B. Joint Commission Health Equity Review



Berkshire Health Systems

August 2023

Joint Commission Health Equity Review Addressing Social Determinates of Health to Prevent Outcome Disparities and Promote Health Equity Our commitment to diversity, equity, and inclusion is at the foundation of how we identify ourselves and who we strive to be.



#### Our Mission

To advance health and wellness for everyone in our community in a welcoming, inclusive, and personalized environment

#### Our Vision

To be the region's trusted healthcare partner and community advocate for improving overall quality of life.



#### **Our Values: BHS CAREs**

Compassion 
 Accountability 
 Respect 
 Excellence

Berkshire Health Systems

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#### It's embedded in how we approach our long-term goals....

**Destination Metrics** 

2027

#### Patients

- BMC designated one of Healthgrades "America's Best Hospitals" (Top 250; 95th percentile)
- BMC, FVH, the Medical Group, and BVNA all have achieved and maintained top quartile
  performance on
  CMS Patient Experience measures (CAHPS)\* ("rate this hospital, provider, or home health agency")

#### People

- Top quartile performance on BHS employee engagement
- Top quartile performance on BHS provider engagement

#### Community

- Berkshire County has improved its ranking to no lower than 9<sup>th</sup> among the 14 Massachusetts counties for overall health factors
- Demonstrated reduction in health inequities impacting Berkshire populations that have been historically marginalized

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#### Creating a Shared Vocabulary

**Health Equity:** The opportunity for everyone to attain their full health potential. No one is disadvantaged from achieving this potential because of their social position (class, socio-economic status) or socially assigned circumstance (race, ethnicity, gender identity, sexual orientation, geography, ability)

**Health Inequities:** Differences in health status and mortality rates across populations groups that are systemic, avoidable, unfair, and unjust. These differences are often attributable to the social, economic, environmental conditions in which people live, work, and play.

Health Disparities: measurable differences in health and wellness between populations

Populations can be organized according to shared characteristics such as:

RELD: Race, Ethnicity, Language, Disability SOGI: Sexual Orientation and Gender Identity HRSN: Health Related Social Needs (such as food insecurity, housing instability, or lack of transportation)

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Source:

# Health Disparities in our Community

Our Community

#### Who We Are

Berkshire County is ranked 13 of 14 Massachusetts counties for health outcomes according to the Robert Wood Johnson Foundation's 2022 County Health Rankings.

- Population: about 126,000
- Median age: 47
- Socioeconomics: The median household income in Berkshire County is 30% lower than that of the state.
- Education: Only 19% of the population aged 25 and over in Berkshire County has a bachelor's degree, compared to 45% statewide.
- Berkshire County primarily has White residents (91%).
- 12% of Berkshire residents are foreign-born.

Source: BHS Community Health Needs Assessment (CHNA), 2022

Our Community

#### Community Health Indicators

Rate of premature deaths in the County is at least 30% higher than the rest of the state.

"Measuring premature mortality, rather than overall mortality, focuses attention on deaths that might have been prevented."







Start Here: Building a System-Wide Strategy to improve Health Equity

#### **Our Approach**



Information

Collecting and

analyzing patient

and population

health data



Relationships

Building new

partnerships with

patients, families

and community

partners



Education

Health disparities education for providers and staff. Health literacy education for the community.



Action

Partnering with patients and community resources to provide evidencebased practices to promote health equity

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**Start Here: Building** a System-Wide Strategy for **DEI** to improve Health Equity

#### Relationships/Partners

2nd Street, Second Chances Project BASIC: Berkshire Alliance to Support Immigrant Community Berkshire Black Economic Council Berkshire Community College Berkshire County District Attorney's Office LGBTQ+ Health Collaborative Berkshire County Regional Housing Authority Berkshire Harm Reduction Berkshire Hills Regional School District Berkshire NAACP Berkshire Perinatal Opioid Collaborative Berkshire Regional Planning Commission Berkshire Stonewall Community Coalition Berkshire United Way Blackshires BRIDGE Brien Center

City of Pittsfield Dalton Chief of Police Greylock Federal Credit Union Habitat for Humanity HEALing Communities Coalition Manos Unidas Co-op North Adams City Council Northern Berkshire Community Coalition Roots & Dreams and Mustard Seeds Inc. Southern Berkshire Rural Health Network Volunteers in Medicine Westside Legends Railroad Street Project Antidefamation League Jewish Federation BERK12

