Berkshire
Health Systems

Community Health Implementation Plan for Berkshire Health Systems

2026-2028

Executive Summary

2026–2028 Community Health Implementation Plan (CHIP)

I. Purpose of the CHIP

This Executive Summary outlines the formal Community Health Implementation Plan (CHIP) for Berkshire Health Systems (BHS). Developed in response to the 2025 Community Health Needs Assessment (CHNA), this plan serves as our clinical and social roadmap to address the persistent health disparities between our county and the Commonwealth of Massachusetts.

The CHIP satisfies regulatory requirements by allocating resources and focuses on Policy, Systems, and Environmental (PSE) changes that improve health equity and long-term outcomes across the region.

II. Core Priority: Chronic Disease & Maternal Health Equity

Our primary CHIP objective is to reduce the county's Premature Death Rate (495.9 per 100k), which currently sits 60.9% higher than the state average.
Strategy: Integrated Cardiovascular & Postpartum Monitoring: Given the county's 37% hypertension rate for all adults, (MA: 32.4%), BHS will implement a high-touch monitoring program for birthing people. This strategy targets Severe Maternal Morbidity (SMM), which is 3.3x higher in our low-income hubs like Pittsfield and North Adams.

Strategy: Metabolic Health Intervention: With 34.3% adult obesity (MA: 27.2%), the CHIP scales community-based nutrition and exercise programs to mitigate the onset of Type 2 Diabetes and related comorbidities.

III. Core Priority: Mental Health & Recovery Equity

The CHIP recognizes "Deaths of Despair"—overdose, suicide, and alcohol-related mortality—as the leading drivers of the gap in life expectancy for Berkshire residents.

Strategy: Recovery-Ready Workplace (RRW) Implementation: To combat the county's opioid overdose rate (48.0 per 100k) and 11.9% Alcohol Use Disorder (AUD) prevalence, BHS will lead as a "Recovery-Ready Workplace." This involves adopting internal policies that support employees with lived experience and removing barriers to seeking-help.

Strategy: Workforce Pathway Reinforcement: We are working towards addressing the "critical workforce shortage" by evaluating the need for Recovery Assistant

certifications. This moves residents from "recovery to recruitment," stabilizing our internal labor force.

IV. Core Priority: Stigma Reduction & Cultural Humility

The 2025 CHNA identified "Fear of Judgment" as a top barrier to care in rural Berkshire communities, particularly for those seeking behavioral health support.

Strategy: System-Wide Implicit Bias Training: Our CHIP mandates skill reinforcement for all clinical and non-clinical staff to ensure that Berkshire residents receive care that is stigma-free and person-centered. By reshaping provider perception, we aim to increase care-seeking earlier and reduce the 5.1 poor mental health days reported monthly by our residents.

CHIP Baseline Data

CHIP Indicator	Berkshire County	Massachusetts	Notes
Premature Death Raes: age 75 and below: death	495.9 per 100,00	308.1 per 100,000	
Hypertension	37%	32.40%	
Opioid Overdose Deaths	32.6 per 100,000	88 per 100,00	MA Opioid related deaths have decreased by 36%
Obesity	34%	27.20%	
Coronary Heart Disease	5.10%	4.70%	
Diabetes Type2	11.20%	9.80%	
Asthma	12.80%	10.40%	
Multiple Chronic Conditions	13.50%	9.20%	
Poor Mental Health Days	5.10%	4.60%	
Severe Maternal Mortality (unexpected complication during labor or delivery. Hemorrhage, heart failure or sepsis).	112-118 (Estimated per 10,000 Deliveries)	100.4 (per 10,000 Deliveries)	Blak Non-Hispanic 190.8 per 10,000, Hispanic/Latine 125.6 per 10,000. Rural area often experience higher SMM rates due to longer travel and limited access to specialized postpartum follow-up
Suicide per 100k	13.2	9	
Alcohol Related Deaths per 100k	36	29	

Board Action Requested: Approval of the 2026-2028 CHIP priorities and authorization to move forward with the implementation of the outlined community health strategies.

The Priorities

The mission of Berkshire Health Systems (BHS) is to advance health and wellness for all members of the community in a welcoming, inclusive, and personalized environment. This mission is grounded in principles of diversity, health equity, and inclusion, ensuring equitable care and improved outcomes for all populations in Berkshire County.

