



Community Health Implementation Plan

2025-2027

Developed in response to the 2025 Community Health Needs Assessment

Adoption date: _____

Purpose and Background

Harbor Beach Community Hospital completed its 2025 Community Health Needs Assessment to identify the most significant health needs affecting residents of its service area. The assessment combined available health and demographic data with community input and a structured prioritization process. This implementation plan describes how HBCH will respond during the 2025-2027 cycle through hospital-led strategies, continued programs, and collaboration with community partners.

The plan concentrates expanded effort on two focus areas: barriers to financial access for patients and chronic disease. HBCH will also continue to address tobacco and vaping, cancer, and mental health as priority needs. Broader needs that require coordinated regional action will be addressed through partnerships, referrals, education, and participation in collaborative initiatives.

Implementation Approach

- Continue effective hospital programs and services already in place.
- Expand or strengthen activities in the two selected focus areas.
- Coordinate with healthcare, public health, human service, transportation, fitness, food-access, and other community partners.
- Review progress at least annually and refine activities when needs, resources, or opportunities change.
- Establish realistic numeric targets after baseline data and operational capacity are confirmed.

2025 Community Health Priorities

Category	Identified needs	Planned response
Focus areas	• Financial barriers to access for patients • Chronic disease	Detailed work plans with continued and expanded hospital action
Priority needs	• Tobacco and vaping • Cancer • Mental health	Ongoing hospital services, education, prevention, screening, referral, and targeted enhancement
Collaborative areas	• Mental health • Substance use disorders • Social determinants of health • Prenatal health • Environmental health • Nonintentional injuries • Violence • Dental care • Safety • Infectious disease	Partnership, referral, coordination, education, and support for regional initiatives

Accountability and Review

HBCH leadership and designated department leads will review implementation progress using available service, outreach, referral, participation, and communication data. The plan may be refined during the cycle to reflect the completed resource assessment, new community partnerships, funding opportunities, service changes, and emerging needs. Updates should document what was completed, what was learned, and what changes are needed for the next reporting period.

Focus Area 1 Barriers to Financial Access for Patients

Goal: Reduce financial barriers that prevent patients from obtaining needed healthcare, medications, insurance coverage, and follow-up services.

Approach: Continue every established financial-access strategy from the prior implementation cycle and expand education, navigation, and connection to assistance when feasible.

Current HBCH Efforts to Continue

Existing activity	Purpose
Charity care and financial assistance program	Help eligible patients avoid or reduce medical debt and understand available assistance.
Collaboration with local employers	Respond to the requirements of employer-sponsored insurance programs and help improve access for covered employees.
Insurance marketplace certified application counseling	Assist eligible patients with understanding and completing marketplace enrollment.
Promotion of insurance open enrollment	Increase awareness of enrollment periods and coverage options.
Rural Health Clinic designation at Port Hope Clinic	Support access to primary care in a rural community.
Participation in the 340B program	Support access to eligible medications and related services.
Staff assistance with Medicaid enrollment	Help eligible patients apply for and maintain Medicaid coverage.

2025-2027 Financial Access Work Plan

Strategy and activities	Anticipated result	Measures	Potential lead and partners	Timing
- Continue charity care and financial assistance processes. - Provide clear information about eligibility, application steps, and available payment assistance.	Patients are better able to understand and access financial assistance.	- Number of applications or patients assisted - Assistance approved or provided, when available - Common barriers or questions identified	Finance and patient financial services	Ongoing
- Continue marketplace and Medicaid enrollment assistance. - Promote applicable enrollment and renewal periods.	Eligible residents receive help obtaining or retaining coverage.	- Enrollment contacts - Applications or renewals assisted - Outreach activities	Enrollment staff; MDHHS; marketplace resources	Ongoing and during enrollment periods
- Educate the public about the importance of health coverage and cost of marketplace plans. - Share information through community outreach and hospital channels.	Residents have better information for making coverage decisions.	- Education materials or posts - Outreach events or contacts - Referrals for enrollment help	Finance; community relations; TCHP	At least annually and as needed

Strategy and activities	Anticipated result	Measures	Potential lead and partners	Timing
Provide education about Medicare options and common scams before beneficiaries change plans.	Older adults and caregivers are better prepared to make informed coverage decisions.	• Educational communications • Partner referrals or presentations	HBCH; Region VII Area Agency on Aging; community partners	During Medicare enrollment periods and as needed
Continue collaboration with local employers regarding insurance requirements and access issues.	Employer and employee concerns can inform navigation and service coordination.	• Employer contacts • Access issues identified and addressed	Administration; finance; local employers	Ongoing
Maintain the Port Hope Rural Health Clinic designation and participation in the 340B program.	Rural patients retain access to supported primary care and eligible medication resources.	• Program participation maintained • Relevant service utilization	Administration; clinic leadership; pharmacy partners	Ongoing

Potential Financial Access Partners

Potential partners include Region VII Area Agency on Aging, Thumb Community Health Partnership, the Michigan Department of Health and Human Services, marketplace enrollment resources, local employers, pharmacies, and other organizations that help residents obtain coverage or financial assistance.

