ul style="list-style-type: none"> Improved access to resources Increased diversity of behavioral health workers in the community 	<ul style="list-style-type: none"> Improved access to resources Increased diversity of behavioral health workers in the community Strengthened connections between patients and healthcare workers with shared experiences
<i>Data Source</i>	Program Data	

SOCIAL ECONOMIC CONDITIONS THAT INFLUENCE HEALTH

Rationale: Community feedback on the CHNA identified the need to create welcoming and equitable environments of care by improving the early identification of and support for issues impacting Social Determinants of Health (SDOH). Socioeconomic status, education, employment, housing, food security, transportation and social protective factors all have an impact on the physical and mental well-being of the population, including the circumstances people find themselves, and many cases the life choices they make or are forced to make due to social or environmental conditions. Developing an inclusive workforce is especially important to these initiatives, particularly in disciplines that impact behavioral health and navigation of community resources.

GOAL: Reduce burdens of social determinants of health by strengthening collaborations and expanding services and employment opportunities in the county		
Objective 1: Develop strategic partnerships that address housing tenancy and homelessness		
	Strategy 1	Strategy 2
	Screen and assess BHS Primary Care patients for housing instability and connect to community resources that provide services related to housing and financial counseling	Collaborate with municipalities and community agencies in investing in housing needs to address the challenges of inpatients who are chronically homeless
<i>Population</i>	Patients experiencing Housing Instability	Chronically homeless or at risk of homelessness
<i>Potential New Resources</i>	BHS Investment Philanthropy	BHS Investment in collaboration with community municipalities and organizations
<i>Current Initiatives</i>	Medicaid ACO Flexible Services BFHC screening patients in the Community Pilot project with embedded CHW in PCP Screening patients for all SDOH and making referrals to services appropriate to address the person's needs Northern Berkshire Hub Program	ED-based Community Health Worker ED-based Social Workers
<i>Collaborations</i>	18 Degrees, Berkshire District Attorney's Office, Berkshire County Sheriff's Department, Berkshire County Regional Health Systems, Berkshire County Regional Housing Authority, Berkshire Health Systems, Berkshire Medical Center, The Brien Center, City of Pittsfield mayor's office, County Ambulance, Department of Children and Families, Department of Youth Services, Juvenile Resource Center, Massachusetts Trial Courts, Pittsfield Health Department, Pittsfield Housing Authority, Pittsfield Fire Department, Pittsfield Police Department, Pittsfield Public Schools, ServiceNet	City of Pittsfield, Mayor's End Homelessness Committee Housing and shelter providers
<i>Expected Outcomes</i>	<ul style="list-style-type: none"> Improved Housing Stability 	<ul style="list-style-type: none"> Increased housing stability Reduced ED utilization
<i>Data Source</i>	Program Data	Program Data

GOAL:

Reduce burdens of social determinants of health by strengthening collaborations and expanding services and employment opportunities in the County

Objective 2: Develop community partnerships that address food insecurity and access to healthy foods

	Strategy 1	Strategy 2
	Screen and assess BHS Primary Care patients for food insecurity and connect to community resources that provide services related to accessing food and to foods that help prevent chronic disease	Develop a food pharmacy or food prescription program focused on prevention, treatment, and reversal of chronic diseases through education and access to healthy and affordable food
<i>Population</i>	Patients who screen positive for food insecurity	People who screen positive for food insecurity along with a diagnosis of hypertension, diabetes, or chronic disease
<i>Potential New Resources</i>		Federal Funding BHS Investment
<i>Current Initiatives</i>	Medicaid Flexible Services Program <ul style="list-style-type: none"> • Medically Tailored Meals • Grocery delivery program SNAP benefit program WIC Operation Better Start	Medicaid Flexible Services Program <ul style="list-style-type: none"> • Medically Tailored Meals • Grocery delivery program
<i>Collaborations</i>	Berkshire Bounty, Berkshire Community Providers, BHS, Berkshire Immigrant Center, Community Health programs-FQHC, Diabetes Education, Food Bank of Western MA, Local farmer's markets, Volunteers in Medicine	Primary Care Practices, Medicaid ACO, BHS Nutrition Department, Case Management, Berkshire Bounty, Local Grocery Stores, Diabetes Education, Food Bank of Western MA, Visiting Nurse Associations
<i>Expected Outcomes</i>	<ul style="list-style-type: none"> • Improve access to food • Improve health 	<ul style="list-style-type: none"> • Improve access to food • Improved education about illness prevention • Improved health
<i>Data Source</i>	Program Data	Program Data

GOAL:

Reduce burdens of social determinants of health by strengthening collaborations and expanding services and employment opportunities in the County

Objective 3: Invest in recruitment, retention, and skill development of the healthcare workforce to enhance knowledge, skill, and financial stability.