Start Here: Building a System-Wide Strategy for DEI to improve Health Equity

# Action

- Appointed a system-wide Diversity, Equity, and Inclusion Officer
- Promoting workforce diversity by reducing barriers to access through employment training and pipeline programs
- Evaluating current status of RELD, SOGI, and HRSN data and develop actions to improve accuracy and completion
- · Health Equity Committee comprised of stakeholders to develop and refine actions
- Evaluating patient experience and quality measures with DEI/Health Equity lens

Contact Charles Redd with questions, concerns, ideas

Charles Redd BHS Diversity, Equity, and Inclusion Officer credd@bhs1.org 413-447-2023





#### Language Services

#### Language Services

- We provide Foreign Language and ASL (American Sign Language)
- We provide in-house, <u>in-person</u>, interpretation in Spanish and Russian
  - For other languages and ASL we contract with agencies
    - 24-hour telephone system interpretation in 200 languages
    - Provided services in 24 languages and ASL in 2022
    - Wireless Video interpreting for ASL
- We translate written materials by request
- We cover all Berkshire County









#### Age

- 25% of Berkshire County residents are 65 years or older • That is 1.5x the State and National Rate of 17%
- To meet the needs of these patients we have targeted initiatives:
  - The BMC Emergency Department has a Geriatric Emergency Department Accreditation from the American College of Emergency Physicians (ACEP)
  - BMC has a Geriatric Fracture Program
  - Participating in the Institute for Healthcare Improvement (IHI) Age-Friendly Care Collaborative

#### Overall BMC, Readmission Data

Hospital Utilization by Select Demographic	\$								
	Time Period: Jan-22 - Dec-22								
	(Rolling 4 Quarters)								
		Hospital		State	IPRO QIN Region				
		Live							
	# Readm	Discharges	Readm %	Readmission %	Readmission %				
All	798	4,216	18.9%	18.6%	17.59				
Gender									
Female	371	2,144	17.3%	17.8%	16.89				
Male	427	2,072	20.6%	19.5%	18.25				
Race/Ethnicity									
Asian	5	14	35.7%	17.2%	17.59				
Black or African American	22	100	22.0%	22.7%	20.69				
Hispanic	6	19	31.6%	22.6%	20.25				
Native American	0	2	0.0%	22.6%	19.5				
White	745	3,968	18.8%	18.4%	17.09				
Other or Unknown	20	113	17.7%	17.5%	17.05				
Age									
Individuals Under 65	188	790	23.8%	23.3%	22.15				
Individuals 65 - 74	235	1,175	20.0%	17.9%	16.65				
Individuals 75 - 84	212	1,280	16.6%	17.6%	17.05				
Individuals 85+	163	971	16.8%	17.5%	16.59				
Beneficiary Disability Status (Based on a b Beneficiaries with a disability	eneficiary's original 370	reason for e 1,579	23.4%	Medicare) 22.5%	20.95				
Beneficiaries without a disability	428	2,637	16.2%	16.2%	16.25				

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Our Community

## Health Disparities

Some of the data currently available for our local populations shows that Black patients visit our emergency departments for heart disease at more than 3 1/2 times the rate of White patients. Heart Disease Emergency Department Visits by Race, 2016-2019 Age-Adjusted per 100,000



Source: MDPH, Hospital Admissions, State Tables, 2016-2019. Age-adjusted per 100,000. Source: BHS Community Health Needs Assessment (CHNA), 2022



#### Challenges & Opportunities

# Sepsis, Readmission Data

IPRO QIN-QIO Sepsis Hospital Care Transitions Report <u>BERISHINE MEDICAL CENTER</u> Sepsis Hospital Utilization by Select Demographics The following shows 30-day hospital readmissions based on demographic characteristics of the Medicare Fee-For-Service population seen at your hospital and had a diagnosis code of sepsis.

	Time Period: Jan-22 - Dec-22 (Rolling 4 Quarters)						
	Hospital			State	IPRO QIN Region		
	Readmits Within 30 Days	Live Discharges	Readmit %	Readmission %	Readmission %		
All	130	628	20.7%	21.7%	20.5%		
Gender							
Female	54	284	19.0%	21.0%	20.29		
Male	76	344	22.1%	22.3%	20.79		
Race/Ethnicity Asian Black or African American	1	3	33.3%	18.2%	21.69		
Hispanic	3	15	60.0%	22.3%	23.47		
Native American	0	0	00.076	44.4%	13.39		
White	115	591	19.5%	21.5%	19.99		
Other or Unknown	5	14	35.7%	20.5%	21.39		
Age							
Individuals Under 65	21	92	22.8%	25.1%	23.79		
Individuals 65 - 74	44	197	22.3%	22.1%	21.0%		
Individuals 75 - 84	53	211	25.1%	21.5%	20.39		



