

Corewell Health Ludington Hospital



Community Health Needs
Assessment

2026-2028 Implementation Strategy

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Executive summary

In November 2025, Corewell Health Ludington Hospital adopted the Community Health Needs Assessment that identified the top community health needs in Mason and Oceana counties. The present report provides details on strategies Corewell Health Ludington Hospital will employ to address these community health needs between Jan. 1, 2026 and Dec. 31, 2028. The significant health needs identified in the most recent 2024-2026 MiThrive Community Health Needs Assessment included health care access, mental health, and obesity. Through stakeholder input, it was decided to address health care access and mental health in the present implementation strategy. The process of identifying or developing strategies to address these needs was a collaborative effort between Corewell Health Ludington Hospital leaders, community subject matter experts, and Corewell Health Ludington Hospital Community Advisory Board.

Corewell Health Ludington Hospital will dedicate significant resources toward improving the health of our community with a focus on health care access and mental health. By committing to the included strategies, strengthening community collaborations, and focusing on measurable outcomes, we plan to show improvement in these areas by the end of 2028.



Introduction

Mission

Corewell Health's mission is to improve health, instill humanity and inspire hope. People are at the heart of everything we do, and the inspiration for our legacy of outstanding outcomes, innovation, strong community partnerships, philanthropy and transparency. Through experience and collaboration, we are reimagining a better, more equitable model of health and wellness.

Description of hospital

Corewell Health is a not-for-profit health system that provides health care and coverage with an exceptional team of 65,000+ dedicated people — including more than 12,000 physicians and advanced practice providers and more than 15,500 nurses providing care and services in 21 hospitals, 300+ outpatient locations and several post-acute facilities — and Priority Health, a provider-sponsored health plan serving more than 1.3 million members. Through experience and collaboration, we are reimagining a better, more equitable model of health and wellness. For more information, visit corewellhealth.org.

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 Ludington Hospital produced a 2024-2026 Community Health Needs Assessment and this document, the 2026-2028 Implementation Strategy.

About this plan

Selection of significant needs

The MiThrive Community Health Needs assessment identified the following health needs:

- Broadband
- Education
- Economic security
- Environment/infrastructure
- Health care access
- Housing
- Mental health
- Obesity
- Safety and wellbeing

These nine health needs were further prioritized during a prioritization event where three significant health needs were identified to be addressed by MiThrive and community partners. They are:

- Health care access
- Mental health
- Obesity

The list of nine health needs was reported to the Corewell Health Ludington Hospital Implementation Strategy Workgroup in March 2025. In workgroup meetings, members discussed the data from the MiThrive Community Health Needs Assessment and deliberated on which significant needs would be appropriate for Corewell Health Ludington Hospital to address. The workgroup made the recommendation for the hospital to focus on two health needs to create intentional tactics and objectives that create long-lasting change

Needs addressed in the implementation strategy

The significant health needs addressed in this document include:

- Health care access
- Mental health

By choosing two significant health needs to address, resources will be focused on taking a comprehensive approach to addressing the needs: utilizing the data from the needs assessment to determine which populations have been experiencing disparate health outcomes, and what Corewell Health can do from a programming perspective to tailor existing interventions or build new interventions.

Needs not addressed in the implementation strategy

The seven health needs not addressed include:

- Broadband
- Education
- Economic security
- Environment/infrastructure
- Housing
- Obesity
- Safety and wellbeing

Compared to health care access and mental health, these seven health needs were not ranked as high in terms of six prioritization criteria: (1) severity, (2) magnitude, (3) impact, (4) sustainability, (5) achievability, and (6) health equity. Though not selected as a priority area, some of the non-prioritized needs will be indirectly addressed through enhancing health care access and mental health and by partnering with lead organizations outside of this implementation strategy who are addressing these areas.

Process for developing the implementation strategy

An Implementation Strategy Workgroup was established for Corewell Health Ludington Hospital. This workgroup was made up of community board members, hospital leadership, and representatives of community partner organizations. In March 2025, the workgroup met to identify which of the nine significant health needs identified in the assessment would be addressed by the hospital. To achieve this, a voting matrix that plotted criteria such as feasibility, impact, and community benefit considerations was utilized. The Corewell Health Ludington Hospital's Implementation Strategy Workgroup discussed each of the areas and recommended health care access and mental health as the significant health needs to be addressed in the 2026-2028 Implementation Strategy. The Corewell Health Ludington Hospital's Implementation Strategy Workgroup focused on the selection of strategies and report development from March 2025 to Oct. 2025. Throughout this process there was robust dialogue around current strategies for the county, gaps in service, and potential collaborations between agencies and the hospitals.

