



Charting a healthier future through change

2025 Community Health Impact Report



Michigan's largest health care network: Delivering statewide excellence



Table of contents

Leading with equity	2	Belonging	50
A message from our community health impact and belonging leader.....	2	Building belonging: learning and development	52
Our purpose and plan	4	Leading with integrity: policies and practices	53
Corewell Health: who we are	4	Shaping our culture: workforce and workplace development	53
Corewell Health strategy	6	Community benefits and community health needs assessment. .	56
Office of community health impact and belonging: who we are	7	The purpose and power of community benefits.....	57
A sustainable operating model for community health	10	Shared focus, local impact: systemwide priorities for health equity.....	59
Healthier communities portfolio development	11	Continuous evolution: transforming the CHNA from compliance to strategic value.....	59
Belonging portfolio development	12	Enhancing CB data integrity: standardizing reporting and maximizing impact.....	60
The road map to impact	13	Strategic partnerships: collaborative CHNA for shared community impact.....	61
Place-based care and wellness	14	Integrating equity into clinical care	62
Empowering better health through lifestyle: preventing and managing chronic disease.....	15	Advancing measurement and accountability	63
Community care in action: transforming care and outcomes.....	22	In pursuit of equity: Excellent Health Outcomes for All certification.....	64
Empowered health: education for lifelong wellness	26	Funding integrated clinical and social care quality improvement	64
Maternal, infant, child and adolescent health	28	Sustaining our momentum.....	66
Foundations for a healthy beginning: Maternal Infant Health Program ..	30		
Strong starts, healthy beginnings	32		
Nurturing potential: school- and youth-based wellness	35		
Community building and civic engagement	40		
Together we thrive: belonging and collective action.....	41		
Empowering local leadership	44		
Equitable resource mobilization	47		





Leading with equity

A message from our community health impact and belonging leader

The most powerful connection we share is the desire for a good and healthy life. It is the universal language of well-being, transcending geography and circumstance.

“We are reminded daily that behind every policy change is a patient, family or community; the shifts we’re seeing in health care aren’t abstract — they directly affect access, affordability, safety and the quality of care for millions.”

Corewell Health’s office of community health impact and belonging is committed to creating opportunities for all to thrive. Guided by our mission, our team focuses on effecting positive change. **We do this by responding to the unique health needs of every community we serve, refining policies and practices to maximize our impact, and fostering a deep sense of belonging for everyone.**

But we know what worked yesterday may not work today. To navigate a shifting and sometimes volatile health care landscape, we must make bold changes to ensure everyone in our communities has the opportunity to live a healthy, thriving life. We’re reminded daily that behind every policy change is a potential impact to every individual touched by our organization (i.e., patients, communities, team members and plan members); the shifts we’re seeing in health care aren’t abstract — they directly affect access, affordability, safety and the quality of care for millions.

That’s why our team puts the Corewell Health mission at the center of everything we do. Our mission serves as our moral compass, ensuring that the decisions we make and the actions we take are aligned with our purpose. It reminds every team member, regardless of their role, that their work directly impacts the lives of others.

Throughout this report, you'll see how the office of community health impact and belonging supports better health for the people and places we call home.

We'll share stories from our team members, patients and providers that illustrate our approach to leveraging partnerships and making investments to meet people where they are. Like the community health workers who treat patients in emergency departments, fire stations and community centers. Or our colleagues who are addressing the physical and mental health of students through our innovative school nursing program and our child and adolescent health centers. And the clinicians who provide holistic care — from prevention to intervention — at local Corewell Health Centers for Wellness, ensuring healthy outcomes for all.

Change is inevitable, but it also creates a pathway for progress. Our shared success hinges on our willingness to embrace new ways of thinking and collaborating with all our stakeholders. As you read this report, I hope you are as inspired as I am by the possibilities ahead as we harness the collective talent, expertise and passion of our people to navigate the new landscape.

Here at Corewell Health, we aren't just adapting to new policies and challenges; we're charting a new course, shaping the future of health care.



Carlos Cubia

Chief Community Health Impact and Belonging Officer





Mission

Improve health, instill humanity and inspire hope

Vision

A future where health is simple, affordable, equitable and exceptional

Values

Compassion. Collaboration. Clarity. Curiosity. Courage.

Our purpose and plan

Corewell Health: who we are

It all starts with our people.

Our team is the driving force sustaining our legacy of outstanding outcomes, innovation, strong community partnerships, philanthropy and transparency.

Corewell Health is a not-for-profit health system that provides health care in 21 hospitals, 300+ outpatient locations and several post-acute facilities, and coverage through Priority Health, a provider-sponsored health plan serving more than 1.3 million members. Our exceptional, dedicated team — 65,000+ strong — works together to deliver quality outcomes and experience, and to educate and advocate for the diverse communities we serve across Michigan.

Our shared commitment to make health better for patients, communities, team members and plan members is at the center of everything we do at Corewell Health. We strive to do this for every person, every place, every time. Our commitment guides our work, our behaviors and every interaction. Our values are how we deliver on our commitment; our values ensure we're not just fulfilling our commitment, but doing it with the conviction, conduct and character that reflect who we are.

Key data

65,000+
team members

300+
ambulatory/outpatient locations

1.3M+
health plan members

12,000+
affiliated, independent and
employee physicians and
advanced practice providers

21
hospital facilities

16,000+
nurses

9,000+
employers contracted
with Priority Health

5,000+
licensed beds





Corewell Health strategy

Our strategy provides the clarity and direction we need to respond to a dynamic and unpredictable health care landscape.

It's how we're turning challenges into opportunities and charting a healthier future through change.

