Corewell Health in Southwest Michigan

Corewell Health Lakeland Hospitals - Niles Hospital

Corewell Health Lakeland Hospitals - St. Joseph Hospital

Corewell Health Watervliet Hospital

Community Health Needs Assessment

2025 - 2027 Implementation Strategy

Corewell Health™

Contents

Executive summary

In November 2024, Corewell Health in Southwest Michigan adopted the Community Health Needs Assessment that identified to top community health needs in Berrien, Cass, and Van Buren Counties. The present report provides details on the strategies that Corewell Health in Southwest Michigan will employ to address the community health needs between Jan. 1, 2025 and Dec. 31, 2027. The significant health needs identified in the most recent Corewell Health in Southwest Michigan Community Health Need Assessment included mental health, health care access, economic and employment conditions, the food environment, and social cohesion. This Implementation strategy addresses all five of these significant health needs. The process of identifying or developing strategies to address these needs was a collaborative effort between Corewell Health in Southwest Michigan subject matter experts from multiple service lines.

Corewell Health in Southwest Michigan will dedicate significant resources toward improving the health of our community. By committing to the included strategies, strengthening community collaborations, and focusing on measurable impact, we plan to show improvement in these areas by the end of 2027.

Introduction

Mission

Corwell Health's mission is to improve health, instill humanity and inspire hope.

Vision

A future where health is simple, affordable, equitable and exceptional.

Values

Compassion. Collaboration. Clarity. Curiosity. Courage.

Description of hospital

Formerly known as Spectrum Health Lakeland, Corewell Health in Southwest Michigan is headquartered in Berrien County, Michigan. It also has facilities and serves patients in the adjacent counties of Van Buren and Cass. Roughly 240,000 people are estimated to reside in this service area. Corewell Health in Southwest Michigan is a not-for-profit, community-owned health system serving Southwest Michigan and Northern Indiana with a full continuum of care and wellness services and offers the latest in care and technology in a patient-friendly setting. Employing more than 3,500 professionals, the hospital system provides 335 licensed beds and a comprehensive array of services, including three hospitals, 37 ambulatory locations and 335 primary and specialty care physicians.

Inclusion and belonging

Corewell Health is committed to working toward the best possible health outcomes for all people we serve. This includes understanding where efforts and resources can be targeted to make the largest impact and intentionally seeking the perspectives of a very diverse group of community stakeholders when setting priorities. This implementation strategy has been developed with these considerations in mind. Numerous community stakeholders helped set the priorities and strategies outlined in this document and will continue to serve in an advisory capacity during its three-year implementation period.

Internal Revenue Service requirements

The Patient Protection and Affordable Care Act of 2010 set forth additional requirements that hospitals must meet in order to maintain their status as a 501(c) (3) Charitable Hospital Organization. One of the main requirements states that a hospital must conduct a Community Health Needs Assessment and must adopt an implementation strategy to meet the community health needs identified through the assessment. The law further states that the assessment must consider input from persons who represent the broad interests of the community, including those with special knowledge of, or expertise in, public health. In response to the Affordable Care Act's requirements, Corewell Health hospitals in Southwest Michigan produced a 2025 Community Health Needs Assessment and this document, the 2025-2027 Implementation Strategy.

About this plan

Selection of significant needs

As discussed in the 2025-2027 Community Health Needs Assessment for Corewell Health in Southwest Michigan, the significant health needs (i.e., priority health needs, or PHNs) were identified as::

- Mental health
- Health care access.
- Economic and employment conditions.
- Food environment
- Social cohesion

Needs addressed in implementation strategy

No significant health need identified in the CHNA for Corewell Health in Southwest Michigan was left unaddressed.

Process for developing the implementation strategy

The creation of this implementation strategy began with the identification of two to three strategic priorities for each significant health need identified in the CHNA. These strategic priorities help to set the direction of the Implementation Strategy, or IS, programing over the next three years. Community input from the CHNA about what is needed to make a thriving community was a major driver of this development, providing critical insights into the community's health aspirations.

Next, objectives were set based on what was within the scope of Corewell Health and partnering organizations to achieve in our collective efforts to address significant health needs. Specific programs were then identified to achieve the objectives under each strategy with care taken to ensure that there was a mix of programs that targeted multiple levels of the transformation map.

Finally, the expected outcomes of the work undertaken to meet the objectives were determined based on what could be achieved in the near to midterm. These outcomes will serve as the primary way that Corewell Health in Southwest Michigan will determine if the anticipated impact was achieved. These outcomes were grounded in a strong theoretical basis, providing a clear path to improving each significant health need. This approach ensured that the implementation strategy was well-rounded, community-focused and actionable, laying the groundwork for meaningful improvements in health outcomes.