Health transformation framework

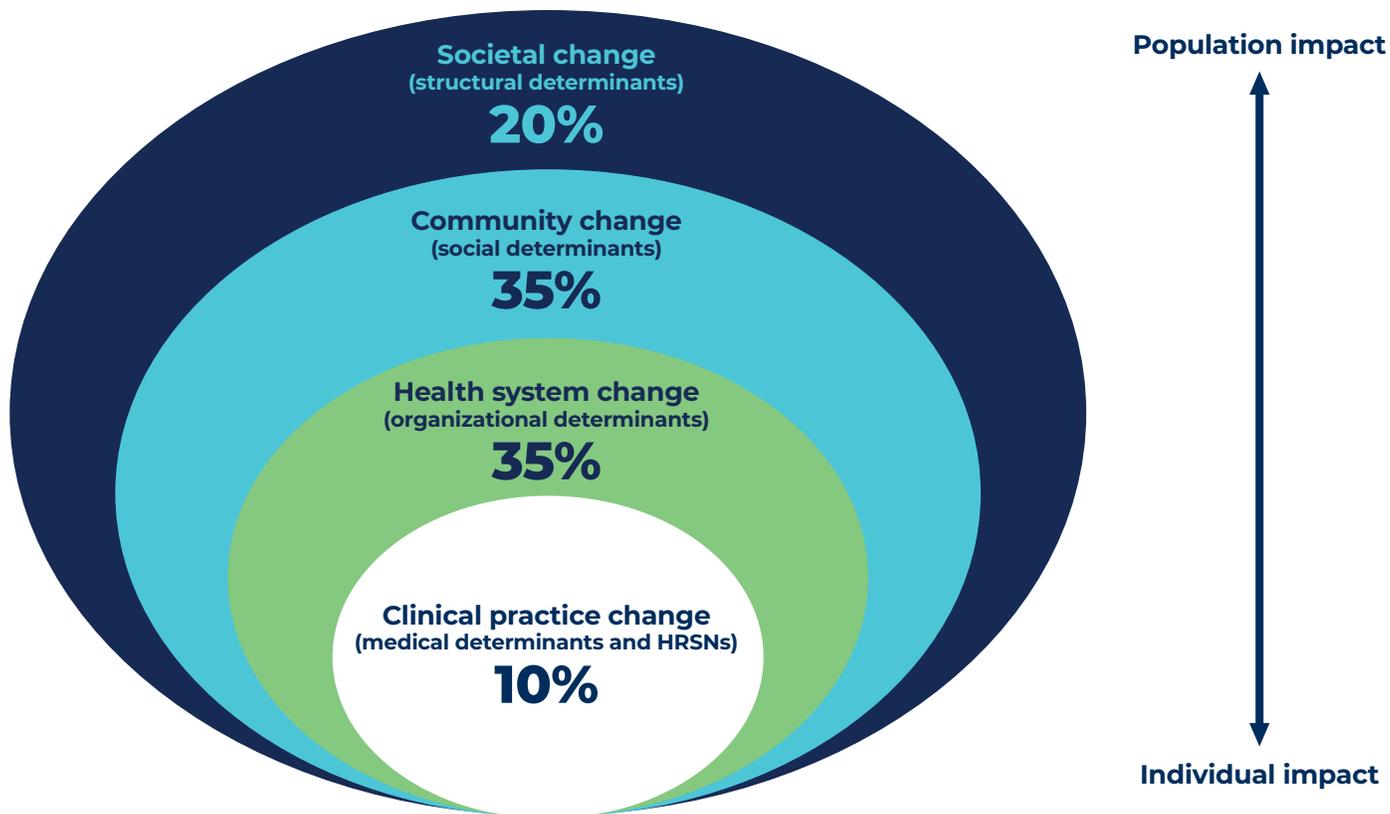
Corewell Health, in collaboration with HealthBegins, developed a strategic framework to guide its population health work. Health care systems have traditionally focused on meeting the medical and health care needs of individual patients. A deepened understanding of the significance of community and societal factors on health has strengthened our focus to prevent poor health outcomes and ensure everyone has a fair and full opportunity to be as healthy as possible.

