Corewell Health Big Rapids and Reed City Hospitals

Community Health Needs Assessment

2026-2028 Implementation Strategy

Corewell Health™

Contents

Executive summary

In November 2025, Corewell Health Big Rapids and Reed City hospitals adopted the Community Health Needs Assessment, which identified the top community health needs in Lake, Mecosta and Osceola counties. The present report provides details on strategies Corewell Health Big Rapids and Reed City hospitals 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. Following stakeholder input, we 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 Big Rapids Hospital and Reed City Hospital leaders, community subject matter experts, and the Corewell Health Big Rapids and Reed City Hospital Community Advisory Board.

Corewell Health Big Rapids and Reed City hospitals 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 Big Rapids and Reed City hospitals 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 data preview 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 Big Rapids and Reed City hospitals Implementation Strategy Workgroup in February 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 Big Rapids and Reed City hospitals to address. The workgroup made the recommendation for the hospitals 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

Choosing two significant health needs to address means resources can be focused on taking a comprehensive approach: 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 priority areas, some of the nonprioritized needs will be indirectly addressed through enhancing health care access and mental health and by partnering with lead organizations outside of this implementation strategy that are addressing these areas.

Process for developing the implementation strategy

An Implementation Strategy Workgroup was established for Corewell Health Big Rapids and Reed City hospitals. This workgroup was made up of community board members, hospital leadership and representatives of community partner organizations. In February 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 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 workgroup focused on the selection of strategies and report development from Feb. 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

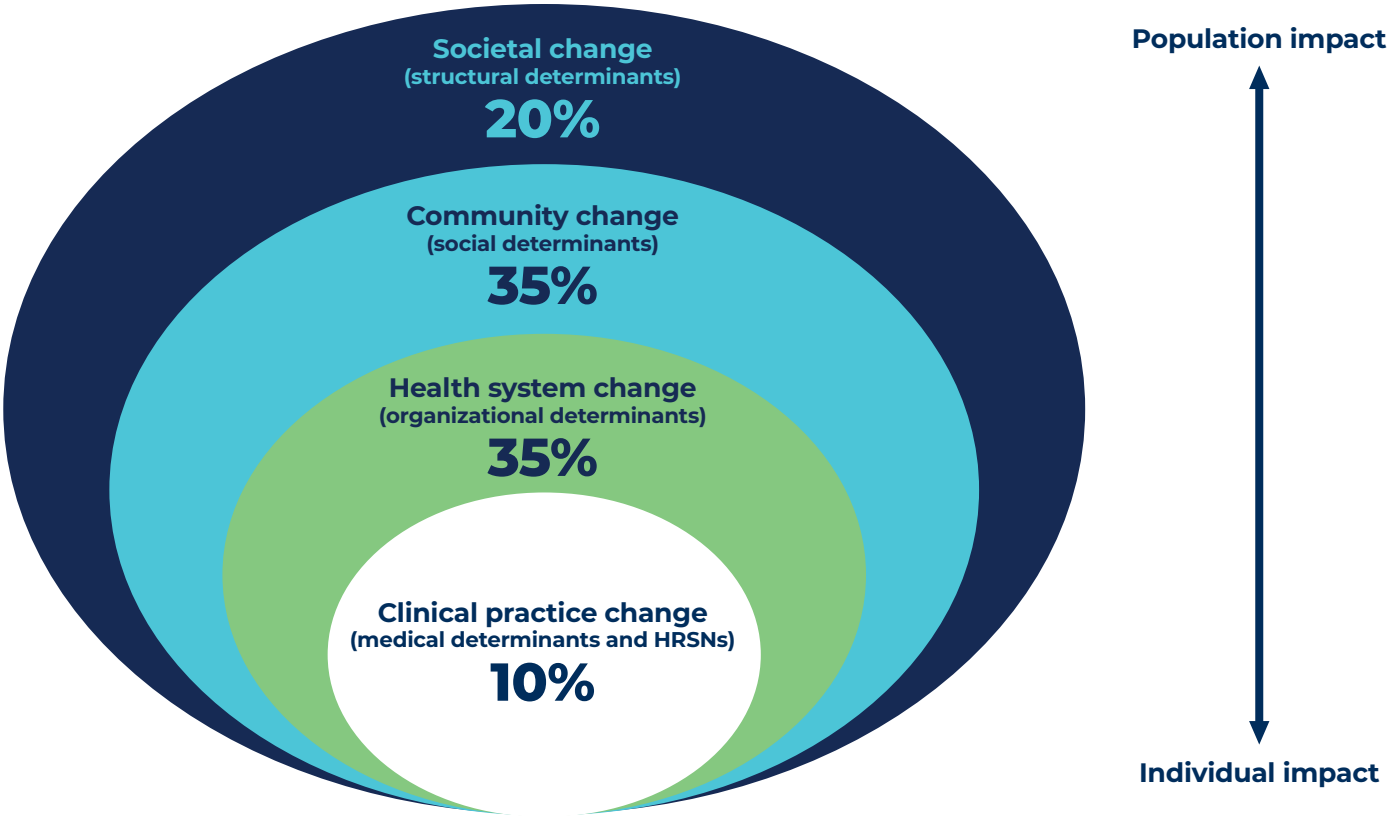
Corewell Health, in collaboration with HealthBegins, developed a strategic framework to guide our population health work. Health care systems have traditionally focused on meeting the medical and health care needs of individual patients. A deepened understanding of the significance of community and societal 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 collaborating 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 residents' social needs. 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 is programs that engage families and communities in supporting pregnant women and new mothers, with interventions such as peer support groups for breastfeeding and community baby showers to provide essential items and information to expectant mothers.