Health equity framework

Corewell Health has iterated on the Health Equity Framework presented in the 2022-2024 CHNA to explicitly call out a new target for change: organizational policy, practice and systems.

Individual behavior: This level includes interventions that directly serve individuals and/or impact individual actions that contribute to achieving better health outcomes. These interventions might focus on providing health education, facilitating individual access to health care services, connecting people with food when they are food insecure or enrolling individuals in a blood pressure management program.

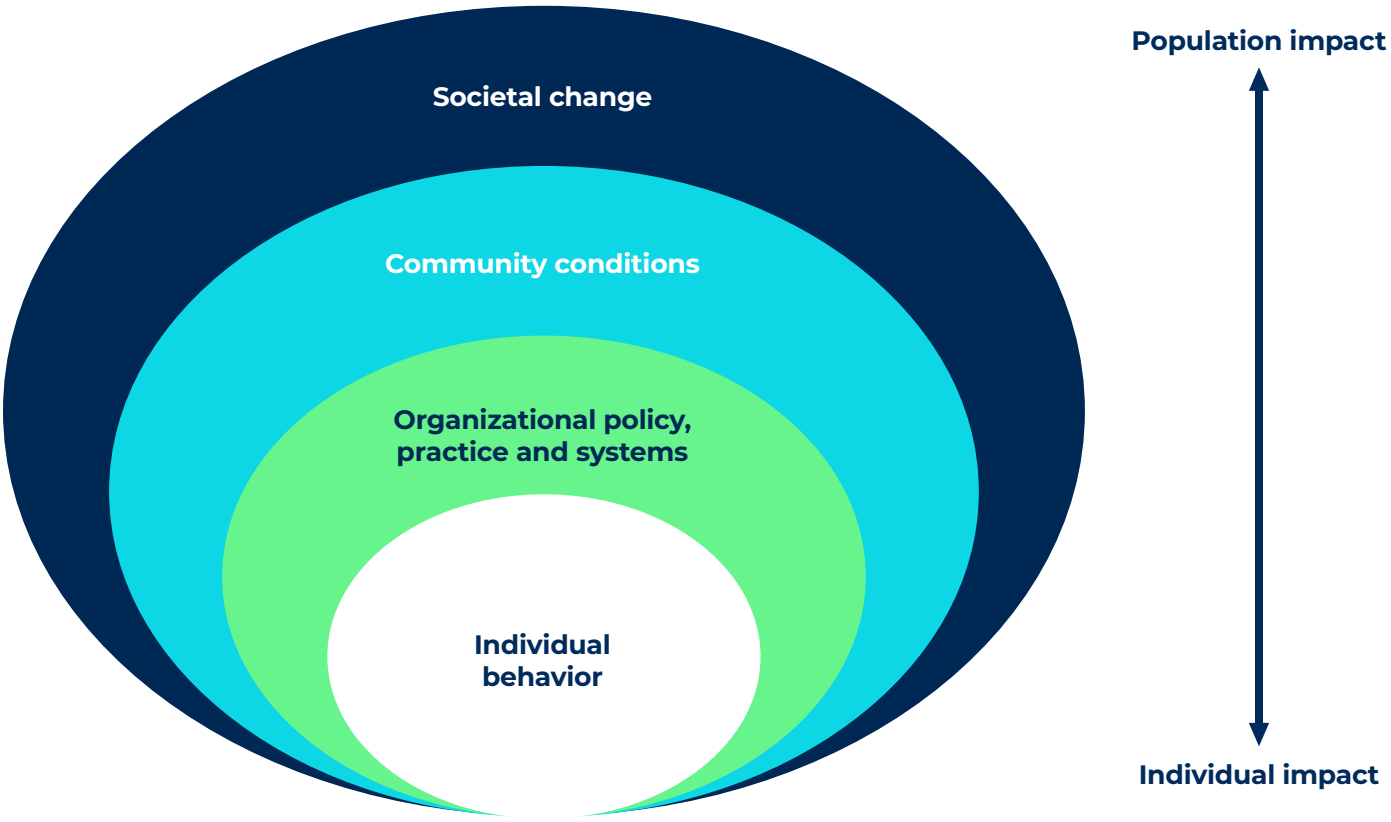
Organizational policy, practice and systems: These initiatives are focused on changing organizations in ways that ensure they are serving and supporting people more equitably. This may include changing contracting guidelines to make it easier for small businesses to work with large organizations, improving the ways in which patient care is delivered to ensure equity is infused into clinical practice, or shifting human resource guidelines to make employment more accessible to people who were formerly incarcerated.

Community conditions: Initiatives at this level aim to improve the conditions that impact health, often referred to as the social determinants of health. This could include initiatives to improve public transportation networks within communities, make grocery stores more accessible to improve the food environment or make educational systems more equitable to increase access to postsecondary educational opportunities.