Our strategy revolves around five priorities that guide our organization as we work together to grow and improve in the face of tough realities:

- 1 Strengthen culture:** getting better at connecting our teams to purpose, being clear about direction, investing in leadership and getting better at managing change, listening and then acting on it.
- 2 Simplify:** reducing the friction for patients and members so that we can reduce the frustration our team members have to deal with — all while lowering costs.
- 3 Transform:** adapting our care model by evolving our physical footprint, aligning to best practices and leveraging innovative technologies to deliver excellent, consistent quality and meet higher demand.
- 4 Prove:** building better foundations for an integrated model — governance, alignment, integrated technology and analytics — to unlock the value between the payer and provider sides of our organization.
- 5 Expand:** increasing access to the incredible products and services we provide in a way that's sustainable — both in expanding what we already provide and partnering with others who bring complementary expertise to what we have.

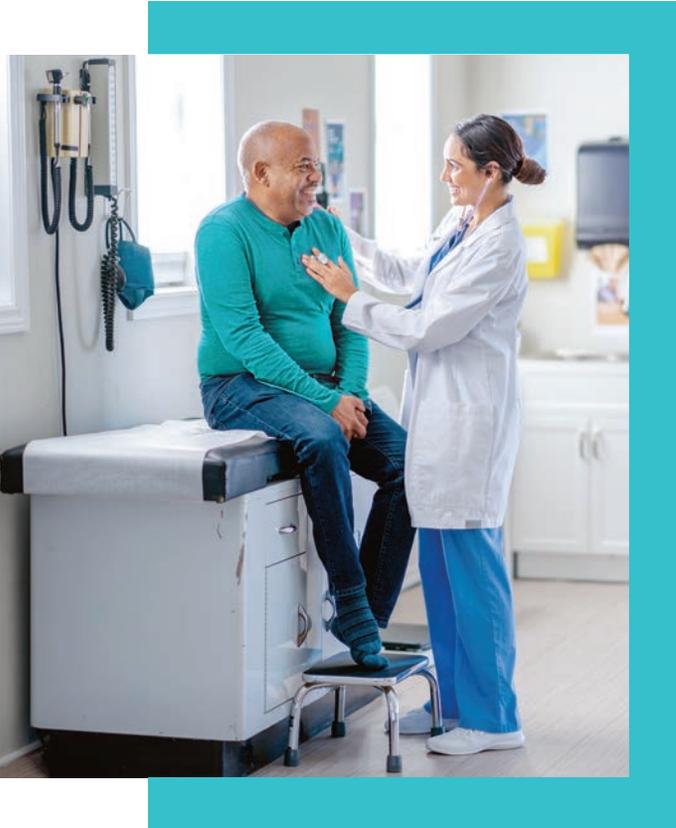
 **Office of community health impact and belonging:
who we are**

Our team brings essential experience and expertise, ensuring the company delivers on its commitment to help people live their healthiest life possible. We use data to better understand and respond to the unique needs of every community, continually refining our policies for maximum impact, and building an inclusive culture where everyone feels welcomed, valued and respected. While our commitment doesn't waver, we know that we must also prepare for change; it's a mechanism for continuous improvement, future relevancy and long-term success.

Our office of community health impact and belonging team works across our health care delivery system, bridging clinical and community solutions and applying our global strategy in a local, market-based approach to advance community health in a meaningful, relevant way.

- **Healthier communities:** deliver impactful programming and investment to meet local needs and drive changes in the community conditions that impact health.
- **Health Equity Evaluation, Assessment and Analytics Team (HEEAAT):** employ data, including community health needs assessments, to support large-scale and locally based strategic decisions.
- **Equitable outcomes:** integrate equity into clinical care with an emphasis on quality, safety and experience.
- **Belonging:** ensure that all stakeholders — patients, communities, team members and plan members — feel a sense of belonging, and our workforce reflects the communities we serve, with a workplace culture that fosters inclusivity.





Why read on?

This report represents our commitment to deliver on our mission to improve the health of our communities and patients, while ensuring we align with and support Corewell Health’s strategy and priorities. **In the office of community health impact and belonging we know that behind every number is a patient, plan member, teammate and community.** The stories you’ll read throughout this report illustrate the impact of the critical work our team is doing to create a more sustainable and effective model of care for everyone.

2025 key drivers

To ensure that we applied a consistent approach and sharp focus to the work of the office of community health impact and belonging, we outlined five key drivers to guide our work in 2025. They served as the cohesive framework, explicitly translating our Corewell Health system strategy and commitment into an actionable road map for the year:

- 1 Integrating equity into clinical care:** embedding health equity principles into all aspects of health care delivery, including social care, to ensure that receive high-quality, culturally responsive and patient-centered care.
- 2 Valuing differences:** respecting and including diverse backgrounds, perspectives and experiences in our system and community to foster equitable access, improve patient-provider experiences, and create policies that address disparities.
- 3 Investing in conditions that impact health:** investing strategically in initiatives that support critical community-based programming and investments, cross-sector partnerships, and advocacy for equity-enhancing policies to improve health outcomes, reduce the cost of care, and advance health equity.

4 Culture: creating a resilient culture of belonging, engagement, accountability and problem-solving that fosters trust, supports team effectiveness and adaptation, and drives positive patient outcomes, workforce well-being and organizational success.

5 Evaluation and analytics: establishing systems and processes to generate science-based evidence, guide informed decisions, and evaluate patient and community impact. This integrated approach ensures data-driven decisions, continuous improvement and effective investment of resources across all principles.

Advancing community health and belonging in times of change

The shifts we experienced in 2025 health care policy and regulation aren't abstract; they directly affect access, affordability and the quality of care for millions of people. We expect more changes in 2026, and we're committed to adapting to them without compromising healthy outcomes.