Focus Area 2 Chronic Disease

Goal: Improve prevention, early identification, management, and support for chronic disease while reducing barriers that make healthy choices and follow-up care difficult.

Approach: Build on HBCH clinical services, primary care, care management, Community Health Worker support, physical activity opportunities, and community resources. Add education, outreach, support, food-access coordination, and transportation connections as capacity allows.

Current HBCH Efforts

Current effort	Connection to chronic disease
Urology services	Provide local specialty evaluation and treatment for chronic and ongoing conditions.
Podiatry services	Support foot health and prevention of complications, including for patients living with diabetes.
Orthopedic services	Address musculoskeletal conditions that affect mobility, activity, and quality of life.
General surgery services	Provide local access to evaluation and surgical care when appropriate.
Primary care wellness visits	Support prevention, screening, risk identification, care planning, and follow-up.
Care management	Help patients understand and manage ongoing conditions and coordinate needed care.
Community Health Worker services	Connect patients with healthcare and community resources and help address nonmedical barriers.
Pickleball	Provide an accessible opportunity for physical activity and social connection.

Current Community Efforts and Resources

Community resource or activity	Role in the implementation strategy
SilverSneakers	Offers structured fitness opportunities, particularly for eligible older adults.
Weight Busters	Provides community-based weight management and peer support.
Community House gym	Provides a local setting for exercise and physical activity.
Personal trainers and fitness resources	Offer individualized fitness guidance and support.
TCHP chronic disease initiatives	Support regional coordination, education, referrals, and chronic disease programming.
CHW follow-up after emergency department visits	Connects patients to follow-up care, resources, and support after an emergency visit.

2025-2027 Chronic Disease Work Plan

Strategy and activities	Anticipated result	Measures	Potential lead and partners	Timing
- Continue and promote primary care wellness visits, specialty services, care management, and CHW services. - Strengthen referrals and follow-up among these services.	Patients have better access to prevention, specialty care, coordinated follow-up, and disease-management support.	- Wellness visits - Care-management contacts - CHW referrals and completed follow-ups - Relevant specialty utilization	Primary care; specialty clinics; care managers; CHWs	Ongoing
- Add or expand diabetes education. - Determine the most feasible delivery model, referral process, and staffing approach.	People living with or at risk for diabetes have access to practical self-management education.	- Education encounters or sessions - Participants referred and served - Participant feedback - Clinical indicators when appropriate and available	Clinical leadership; primary care; diabetes educator; care management	Develop during the cycle; implement as capacity allows
Offer or promote fitness classes and existing physical activity options, including pickleball, SilverSneakers, Weight Busters, the Community House gym, and personal trainers.	Residents are more aware of and connected to accessible physical activity opportunities.	- Classes or opportunities promoted - Participation when available - Referrals to community fitness resources	Community relations; wellness staff; local fitness partners	Ongoing; expand during the cycle
- Develop CHW relationships with food pantries. - Create a practical referral and communication pathway for patients who need healthy food and related resources.	Patients experiencing food insecurity are connected to local food resources and supportive services.	- Food-resource referrals - Food pantry partnerships - Completed connections when trackable	CHWs; care managers; food pantries; TCHP	Build and strengthen during the cycle

Strategy and activities	Anticipated result	Measures	Potential lead and partners	Timing
		Common needs identified		
Create a monthly chronic disease education and awareness bulletin board.	Patients, visitors, and staff receive timely, understandable health information.	- Monthly topics completed - Materials distributed or resource requests	Clinical education; community relations	Monthly
Use the employee newsletter to promote employee health and wellness.	Employees receive regular information about prevention, healthy behaviors, and available resources.	- Newsletter items published - Topics covered - Employee engagement when available	Human resources; employee wellness; community relations	Regularly throughout the cycle
- Increase chronic disease awareness through social media and other marketing. - Coordinate messages with seasonal and national health observances when useful.	Community members receive prevention, screening, self-management, and service information.	- Posts or campaigns - Reach and engagement - Service inquiries or referrals when trackable	Community relations; clinical departments; TCHP	Ongoing
Explore and develop support groups based on demonstrated community need and available facilitators.	Patients and caregivers gain peer support, education, and connection to resources.	- Needs assessed - Groups offered - Participation and feedback	Care management; clinical departments; community partners	Assess early in the cycle; implement as feasible
- Identify and address transportation barriers to appointments, follow-up services, healthy food, and wellness activities. - Refer patients to available transportation resources and participate in regional transportation coordination.	Transportation is less likely to prevent participation in care and chronic disease supports.	- Transportation needs identified - Referrals or rides coordinated - Reported missed-care barriers	CHWs; care managers; Thumb Area Transit; TCHP	Ongoing

Chronic Disease Evaluation Questions

- Are more patients being connected to preventive, specialty, care-management, CHW, diabetes education, food, fitness, and transportation resources?
- Which outreach and referral methods produce completed connections rather than referrals alone?
- What barriers continue to interfere with chronic disease prevention and management?
- What participant or patient feedback should shape future services?