# WHAT ARE WE DOING TO MAKE A DIFFERENCE? Social Determinants of Health (SDOH) Assessment

#### Social Determinant of Health Screening (SDOH)

#### Background

- Implemented SDOH screening in pilot practice beginning April 2022.
- Aligned Community Health Worker (CHW) to support patients with positive screen.
- Started in one practice for Medicaid only patients.
- Expanding to all BMC Primary Care Practices for all payers by end of August.
- Screening is done:
  - Pre-visit planning (call ahead of visit)
  - At registration (paper form)
  - At beginning of visit (verbally with Medical Assistant)
- Any patient with a positive screen is provided resource lists and/or referred to a CHW for additional assistance.



#### Social Determinant of Health Screening (SDOH)

#### **Community Resources Available**

- Barrier identified during pilot:
  - Providers concern about asking patients SDOH questions without aligned resources to provide support to patients.
- Action:
  - Comprehensive community resource lists created by category of need (i.e., food, transportation, housing, clothing, utilities).
  - This list is maintained and updates regularly by our care management team.
  - List is available to all staff electronically (shared resource sites) and on paper at inpatient care locations.
  - Provide referrals for identified needs, including assistance with with MassHealth (Medicaid) transportation forms, SNAP benefits for food insecurity, and utility assistance



Decreases in June are related to provider vacations and once a new practice has screened their patients, they won't need to be done again for another year. Berkshire Internists is the largest practice, which accounts for the spike in May.



#### Social Determinant of Health Screening (SDOH)

## Next Steps

- Finalize implementation of payer agnostic SDOH screening to all primary care practices by end of August.
- Incorporate formal SDOH screening for ED and Inpatient settings.
- Include processes for referral and resource distribution with implementation of new areas
  - Incorporate as part of patient discharge instructions

# WHAT ARE WE DOING TO MAKE A DIFFERENCE? Social Determinants of Health (SDOH) Initiatives

#### Flexible Services Program

#### **Flexible Services**

- Community Health Needs Assessments (CHNA) and analysis of our Medicaid ACO population identified housing, food, and transportation insecurity as three of our highest needs.
- We were able to use funding through the Flexible Services Program Grant from the Medicaid ACO to support additional resources for:
  - Housing
  - Food Insecurity
  - Transportation
- Patient's qualified for program by having one of the following identified Health Needs Based Criteria (HNBC) and Risk Factor:
  - Risk Factor:
    - Homelessness
    - At risk for Homelessness
    - At risk for nutritional deficiency
  - HNBC:

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- BH need
  - Repeated ED use
- High-risk or complicated pregnancy

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Uncontrolled diabetes

## Housing Insecurity: Flexible Services

#### Flexible Services, Housing

- Services provided in collaboration with Community Partners including:
  - Berkshire County Regional Housing (BCRHA)
  - Service Net
- Services Available include:
  - Tenancy Preservation Program Services
  - Housing Search Intervention

## Transportation Flexible Services

#### Flexible Services, Transportation

- Programs provided home delivery of goods for patients with transportation needs.
- Also provided transportation support through bus and taxi vouchers as appropriate.
- MassHealth (Medicaid) transportation services

#### Food Insecurity: Flexible Services

#### Flexible Services, Food Insecurity

- Services provided in collaboration with Community Partners including:
   Berkshire County Sheriff's Office (BCSO)
  - Community Health Programs (CHP)
  - Berkshire Fallon ACO
  - Big Y
  - Harry's Grocery
  - Local Farmer's Markets
  - Berkshire Bounty
- Services Available include:
  - CSA Shares (partnership with local Farmers)
  - Food and Formula Vouchers
  - · Education including cooking classes and meeting with nutritionist
  - Grocery Gift Cards
  - Grocery Home Delivery Program
  - Medically Tailored Meals
  - Nutrition Kitchen Supply Funds

#### Challenges & Opportunities

#### Food Insecurity: Operation Better Start

#### **Food Insecurity Actions**

- Clinical Programming for infant through young adult
  No co-pay, no balance billing
  - No co-pay, no balance billi
    No limitation on visits
- Western Mass Growth and Nutrition Program (one of five in Mass. Partnership with MaDPH)
- Operation Better Start Feeding Clinic
- Berkshire County Head Start- 7 sites (nutrition and Nursing services)
- Community Education
  - Local Schools
  - YMCA
  - Boys & Girls Club
  - Televised Cooking Classes (on public television and BHS website)