Clinical practice change (medical determinants and health-related social needs): This level describes efforts to meet the immediate medical and social needs of individual people such as addressing unstable housing situations, household food insecurity, access to health care, medication management and job opportunities. This level of work provides immediate relief to those in urgent need and utilizes existing resources in the community.

Health system change (organizational determinants): This level describes work to improve the conditions of places where people are born, grow, live, work and age through hospital policies, practices and initiatives. For example, when it comes to housing, community-level work involves working with local housing stakeholders to ensure adequate quality housing exists in the community and is accessible to those who need it. A hospital breastfeeding policy that supports skin-to-skin contact and offers lactation consulting services is another example of a hospital-led intervention.

Community change (social determinants): This level describes the reformation of institutional policies and practices to ensure that community conditions meet the social needs of residents. Work at this level creates long-lasting improvements to systems that impact community conditions and social determinants. One example of an initiative that falls into this category would be family and community support programs that engage families and communities in supporting pregnant women and new mothers, with interventions such as peer support groups for breastfeeding or community baby showers to provide essential items or information to expectant mothers.

Societal change (structural determinants): This level describes interventions that impact processes and policies, such as state or federal social and economic guidelines. An example of this work could include policies that provide subsidies for childcare to low-income families, ensuring that children have access to safe and stimulating environments while their parents work or pursue education.



To save lives and improve population health, we must work to simultaneously address concerns at the individual level by addressing social needs, the community level by addressing social determinants, and society level by addressing structural determinants of health. Each project described in this Implementation Strategy impacts one or more components of this framework.

Significant health needs addressed

Health care access

About the significant need

Access to care is more than just the availability of medical services. A constellation of factors determines whether residents in Mason and Oceana counties can get appropriate care when they need it. These factors include affordability of co-payments and deductibles, provider office hours, transportation and health literacy, to name a few. The consequence of these barriers is delaying, rationing and choosing other essential needs (i.e., housing, utilities, and food) over their health care needs.

Barriers to health care access can create significant disparities in health outcomes. Individuals facing financial hardships, living in rural areas or struggling with complex health care systems often experience gaps in care, leading to worsened health conditions and increased medical costs over time. In the state of Michigan, there are approximately 78 primary care providers per 100,000 residents (County Health Rankings, 2021), which is a higher or equal rate that is seen in Mason County (78 primary care providers per 100,000 residents), and Oceana County (49 primary care providers per 100,000 residents). This makes it harder for residents to seek care for acute or chronic diseases. The long-term consequences of a lack of access to care include complex medical conditions, comorbidities, premature disability, or poor quality of life. Of the respondents to the community survey, 34.9% of respondents identified difficulty getting an appointment due to the lack of time slots at their provider as one of their top issues with access; 39.2% of respondents cited the high cost of care (including out-of-pocket expenses).

Additionally, factors within the health care system contribute to the lack of health care access. Factors such as provider shortages, proximity and access to health care facilities, health care costs, fragmentation within the health care system, and navigating the complexities of the health insurance and health care system all contribute to barriers to care. The COVID-19 pandemic exacerbated technological barriers to health care. People without technological means (either because of lack of high-speed internet access or equipment) or knowledge and skills to utilize their technological resources found themselves excluded from virtual health care opportunities. When people can access preventive care, manage chronic illnesses, and receive necessary treatments without financial or logistical obstacles, they are more likely to experience better health outcomes, improved well-being, and a higher quality of life.

Goal

Work collaboratively to expand access to care in rural communities, fostering healthier lives and building stronger, more resilient communities through equitable and sustainable health care solutions.

Addressing the need

Strategy No. 1: Explore establishing a rural mobile health care unit.

Background

For Mason and Oceana County residents, the rural nature of the area and limited number of primary care providers makes accessing health care challenging. Mobile health units, vehicles such as buses or vans equipped with medical personnel offering a variety of services, are one way to meet community members where they are and remove barriers to care. Through the exploration and implementation of a rural mobile health unit, Corewell Health can provide trusted medical care and improve health outcomes for community members that are experiencing barriers to accessing health care.

Main objective

Tactics will explore establishing a rural mobile health care unit to reach patients and families in Mason and Oceana counties.

Anticipated impact

The anticipated impact of this strategy is to better reach patients who may be disengaged and not seeking regular, routine care. By reaching patients where they are located throughout Mason and Oceana County, we can break down the transportation barrier and offer trusted medical care close to home.

Strategy No. 2: Embed community health worker into Corewell Health Ludington Hospital Emergency Department.