Across the 2025 CHNA process, the following regional focus areas emerged as those with significant needs and target populations:

- Maternal Health and Birth Equity
- Mental Health Equity
- Substance Use and Recovery Equity

Based on past assessments, historical commitments, and the Attorney General's defined priorities, Berkshire Health Systems will 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

Maternal Health & Birth Equity

Rationale: The 2025 CHNA found rising maternal complications and clear differences in outcomes based on age, race, income, and geography. Many birthing people face barriers such as limited prenatal and postpartum care, transportation challenges, and behavioral health needs. Improving Maternal Health and Birth Equity requires focused efforts to remove these barriers and ensure all birthing people receive timely, culturally responsive, and coordinated care.

GOAL:
Improve maternal and infant health outcomes by ensuring that all birthing people—especially those disproportionately affected by inequities—have equitable access to high-quality, culturally responsive, and coordinated prenatal, birthing, and postpartum care.

OBJECTIVE 1:
To support and strengthen parents personal growth by providing skill building opportunities that enhance effective parenting, self-awareness and confidence.

STRATEGY 1:
Berkshire Health Systems will partner with community organizations to strengthen parenting and personal skills by expanding access to culturally responsive mentoring, parent education, and family support programs. This strategy focuses on empowering parents and caregivers with the knowledge, skills, and resources needed to support healthy child development, improve family well-being, and reduce disparities in maternal and childhood outcomes.

Population	• Black, Latine, Asian & Indigenous People • Teens • Public Insurance • Mental Health • Substance Use • Gender Diverse People
Potential New Resources	• Maternal Hypertension Program (Grant) • Remote blood pressure monitoring for women with chronic hypertension and hypertensive diseases of pregnancy will enhance early diagnoses of critical escalation of condition
Current Initiatives	• Various Childbirth & Parenting Classes: Taught by certified childbirth instructors at NARH, FVH and BMC • Berkshire Connections • Expansion of Midwifes and Doulas within BHS • Operation Better Start • WIC
Collaborations	• Northern Berkshire Community Coalition • Berkshire Nursing Families • Embrace Diversity Birth Circle: Peer support for Women of Color
Expected Outcomes	• Reduction in severe maternal morbidity among high-risk populations, including Black, Latine, Indigenous, publicly insured, and rural birthing people. • Reduction in severe consequences of chronic hypertension and hypertensive diseases of pregnancy • Increased early and adequate prenatal care utilization. • Greater patient access to lactation support, care navigation, and community-based postpartum resources. • Improved patient satisfaction and a sense of support during the postpartum period. • Improved outcomes for women with active or history of substance use disorder

Maternal Health & Birth Equity

Data Source	2025 Community Health Needs Assessment 2026 Initiative

GOAL:
Improve maternal and infant health outcomes by ensuring that all birthing people—especially those disproportionately affected by inequities—have equitable access to high-quality, culturally responsive, and coordinated prenatal, birthing, and postpartum care.

OBJECTIVE 2:
To provide timely postpartum care that supports individuals in developing confidence and competency in childbirth recovery, and newborn care.

STRATEGY 2:
BHS will strengthen postpartum follow-up care by implementing coordinated, culturally responsive, and evidence-based supports that ensure all birthing people receive timely, comprehensive postpartum services. This strategy focuses on improving maternal health outcomes by expanding access to postpartum visits, mental health screening, lactation support, and care navigation—particularly for populations experiencing the greatest disparities..

Population	• Black, Latine, Asian & Indigenous People • Teens • Public Insurance • Mental Health • Substance Use • Gender Diverse People
Potential New Resources	• Implementation of Mental Health Survey
Current Initiatives	• OB/GYN 2 Week Postpartum Follow Appointment includes screening for Postpartum Depression. • Berkshire Connections
Collaborations	• Northern Berkshire Community Coalition • Berkshire Nursing Families • Embrace Diversity Birth Circle: Peer support for Women of Color • CHP • 18 Degrees • Brien Center • Emergency Department • WIC
Expected Outcomes	• Reduce barriers to postpartum care by offering telehealth options, transportation support, and community-based check-ins. • Improved postpartum follow-up rates, especially for individuals with medical or behavioral health risk factors. • Higher engagement in postpartum education, lactation support, and parenting resources. • Reduced disparities in postpartum outcomes among high-risk and underserved populations.
Data Source	2025 Community Health Needs Assessment 2026 Initiative

Maternal Health & Birth Equity

GOAL:
Improve maternal and infant health outcomes by ensuring that all birthing people—especially those disproportionately affected by inequities—have equitable access to high-quality, culturally responsive, and coordinated prenatal, birthing, and postpartum care.