Societal structures: This level recognizes the broader structural forces that impact all the levels below and, ultimately, the health of people and communities. This includes a focus on the social policies that cause harm and the promotion of changes to policy that will promote healing and justice.

Health is composed of many factors beyond health care, including access to quality housing, transportation, education, economic opportunity, social networks, healthy food and more. This updated health equity framework guides Corewell Health in Southwest Michigan to simultaneously work to promote health, address the immediate needs of community members and patients who are experiencing health problems now, prevent people who are on the cusp of a potential health crisis from developing detrimental outcomes in the future and prevent future health problems for those who may consider themselves in good health right now.

Transformation model



Significant health needs addressed

PHN 1: Mental health

About the significant need

Mental health was the most significant need identified by the 2025-2027 CHNA. However, mental wellness and illness are rarely isolated concerns; they are deeply interconnected with other critical health and socioeconomic challenges. Economic hardship, lack of access to essential resources and chronic stressors can initiate and/or compound mental health struggles, making these issues especially prevalent and difficult to address. For communities, addressing mental health is essential to achieving broader social and health equity.

Goal

Improve mental health in the Corewell Health in Southwest Michigan service area.

Addressing the need

Strategy 1.1: Improve mental health care by providing affordable and accessible mental health services.

Programs that address the need for affordable and accessible mental health services include: Counseling services (both onsite and virtual).

Target populations

Populations experiencing disproportionate mental health burdens.

Partners

Southwestern Medical Clinic Counseling Services.

Objective 1.1a

Provide mental health counseling services at the Corewell Health Center for Wellness to increase access to mental health services.

Anticipated impact

Providing mental health counseling in a community that had previously been without mental health services will contribute to increased mental health literacy and skills to support mental wellness in the target population.

Strategy 1.2: Support mental wellness by educating and empowering community members to create support systems for youth.

Programs that are addressing mental wellness support systems for youth include: Berrien Whole Child County Collaborative, Youth Mental Health First Aid and the Community Resiliency Model program.

Target populations

School age youth who may be experiencing mental health issues and the caregivers, community members and educators who support them.

Partners

Berrien RESA (Regional Education Service Agencies) and local school systems, community participants and those who are in public-facing professions.

Objective 1.2a

Provide training to increase resiliency and to recognize the signs and symptoms of mental health distress in youth, in order to increase caregivers' ability to connect youth with help.

Anticipated impact

Providing these trainings to adult community members will result in increased awareness of local mental health resources, increased mental health literacy and skills to create a supportive environment for youth.

Objective 1.2b

Provide a trusting, collective and creative space in which key stakeholders come together to learn, collaborate, advocate and take action to change systems that impact the mental wellness and resiliency of young people, families and school staff.

Anticipated impact

Aligning professional development among key stakeholders, investing in school leadership, building capacity of school staff, opening communication pathways between schools and health care professionals and engaging and centering student and staff voices to guide action, will result in an increased ability to self-regulate, increased mental health literacy and an increased awareness and connection to resources that support mental wellness.

Strategy 1.3: Foster a community where mental health is openly acknowledged and addressed without judgment.

Programs that are addressing mental health stigma include: Adult and Youth Mental Health First Aid, the Community Resiliency Model program and the Berrien Whole Child County Collaborative.

Target populations

Organizations in the community desiring to expand their knowledge regarding identification of mental health needs, building resiliency and reducing stigma around mental health.

Partners

Berrien RESA (Regional Education Service Agencies) and the corresponding school systems.

Objective 1.3a

Provide a trusting, collective and creative space in which key stakeholders come together to learn, collaborate, advocate and take action to change systems that impact the mental wellness and resiliency of young people, families and school staff.

Anticipated impact

Aligning professional development among key stakeholders, investing in school leadership, building capacity of school staff, opening communication pathways between schools and health care professionals and engaging and centering student and staff voices to guide action, will result in an increased ability to self-regulate, increased mental health literacy and an increased awareness and connection to resources that support mental wellness.

Objective 1.3b

Provide training that addresses common myths and misconceptions about mental health, promotes empathy and encourages open conversations about mental health to reduce stigma.

Anticipated impact

Providing these trainings will result in an increase in mental health literacy, leading to improved understanding of the drivers of mental health.

PHN 2: Health care access

About the significant need

Access to health care is a pressing issue across Southwest Michigan, where transportation barriers, high costs and limited provider availability restrict timely and essential care. Additional access concerns include restricted clinic hours, minimal Medicare and Medicaid acceptance and scarce local services all of which often force residents to travel or pay high out-of-pocket costs to access services.

Goal

Ensure accessible and quality health care in the Corewell Health in Southwest Michigan service area.

Addressing the need

Strategy 2.1: Establish new options for community members to increase access to essential health care services.