Food **Insecurity:** Berkshire North Women, Infants and Children's Program (WIC)

#### **Food Insecurity Actions**

- Berkshire North WIC hosts:
  Healthy eating
  Food insecurity support
  Breastfeeding support
  Eating on a budget
  Formula
  Food Pantry (supported by staff and Berkshire Bounty, emergency food formula for participants and popparticipants) nonparticipants)
- Coordinates services with Family Birthplace (BMC Labor and Delivery Unit)
- Diapers distributor for the Berkshire diaper project (do not have to be a WIC participant)


Phelps Cancer Center Care Navigation	<ul> <li>Transportation</li> <li>Collaborative Member with Dana Farber</li> <li>Allows access to protocols, treatments, studies without travel to Boston</li> <li>Virtual visits</li> </ul>
	<ul> <li>MassHealth (Medicaid) PT-1 Transportation Forms, Taxi Vouchers, Bus passes</li> </ul>
Berkshire Health S	ystems

Phelps Cancer Center

Care Navigation

## Screening

- Distress Screen for all new patients and those transitioning into Survivorship
  - Identify social challenges and barriers to care
- Integrated Health services provided *free of charge* to all patients/caregivers
  - Yoga
  - Health Coaching
  - Cooking Demonstrations
  - Exercise Therapy
  - Mindful Meditation
  - Reiki
  - Acupuncture

	Nurse Navigation
Phelps Cancer Center Care Navigation	<ul> <li>Assist with access to primary care and specialist</li> <li>Assist with our identified barriers for care: <ul> <li>Transportation</li> <li>Sexuality/Body Image</li> </ul> </li> <li>Access to restricted funds and supplies <ul> <li>Colonoscopy prep</li> <li>Copays</li> </ul> </li> <li>Arrange transportation: <ul> <li>Assist with volunteers</li> <li>Taxi vouchers</li> <li>Medicaid PT-1 forms</li> </ul> </li> <li>Provide Cancer Screening events in the community. <ul> <li>First Lutheran Church on 1<sup>st</sup> street</li> <li>Pride Festival</li> <li>Latino Festival</li> <li>Relay for life</li> </ul> </li> </ul>

	Social Worker
Phelps	<ul> <li>Assess barriers to care and identify social determinants of health</li> <li>Referrals to available services</li> </ul>
Cancer	Transportation
	<ul> <li>Medicaid PT-1, Wheels for Wellness, BRTA Paratransit, Soldier C</li> <li>Housing</li> </ul>
Center	Rent Assistance, RAFT, housing searches, tenant support
	Utilities     Access grant money and restricted funds
Care	<ul> <li>Access grant money and restricted funds</li> <li>Referrals to local support programs</li> <li>Ability to pay for medical services and medications</li> </ul>
Navigation	<ul> <li>Health Insurance: plan review, Advocacy for Access, SHINE</li> <li>Assistance with: Paid Family Medical Leave, Social Security</li> </ul>
	<ul> <li>Co-pay assistance</li> <li>Food Insecurity</li> </ul>
	• SNAP
	Social Supports resources
	<ul> <li>Support groups</li> <li>Mindful Meditation</li> </ul>
	Elder Services referrals
	<ul> <li>Integrative Health Program</li> <li>Financial assistance</li> </ul>
	<ul> <li>DTA/Emergency Cash assistance</li> <li>Access to restricted funds</li> </ul>

## Phelps Cancer Center

## Care Navigation

## Nutritionist

- Utilizes the Distress screen and Nutrition screen to identify food insecurity
- Provides
  - Cooking Demonstrations
  - Nutritional Supplements for patients
  - Tube feeding education and support
  - SNAP benefits





### Substance Use in Berkshire County

#### Overview

- Substance Use in Berkshire County is a top health condition ranks in the top 10 list of most common conditions seen at Berkshire Health System
- Substance Use Deaths, for any reason results in a growing number of deaths each year
- We provide multiple referrals to aid community members with this issue
- We partner with community programs to support this population in addition to health system services