	Strategy 1	Strategy 2
	Develop talent pipeline programs at BHS to train and develop low-moderate income residents	Collaborate with other agencies in workforce development strategies for low- and moderate-income residents of Berkshire County
<i>Population</i>	New and current BHS staff who are low- and moderate-income residents of Berkshire County	People who are low income, low skill, and people with barriers to employment
<i>Potential New Resources</i>	Hospital Investment Philanthropy	Hospital Investment Federal Funding Community Organizations
<i>Current Initiatives</i>	Community health workers (CHW's) funded to take CHW courses and certification exam RN, LPN, medical assistant, and nursing assistant pipeline programs	
<i>Collaborations</i>	Local Colleges Technical Schools with healthcare programs Online Learning Programs	Berkshire United Way Local Colleges Community Organizations
<i>Expected Outcomes</i>	<ul style="list-style-type: none"> • Increased income • Increased full-time, benefitted employment 	<ul style="list-style-type: none"> • Increased employment • Increased full-time, benefitted employment • Increased income
<i>Data Source</i>	Program Data	Program Data

ACCESSING SERVICES (HEALTHCARE, INSURANCE, COVID-19 TESTING & VACCINATIONS)

Rationale: Community feedback on the CHNA identified a need for access to equitable primary care appointments, assistance with MA Health insurance, and the continuing need for COVID-19 testing and vaccination.

GOAL: Ensure all BHS patients and community members have access to equitable health and family support services by strengthening partnerships and expanding services/resources to support overall health		
Objective 1: Increase the capacity of health services to provide equitable, culturally, and linguistically competent care		
	Strategy 1	Strategy 2
	Increase capacity at provider practices to reduce barriers to care for patients with the use of community health workers, social workers, and patient navigators	Increase use of medical interpreting and translation services in-person, over the phone, and through video in up to 140 languages using qualified interpreters
<i>Population</i>	Patients with complex health and social needs	Patients with limited English proficiency
<i>Potential New Resources</i>	Hospital Investment Grants Philanthropy State and Federal Funding	Hospital Investment State and Federal Funding
<i>Current Initiatives</i>	SDOH pilot	Inpatient Care Units and Ambulatory Departments Ambulatory Practices Brien Center Private Primary Care Practices Advocacy for Access
<i>Collaborations</i>	Berkshire Faculty Services, Medicaid ACO, Language Interpreter Services	Advocacy for Access, All BHS entities, Harm Reduction Program
<i>Expected Outcomes</i>	<ul style="list-style-type: none"> • Increased appointment attendance • Increased care coordination • Increased involvement in care plan adherence • Increased funding to deliver equitable care 	<ul style="list-style-type: none"> • Improve access to care • Reduce risk of adverse events • Improve patient satisfaction
<i>Data Source</i>	Program Data	Program Data

GOAL: Ensure all BHS patients and community members have access to equitable health and family support services by strengthening partnerships and expanding services/resources to support overall health		
Objective 2: Support efforts that increase access and timeliness to care through care coordination services and insurance coverage, enrollment, and support		
	Strategy 1	Strategy 2
	Maintain current services offered by Mass Health and other health coverage plans	Continue to provide Patient Pharmacy Benefits and Durable Medical Equipment to patients without insurance by signing them up for an appropriate plan, and fill/back-fill prescriptions needed for discharge.
<i>Population</i>	Children, Disabled Adults, Medically Underserved	Uninsured and Medically Underserved
<i>Potential New Resources</i>	MA Health Funding	Hospital Investment State and Federal Funding
<i>Current Initiatives</i>	Medicaid ACO Advocacy for Access MA Health patient enrollment assistance	Patient Pharmacy Benefits and Durable Medical Equipment Program
<i>Collaborations</i>	Berkshire Community Providers, Berkshire County House of Correction, Berkshire Faculty Services Berkshire Fallon Health Collaborative, Elder Services, Interpreter Services, WIC, Wellness at Work	Advocacy for Access, All BHS entities, BMC Case Management, BMC, BVNA, Clinical Support Options
<i>Expected Outcomes</i>	<ul style="list-style-type: none"> Improved patient enrollment Improved access to care coordination 	<ul style="list-style-type: none"> Improved patient health due to med compliance Reduce hospital utilization
<i>Data Source</i>	Program Data	Program Data

GOAL: Ensure all BHS patients and community members have access to equitable health and family support services by strengthening partnerships and expanding services/resources to support overall health		
Objective 3: Engage with community organizations and municipalities in assisting older and disabled adults in maintaining independence while identifying their social and health-related needs		
	Strategy 1	
	Collaborate with community organizations in providing programs such as nutritional education, blood pressure screenings, and matter-of-balance classes	
<i>Population</i>	Low-income older and disabled adults	
<i>Potential New Resources</i>	Berkshire Regional Planning Commission Pittsfield Health Alliance	
<i>Current Initiatives</i>	Community Coordinated Health Education Events and Health Fairs	
<i>Collaborations</i>	Berkshire Regional Planning, Pittsfield Health Alliance,	
<i>Expected Outcomes</i>	<ul style="list-style-type: none"> Improved health Improved Chronic Disease Management Reduced Social Isolation 	
<i>Data Source</i>	Program Data	

GOAL:

Ensure all BHS patients and community members have access to equitable health and family support services by strengthening partnerships and expanding services/resources to support overall health

Objective 4: Continue to meet the needs of the community by providing COVID-19 testing, immunizations and therapies

	Strategy 1	Strategy 2
	Provide COVID-19 testing and education to patients/families who test positive and administer COVID-19 vaccines at testing and vaccination centers across the county	Coordinate and implement an antiviral and monoclonal antibody infusion therapy center
<i>Population</i>	All people	All Positive COVID-19 patients who screen positive to be treated with antivirals or monoclonal antibodies
<i>Potential New Resources</i>	State & Federal Funds Hospital Investment	State & Federal Funds Hospital Investment
<i>Current Initiatives</i>	Onsite testing & vaccinations Mobile vaccine clinics Large-scale vaccine clinics with the	Stand-up community COVID-19 Therapy Center
<i>Collaborations</i>	Berkshire Vaccine Collaborative Northern Berkshire EMS Public Health Agencies	Berkshire Faculty Service Providers & Staff MA DPH Community Organizations
<i>Expected Outcomes</i>	<ul style="list-style-type: none"> • Reduced spread of COVID-19 • Reduced contracting COVID-19 with vaccines • Reduced hospitalizations 	<ul style="list-style-type: none"> • Reduced severity of illness through antivirals or monoclonal antibodies • Reduced hospitalizations
<i>Data Source</i>	Program Data	Program Data

CHRONIC DISEASE

Rationale: Data shows that cancer, circulatory disease, respiratory disease, and other chronic diseases are drivers of mortality. Berkshire County has the highest rate of premature death in the Commonwealth of Massachusetts, according to the Robert Wood Johnson Foundation’s Community Health Rankings (2021). Health-related disparities for heart disease and stroke are more prevalent in Black (Non-Hispanic) populations in the county.

GOAL: Develop programs and strategies that help improve the health outcomes for people with chronic disease	
Objective 1: <i>Ensure that people with chronic diseases (Cancer, Heart Disease, Diabetes) receive access to care coordination that addresses social determinants of health, medications, screening exams, and other resources needed to better manage their disease.</i>	
	Strategy 1
	Improve the health of patients with chronic disease through navigation, resources, and support
<i>Population</i>	People with cancer, heart disease, diabetes
<i>Potential New Resources</i>	State and Federal Funding Hospital Investment
<i>Current Initiatives</i>	MA Health Flexibles services SUT Primary Care Program (See BH/SUD) Hospital and Community-based CHW's Cancer Care and Navigation Heart Failure Care and Navigation Diabetes Screenings in the Community
<i>Collaborations</i>	Many throughout the county
<i>Expected Outcomes</i>	<ul style="list-style-type: none"> • Decreased disease burden • Increased appt attendance • Increased medication adherence • SDOH's addressed
<i>Data Source</i>	Program Data

IMPROVING COMMUNITY SAFETY

Rationale: Community members also identified the importance of continuing to improve community safety. Berkshire County ranks 10th of 14 counties in the state for violent crimes, but 3rd in the state for homicide risk at 2.36 per 100,000 people. (RWJF County Health Rankings, 2021). Data from the City of Pittsfield Police Department’s Crime Map demonstrates that most crimes are attributed to aggravated assault, residential burglary, and theft. (LexisNexis® Community Crime Map). There is very little data available on interpersonal or domestic violence.

GOAL:		
Establish programs and policies to achieve safety in the community and at home		
Objective 1: Promote safety in the community and in the home through clinical care and education, community collaboration and engagement.		
	Strategy 1	Strategy 2
	Develop programs and educational tools for patients and community residents who experience interpersonal or domestic violence.	Develop programs with community partners to support community safety awareness and home safety
<i>Population</i>	Patients and community members experiencing community violence	Patients and community members who feel they are unsafe in the community or home due to theft or home burglary
<i>Potential New Resources</i>	Philanthropy State & Federal Funding	Philanthropy State & Federal Funding
<i>Current Initiatives</i>	MA DPH SANE Program The Kid’s Place (for children who witness violence or victims of violence) ED’s Screening patients for safety and making referrals to social workers ED and Inpatient social workers RAD (Rape, Assault, Defense) training by Pittsfield Police Department Pittsfield Neighborhood Watch Program	Pittsfield Neighborhood Watch Program Drug Disposal Programs across Berkshire County TRIAD program facilitated by the Berkshire County Sheriff’s Office and the Berkshire District Attorney’s Office. Berkshire Violence Prevention Center Elizabeth Freeman Center
<i>Collaborations</i>	Many community agencies inclusive of Pittsfield Police Dept, North Adams Police Department, Great Barrington Police Department	Many community agencies inclusive of Pittsfield Police Dept, North Adams Police Department, Great Barrington Police Department
<i>Expected Outcomes</i>	Increased access to resources Decreased trauma Increased resiliency	Increased access to resources Decreased residential burglaries Increased resiliency
<i>Data Source</i>	Program Data	Program Data