Programs addressing the proximity of health care facilities include: the addition of primary care services at Corewell Health Center for Wellness in Benton Harbor, partnering with other health care providers to bring health care to rural, underserved communities, implementing new care delivery models that reduce the need to travel outside our market for some specific types of care.

Target populations

Residents who may experience barriers to obtaining health care due to lack of reliable transportation and their location relative to health care facilities.

Partners

Corewell Health physicians, Corewell Health Community Connect Practices, InterCare Community Health Network, Cass Family Clinic Network.

Objective 2.1a

Provide primary care at the Corewell Health Center for Wellness in Benton Harbor.

Anticipated impact

Community members who do not have a primary care provider or are not currently engaged with their primary care provider would establish a medical home. The social care, health education and other ancillary services of the Corewell Health Center for Wellness will be integrated with the primary care services in a mechanism that is seamless to the patient and will improve control rates for common chronic diseases and improve health outcomes.

Objective 2.1b

Bring health care services to select rural communities that have limited access to these services through a mobile unit in partnership with a federally qualified health center.

Anticipated impact

The access to licensed medical providers will improve with transportation no longer being as large of a barrier for the selected communities.

Strategy 2.2: Prioritize empathy, seamless care and cultural awareness to establish compassionate, trauma-informed care as a community norm, ensuring high-quality health services.

Programs that are addressing the need for quality, compassionate care include: childbirth classes, lactation clinic, Maternal and Infant Health Program, INSPIRE, HOPE, Connect, apartment home visits with community health workers and the addition of primary care services at the Corewell Health Center for Wellness in Benton Harbor and the Substance Use Treatment and Education Center, or, SUTEC.

Target populations

Expectant mothers, new parents, patients with chronic health conditions such as hypertension, those living in underserved or low-income areas and all other patients desiring quality and compassionate health care.

Partners

Corewell Health physicians

Objective 2.2a

Ensure access to childbirth and lactation education in community-based locations from a diverse set of certified and licensed professionals (i.e. registered nurses, certified lactation consultants and doulas).

Anticipated impact

Increased engagement of pregnant people and their families in these education opportunities by making them more accessible and addressing a broader variety of contexts. Participants receiving these services will have the opportunity to seek referral to additional services, particularly social care or health care services, to meet unmet needs.

Objective 2.2b

Educational opportunities for providing trauma-informed care as well as technical assistance on how to apply skills learned in educational sessions will continue to be made available to health care providers and team members.

Anticipated impact

Providers will be better equipped to understand factors that contribute to ongoing health risk behaviors or increase risk for future health problems so they can be proactively addressed with patients. Patients will also have improved experiences when receiving care.

Objective 2.2c

Services will be enhanced, expanded, or launched in new locations and more accessible enrollment processes will be adopted to better address their maternal and infant health needs and hypertension.

Anticipated impact

Pregnant patients will have earlier and more consistent access to prenatal care while also improving their ability to advocate for themselves as a leader in their own care.

PHN 3: Economic and employment conditions

About the significant need

Economic security and employment play a crucial role in low-income communities. When individuals and families face inadequate wages, rising living costs and limited job opportunities, these stressors contribute to housing insecurity, limited access to nutritious food and challenges in affording health care as reported by residents in interviews, focus groups and surveys. Economic conditions have been shown to significantly impact both mental and physical health, with chronic financial strain linked to stress-related illnesses like heart disease and diabetes as well as mental health conditions such as major depressive disorder.

Goal

Support economic stability of community members in the Corewell Health in Southwest Michigan service area.

Addressing the need

Strategy 3.1: Offer programs which provide job skills training and by connecting individuals with resources to improve employability to increase access to opportunities for fairly compensated employment.

Programs addressing increased employment opportunities include: The GROWTH internship, Pipeline Programs and Social Navigation with community health workers.

Target populations

School age community members aged 16-19 in underserved areas of the county, adults who are seeking additional training for job skills, adults seeking resources to become more employable and Corewell Health team members seeking their first or a more advance licensure.

Partners

Michigan Works, Kinexus, Boys and Girls Club, Corewell Health clinical and non-clinical departments and medical practices, targeted schools including those in Niles and Benton Harbor.

Objective 3.1a

Provide health care career exploration and exposure opportunities, mentorship from health care professionals and professionals within community organizations and tailored professional development and skill building targeted at local youth.

Anticipated impact

Providing these opportunities will result in increased workforce readiness and increased connections between institutions and communities.

Objective 3.1b

Connect community members with resources and services which can help to reduce barriers to employability such as expungement, legal assistance, skill development programs and other community programs.

Anticipated impact

Connecting community members with these resources will result in increased workforce readiness.

Objective 3.1c

Implement and expand professional pipeline programs including those that help with attainment of licensure for the following types of roles: nursing, respiratory therapy, surgical technician, sleep lab technician and medical assistant.