OBJECTIVE 3:
To advance the professional development of healthcare providers serving maternal health patients by increasing awareness of individual biases and promoting equitable and respectful care.

STRATEGY 3:
BHS will enhance the capacity of health care providers to effectively support vulnerable populations by implementing an ongoing professional development program. This approach will focus on building provider competencies in cultural humility, trauma-informed care, communication across diverse backgrounds, and evidence-based practices that advance health equity. Through targeted training and regular skill reinforcement, BHS will ensure that providers are well-prepared to deliver respectful, equitable, and high-quality care to all individuals.

Population	• Health Care Providers
Potential New Resources	• Regional diverse training programs • Medical Education platform - HealthStream • Guest Speakers: Springfield Family Doulas
Current Initiatives	• HealthStream Classes • Training Seminars
Collaborations	• Berkshire Health Systems OB/GYN Team • Springfield Family Doulas • BHS Pediatric Practices • CHP • Maternity and Peds acute care • Northern Berkshire Pediatrics • Northern Berkshire Community Coalition • Emergency Services
Expected Outcomes	• Increased provider knowledge and competency in trauma-informed, culturally responsive, and equity-centered care practices. • Improved the ability of providers to identify and address social determinants of health affecting vulnerable populations. • Enhanced communication, care coordination, and patient-engagement skills among clinical and non-clinical staff. • Greater confidence in managing complex patient needs, including behavioral health, chronic disease, and co-occurring conditions.
Data Source	2025 Community Health Needs Assessment 2026 Initiative

Mental Health Equity

Rationale: The 2025 CHNA identified mental health as a top concern across Berkshire County, with residents experiencing long wait times, limited access to culturally responsive care, and significant stigma that discourages help-seeking. Rural isolation, transportation barriers, workforce shortages, and financial hardship further contribute to inequitable mental health outcomes. Improving Mental Health Equity requires coordinated efforts to reduce these barriers, promote early access to care, and ensure all residents receive timely, compassionate, and culturally responsive mental health support.

GOAL:
To ensure that all Berkshire County residents—particularly those experiencing disproportionate barriers due to geography, socioeconomic status, age, race, or housing instability—have equitable access to high-quality, timely, and culturally responsive mental health services. This goal focuses on reducing disparities in mental health outcomes, strengthening the behavioral health workforce, improving care coordination, and addressing the social and structural factors that contribute to mental health challenges across the region.

OBJECTIVE 1:
Strengthen and Scale Care Navigation, Case Management, and Community Health Workforce Capacity.

STRATEGY 1:
BHS will expand access to coordinated, person-centered support by increasing care navigation, case management, and community health worker services across clinical and community settings. This strategy focuses on improving access, reducing barriers, and ensuring individuals—especially priority populations—receive consistent, culturally responsive guidance throughout their health and social service journeys.

Population	• All Berkshire County Residents
Potential New Resources	• BHS investment • Philanthropy • Government funding/grants • Development of a social work pathway • Development of a Community Health Worker/Case Management pathway • Development of new clinic at 510 North Street
Current Initiatives	• BHS Pathways Program, various clinical positions • CHW training & certification program • Recovery Coach Training Programs • Urgent Care • BHS Nurse Line • Interpreter Services
Collaborations	• Brien Center • Local Colleges and Community Organizations
Expected Outcomes	• Improved access to resources • Increased diversity of behavioral health workforce in the community
Data Source	2025 Community Health Needs Assessment 2026 Initiative

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OBJECTIVE 2:
Strengthen Community Access to Comprehensive Support Services.

STRATEGY 2:
BHS will improve community access to comprehensive health and social services by reducing structural, cultural, and logistical barriers. This strategy emphasizes person-centered pathways to care, equitable service availability, and stronger connections between clinical and community resources.