### Substance Use in Berkshire County

#### Overview

- As a health system, many services are in place to aide in this crisis:
  - Acute Detoxification Unit
  - Clinical Stabilization Unit
  - Substance Use Disorder Team on the Acute Medicine Service
  - Bridge Program in the ED for Suboxone use to prevent the need for hospitalization
  - Partial Hospitalization Program, with a dual diagnosis tract
  - Adolescent Intensive Outpatient Program
  - Substance Use Treatment Clinic at Hillcrest Family Health
  - Harm Reduction Program
  - Berkshire Connections
  - Care Coordination Services that include Behavioral Health Care Coordinators and Community Health Workers

## Primary Care Medical Home for Substance Use

## Substance Use Treatment Clinic at Hillcrest Family Health

- Specializes in working with people with substance use disorders (SUD)
- Harm Reduction Model
- Mid-Level Provider treats patients with all forms of SUD
- Care includes support, medications including inductions, oral, sublingual, injectable and transdermal formulations
- Coordinates care with PCP and social services
- RN who does assessment, intake, and planning
- Recovery Coach Support
- Coordination with:
  - Primary Care

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Social Services to meet identified needs





## WHAT ARE WE DOING TO MAKE A DIFFERENCE? Harm Reduction Programs

## Harm Reduction Program

#### What we do.....

- Reduce negative consequences associated with drug use
   Overdose prevention education & naloxone distribution
   Testing for HIV, HCV, and other STI's
   Provide treatment for HCV via telehealth
   Basic wound care
   Provide referrals for community support services
   Community Syringe disposal
   Correctional linkage to care post

- Correctional linkage to care post incarceration





## Harm Reduction Program

## **Our Program**

- Berkshire County has seen a decrease in:
  - Overdose deaths (down 22%) in 2022
  - HCV+ rates (down 6.3%)
- Distributed over 4,200 dose of naloxone in the community





https://www.mass.gov/doc/opioid-related-overdose-deaths-by-county-June-2023/download

## WHAT ARE WE DOING TO MAKE A DIFFERENCE? Perinatal Support for SUD

## Berkshire Connectio

**NS**gan March 2022

#### Overview

- Health Policy Commission, MA DPH initially funded a pilot project to design and implement wrap around services for pregnant and postpartum women with opioid use disorder (OUD)
- Criteria for enrollment: any active or history of OUD.
- In one year, 49 women were enrolled.
- Critical success factors included
  - Development of new roles: Outreach Coordinator
  - Embedding the program in the BMC OB practice
  - 40 community partnerships
  - Initiating care coordination mtgs with FBP, SUD team, MOUD provider
  - Initiation of a peer support group with strategies to reduce barriers to attendance



	Evaluation of Effectiveness
Berkshire Connections Began March 2022	<ul> <li>Monthly communication to OB providers and Family Birthplace Leadership on:</li> <li>Enrollment, program changes, new partners and resources.</li> </ul>
	<ul> <li>Continual awareness of stigma</li> </ul>
	Coordination of OB care from incarceration
Berkshire Health Sy	<ul> <li>Community referrals include:</li> <li>OB providers</li> <li>Harm reduction programs</li> <li>Self-Referrals</li> </ul>





Sustainable
Funding
from MA
BSAS:
Moms Do
Care
Program
through
2030

## Berkshire Connections Program Enhancements with Sustainable Funding

- Eligibility expanded for all SUD, including nicotine
- Care out to 3 years postpartum
- Additional Staff Roles Being Implemented:
  - Certified Drug and Alcohol Counselor (Counseling on Drug Use Decisions)
  - Licensed Independent Certified Social Worker (Focus on Trauma Therapy for Both Parents)
  - Recovery Coach / Outreach Coordinator for Male Partners

## MA Attorney Generals Office: Maternal Health Equity Award



## Berkshire Medical Center – Berkshire Nursing Families – Springfield Family Doulas Partnership

- Newly Awarded: August 2023
- Implement Continuous Perinatal Education and Support on Infant Nutrition, Benefits of Breast Feeding
- Implement Weekly Perinatal Support Groups Lead by Certified Perinatal Mental Health Professionals: In person and virtual
- Perinatal Support Groups for Women of Color Lead by Springfield Family Doulas: In person, Central County.
- Annual Education for Perinatal Professionals on Birth Equity Lead by Springfield Family Doulas