Anticipated impact

A highly skilled and increasingly diverse workforce will be available to fill needed health care roles within our community. Individuals working at Corewell Health or other employers will have an opportunity to move to a career track that provides additional opportunity for learning and salary growth.

Strategy 3.2: Enhance financial stability of community members in Corewell Health in Southwest Michigan through reducing the economic burden of basic costs of living in order to improve the financial stability of community members in the Corewell Health in Southwest Michigan service area.

Programs addressing financial stability through reducing the economic burden of basic costs of living include: ValleyHUB food distribution, social navigation with community health workers, car seat installations and diaper distribution.

Target populations

Low-income community members.

Partners

ValleyHUB through Kalamazoo Valley Connection, Community Action of Allegan County (CAAC), of Allegan, MI, United Through Motherhood (UTM), of Benton Harbor, MI, Michigan Office of Highway Safety Planning.

Objective 3.2a

Connect community members with partner organizations that offer resources and services like food, utility and rent/mortgage assistance to alleviate the financial burden of living expenses.

Anticipated impact

Connecting community members with partner organizations which increases access to material goods and necessities that will enhance their standard of living.

Objective 3.2b

Provide community members with resources and services such as free diapers, car seats and food assistance to alleviate the financial burden of living expenses.

Anticipated impact

Providing community members with these resources and services which increase access to material goods and necessities will enhance their standard of living.

PHN 4: Social cohesion

About the significant need

Social cohesion can be defined as the strength of the bonds that hold members of a community together. People in socially cohesive communities have strong interpersonal relationships. They adhere to a shared system of values, beliefs and norms. Social connections and caring behaviors are associated with lower stress and reduced release of stress hormones, which are causally linked to a reduced risk of cardiovascular, gastrointestinal, endocrine and immune system problems. Other indicators of social cohesion, such as trust, are associated with reduced mortality.

Goal

Promote the creation of strong social connections between individuals, communities and institutions.

Addressing the need

Strategy 4.1: Create and maintain community spaces and opportunities that encourage intergenerational interactions, resource and information sharing and mutual support to foster strong social networks and reduce isolation.

Programs addressing the need to foster stronger social connections in our area include: Triple P, Building Bridges: Community Speakers, Sprouts, Breaking Bread, Mom Support Group, 84s, Community Leadership Academy, Achieving Birth Equity Through System Transformation (ABEST), Berrien Whole Child County Collaborative and Common Agency.

Target populations

Parents, school age children, current and future community leaders, breastfeeding parents and those who support them and other community residents with the desire for connection in their neighborhoods and communities.

Partners

Organizations involved in Achieving Birth Equity Through System Transformation (ABEST) group, Berrien RESA (Regional Education Service Agencies) and the local school systems and Be Healthy Berrien.

Objective 4.1a

Implement programing which provides community members with the opportunity to connect with others for specific purposes such as cooking classes, exercise clubs and support groups.

Anticipated impact

Implementing programing which provides individuals an opportunity to gather for a purpose will result in an increase in strong relationships, a sense of belonging and increased cultural connectedness.

Objective 4.1b

Provide opportunities for community members to meet and work collaboratively to address community needs and build community.

Anticipated impact

Implementing programing to support community members in working collaboratively will contribute to an increase in strong relationships, a sense of belonging and an increase in cultural connectedness.

Objective 4.1c

Provide a trusting, collective and creative space in which key stakeholders come together to learn, collaborate, advocate and take action to change systems that create a comprehensive approach that enhances academic achievement and fosters a sense of belonging and active participation among all stakeholders.

Anticipated impact

Aligning professional development, investing in school leadership, building staff capacity, enhancing communication between schools and health care professionals, and centering student and staff voices to guide action, will result in an increase in sense of belonging, and strengthen relationships between and among students, school staff, community members and families, and community organizations.

Strategy 4.2: Support efforts which ensure engaged leadership and strengthen community involvement in civic life.

Programs which are addressing efforts to ensure engaged leadership and community involvement include: Community Leadership Academy, Achieving Birth Equity Through System Transformation (ABEST), Berrien Whole Child County Collaborative.

Target populations

Current and future community leaders, both formal and informal.

Partners

Internal and external organizations involved in Achieving Birth Equity Through System Transformation (ABEST) group, Berrien RESA (Regional Education Service Agencies) and the corresponding school systems, Be Healthy Berrien.

Objective 4.2a

Provide a trusting, collective and creative space in which key stakeholders come together to learn, collaborate, advocate and take action to change systems that create a comprehensive approach that enhances academic achievement and fosters a sense of belonging and active participation among all stakeholders.

Anticipated impact

Aligning professional development, investing in school leadership, building staff capacity, enhancing communication between schools and health care professionals, and centering student and staff voices to guide action, will result in an increase in sense of belonging, and strengthen relationships between and among students, school staff, community members and families, and community organizations.

