BEACON HEALTH SYSTEM

Implementation Strategy Plan

2025-2027

Tactics and Output Measures Reference

Priority Area: Access to Providers

For Elkhart County, IN, Marshall County, IN, St. Joseph County, IN, and St. Joseph County, MI

Purpose and reporting approach

This reference summarizes the tactics and output measures in Beacon Health System's 2025-2027 Implementation Strategy Plan. The plan responds to the systemwide CHNA priority of improving access to providers across Elkhart, Marshall, St. Joseph County, Indiana, and St. Joseph County, Michigan.

Output measures describe the immediate volume or deliverables of the work, such as referrals, people served, trainings and participation. Many baselines are established during Year 1. Progress data are collected and reviewed over the implementation period, with quarterly reporting used for applicable output measures and annual review used to assess broader outcomes and improvement over time.

The four connected strategies

#	Strategy focus	What it advances
1	**Non-clinical support**	Integrate CHWs, peer support specialists, peer recovery coaches and health navigators to address social drivers of health and improve care coordination.
2	**Connected care**	Improve communication and care coordination through standardized referrals, secure data sharing and collaboration across organizations.
3	**Expanded access**	Strengthen partnerships, recruitment, navigation, transportation, language access and workforce development to reach underserved populations.
4	**Community trust**	Promote patient-centered care, trusted relationships, outreach, education and provider engagement in each county.

Strategy 1

Expand access to non-clinical community health services by integrating community health workers, peer support specialists, peer recovery coaches and health navigators to address social drivers of health and improve care coordination.

tic	Description	Output measures tracked
	Engage community organizations and providers using CHWs or peer support specialists to identify collaboration opportunities and best practices.	• Number of organizations supporting non-clinical commur health services • Number of best practices implemented across the four counties
	Establish referral pathways from hospital emergency departments and primary care practices to non-clinical community health services.	• Number of referrals from hospitals or clinical practices to non-clinical services • Percent of patients screened for social needs • Percent of identified social needs followed up on by non-clinical services
	Collaborate with community partners to develop Mobile Integrated Health models, particularly where rural OBGYN access is limited.	• Number of patients served through Mobile Integrated Hea • Percent increase in prenatal and postpartum care access rural areas
	Enhance the Michiana Community Health Coalition resource guide with county-specific guides and a Spanish-language guide.	• Number of resource-guide website visits • Completion and publication of a Spanish resource guide • Percent of county-specific guides completed

Strategy 2

Enhance communication and care coordination inside and outside Beacon Health System through standardized referral processes, secure data-sharing platforms and cross-organizational collaboration.

tic	Description	Output measures tracked
	Audit internal and external providers to identify communication challenges across data systems.	• Percent of internal and external providers participating in t audit • Implementation rate of corrective actions identified throu the audit
	Train providers and staff to use the Indiana Health Information Exchange (IHIE) and Michigan Health Information Network (MiHIN) to access external patient data.	• Number of providers using IHIE and MiHIN • Percent of providers trained to use IHIE and MiHIN
	Engage practices that are not contributing data to IHIE or MiHIN to increase participation.	• Percent of practices participating with IHIE and MiHIN
	Improve the non-clinical referral pathway by supporting timely and accurate transfer of patient information.	• Completion of the Level Zero data-sharing milestone

Strategy 3

Improve healthcare access by strengthening community partnerships, recruiting and developing the workforce, expanding services for underserved populations and improving healthcare navigation.

tic	Description	Output measures tracked
	Develop and follow a three-year primary and specialty care recruitment plan with defined targets.	• Annual review of the Beacon Health System three-year recruitment strategy
	Increase enrollment in the patient portal for health information, scheduling and provider communication.	• Percent of unique Beacon patients enrolled in the patient portal
	Improve discharge workflows so follow-up appointments are scheduled before discharge.	• Number of ED patients scheduled for follow-up at dischar • Unattributed patient rate
	Expand options for community residents who experience transportation barriers.	• Number of patients served through the Mobile Mom Unit • Number of telehealth trainings provided • Number of transportation incentives distributed to people with identified transportation needs
	Increase access to providers and services in the patient's preferred language.	• Number of staff trained to use the language line • Language-line utilization
	Collaborate with FQHCs to improve access for people who are uninsured, underinsured or experiencing social-driver barriers.	• Number of FQHC partnerships established • Appointment wait times at FQHCs • Percent of patients screened for social needs at FQHCs • Percent of identified social needs followed up on • Number of non-compliant wellness-visit patients referred an FQHC
	Expand health-system workforce development opportunities.	• Participation in pathway programs • Participation from schools in target ZIP codes • Participation in medical education programs at Memorial Hospital of South Bend and Elkhart General Hospital

Strategy 4

Build community trust by promoting patient-centered care in each county.

tic	Description	Output measures tracked
	Provide trust-building and patient-centered training, including Think Cultural Health, HEAL and trusted-person approaches.	• Number of providers and staff receiving training • Number of providers reporting increased understanding o how to be a trusted person in their communities
	Use Community Health Workers to build trust with vulnerable populations.	• Number of CHW-led outreach sessions in target populatio • Number of individuals reached through home visits, educ and healthcare navigation
	Enhance the Joint Commission Dyad team to address social drivers of health among priority chronic-health and maternal-health populations.	• Number of Dyad strategic meetings focused on actionable social-driver discussions
	Educate emergency and primary care providers about medications for opioid use disorder (MOUD).	• Number of providers attending Grand Rounds sessions or MOUD • Number of primary care providers participating in MOUD education
	Develop an outreach plan that encourages provider participation in community health events.	• Number of providers participating in community events

Important interpretation notes

- Output measures capture activities and near-term deliverables. They should not be presented as proof of long-term health improvement on their own.
- Where the plan states "establish in Year 1," the first implementation year is used to define the baseline for future comparison.
- Counts of unique individuals should be deduplicated when the measure is intended to represent people rather than encounters or activities.
- Quarterly values should only be summed when the measure represents additive activity. Annual unique-person measures require an unduplicated year-end count.
- The ISP is iterative. Tactics and measures may be refined as community needs, partnerships, resources, policies and data availability change.