Background

Some patients rely on emergency departments as their primary health care source, often because of complex social determinants. Community health workers are frontline public health workers and trusted community resources that address social determinants of health, such as food insecurity, transportation barriers, household utility barriers and health access barriers. The placement of a community health worker in the emergency department is an optimal location to support patients with complex needs. By connecting patients to community resources, community health workers can help reduce avoidable emergency department utilization and improve patient health outcomes.

Main objective

Tactics will establish an emergency department community health worker program that will include patient screening, referral to community resources and follow-up after discharge to help with care coordination.

Anticipated impact

The anticipated impact of this objective is to address identified needs such as preventable emergency department use, access to care and social determinants of health needs.

Strategy No. 3: Add one Advance Care Planning Facilitator at Ludington Hospital.

Background

The advance directive is a legal document that describes specific preferences for medical treatments in case someone is unable to do so. Certified Advance Care Planning Facilitators will be available to meet with Mason and Oceana county patients and families to discuss their wishes and preferences for future health care decisions as well as assist with the completion of an advance directive. Embedding an Advance Care Planning Facilitator within Corewell Health Ludington Hospital will ensure patient end-of-life care medical decisions are honored.

Main objective

Tactics will lead to an increased number of completed advance directives by partnering with local physicians and clinics.

Anticipated impact

The anticipated impact of this strategy is to increase the number of completed advance directives for the adult population living in Mason and Oceana counties. By documenting patient wishes, advocates are better informed when making medical decisions about end-of-life care.

Strategy No. 4: Connect patients with financial counseling services.

Background

National Health Service Corps (NHSC) or Michigan State Loan Repayment Program (MSLRP) are state and federal programs that allow providers to apply for student loan forgiveness in exchange for working at a practice that is in a health physician shortage area (HPSA). Recruitment of providers to these areas can be difficult. These programs offer an incentive for providers to commit to employment for a specified period and help Corewell Health with provider recruitment and retention. The NHSC/MSLRP programs also require that the practice has a financial assistance program that complies with program requirements. It requires that the practice notifies all patients of this policy and assists any patients that would like to apply. Corewell Health must report the volume of utilization of the program yearly to show compliance with this requirement. These programs are a benefit to our patients, as they are much less restrictive than the Corewell Health system policy and allow for a greater number of patients who qualify for financial assistance.

Main objective

Tactics will increase awareness and expand access to financial counseling services within Corewell Health community programs, ambulatory sites, and hospitals.

Anticipated impact

The anticipated impact of this strategy for patients at Corewell Health offices in Oceana and Mason counties will be the ability to access medical care, which will increase as the number of approved applications for financial assistance also increases. This will lead to improved health outcomes for those who seek medical services.

Strategy No. 5: Improve strategy for addressing social drivers of health.

Background

Creating linkages within Corewell Health in West Michigan is essential for addressing barriers related to social drivers of health. By fostering these internal connections, Corewell Health can leverage its extensive network and resources to develop comprehensive strategies that address the root causes of health disparities. This collaborative approach ensures that interventions are tailored to the unique needs of the community, promoting equitable access to care and improving overall health outcomes. Strengthening these linkages is crucial for creating a more integrated and effective health care system that can respond to the diverse needs of the population. Corewell Health's commitment to addressing social drivers of health is reflected in its strategic priorities and community engagement efforts.

Main objective

Tactics will establish partnerships between Corewell Health and external partners that support addressing social drivers of health (i.e. transportation).

Anticipated impact

The anticipated impact of encouraging internal service lines to create infrastructure and linkages across the continuum of care to collect, act on and monitor health related social needs data will remove barriers to care and lead to improved health outcomes for those who seek medical services. Additionally, this work will serve to connect identified social determinant of health data with community partner resources and investments.

Strategy No. 6: Distribute community investment grants to foster collective impact within the community.

Background

No one organization or entity can solve the deep-rooted and often complex issues that produce disparate health outcomes alone. Significant health needs that emerge in the Community Health Needs Assessment, such as access to care, mental health, housing and chronic disease, are interconnected, and require a cross-sector, collective impact approach to make meaningful change. Establishing a community health investment strategy, aligned with Corewell Health's mission, vision and values, is one way to build capacity within the community to remove barriers to care and generate positive communitywide impact.

Main objective

Tactics will establish a funding process that strategically invests in local organizations aligned with Corewell Health's mission and values to better serve adults and families in Mason, Lake, and Oceana counties.

