Corewell Health Greenville Hospital

→ Community Health Needs Assessment

2026-2028 Implementation Strategy

Corewell Health™

Contents

Executive summary

In November 2025, Corewell Health Greenville Hospital adopted the Community Health Needs Assessment, which identified the top community health needs in Montcalm County. The present report provides details on strategies Corewell Health Greenville Hospital will employ to address these community health needs between Jan. 1, 2026, and Dec. 31, 2028. The significant health needs identified in the 2024-2025 Community Health Needs Assessment included access to health care and social services, financial security, substance use, and mental health. 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 Greenville Hospital leaders, community subject matter experts and the Corewell Health Greenville Hospital Community Advisory Board.

Corewell Health Greenville 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 Greenville Hospital produced a 2024-2025 Community Health Needs Assessment and this document, the 2026-2028 Implementation Strategy.

About this plan

Selection of significant needs

The Montcalm County Community Health Needs assessment identified the following health needs:

- Access to health care and social services
- Access to healthy food
- Financial security
- Mental health
- Safe and affordable housing
- Substance use
- Transportation

These seven health needs were further prioritized during a data preview event where four significant health needs were identified to be addressed by Corewell Health, Mid-Michigan District Health Department, Sheridan Community Hospital and Healthy Montcalm. They are:

- Access to health care and social services
- Financial security
- Substance use
- Mental health

The list of seven health needs was reported to the Corewell Health Greenville Hospital Implementation Strategy Workgroup on March 7, 2025. In workgroup meetings, members discussed the data from the Montcalm County Community Health Needs Assessment and deliberated on which significant needs would be appropriate for Corewell Health Greenville 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

Choosing two significant health needs to address means resources can 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 five health needs not addressed include:

- Access to healthy food
- Financial security
- Safe and affordable housing
- Substance use
- Transportation

Compared to health care access and mental health, these five health needs were not ranked as high in terms of two prioritization criteria: (1) impact and (2) feasibility. Though not selected as priority areas, some of the nonprioritized needs will be 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 Greenville 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 seven 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 March 2025 to Oct. 2025. Throughout this process, there was robust dialogue around current state strategies for the county, gaps in service, and potential collaborations between agencies and the hospital.