Population	• All Berkshire County Residents
Potential New Resources	• Expanded access to inpatient and virtual Behavioral Health treatment
Current Initiatives	• Partial Hospital Program addition of virtual treatment track to supplement in-person program. • Intensive outpatient Behavioral Health care • YIOP – Youth Intensive Outpatient Program • Continued virtual and in-person access to Behavioral Health Integration (BHI) team. • Licensed BH clinicians embedded in BFS/BHS primary care • Licensed BH Clinicians in the Psych area of the ED
Collaborations	• BMC Behavioral Health Team • Clinical Support Options • Love of T, Berkshire Coalition for Suicide Prevention • Mass Ability • Unit Council • Brien Center
Expected Outcomes	• Improved access to mental health services with shorter wait times and quicker connections to support. • Enhanced continuity of care through stronger referrals, warm handoffs, and follow-up. • Reduced unmet mental health needs by addressing cost, transportation, stigma, and provider shortages. • Increased community awareness of available services and stronger trust in the mental health system.
Data Source	2025 Community Health Needs Assessment 2026 Initiative

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OBJECTIVE 3:
Reduce stigma across the health system and the broader community by fostering a culture of respect, inclusion, and understanding.

STRATEGY 3:
BHS will reduce stigma related to mental health by promoting inclusive, accurate, and compassionate understanding of mental health conditions throughout the health system and the broader community. This strategy focuses on improving provider awareness, reshaping public perception, and fostering environments where individuals feel safe seeking support and care.

Population	• All Berkshire County residents • BHS Providers, clinical staff and allied health professionals
Potential New Resources	• BHS Philanthropy • Government funding/grants • Best Practices for outreach to previous patients of the ED
Current Initiatives	• Mass DPH Suicide Prevention grant-funded activities in BMC Dept of Psychiatry • Social Justice/Equity education for providers, clinical staff and allied health professionals • Continuing to communicate and offer opportunities to learn skills to support the variety of populations in need. • Mental Health first aid training for all managers • Collaborative Effort with Community Partners – Annual Suicide Prevention Conference (Year 12)
Collaborations	• BMC Department of Psychiatry & Behavioral Sciences • Brien Center • Volunteers in Medicine • Families Like Ours • Love of T • NAMI
Expected Outcomes	• Increased comfort among community members and patients discussing mental health concerns and seeking support without fear of judgment. • Higher rates of early screening, self-referral, and timely entry into mental health services. • Improved provider communication practices, including greater use of non-stigmatizing, person-first, and culturally responsive language
Data Source	2025 Community Health Needs Assessment 2026 Initiative

Substance Use & Recovery Equity

Rationale: Substance use continues to be a major health concern in Berkshire County, with residents facing challenges such as limited treatment access, transportation barriers, stigma, and a shortage of recovery supports. These barriers disproportionately affect people with low income, unstable housing, and co-occurring mental health needs. Improving Substance Use and Recovery Equity requires focused efforts to reduce these barriers, increase reliable pathways to care, and support long-term recovery through compassionate, culturally

GOAL:
To ensure that all individuals across Berkshire County—especially those disproportionately affected by substance use, co-occurring mental health conditions, and social or geographic barriers—have equitable access to comprehensive, compassionate, and culturally responsive prevention, treatment, harm reduction, and recovery services. This goal focuses on reducing disparities in substance use outcomes, strengthening recovery pathways, expanding the workforce, and addressing the social and structural factors that impact long-term recovery and well-being.

OBJECTIVE 1:
Strengthen reimbursement mechanisms to support workforce development and structured learning pathways.

STRATEGY 1:
BHS will increase access to education, training, and career-pathway opportunities by expanding reimbursement supports and removing financial barriers that prevent individuals—particularly those in recovery, underrepresented groups, or facing economic hardship—from advancing in the healthcare workforce.

Population	• Individuals in recovery • Professionals reentering the workforce
Potential New Resources	• Community Networks to expand workforce development and continuing education •
Current Initiatives	• BHS Pathway Program • Recovery Ready Workplace Training • Partnership with BCC, MCLA, Mass Hire
Collaborations	• Berkshire United Way • Berkshire County Public Secondary Schools • Second Street Second Chances • Mass Hire • Brien Center
Expected Outcomes	• Increased enrollment of individuals in recovery into workforce training, certification programs, and educational pathways. • Stronger recovery pathways are supported by meaningful employment and long-term career advancement. • Increased diversity and lived-experience representation within the regional behavioral health and recovery workforce.
Data Source	2025 Community Health Needs Assessment 2026 Initiative

Substance Use & Recovery Equity

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To ensure that all individuals across Berkshire County—especially those disproportionately affected by substance use, co-occurring mental health conditions, and social or geographic barriers—have equitable access to comprehensive, compassionate, and culturally responsive prevention, treatment, harm reduction, and recovery services. This goal focuses on reducing disparities in substance use outcomes, strengthening recovery pathways, expanding the workforce, and addressing the social and structural factors that impact long-term recovery and well-being.