Rather than focus on obstacles, however, last year we seized the opportunity to reimagine how we deliver care. True well-being is not just about ensuring fair access to services but also fostering an environment where all our stakeholders — from patients and families to aides and doctors — feel valued and included. We know this isn't some solo exercise. Building a culture of belonging and partnering with communities to address the social and environmental factors that influence health helps to create a more sustainable and effective model of care for everyone.

In 2025, we introduced innovative ways to meet the needs of our communities, close gaps in health care access and provide social services, including employment and economic stability.

Though we recognize there's significant work ahead, we celebrate these achievements as proof of our impact and potential.





A sustainable operating model for community health

Last year, as we integrated Corewell Health in Southeast Michigan, Corewell Health in Southwest Michigan and Corewell Health in West Michigan into a single, cohesive system, the office of community health impact and belonging moved from a patchwork of programs to a collective and connected set of initiatives. This pivotal shift enables us to extend our healthier communities portfolio of programs and expand our distinctive Belonging approach consistently across the entire organization. By working in concert together — sharing best practices, data and resources — we continue to sharpen our focus on health equity and achieve maximum measurable impact across the communities we serve.

Our goal is to leverage our exceptional team members, resources and broad reach to improve outcomes for all our patients and communities.



Healthier communities portfolio development

To optimize alignment, impact and accountability across our regions, we launched a systemwide program portfolio review, including an assessment of our resources and our community health priorities. As part of this effort, healthier communities initiatives were organized into three standard portfolios:

- 1 Place-based care and wellness:** integrates primary care, mental health, prevention and social care in community-centric settings.
- 2 Community building and civic engagement:** builds community leadership, strengthens civic infrastructure, and supports regional policy and systems change.
- 3 Maternal, child and adolescent health:** provides holistic, life-stage health interventions, including maternity care, school-based health programs, violence prevention and family well-being.

Portfolio outcomes areas

-  Improved chronic disease management
-  Improved perinatal outcomes
-  Improved child and adolescent health
-  Increased trust in Corewell Health as a health care partner
-  Improved food security for people and communities



Program prioritization and optimization is enabling healthier communities to strategically allocate funds and staffing, and effectively promote coordination among community health, clinical services and social support systems.

By adopting an iterative approach, healthier communities can adapt to today’s complex challenges in meeting community needs and navigating policy reform and funding shifts while staying focused on Corewell Health’s strategies and portfolio priorities.

Belonging portfolio development

Our commitment to belonging is foundational to how we advance our mission and deliver equitable, high-quality care. It shapes our community engagement, patient experience, workplace culture, and efforts to eliminate disparities in access and opportunity. To move from intention to systemic change, we conducted an enterprise-wide assessment of our policies and workforce strategies. The result is the belonging portfolio intentionally organized into three strategic areas of focus:

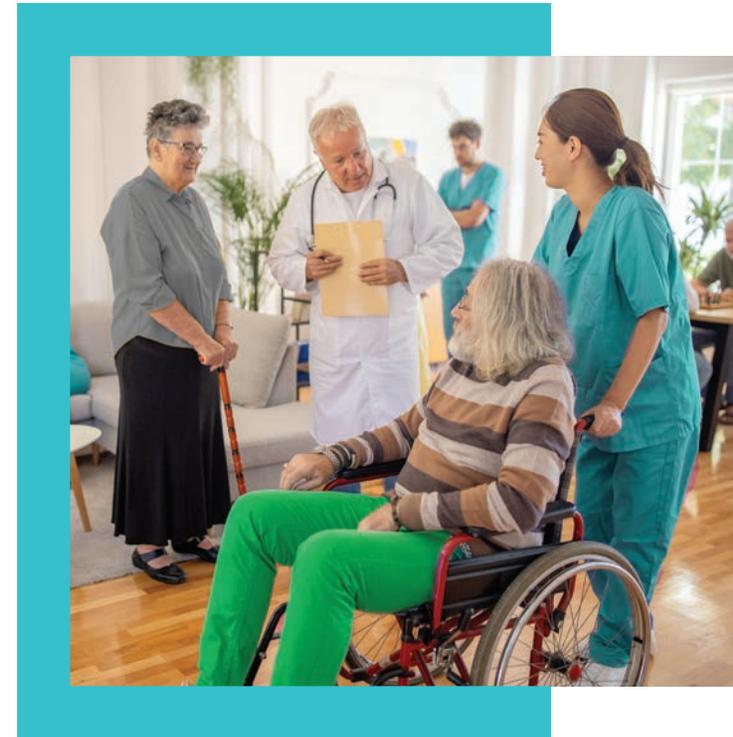
- 1 Learning and development:** redesigned to deepen cultural competency, including our team members’ awareness and skills to eliminate disparities and create a stronger sense of belonging for patients, plan members and one another.
- 2 Policies and practices:** established new governance to ensure that existing policies are reviewed for unintentional adverse impacts, and new policies are shaped with an unbiased and inclusive lens.
- 3 Workforce and workplace development:** embedded culturally responsive care to ensure our organization is representative of the communities we serve and to improve trust with and the experiences of patients, plan members and team members.



The road map to impact

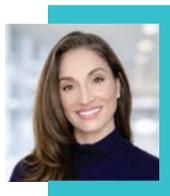
Across the office of community health impact and belonging, a unified strategy is guiding our actions. To sustain progress, our Health Equity Evaluation, Assessment and Analytics Team (HEEAAT) is collaborating with healthier communities and belonging leaders to embed key success indicators, track outcomes, and measure impact over the long term.