Objective 4.2b

Implement a leadership program which will provide opportunities for current and future leaders to form connections which can support long-term efforts to improve community needs.

Anticipated impact

Implementing this leadership program, we will see an increase in strong relationships and a sense of belonging which will contribute to increased civic engagement.

Strategy 4.3: Increase intentional communication through new and existing networks to promote awareness of services and community activities that contribute to social cohesion.

Programs addressing efforts to increase awareness of services and activities include: Achieving Birth Equity Through System Transformation (ABEST) group, Common Agency and residential visits with community health workers and nurses.

Target populations
Under resourced community members.

Partners
Internal and external organizations involved in Achieving Birth Equity Through System Transformation (ABEST) group.

Background
Programs addressing efforts to increase awareness of services and activities include: Achieving Birth Equity Through System Transformation (ABEST) group, Common Agency and the Center Comes to You.

Objective 4.3a
Leverage the relationships that community health workers build within communities to distribute information about activities, including those designed to create opportunities for engagement and foster social cohesion among community members.

Anticipated impact
Leveraging the connection between community health workers and community members to share information on social cohesion forming activities will result in increased attendance from members of under resourced communities, contributing to an increased sense of belonging among participants.

Objective 4.3b
Utilize the ABEST network to distribute informational materials, promote events and leverage the local knowledge and connections of taskforce members to ensure families are informed about and connected to vital services, while also hosting and partnering on events that raise awareness and provide direct support to the community.

Anticipated impact
Leveraging the ABEST network to create opportunities for parents to connect with others experiencing similar life changes will result in an increased sense of belonging amongst parents.

Objective 4.3c
Deploy a platform which will enable community members to share and discover community events, cultural events and other opportunities to engage.

Anticipated impact
Deploying this platform will result in an increase in a sense of belonging, increased cultural connectedness and strengthen relationships between community members.

PHN 5: Nutrition environment

About the significant need

Research has long established that diets rich in fruits, vegetables, whole grains and lean protein, with moderate amounts of dairy, are associated with lower rates of obesity, diabetes, heart disease and certain types of cancer. However, fruit and vegetable consumption remains low in Michigan and Berrien County. There are many programs aimed at changing health behaviors through education. However, it is also important to ensure that food is available and accessible for long-term behavioral shifts. This requires addressing the barriers present in the food and nutrition environment. Other barriers include policy, environmental and lifestyle variables. To influence eating patterns, a full understanding of contextual information and environmental barriers and supports is required.

Goal

Enhance access to nutritious and healthy foods in the Corewell Health in Southwest Michigan service area.

Addressing the need

Strategy 5.1: Support efforts to increase the availability of healthy food retail options by fostering consistent business to maintain these outlets.

A program that is addressing the availability of healthy food retail options is Prescription for Health.

Target populations

Community members living in areas that have burdened availability to healthy foods, particularly fresh fruits and vegetables.

Partners

Benton Harbor Farmers Market through the Berrien County Health Department.

Objective 5.1a

Provide funds to low-income participants in the Prescription for Health program to spend on fruits and vegetables at the farmers market, boosting weekly traffic and supporting its sustainability.

Anticipated impact

Supporting the sustainability of the farmer's market will result in ensuring that a seasonal point of access to nutritious foods is available in the future.

Strategy 5.2: Support efforts to make nutritious, whole-food items affordable by providing financial or material aid in the form of nutritious food for low-income families.

Programs that address the financial barriers to healthy food include: Prescribe Life, Rx for Health and the ValleyHUB food distribution program.

Target populations

Community members with financial barriers to obtaining healthy foods.

Partners

Benton Harbor Farmers Market through the Berrien County Health Department, Prescribe Life at Corewell Health in Southeast Michigan and ValleyHUB through Kalamazoo Valley Connection.

Objective 5.2a

Provide financial support for low-income families to purchase healthy foods of their choosing at the Benton Harbor Farmers Market and Meijer.

Anticipated impact

Providing funds to spend on healthy foods will positively impact the accessibility of healthy foods.

Objective 5.2b

Provide locally sourced and processed foods including whole and frozen fruits and vegetables, meat, beans and other nutritious foods for low-income individuals, and also increases business for local farmers and food producers.

Anticipated impact

Providing healthy foods will positively impact the accessibility of healthy foods.

Strategy 5.3: Reduce barriers to healthy eating by increasing knowledge and skills related to procuring and preparing nutritious meals.

Programs that are addressing these barriers include: Sprouts, Centered and Prescribe Life.

Target populations

Community members who desire more education about preparing healthy foods, including those with specific chronic conditions such as diabetes and hypertension.

Objective 5.3a

Provide education to enhance skills needed for preparing healthy meals, including cooking, meal planning and shopping on a budget.