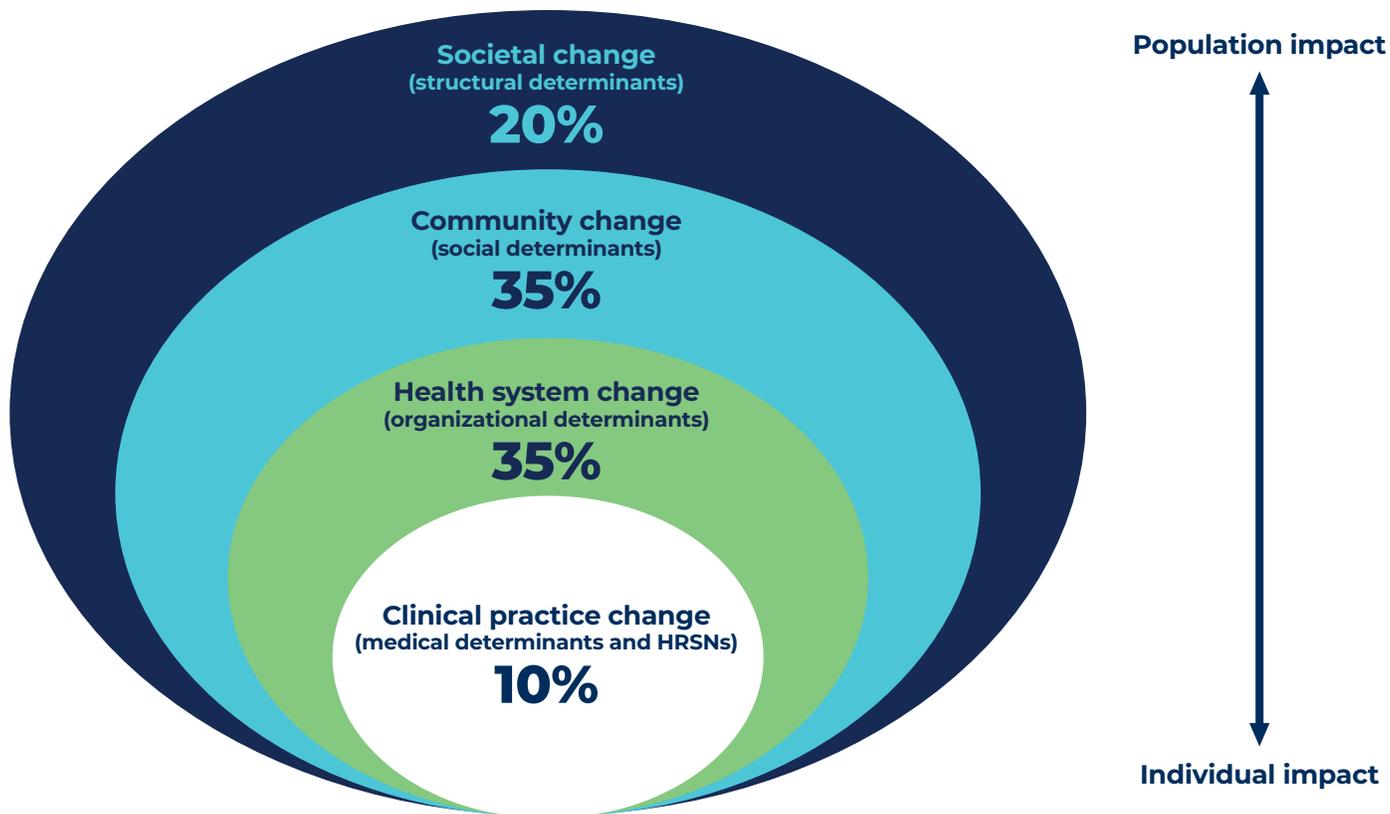## Health transformation framework

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 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 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.

Population impact

Societal change
(structural determinants)
20%

Community change
(social determinants)
35%

Health system change
(organizational determinants)
35%

Clinical practice change
(medical determinants and HRSNs)
10%

Individual impact

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 Montcalm County 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. During 2020-2022, 9.4% of adults in Montcalm County reported being unable to see a health care provider due to cost, a higher percentage than the Michigan average of 7.9%. This barrier was most reported among adults aged 35-54 (14.4%), females (11.0%), individuals from racial or ethnic groups other than non-Hispanic white (26.5%), those with some college education (13.5%) and adults earning less than $25,000 per year (19.1%). The long-term consequences of a lack of access to care include complex medical conditions, comorbidities, premature disability and poor quality of life. In 2020-2022, the percentage of adults reporting having fair/poor general health was lower in Montcalm County (12.7%) than in Michigan (16.3%).

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 either 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: Connect patients with financial counseling services.

Background

The National Health Service Corps and (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 in an area with a provider 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 that the practice 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 Montcalm and Ionia 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 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 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 strategy is a positive impact on both patient outcomes and facility efficiency. Specifically:

- 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 care.
- Improve 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 of this objective is 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.

Strategy No. 5: Establish initiatives that support 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 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 encouraging cross-functional departments and service lines to create infrastructure and pathways across the continuum of care to collect, act on and monitor health-related social needs data is that it 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 determinants of health data with community partners, resources and investments.

Strategy No. 6: Explore the transportation needs of underserved populations in Montcalm County by engaging stakeholders to make data-driven recommendations.

Background

In rural communities such as Montcalm County, transportation poses ongoing challenges for individuals who need to access health care and other essential services. Limited transportation options stem from a lack of coordination across programs and services, low population density, long distances and limited infrastructure. Through the exploration of transportation needs in Montcalm County, community partners will develop data-driven recommendations to address transportation barriers for underserved populations such as people with disabilities, older adults, individuals who are low-income, veterans and those with special health care needs. Addressing transportation barriers will enable more individuals to receive the medical care they need and will improve health outcomes.

Main objective

Tactics will explore transportation gaps and make recommendations for improvement.

Anticipated impact

The anticipated impact of this strategy includes:

- Improved access to essential services
    - Health care: Fewer missed appointments and improved health outcomes due to better transportation to clinics and hospital services
    - Employment: Increased job access, especially for underserved populations, by connecting people to employment
    - Education: Enhanced school attendance and student participation in extracurricular activities
    - Improved transportation infrastructure can attract businesses and stimulate local economies
    - Reduced transportation-related costs for families and individuals
- Enhanced equity and inclusion
    - Addresses transportation barriers faced by low-income households, seniors and people with disabilities
- Data-driven decision making
    - Collection and analysis of local transportation data will:
        - Identify gaps and inefficiencies in the transportation system
        - Support evidence-based policy and funding decisions
        - Enable targeted interventions
- Strengthened community engagement
    - Formation of a community task force on transportation would foster collaboration and local ownership
    - Builds trust between residents, local government and service providers
- Policy and funding leverage
    - Informs policy advocacy efforts to secure long-term support and systemic change
    - Strengthens applications for state, federal and private funding

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 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). The suicide rate has remained higher in Montcalm County than in Michigan. Based on three-year rolling averages, the rate in Montcalm County decreased from 22.8 to 21.3 deaths per 100,000, while Michigan saw a smaller decline, from 14.3 to 14.2 deaths per 100,000, over the same period.

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. Poor mental health was more commonly reported among adults aged 55 and older compared to those aged 18-34. Females and adults with annual incomes below $25,000 per year were over three times more likely to report poor mental health than their counterparts. Those with less than a high school education also reported higher rates of poor mental health than other education groups. 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

Question, Persuade, Refer (QPR) is a suicide prevention program that teaches community members to recognize and respond to mental health crises. This training presents information on the unique challenges individuals face that can lead to stress, depression and suicide, as well as how to implement QPR interventions with individuals at risk of suicide. This strategy will equip community members with effective suicide prevention skills and strengthen the community's capacity to address mental health needs.