In 2026 and beyond, our steadfast commitment to measuring progress will enable informed decision-making and allow our team to optimize our investments in wellness and quality care and drive the greatest impact for our patients and communities.





Place-based care and wellness



We provide the right care at the right time and place by meeting patients where they are — from schools and senior centers to emergency response sites. Our place-based approach simplifies health care and removes barriers to access for the communities we serve.

— **Kaley Petersen**, Senior Director, Healthier Communities



By encouraging and enabling sustainable healthier behaviors, we're helping to build more resilient and holistically well communities.

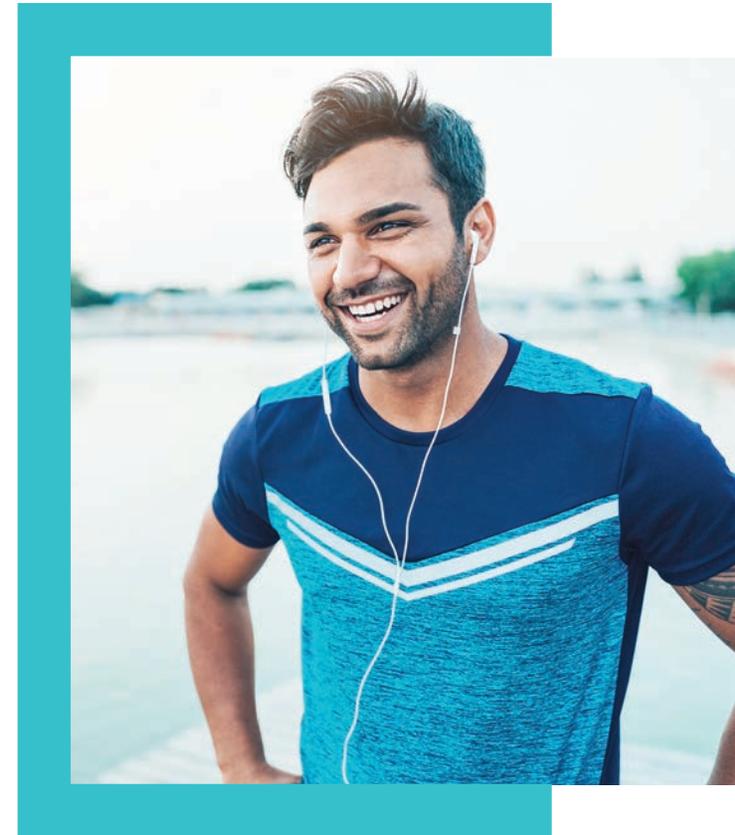
Our Place-based Care and Wellness portfolio recognizes health is profoundly shaped by where people live and work. Social determinants — nonmedical factors — like access to quality housing, education, job opportunities, and clean air and water significantly impact health outcomes. Recognizing this reality, all of our programs are strategically aligned, unified by our overarching goal to drive health equity and achieve measurable improvements in community health outcomes.

The healthier communities team within the office of community health impact and belonging works with clinical staff, community health workers and community-based partners to target the root causes of health inequities, integrating accessible, affordable, and culturally accommodating mental health services, prevention programs and social care investments into accessible community-based locations.



Empowering better health through lifestyle: preventing and managing chronic disease

Shifting from reactive to proactive care, healthier communities employs inclusive wellness strategies to improve long-term health outcomes for chronic disease and prevention. We meet people where they are — physically, socially and emotionally — using nutrition education, clinical experience and community-based support to empower patients and drive meaningful and sustainable behavior changes.





Impact snapshot
Centered: Cooking for Better Health
 January-September 2025

94%

of respondents
 reported trying new foods, preparation skills and recipes after taking the class

82%

of respondents
 reported that they gained a better understanding of which foods are best suited for managing or preventing their chronic disease

62%

of respondents
 self-reported that their blood pressure reading has shown a decrease

Food as medicine

There’s overwhelming scientific evidence that poor diet quality is a leading risk factor for the most common and expensive chronic diseases. Further, we know that treating diet-related disease with only medication is unsustainable. That’s why we’re offering individuals hands-on, evidence-based nutrition education.

Centered: Cooking for Better Health

Corewell Health in Southwest Michigan’s Centered: Cooking for Better Health service in Benton Harbor uses “culinary medicine” as an inclusive and practical method for chronic disease management and prevention, merging cooking skills with nutrition and medical science to improve health. The program integrates nutrition and culinary instruction with community engagement, increasing knowledge, confidence and healthy habits, and supporting chronic condition management and long-term positive change.

A new recipe for life



Barbara Joseph, 78, was determined to reclaim her health after an injury left her homebound. After gaining 50 pounds and seeing her A1c spike to 9.8%, she was encouraged by her diabetic educator, Annalise Pappa, to join the diabetes culinary medicine class, Cooking for Better Health, where she found not only practical recipes but also a sense of community that helped ease her loneliness. The class reignited her motivation — she began cooking again, attending class regularly, and even signed up for the hypertension class. Her blood pressure is now in a healthier range, her A1c has dropped to 6.6%, and she’s lost 40 pounds. Barbara says she feels energized, proud and finally in control of her health. “I can’t say enough good things — this class helped me turn things around, and I can still enjoy food!”

Prescribe Life

Corewell Health in Southeast Michigan designed Prescribe Life to help patients maintain a healthy diet and manage chronic disease. The nine-month program features nutrition education, coaching and monthly produce vouchers.

Improving access and accountability with iQpay:

iQpay Corewell Health replaced physical gift cards with iQpay, a digital platform that expands retailer options and prevents card loss. iQpay allows participants to shop in-store or online while enabling Corewell to track trends, retain unused funds and improve program efficiency.