Anticipated impact

The anticipated impact of this objective will be to partner with local organizations to support capacity building, infrastructure development, training, coaching and other community power-building interventions that generate positive communitywide impact. This capacity building work has the potential to ensure that community members receive higher quality and more equitable care from Corewell Health's community partners.

Mental health

About the significant need

Mental health, as defined by the World Health Organization, is “a state of well-being in which every individual realizes their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community.” Mental illness can result in severe distress for the person, and it impairs their ability to function and participate in society. A variety of mental illnesses can occur such as mood disorders (such as depression or bipolar disorder); anxiety disorders; personality disorders; psychotic disorders (such as schizophrenia); eating disorders; trauma-related disorders (such as post-traumatic stress disorder); and substance use disorders. Mental disorders can occur individually, or a person have several mental disorders at the same time.

Mental illness often occurs without the person showing any physical symptoms, which causes communities to perceive mental illness as a personal moral failing and not an illness needing treatment. As the data shows, mental health conditions such as depression are being diagnosed more often within the region. CDC PLACES data from 2022 shows that 23.6% of adults in Mason County and 24.4% of adults in Oceana County were currently or had previously been diagnosed with depression. As mental health becomes more acceptable to discuss, the magnitude and consequences of poor mental health become more apparent. Despite its critical role in overall health, many individuals face significant barriers to accessing mental health services, including cost, stigma and provider shortages. Untreated mental illnesses increase the risk of a person choosing unhealthy and/or unsafe behaviors (including substance use, violent/destructive behavior, and intentional self-harm). Mental illness can also increase the risk of chronic physical health conditions, including diabetes, hypertension, stroke and heart disease.

Mental health is influenced by genetics, experiences of trauma, stress, coping abilities and behaviors/habits. In addition to these factors, systemic factors also contribute to mental illness. The complexity of the mental health system locks some patients out of the system entirely. Those who can navigate the system often contend with an insufficient supply of providers to meet community demand. Across the state of Michigan, there are approximately 336 mental health providers for every 100,000 residents (County Health Rankings, 2023). In comparison, Oceana (33 mental health providers per 100,000 residents) has significantly lower rates of providers available to treat mental health disorders. Mason County (343 mental health providers per 100,000 residents) which is higher than the state. Ensuring that everyone has access to timely, quality mental health care is key to fostering healthier individuals and communities.

Goal

Improve accessibility, availability, affordability and quality of mental health services.

Addressing the need

Strategy No. 1: Enhance access to behavioral health services for students living in rural areas.

Background

In rural communities, like Mason, Lake and Oceana counties, accessing behavioral health services can be challenging. These challenges stem from limited access, availability, affordability and stigma of services. School tele-psych clinics bridge the gap for students requiring therapy or counseling by providing access to licensed social workers through secure videoconferencing, ensuring continuity of care and privacy. By exploring and establishing tele-psych clinics, school environments will be able to respond quickly to students who need behavioral support services and ultimately improve outcomes for students.

Main objective

Tactics will explore establishing tele-psych clinics to serve youth aged 14 and older.

Anticipated impact

The anticipated impact of this objective is to continue to create a school environment that responds quickly to students who need behavioral support services. This model intentionally breaks down siloes between community agencies and fosters collaboration so that the student receives the best support service available.

Strategy No. 2: Establish community health worker connection for students and families dealing with issues related to social determinants of health and navigation needs.

Background

Community health workers are frontline public health workers and trusted community resources that address social determinants of health, such as food insecurity, transportation barriers, household utility barriers and health access barriers. The community health worker collaborates with schools, providing targeted support to students with behavioral health concerns. Barriers at home may be the root cause for increased behavioral health events; therefore, the goal of this service is to help decrease complex needs at home, to prevent the uptick in behavioral health events among students. For any behavioral health events or concerns that are present for students, the community health worker can help ensure these follow-ups are completed, navigating and helping resolve any barriers to care. This service is structured to complement processes and programs already in place at the school. Through advocacy, education and providing access to local resources, the community health worker works collaboratively with the student and family outside of the school environment, meeting needs that school-based social workers/team members may often lack the necessary time to fully address.

Main objective

Tactics will enhance coordination of community health worker services by aligning with the Interconnected Systems Framework (ISF) group for school-based community health worker interventions and behavioral health needs.