Main objective

Tactics will, through partnerships, education and prevention efforts, strengthen community capacity to respond to mental health crises.

The anticipated impact of this objective is to create an environment with more intentional services, support and response to residents' mental and behavioral health needs by working collaboratively with Montcalm and Ionia 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 of this strategy is to educate parents, caregivers, teachers and those working with adolescents on the warning signs of risky behaviors related to potential substance use. Through this education, more youth will be connected with the necessary resources they need to access help.

Significant health needs not addressed

Financial security

Justification for decision

The 2024-2025 Montcalm County Community Health Needs Assessment identified financial security as a significant health need. Financial security goes beyond income; it encompasses the ability to consistently meet basic needs, such as having safe housing, nutritious food, health care, transportation and other essentials that support a healthy life. When individuals and families experience economic stability, they are better positioned to thrive, make informed health decisions and access preventive care. Conversely, financial insecurity often leads to chronic stress, which is linked to adverse health outcomes such as hypertension, mental health challenges and reduced life expectancy. Stable finances also influence social determinants of health, including education and employment opportunities, creating a ripple effect that strengthens community resilience. Although it was identified as a significant health need in the 2024-2025 Montcalm County Community Health Needs Assessment, Corewell Health Greenville Hospital has chosen not to address this issue directly in our implementation plan. Financial security is a complex, systemic challenge that falls outside the hospital's core mission and expertise, requiring specialized resources and policy-level interventions best managed by community organizations and government agencies. The hospital will support community partners through collaboration, referrals and advocacy. Additionally, a financial security strategy has been embedded into the health care access implementation strategy, and we remain committed to partnering with local agencies to strengthen economic stability and improve overall health outcomes for Montcalm County residents.

Community resources

The following organizations are tasked with financial security services and programs: EightCAP, Inc. (a community action agency), Montcalm County DHHS (Department of Health & Human Services), United Way of Greater Central Michigan (connecting residents to social services), Michigan 211 (a free, confidential helpline supporting service navigation), Montcalm Care Network (connects individuals to local resources) and West Michigan Works! (supports attainment of employment and job training).

Substance use

Justification for decision

The 2024-2025 Montcalm County Community Health Needs Assessment identified substance use as a significant health need. Misuse of drugs or alcohol can contribute to long-term physical and mental health challenges, as well as disrupt relationships and daily responsibilities. Addressing substance use is essential to fostering healthier individuals and stronger, more supportive communities. However, it will not be a primary focus in this implementation cycle due to several strategic considerations. Effectively addressing substance use requires extensive resources and a coordinated, multisector approach that exceeds our current capacity. Additionally, there are already strong community coalitions and organizations actively working on prevention and treatment, and duplicating these efforts would not be an efficient use of resources. Instead, our plan emphasizes upstream factors such as mental health support and access to care, which are closely linked to substance use risk and can contribute to long-term prevention. While other identified needs ranked higher in terms of feasibility and potential impact, substance use remains an important priority for future planning cycles, and we will continue monitoring trends and collaborating with existing partners to explore integration opportunities as resources allow.

Community resources

The following organizations and collaboratives provide substance use services, programs and support: Montcalm Alano Club (a nonprofit facility offering meeting space and various activities for recovery), Randy's House (sober living recovery residences providing peer support recovery coaching and groups), Wedgwood Christian Services (offers intensive outpatient and regular outpatient treatment), Project Assert Program (a collaboration between Corewell Health and Wedgwood Christian Services to provide patients access to substance use screenings along with referrals to resources), Montcalm Prevention Collaborative (reducing youth substance use throughout Montcalm County schools and the community at large) and Greenville Clinic (provides treatment for people with substance use disorder challenges).

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.	Increase access to medical care and improve 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 Corewell Health 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.	Address social determinants of health needs and reduce unnecessary emergency department visits.	**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.	››	Community members will receive higher-quality and more equitable care from Corewell Health's community partners.	››	**Social structure transformation**
Establish initiatives that support 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**
Explore the transportation needs of underserved populations in Montcalm County by engaging stakeholders to make data-driven recommendations.	››	Improve patient access to essential services.	››	**Community transformation**

Appendix:
Abbreviated table 3

Mental health

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

Strategy

Increase understanding of behavioral health by launching initiatives that highlight and address stigma, fostering a more informed and supportive community.

Anticipated impact

An environment with more intentional services, support and response to the residents' mental and behavioral health needs by working collaboratively with Montcalm/Ionia stakeholders.

Community transformation

Empower youth, families, and communities through education, early intervention and supportive environments to prevent and reduce substance use and vaping.

Increase education for those working with adolescents on risky behaviors and connect more youth with the necessary resources they need to access help.

Community transformation