Nutrition education

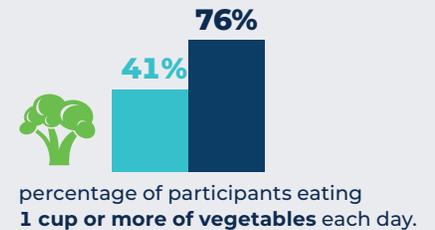
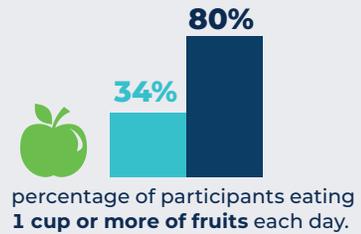
Through a healthier communities and Culinary Medicine partnership, Corewell Health in West Michigan offers dietitian-led classes at Community Action House. The program teaches evidence-based nutrition and portion guidance and provides affordable recipes and take-home ingredients.

 **Impact snapshot**
2025 Nutrition Education

14	300	Topics: Bone health, brain health, eating to reduce inflammation, benefits of herbs and spices; diabetes management and prevention
classes	participants	

» At a glance:

Prescribe Life greatly increased fruit and vegetable consumption for program participants.



» At a glance:

Prescribe Life showed a modest but meaningful effect on families' food security.



- Before the program
- After the program



Impact snapshot
2025 Start Now

1,788
biometrics screenings
completed

2,902
completed visits

35
patients
reported reduction in their
HbA1c on an average of **20%**

35
patients
reported results in the
Green Heart Failure Zone

41
patients
reported an increase in
their self-efficacy score by
an average of **5.2** points

Community-driven proactive pathways

To establish greater trust in the health care system, ensure cultural relevance and address the root causes of health issues, our healthier communities team supports community-driven proactive pathways to health. **These local resident- and organization-led programs provide comprehensive lifestyle education, skill building and social cohesion opportunities to empower participants to make lasting lifestyle changes.**

Start Now

Corewell Health in West Michigan's Start Now program focuses on preventing premature death and improving quality of life for individuals living with chronic diseases like diabetes, heart failure and chronic obstructive pulmonary disease. The program operates through a care team model consisting of registered nurses and community health workers. It aims to enhance social and clinical outcomes by increasing patients' knowledge and medication adherence through education, tracking tools and personalized support. Start Now promotes long-term health outcomes by encouraging behavior changes like healthier eating, increased physical activity and better health care engagement.



More Life Mas Vida

This innovative community-based program from Corewell Health West supports long-term health improvements by promoting behavior changes such as improved nutrition, increased physical activity, reduced tobacco use, and enhanced engagement with health care and community resources. **By supporting lifestyle modifications, More Life Mas Vida can help participants reduce cardiovascular disease and diabetes mellitus risks and, ultimately, prevent the incidence of chronic disease.**



Impact snapshot
2025 More Life Mas Vida

1,030
completed visits

1,014
biometrics screenings
completed

Risk of cardiovascular disease
listed by participants as
top enrollment reason

» **At a glance:**

Primary Care at the CHCW saw **1,126** encounters; **55%** were telephone or telemedicine encounters and **45%** were office visits.

Telephone or telemedicine encounters



Office visits



Encounters (total)



3% were same-day office visits, and **1%** were same-day telephone or telemedicine encounters. **4%** of all primary care patients received same-day care, demonstrating flexibility and accessibility of CHCW primary care.

Same-day office visits



Same-day telephone or telemedicine encounters



Scheduled primary care appointments (at least 1 day in advance)



Whole health neighborhoods: wellness where we live

The Primary Care at Corewell Health Center for Wellness (CHCW) is a model for community health care, recognizing that health is influenced by more than just medical factors. Founded by Corewell Health in Southwest Michigan to improve health outcomes for Benton Harbor residents, the clinic offers accessible primary care and integrated wellness programs, addressing preventive care gaps, chronic disease management, and family medicine needs, while supporting early intervention through combined medical and social services. Providers specialize in addiction, family and obesity medicine, and patients receive social support and health education.



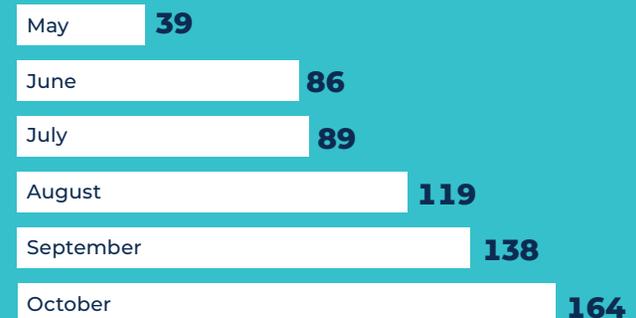
Impact snapshot

CHCW primary care patients* | May-October 2025

Primary Care launched at the Center for Wellness in May 2025.