Societal change (structural determinants): This level describes interventions that impact processes and policies, such as state and federal social and economic guidelines. An example of this work is 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 the societal 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 Lake, Mecosta and Osceola 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 residents delaying, rationing and choosing other essential needs (e.g., 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 rate than is seen in Lake County (8 primary care providers per 100,000 residents), Mecosta County (48 primary care providers per 100,000 residents) and Osceola County (30 primary care providers per 100,000 residents). This makes it harder for residents to seek care for acute and chronic diseases. The long-term consequences of a lack of access to care include complex medical conditions, comorbidities, premature disability and poor quality of life. Of the respondents to the community survey, 48.4% identified difficulty getting an appointment due to the lack of time slots at their provider as one of their top issues with access; 43.2% 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. Provider shortages, lack of 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 are barriers to care.

The COVID-19 pandemic exacerbated technological barriers to health care. People without technological means (because of a lack of high-speed internet access and equipment, and/or the ability to afford it) 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: Connect patients with financial counseling services.

Background

The National Health Service Corps (NHSC) or Michigan State Loan Repayment Program (MSLRP) are federal and state programs, respectively, that allow health care 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 them to commit to employment for a specified period and help Corewell Health with provider recruitment and retention. The NHSC/MSLRP programs also require the practice to have a financial assistance program that complies with program requirements, and to notify all patients of this policy and assist any patients who 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 a greater number of patients to qualify for financial assistance.

Main objective

Tactics will increase awareness of 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 of Corewell Health in Lake, Mecosta and Osceola counties is 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. 2: Establish deliberate community clinical partnerships between select service lines and community programs.

Background

Establishing deliberate community and clinical partnerships between select service lines and community programs is essential for addressing the significant health needs identified in the MiThrive Community Health Needs Assessment. By fostering these partnerships, Corewell Health can leverage local knowledge and resources, ensuring that interventions are tailored to the unique needs of the community. This collaborative approach not only enhances the effectiveness of health strategies but also promotes trust and engagement among community members, which is essential for sustainable health improvements. Strengthening community collaborations and focusing on measurable outcomes are key components of Corewell Health's strategy to improve health equity, and the commitment to establishing deliberate community and clinical partnerships is reflected in Corewell Health's strategic priorities and community engagement efforts.

Main objective

Tactics will integrate community programs into clinical pathways.

Anticipated impact

The anticipated impact of creating referral pathways between clinical service lines and Corewell Health Healthier Communities programming is that patients who follow through with referrals to such programming will see improvements in health outcomes related to their conditions.

Strategy No. 3: Explore the deployment of community health workers in the 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 front-line public health workers and trusted community resources who address social determinants of health, such as food insecurity, transportation barriers, household utility barriers and health access barriers. The emergency department is an optimal location to place a community health worker to support patients with complex needs. By connecting patients to community resources, community health workers can help reduce preventable emergency department utilization and improve patient health outcomes.

Main objective

Tactics will address social determinants of health needs and preventable emergency department utilization.

Anticipated impact

The anticipated impact of this objective is a positive effect on both patient outcomes and facility efficiency. Specifically:

- Reduction of emergency department visits by frequent utilizers
- Reduced 30-day hospital readmissions
- Improved health outcomes by identifying and addressing social determinants of health needs
- Reduced cost of care by diverting patients' future visits to more cost-effective facilities
- Improved patient engagement by acting as navigators and educators
- Improved departmental efficiency by reducing unnecessary emergency department visits

Strategy No. 4: Distribute community investment grants to foster collective impact within the community.