## WHAT ARE WE DOING TO MAKE A DIFFERENCE? Behavioral Health Programs

## Behavioral Health Integration (BHI)

## Program Scope

- Clinically focused, time-limited consultation service intended to increase access to behavioral health (BH) care for primary care patients who may be suffering from common mental health issues.
- BHI clinicians are embedded in primary care practices
  - Provide brief, evidence-based BH treatment to patients
  - Staff include:
    - Masters-prepared, independently licensed BH clinicians
    - Psychiatry residents
    - Advanced practice psychiatric nurses
    - Psychiatrists

## Adolescent Intensive Outpatient Program (IOP)

## Program Initiatives

- Short-term, structured ambulatory behavioral health treatment for Adolescents (age 12-17 years old)
- Evidence-based and trauma informed care
- Targeted care 3 times per week for 8 weeks
- Screenings and assessments are completed to ensure appropriate care coordination supports are put into place
- Groups focus on needs of participants and include but are not limited to:
  - Gender Identity
  - Body Image
  - Eating Disorders
  - How to cope
  - How to interact
  - Expressive Therapy
  - Building Trust
  - Emotion Regulation

Mindfulness
 Mindfulness



### Berkshire Medical Center Community Pharmacy

- Medications for discharging patients (Meds to Beds)
  - Medications brought to the bedside
  - Helps patients lacking transportation
  - Ensure vital medications are not missed and makes a smoother • transition home
- Co-Pays assistance
- Script Center (24/7 prescription pick-up kiosk)
- Medicine-On-Time:
  - Bundling of multiple medications into easy-to-use packets
- 90-day orders
- Delivery Services throughout Berkshire County

#### mobileRX With the mobilefix 'Pharmacy app, you can use an iPhone' or Android'' device to request refills while on the go. Follow the steps below to get started. • Specialty Pharmacy

Flexible spending account options

- Pet medications
- Immunizations

The Berkshire Community & Specialty Pharmacy Program provides unmatched service and convenience:



Learn More The Berkshire Community & Specialty Pharmacy Program is available to all patients. Call our pharmacy staff to learn more: (413) 395-7610.

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725 North Street, Pittsfield, MA 01201 Enter at the Warriner Entrance berkshirehealthsystems.org (413) 395-7610

Hours of Operation: Monday–Friday, 7::00am–7:00pm Saturday–Sunday, 7::30am–2:00pm

Dave MacHaffie, RPh, Director Berkshire Community & Specialty Pharmacy



ACCREDITED Byscielly Plermas Explose #9(12034

The Berlen re Community Pharmacy has earned both URAC at a Accreditation Commission for Health Care (ACHC) Accreditation. When choosing a phermacy with these star-dards, you can take confront in forowing you will receive the Fightest quelity of care. Berkshire Community and Specialty Pharmacy\_R\_



#### Berkshire Community & Specialty Pharmacy Program

Living with a chronic condition can be challenging and obtaining required medications can be complex.

If you have been prescribed a "speciality medication" such as a biologic, oral chemotherapeutic or injectable: Help is here!

Our Specialty Pharmacy Program works with you and your clinician to simplify every aspect of your care. At no cost to you.

## Wellness and Community Health

- Community Events bring health education awareness, fun, and referrals to local community events
- Connect with our neighbors to engage in conversations about their health, well-being, and needs

#### • Provide:

- Provide resources: BP, Diabetes, age-appropriate screenings, schedule appointments
- Health Care Proxy information
- Offer fun games to engage all ages in discussions about health and well-being



Wellness and Community Health – North Adams Downtown Celebration







## Wellness and Community Health

Programming to Help People Stay Healthy and Meet their Health Needs









## Talent Pipeline

- BHS initiative to provide training for people to gain careers in healthcare without prior experience or education
- Get paid full-time salary while going to school
  - BHS invests \$7 million dollars annually to this program
- Programs include:
  - Medical Assistant
  - Nursing Assistant
  - Licensed Practical Nurse
  - Registered Nurse (Associate's Degree)

## Talent Pipeline

# One Possible Pathway to Becoming a Registered Nurse





Programming to Help People Stay Healthy and Meet their Health Needs	<ul> <li>Initiatives</li> <li>2<sup>nd</sup> Street, Second Chances</li> <li>A collaborative program with local agencies to give formerly incarcerated individuals respect and encouragement</li> <li>Services provided include: <ul> <li>Medical</li> <li>Mental Health</li> <li>Substance use disorder services</li> <li>Financial resources and literacy</li> <li>Transportation</li> <li>Housing</li> </ul> </li> </ul>
Berkshire Health Sys	<ul> <li>Family Reunification</li> <li>Employment</li> <li>Job Training</li> <li>Legal Services</li> </ul>