>630
total visits
representing a
343%
increase
from May to October

Visits by month

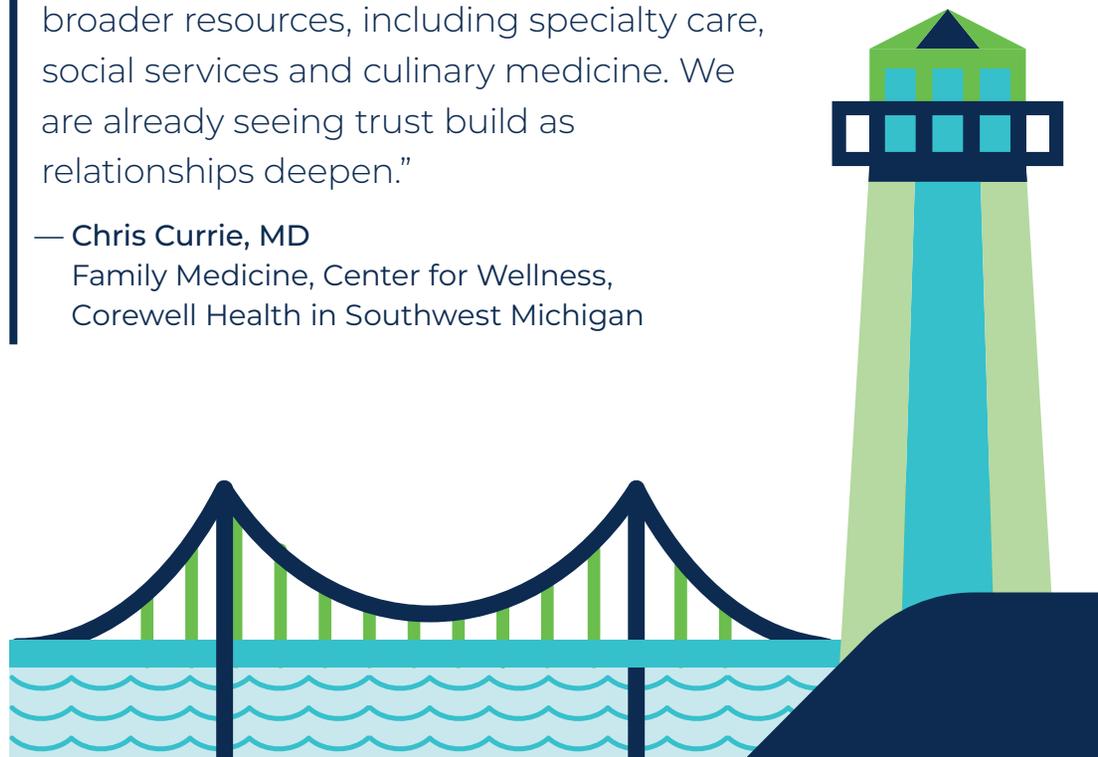


*71% of patients were residents of Benton Harbor.



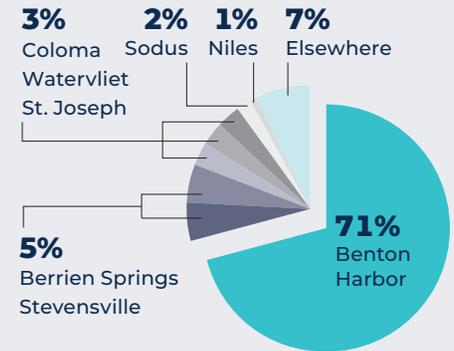
“Returning to Benton Harbor feels like an opportunity to give back to a community that has long faced significant barriers to care, contributing to a nine-year life expectancy gap. Providing primary care is not only about filling a large, documented gap, it’s also about rebuilding trust and providing the kind of comprehensive, community-focused medicine our patients deserve. We’re meeting patients where they are, providing recommendations rather than forcing treatment, and connecting them with broader resources, including specialty care, social services and culinary medicine. We are already seeing trust build as relationships deepen.”

— **Chris Currie, MD**
 Family Medicine, Center for Wellness,
 Corewell Health in Southwest Michigan

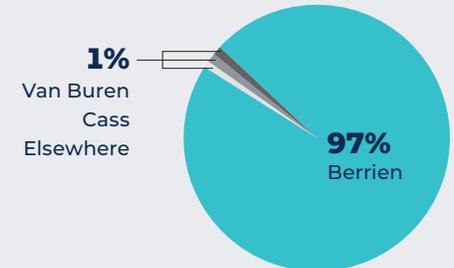


Strong local engagement with CHCW primary care patients:

Residency by city:



Residency by county:





Impact snapshot
Social navigation
 January-October 2025

901

individuals
 served by community health workers via walk-in or phone

569

individuals
 served via clinical referral

1,321

requests
 were referred to resources at the Center for Wellness

2

community health workers



Community care in action: transforming care and outcomes

Community health workers (CHWs) are front-line public health professionals and trusted members of the communities who serve as a compassionate link between complex health care systems and underserved populations. The office of community health impact and belonging is leveraging CHWs to connect people to community resources to address social needs, provide culturally relevant education and preventive programs, and support chronic disease management.

The integration of CHWs across diverse settings — from fire departments to emergency rooms to wellness centers — is a scalable model for advancing health equity and delivering lower-cost preventive care.

Bridging care beyond crisis

Our approach to community programs aims to shift the focus from treating a crisis to proactive management by addressing the root causes of poor health. CHWs provide and connect patients to a range of community-based resources and services, including clinical care, care coordination and education, housing, food, transportation and public assistance. These locally based, culturally responsive programs can reduce unnecessary costs and advance health equity, ultimately improving health outcomes for underserved populations.

Social navigation at Corewell Health in Southwest Michigan

As part of the social navigation service, CHWs help residents access essential resources, like housing, food, transportation and public assistance, and connect clients to financial support resources for utilities and housing. As members of the community, CHWs provide culturally competent support and advocate for equitable care and connect individuals and families to the health and social programs they need to thrive.

Right care, right time

Last year, Corewell Health West expanded several innovative programs and piloted new ones to reduce unnecessary emergency department (ED) visits and enhance patient outcomes. **These real-time, community-based services aim to tackle barriers to care, coordinate follow-up care and support health-related social needs.** For example, in our Pennock and Ludington hospitals, CHWs worked in the ED to identify cases where patients need social support or non-ED services and connect them to more appropriate resources and care. The goal was to ensure patients were connected to the right care to improve their health, and to avoid costly ED visits in the future. Additionally, our Grand Rapids team is embedding CHWs within the fire department and accompanying them on targeted calls where individuals are more likely to benefit from social and health support services rather than an ED visit.