OBJECTIVE 2:
Promote ongoing professional self-development to cultivate a skilled, adaptable, and continuously improving workforce.

STRATEGY 2:
BHS will strengthen pathways to employment, skill-building, and career advancement for individuals in recovery by expanding access to professional development opportunities, reducing systemic barriers, and partnering with community organizations to promote long-term stability and economic mobility.

Population	• Individuals in recovery • Professionals reentering the workforce
Potential New Resources	• Berkshire Regional Planning Commission • Mass Hire, return to work initiatives
Current Initiatives	• Recovery Ready Workplace Certification • Support of new CORI reform initiatives • Workplace Readiness Course (14 Classes)
Collaborations	• MassHire • Second Street Second Chances • Berkshire Community College • Recovery community organizations • Local employers • George B. Crane • Brien Center
Expected Outcomes	• Increased participation in professional development and vocational training among individuals in recovery. • Improved employment rates and job retention. • Strengthened partnerships between recovery organizations, employers, and workforce development systems.
Data Source	2025 Community Health Needs Assessment 2026 Initiative

Substance Use & Recovery Equity

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To ensure that all individuals across Berkshire County—especially those disproportionately affected by substance use, co-occurring mental health conditions, and social or geographic barriers—have equitable access to comprehensive, compassionate, and culturally responsive prevention, treatment, harm reduction, and recovery services. This goal focuses on reducing disparities in substance use outcomes, strengthening recovery pathways, expanding the workforce, and addressing the social and structural factors that impact long-term recovery and well-being.

OBJECTIVE 3:
Strengthen the availability and coordination of transitional housing and wraparound services for clients. Partnering with Community Agencies to ensure clients have stable environments.

STRATEGY 3:
BHS will work with its partners by expanding access to safe, stable transitional housing and integrating supportive services that promote long-term stability, health, and independence for individuals recovering from substance use disorders

Population	• Individuals in recovery
Potential New Resources	• Greylock Recovery • City of Pittsfield, City of North Adams
Current Initiatives	• Clinical Stabilization Services • McGee • Program planning and design of a TSS • Zion Church supportive housing
Collaborations	• Keenan House • Recovery Housing Program (Massachusetts) • ALC Men • ALC Women • DMH • Vanderburgh House • Service Net
Expected Outcomes	• Increased availability of transitional housing units dedicated to individuals in recovery. • Higher rates of treatment engagement and retention following discharge from BHS services. • Improved housing stability and reduced homelessness among clients with SUD. • Increased employment readiness and job placements for individuals in recovery.
Data Source	2025 Community Health Needs Assessment 2026 Initiative

Chronic Disease

Rationale: The 2025 CHNA shows that chronic diseases—such as cancer, heart disease, diabetes, COPD, and asthma—remain leading contributors to illness and early death in Berkshire County. These conditions disproportionately affect residents with lower income, limited access to care, and unmet social needs, with higher rates of premature mortality among Black residents. Barriers such as transportation, cost, and limited care coordination make disease management more difficult. Improving chronic disease outcomes requires coordinated support, better access to preventive care, and resources that help individuals manage their health more effectively.

GOAL:
Develop programs and strategies that help improve the health outcomes for people with chronic disease
OBJECTIVE 1:
Ensure that people with chronic diseases (asthma, COPD, 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.
STRATEGY 1:
BHS will improve chronic disease outcomes by increasing access to coordinated care, preventive services, and patient-centered supports that address both medical needs and the social factors that influence health. This strategy focuses on helping individuals manage their conditions more effectively through navigation, education, and reliable connections to clinical and community resources.

Population	• People with cancer, heart disease, diabetes
Potential New Resources	• Hospital investment • State / Federal Funding
Current Initiatives	• MA Health Flexibles services • SUT Primary Care Program (See BH/SUD) • Hospital and Community-based CHW's • Cancer Care and Navigation Services at Phelps Cancer Center • Heart Failure Care and Navigation • COPD Nurse Navigator • Diabetes Screenings in the Community; Diabetes Education Services
Collaborations	• Many throughout the county
Expected Outcomes	• Improved control of chronic conditions such as diabetes, hypertension, COPD, and heart failure. • Increased screening completion and follow-up appointment attendance. • Higher medication adherence rates. • Reduced preventable hospitalizations and ED visits. • Improved quality of life and patient-reported outcomes for individuals managing chronic diseases.
Data Source	2025 Community Health Needs Assessment 2026 Initiative