Priority Needs

HBCH selected tobacco and vaping, cancer, and mental health as priority needs. These needs remain important and will be addressed through continued services, education, screening, referral, and collaboration. Mental health is also a collaborative area because meaningful improvement requires coordinated action across healthcare, behavioral health, schools, emergency response, and community organizations.

Priority need	HBCH and community response	Suggested monitoring
Tobacco and vaping	- Continue prevention and risk education through appropriate hospital, clinic, and school-based channels. - Promote cessation resources and referrals. - Use community communication channels to address tobacco and vaping risks, including youth vaping.	- Education and outreach activities - Cessation referrals or resources distributed - Partnership activities
Cancer	- Continue and promote available screening services, including mammography and other appropriate preventive screening. - Maintain referral and consultation relationships for services not available locally. - Use education and outreach to increase awareness of screening recommendations and early detection.	- Screenings completed when available - Education and outreach activities - Referrals and completed follow-up when trackable
Mental health	- Continue available counseling, social work, telepsychiatry, Senior Life Solutions, school-based supports, and co-located behavioral health services. - Promote crisis and referral resources. - Collaborate on mental health education, suicide prevention, service coordination, and access.	- Behavioral health referrals and encounters - Education or training activities - Collaborative initiatives - Resource connections

Collaborative Areas

The following needs are best addressed with community and regional partners. HBCH will contribute within its mission, services, expertise, and available resources. Activities may include referral, education, data sharing when appropriate, participation in coordinated initiatives, and identification of service gaps.

Collaborative area	Planned role for HBCH and partners
Mental health	Coordinate referral, crisis-resource awareness, education, suicide prevention, and access initiatives with behavioral health and community partners.
Substance use disorders	Continue safe prescribing practices, education, screening and referral as appropriate, and participation in regional prevention, treatment, and recovery initiatives.
Social determinants of health	Use care management, CHWs, social work, 2-1-1, transportation, food, financial, and other community resources to address barriers affecting health.
Prenatal health	Support awareness, referral, and coordination with prenatal, maternal, infant, primary care, and public health resources.
Environmental health	Share appropriate prevention and response information and coordinate with public health and emergency partners when environmental risks affect community health.
Nonintentional injuries	Continue fall-risk and injury-prevention practices and connect patients with rehabilitation, home-safety, and community resources.

Collaborative area	Planned role for HBCH and partners
Violence	Maintain required response and referral practices and collaborate on prevention and support related to domestic violence, child abuse and neglect, bullying, and other safety concerns.
Dental care	Refer patients to available dental resources and collaborate to improve awareness and access, particularly for residents facing financial or transportation barriers.
Safety	Support community education, emergency preparedness, injury prevention, and coordination with public safety and emergency-response partners.
Infectious disease	Support vaccination, prevention education, screening or testing as appropriate, and coordinated public health response.

Needs Not Selected for Detailed Focus Area Work Plans

HBCH selected a limited number of focus areas so that expanded resources and accountability can be concentrated where the hospital can make a meaningful contribution. Tobacco and vaping, cancer, mental health, and the collaborative areas were not selected for separate detailed focus-area work plans. This does not mean that HBCH will discontinue its response to these needs. Existing services and activities will continue, and HBCH will participate in community partnerships and emerging opportunities as resources allow.

Some needs require leadership, infrastructure, or services extending beyond the hospital. HBCH will therefore address those needs primarily through collaboration, referral, education, care coordination, and support of regional efforts. The hospital may elevate or add strategies during the implementation cycle if new data, resources, funding, or service opportunities warrant a change.

Evaluation and Reporting Framework

Review area	Questions for annual review	Evidence to consider
Implementation	Were planned activities completed or advanced? If not, what affected progress?	Program records, meeting notes, communications, service changes
Reach	Who was served or reached, and were people facing access barriers included?	Participation, referrals, service contacts, outreach reach
Connection	Did referrals result in completed connections to care or community resources?	Closed-loop referral data when available, follow-up notes, partner feedback
Experience	What did patients, participants, staff, and partners say about usefulness and remaining barriers?	Surveys, interviews, informal feedback, complaints and compliments
Improvement	What should HBCH continue, change, expand, or discontinue?	Trend data, feasibility, capacity, cost, outcomes, community need

Approval

Authorized body or representative	Date adopted