“When we connected with Corewell Health’s Healthier Communities team, we knew we had found the right match. Like us, their focus is on truly improving outcomes. They were willing to collaborate, share processes and build something together — even when it required give-and-take from both sides — to better serve the residents of Grand Rapids.”

— Brad Brown, Grand Rapids Fire Department Chief



Impact snapshot

Right care, right time

February-June 2025

115

patients

were engaged in Ludington and Pennock hospitals emergency departments

~40

patients

were identified with at least one need such as housing, food insecurity, financial assistance and transportation

This identification of nonclinical needs led community health workers to connect the patients to a resource while at the emergency department. The community health workers also do follow-ups through phone calls.

Impact snapshot
2025 Healthy Baby Connect

2,364
pregnant women
in their second trimester whose charts were analyzed using the aiECHO algorithm

48% **190**
of pregnant women screened **women**
had at least **1** identified social need whose charts showed **3** or more identified health-related social or behavioral needs

1,505
women
among the total cohort who were contacted for enrollment in the Healthy Baby Connect program

74 **23**
women **women**
expressing interest in Healthy Baby Connect by completing the intake form ultimately enrolled in Healthy Baby Connect

aiECHO: How we're closing the maternal health gap with AI
The Healthy Baby Connect pilot service in Corewell Health in Southeast Michigan is dedicated to improving maternal and infant health outcomes for pregnant patients facing significant social challenges. It leverages cutting-edge AI-driven analysis of electronic health records to proactively identify high-risk individuals with needs such as housing instability, food insecurity, transportation, lack of access to care, etc. Based on severity of need, patients with the highest needs are invited to the Healthy Baby Connect initiative, where a community health worker helps them navigate the resource landscape so they can receive personalized support, education and resources to address their needs.

This unique blend of AI and human connection, with bias mitigation and opt-out, may enable early intervention, improves prenatal care quality, helps manage stress, and ultimately works to increase birth weight while reducing NICU admissions and unnecessary health care costs.



This work matters: Kenia Cruz Sánchez



Born and raised in Honduras, Kenia Cruz Sánchez experienced firsthand the struggles and limitations faced by her community. Seeking a better future, she came to the U.S. as a refugee, initially working as a youth specialist helping immigrant youth adjust and thrive.

Kenia’s journey led her to become a community health worker (CHW), a role she values deeply. Her personal story gives her an innate understanding of her patients’ challenges. Starting with More Life Mas Vida, she encountered skepticism from patients who had been failed by past health system initiatives. Rather than making false assurances, Kenia focused on building trust by listening and only promoting resources she was confident would benefit them.

Kenia’s dedication exemplifies the commitment of CHWs. When a patient faced a crisis — her son detained, leaving her without income — Kenia helped on her day off, bringing food and connecting the patient with mental health programs. Kenia’s story is one of resilience, empathy and commitment. She’s driven to understand the community she serves, provide life-changing support beyond clinical care, and bridge health systems and our patients and communities.



“The community health worker was AMAZING! I’m so sad that we will be done with our visits. They were very therapeutic. It was nice to have someone to talk to that could offer you assistance instead of judgment. She was very kind and open to everything going on around me. She also sent me multiple resources that have helped me. I only wish I could have worked with her throughout my entire pregnancy.”

— Patient



Empowered health: education for lifelong wellness

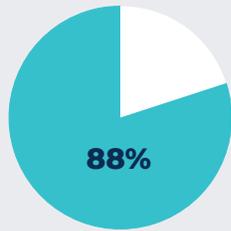
Most health management — from prenatal care to chronic disease to mental wellness — happens outside of the doctor’s office, including all the daily decisions individuals make that directly impact their disease. When people fully understand their condition, treatment plan and warning signs, they’re less likely to experience complications and crises, and more likely to experience better outcomes and a higher quality of life.

We’re making community investments through structured, culturally responsive learning experiences that promote preventive care, reduce health disparities, support chronic care management and empower patients to make critical lifestyle changes.

Strategies for self-support

Our healthier communities teams are dedicated to shifting patients from passive recipients of care to active partners in treatment, a philosophy essential for long-term health adherence and engagement. We accomplish this by offering self-management programs across our service area that equip participants with the confidence and know-how to integrate treatment plans into their daily lives through skills in nutrition, physical activity and stress reduction. This core strategy is implemented via several evidence-based programs — such as the Diabetes Prevention Program (DPP), High Blood Pressure Program (HBP), and Tobacco Nicotine Treatment (TNT) — tailored to specific community needs, ensuring participants gain the practical skills and supportive tools necessary for lasting health improvements.

Diabetes Prevention Program:



88% of DPP participants said they believed continuing their lifestyle changes after the program ends would be either "somewhat" or "very" easy.

At the beginning of the program,



said they were not eating the recommended daily amount of fruits and vegetables.

After the program,



reported that they were eating the recommended amount of fruits and vegetables.

Average number of days and minutes being physically active



High Blood Pressure Program:

» At a glance:

Southeast's hypertension program shows promising results in both monitoring and reducing blood pressure (BP).