Anticipated impact

The anticipated impact of this strategy is to partner with local schools to better support students and families in responding to social and behavioral health needs. Building the capacity to reach students and families through school will help to ease the burden of navigation for those who need wrap around support.

Strategy No. 3: Implement and engage with Interconnected Systems Framework (ISF) in Mason, Lake and Oceana counties.

Background

The Interconnected Systems Framework (ISF) seeks to connect education and mental health systems and staff in order to improve educational outcomes of K-12 students. By identifying ways community interventions and school districts can work together, the ISF can both improve the quality of the individual systems and help eliminate gaps or missing elements of services. The ISF model streamlines referrals for mental health supports and services for students across Mason, Lake, and Oceana counties, allowing quicker support for students in need. ISF is a successful model that has been used throughout the Corewell Health region and is nationally recognized for successfully streamlining mental health interventions for students and strengthening community partnerships, with the hopes of enhancing equitable systems.

Main objective

Tactics will establish a local ISF framework to identify and implement mental health support in schools where support is most needed.

Anticipated impact

The anticipated impact of this objective is to create an environment that will have more intentional services, support, and response to the mental and behavioral health needs of youth.

Significant health needs not addressed

Obesity

Justification for decision

The 2024-2026 MiThrive Community Health Needs Assessment identified obesity as a significant health need. Obesity is a complex health issue influenced by a combination of genetic, behavioral, environmental and socioeconomic factors. While obesity is recognized as a significant health need in our community, it was not selected as a priority for this implementation cycle due to several factors. The workgroup applied a data-driven prioritization process that considered urgency, feasibility, resource availability and potential for measurable impact within the current timeframe. While obesity was not prioritized in this Implementation Strategy, it remains a key focus for future efforts. Additionally, existing initiatives targeting obesity are already underway, allowing us to focus on other unmet health needs where immediate progress can be achieved. This phased approach ensures strategic alignment and builds capacity for future obesity-focused efforts.

Community resources

Corewell Health is committed to supporting services, programs and initiatives that address obesity such as providing Medical Nutrition Therapy and the Lifestyle Medicine program. Additionally, programming is offered to deliver practical nutrition education to empower individuals and families to make healthier choices. For those seeking structured support, Corewell Health also provides weight management programs that combine education, behavioral strategies and ongoing guidance to promote sustainable results.

The following organizations are tasked with obesity prevention and management services and programs: Corewell Health, District Health Department #10, Michigan Department of Health and Human Services, and MSU Extension.

Appendix: Abbreviated table 1

Health care access

Goal: Work collaboratively to expand access to care in rural communities, fostering healthier lives and building stronger, more resilient communities through equitable and sustainable health care solutions.

Strategy

Anticipated impact

Explore establishing a rural mobile health care unit.



To better reach patients who may be disengaged and not seeking regular, routine care.



Health system transformation

Embed community health worker into the Corewell Health Ludington Hospital Emergency Department.



Address identified needs such as preventable emergency department use, access to care and social determinants of health needs.



Health system transformation

Add an advance care planning facilitator at Corewell Health Ludington Hospital.



Increase the number of completed advance directives for the adult population.



Health system transformation

Appendix: Abbreviated table 2

Health care access

Goal: Work collaboratively to expand access to care in rural communities, fostering healthier lives and building stronger, more resilient communities through equitable and sustainable health care solutions

Strategy

Anticipated impact

Connect patients with financial counseling services.



Ability to access medical care and improved health outcomes for those who seek medical services.



Clinical practice transformation

Improve strategy for addressing social drivers of health.



The removal of barriers to care will lead to improved health outcomes for those who seek medical services.



Health system transformation

Distribute community investment grants to foster collective impact within the community.



Increase capacity to ensure community members receive high-quality and more equitable care from Corewell Health's community partners.



Social structure transformation

Appendix: Abbreviated table 3

Mental health

Goal: Improve accessibility, availability, affordability and quality of mental health services.

Strategy

Anticipated impact

Enhance access to behavioral health services for students living in rural areas.



Build capacity for students to access behavioral health services on-site to ensure students receive timely, high-quality behavioral health services.



Community transformation

Establish community health worker connection for students and families dealing with issues related to social determinants of health and navigation needs.



Expand capacity to reach students and families through school and ease the burden of navigation for those who need wrap-around support.



Health system transformation

Implement and engage with Interconnected Systems Framework in Mason, Lake and Oceana counties.



Create an environment that will have more intentional services, support and response to youths' mental and behavioral health needs.



Community transformation