Anticipated impact

Providing this education will increase participants self-efficacy and capacity to prepare healthy food.

Objective 5.3b

Provide education to enhance nutrition knowledge, including food label reading, portion size awareness, principles of food safety, managing dietary restrictions and understanding emotional eating.

Anticipated impact

Providing nutrition education will boost participants' self-efficacy and capacity to make healthy food choices.

Appendix: Program list with descriptions

Glossary

84's: A Benton Harbor, MI based women's running and walking club giving participants the opportunity to support mental health, social cohesion and amplify safety in the built community.

ABEST: The Achieving Birth Equity Through System Transformation (ABEST) Taskforce is a multifaceted coalition dedicated to addressing the root causes of disparities in infant and maternal mortality.

Adult Mental Health First Aid: A program which teaches adults how to identify, understand and respond to signs of mental illness and substance use disorders in others. This six and a half hour training provides adults with the skills they need to reach out and provide initial support to others who may be developing a mental health or substance use problem and help them connect to appropriate care.

Behavioral Health Unit Renovation: The inpatient behavioral health unit at the Corewell Health Lakeland Hospitals - St. Joseph Hospital will be renovated to allow for more updated care delivery models reflecting advances in the science of behavioral health.

Berrien Whole Child County Collaborative Model: Using the Whole School, Whole Community, Whole Child (WSCC) Model, this program uses a framework for addressing health in schools that supports collaboration between education leaders and health sectors to improve each child's cognitive, physical, social and emotional development. The WSCC Model is student-centered and emphasizes the role of the community in supporting the school, the connections between health and academic achievement and the importance of evidence-based school policies and practices.

Brave Talks (BT): An informal, facilitated gathering of a small group of community members, where conversations about the impact of structural racism on communities of color take place. It is an opportunity to share thoughts and impressions, bravely ask questions, be exposed to new ideas, unlearn and learn from other participants.

Breaking Bread: This program aims to develop community relationships through the preparing of a meal as a group while participating in meaningful cultural practices and cultivating mutually beneficial relationships among community members.

Building Bridges: Community Speakers. This program brings in a variety of subject matter experts to speak on relevant health needs topics. These events are open to the public and take place at the Corewell Health Center for Wellness and also in the community.

Car Seat Installation: A program that allows parents and caregivers in need to obtain a size and age-appropriate car seat(s) for their child and have it installed by a certified Child Passenger Safety Technician at no cost.

Centered: Nutrition and hands-on cooking classes geared toward those with chronic illness, particularly diabetes and hypertension led by a professional chef and registered dietitian.

Childbirth and Lactation Education: A targeted intervention program in the form of childbirth education classes specifically designed for our most vulnerable populations. These classes will cover critical topics such as breastfeeding, safe sleep practices, car seat safety and pre- and postnatal care, including postpartum support

Common Agency: Utilizing a hybrid online and in-person platform, this program is facilitated by community ambassadors who will facilitate discussion to foster initial connections. In-person activities are organized and promoted to strengthen community bonds and opportunities for developing leadership skills are offered.

Community Leadership Academy (CLA): A project-based curriculum which will teach participants fundamental knowledge and skills required to address community health concerns in collaboration with neighbors, and governmental and non-governmental institutions.

Community Resiliency Model (CRM)®: A skills-based program designed to teach techniques to re-set the natural balance of the nervous system. The goal of this model is to help create "trauma-informed" and "resiliency-focused" communities that share a common understanding of the impact of trauma and chronic stress on the nervous system and how resiliency can be restored or increased.

Connect: This initiative is designed to alleviate the burden of hypertension by addressing both the physical health of patients and their social needs to reduce disparities in outcomes. Connect is a Community Health Worker-driven program which brings social support, disease education and blood pressure monitoring to patients in community settings. Leveraging a digital health platform, community health workers can screen, manage and connect patients to the resources they need.

Counseling Services: Therapy services provided by a licensed social worker in collaboration with Southwestern Medical Clinic.

Diaper Distribution: Program which allows parents and caregivers in need to obtain diapers and wipes for their children at no cost. This program is offered two days per week through the Corewell Health Center for Wellness.

Discharge Medication Program: This program enables patients at the Corewell Health Lakeland Hospitals - St. Joseph Hospital to have prescriptions needed upon discharge filled by the in-house retail pharmacy prior to leaving the hospital. This enables patients to have their needed medications in hand when they arrive in their home, ensuring they can start taking needed medications right away regardless of their ability to access a pharmacy in their community.

Home Blood Pressure Monitoring Program: The aim of this program is to increase awareness and control of hypertension. Patients enrolled in the program will have access to a Bluetooth enabled blood pressure monitoring system, regular consultation with a cardiologist and assistance with eliminating barriers to accessing diagnostic testing.