Background

No one organization or entity alone can solve the deep-rooted and often complex issues that produce disparate health outcomes. 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.

Anticipated impact

The anticipated impact is improved access to services, enhanced community capacity, aligned values, increased community engagement and reduced health disparities, through strategically investing in partnerships with local human service organizations.

Strategy No. 5: Establish initiatives that support addressing social drivers of health strategy.

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 our 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 our strategic priorities and community engagement efforts.

Main objective

Tactics will create pathways with external community partners within Corewell Health's internal structure that address social drivers of health.

Anticipated impact

The anticipated impact of this strategy is improved patient outcomes, enhanced care coordination, reduction in health disparities, increased organizational efficiency and data-driven decision-making.

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 who has it, and it impairs their ability to function and participate in society. A variety of mental illnesses can occur, including 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 can have several at the same time.

Mental illness often occurs without the person showing any physical symptoms, which can cause communities to perceive it 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 24.5% of adults in Lake County, 26.6% of adults in Osceola County and 26.9% of adults in Mecosta 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. Systemic factors also contribute to mental illness. The complexity of the mental health system locks some patients out of it 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, Lake County (87 mental health providers per 100,000 residents), Mecosta (172 per 100,000 residents) and Osceola (159 per 100,000 residents) each have fewer providers available to treat mental health disorders. 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: Increase understanding of behavioral health by launching initiatives that highlight and address stigma, fostering a more informed and supportive community.

Background

The Interconnected Systems Framework (ISF) seeks to connect education and mental health systems and staff in order to improve the 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 service gaps or missing elements of services. 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. Expanding these services is crucial for improving access to mental health care, reducing health disparities and fostering a supportive environment for all students.

Main objective

Tactics will strengthen the mental and behavioral services in the community through collaboration, supportive policies and community engagement.

Anticipated impact

The anticipated impact of this objective is an environment with more intentional services, support and response to residents' mental and behavioral health needs by working collaboratively with Lake, Mecosta and Osceola stakeholders.

Strategy No. 2: Empower youth, families and communities through education, early intervention and supportive environments to prevent and reduce substance use and vaping.

Background

Mental health is essential to overall well-being, influencing relationships, daily functioning and our ability to lead fulfilling lives. Despite its critical role in overall health, many individuals face significant barriers to accessing mental health services, including cost, stigma and provider shortages. This strategy takes a comprehensive approach, prioritizing youth, families and communities working together in creating safe and supportive environments. Additionally, prioritizing the school and hospital setting will ensure interventions reach target audiences. Expanding education and early intervention efforts is crucial for improving access to mental health care and reducing mental health disparities.

Main objective

Tactics will expand school-based prevention and intervention programs that address substance use, vaping, and tobacco and nicotine use.

Anticipated impact

The anticipated impact is a reduction in substance use through increased awareness and knowledge, earlier identification and intervention, stronger engagement, and improved resilience and decision making related to substance use.

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. 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 time frame. 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 in Lake, Mecosta and Osceola counties: Corewell Health, District Health Department #10, the 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	
Connect patients with financial counseling services.	Increased access to medical care and improved health outcomes for those who seek medical services.	**Clinical practice transformation**
Establish deliberate community clinical partnerships between select service lines and community programs.	Patients who follow through with referrals to Healthier Communities programming will see improvements in health outcomes related to their conditions.	**Health system transformation**
Explore the deployment of community health workers in the emergency department.	Patient health outcomes and facility efficiency will improve.	**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		
Distribute community investment grants to foster collective impact within the community.		Improve access to services, enhance community capacity, align values, increase community engagement and reduce health disparities.		**Social structure transformation**
Establish initiatives that support addressing social drivers of health strategy.		Improve patient outcomes, enhance care coordination, reduce health disparities, increase organizational efficiency, and data-driven decision-making.		**Health system transformation**

Appendix:
Abbreviated table 3

Mental health

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

Strategy	Anticipated impact	
Increase understanding of behavioral health by launching initiatives that highlight and address stigma, fostering a more informed and supportive community.	An environment with more intentional services, support, and response to the mental and behavioral health needs of residents.	**Community transformation**
Empower youth, families, and communities through education, early intervention and supportive environments to prevent and reduce substance use and vaping.	Reduced substance use through increased awareness, early identification and intervention, stronger engagement, and improved resilience and decision-making.	**Community transformation**