Hypertension Monitoring Programs (INSPIRE and HOPE): Hypertension Monitoring Programs (INSPIRE AND HOPE) at the Corewell Health Center for Wellness seek to enhance health care access and boost hypertension management by enrolling eligible patients in the home blood pressure monitoring program.

Lactation Clinic: In-person on-site lactation support for breastfeeding mothers and their support person / people provided by a Certified Lactation Counselor at no cost to the client.

Level Two Nursery: A level two nursery allows for high quality health care for babies born as early as 32 weeks gestation.

MIHP: The Maternal Infant Health Program is an evidence-based program committed to providing no-cost individualized education and resources for supporting a healthy pregnancy and a healthy baby.

Mental Health Support into Primary Care: Behavioral health specialists are integrated into numerous primary care practices to ensure seamless referrals and more efficient delivery of care for patients needing this type of integrated support.

Mobile Rural Health: This initiative will deploy a mobile health unit to select rural communities in a partnership between Corewell Health in Southwest Michigan and Cass Family Clinic Network. The mobile unit will bring health care services to people who live far from care and/or have transportation barriers preventing access.

Mom Support Group: A program for mothers and caregivers committed to providing education, support and empowerment through a variety of resources, including educational materials, emotional support networks and practical tools for everyday challenges.

New Patient Lead Time Quality Improvement Initiative: A multipronged approach is being taken to reduce the amount of time new patients sometimes must wait between the time they make their first appointment and when they are seen by a primary care provider. These efforts include a streamlined process for new patients to make appointments establishing care with a new primary care provider, adjusting practice schedules and adding more primary care providers.

Obstetrical Care Model: This is a care model for labor and delivery that ensures a provider is always on-site at the hospital.

Obstetrical Emergency Department: An obstetrical emergency department ensures rapid access to OBGYN providers for pregnant people in need of emergent care. Emergency departments are typically less able to fully meet these needs as rapidly as other medical emergencies.

Pipeline Programs: This group of programs enables individuals to receive additional education or training to get themselves on a health care career path that create more opportunity for growth and increased earnings. These programs also cultivate a workforce prepared to meet the hiring needs of local health care organizations.

Prescribe Life: This program supports low-income individuals to increase consumption of healthy foods through education and funds to spend on fruits and vegetables at a local grocery store.

Prescription for Health (PFH): A program that helps connect food insecure patients with the means to acquire fresh fruits and vegetables from the local farmers' market. Each participant receives up to $100 in PFH benefits over the course of the Benton Harbor Farmers Market summer season. Additionally, participants receive health and nutrition counseling and education, blood pressure and weight monitoring and assistance with connecting to community resources. Education shared at the farmers market is available to all patrons.

Primary Care at the Corewell Health Center for Wellness: Family medicine services will be available at the center in Benton Harbor to create a new access point in that part of the health system's service area. These primary care health services will be tightly knitted to the community health worker, health education and social care programs at the center in a model of care that is responsive to the needs of patients holistically.

Social Navigation: Corewell Health Center for Wellness team members providing no-cost social navigation services to community members. Theis can include assistance with housing, utilities, employment / income needs, food insecurity and more. The range of services provided with the social navigation program has increased, including providing needed care and safety items to families with babies and young children, such as diapers, properly installed car seats and portable cribs.

Sprouts: A culinary program designed for school age children to help them learn practical hands-on cooking skills and nutrition education.

Substance Use Treatment and Education Center (SUTEC): This Center provides a suite of services for those with substance use disorder including medication assisted treatment, education, social support and navigation and access to mental health services.

The Center Comes to You: A program through which essential health education is brought directly to apartment complexes in under-resourced neighborhoods. Residents are taught about hypertension and cardiovascular health and are introduced to the center's various programs and services. Blood pressure checks are conducted and the dangers of hypertension are discussed by nurses. After the screenings, blood pressure readings are provided to residents by community health workers and recommendations to visit a doctor are given if any abnormalities are detected.

Triple P: Evidence-based parenting programs backed up by more than 35 years of ongoing research. Triple P gives parents simple and practical strategies to help them build strong, healthy relationships, confidently manage their children's behavior and prevent problems developing. Triple P is used in more than 30 countries and has been shown to work across cultures, socio-economic groups and in many kinds of family structures.

ValleyHUB: Food distribution program through Kalamazoo Valley Connection which provides fresh, locally sourced, healthy foods to residents who may have food insecurity and qualify for Medicaid.

Youth Mental Health First Aid (YMHFA): A program which teaches adults how to identify, understand and respond to signs of mental illness and substance use disorders in youth. This six and a half hour training gives adults who work with youth the skills they need to reach out and provide initial support to children and adolescents who may be developing a mental health or substance use problem and help them connect to appropriate care.