% of participants measuring BP at home



● Before the program
● After the program

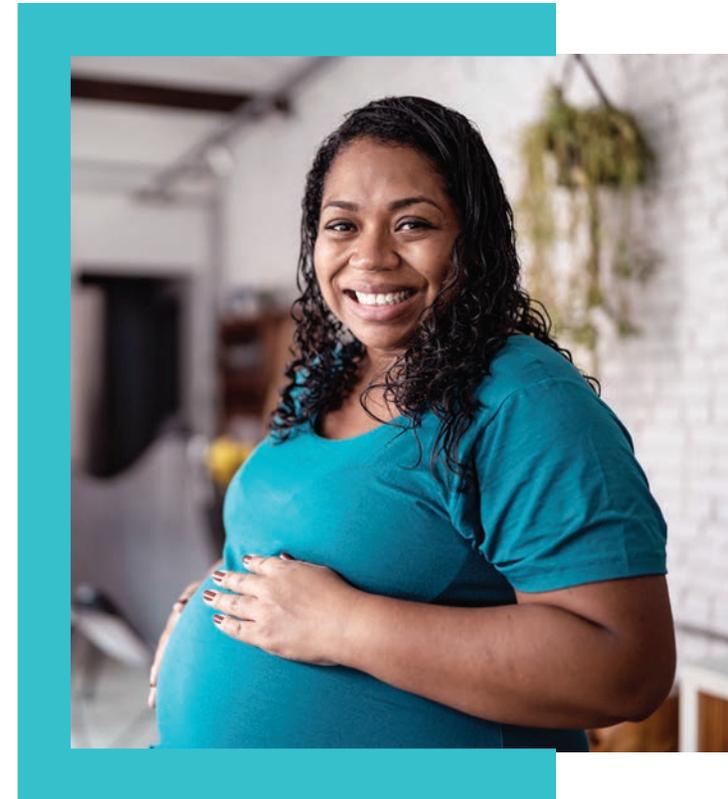
Participants' average BP reading





Family starts at home, and so does our approach to nurturing a healthy beginning.

Investing in the early stages of life has lifelong benefits. From early and consistent prenatal and postpartum care to well-child care, early-childhood development and adolescent health, the healthier communities team within the office of community health impact and belonging empowers families throughout this critical journey. Across our service area, our healthier communities teams address systemic inequities by providing home-based, culturally responsive services and building strong, trusted relationships. We start by listening intently to their unique needs, connecting them to a full spectrum of multidisciplinary programs, including education, physical and mental health care, and a range of social services like transportation, nutrition and housing.



The U.S. is facing a serious maternal mortality health crisis. Consider that nationally:

29%

increase in maternal mortality

from 17.3 to 22.4 deaths related to or aggravated by pregnancy (excluding accidental or incidental causes) occurring within 42 days of the end of a pregnancy per 100,000 live births between 2014-2018 and 2017-2021

~80%

of pregnancy-related deaths and

~66%

of infant deaths are preventable



Foundations for a healthy beginning: Maternal Infant Health Program

Our Healthier Communities approach to prenatal and maternal infant health centers on meeting families where they are — physically and emotionally. Here are four ways we deliver care that strengthens maternal and infant health outcomes:

- 1 Personalized, home-based care:** delivering tailored support directly in the home to reduce barriers and foster trust during pregnancy and early partnering.
- 2 Whole-family support:** addressing the physical, emotional and social needs of both parent and child, recognizing the interconnected nature of family health.
- 3 Equity in maternal and infant health:** providing culturally responsive care that prioritizes underserved communities and reduces disparities in birth outcomes.
- 4 Empowering through education and connection:** equipping families with knowledge, resources and community support to build confidence and resilience during the perinatal period.

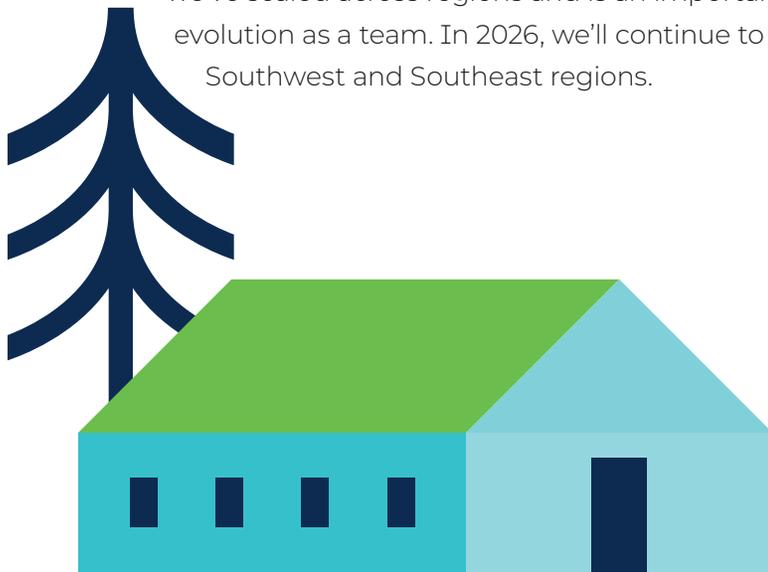
It's all part of our goal to ensure a healthy foundation for life.



Building healthy futures starts at home

The Maternal Infant Health Program (MIHP) is Michigan’s largest evidence-based home visitation program for Medicaid families. MIHP supports healthy pregnancies, positive birth outcomes, and healthy infant growth and development through no-cost, personalized support, including health assessments, education and referrals. Our healthier communities teams aim to reduce maternal and infant morbidity and mortality rates by pairing families with a culturally responsive, knowledgeable and nonjudgemental licensed health care team, including nurses, social workers, community health workers, and nutrition and lactation experts. When baby arrives, our care continues with postpartum mental health screenings and support for mom, newborn care education, resources and referrals to social services.

One of the goals of the office of community health impact and belonging is to share best practices and replicate, as appropriate, programs across our system to maximize efficiency, productivity and impact. Our MIHP program is the first one we’ve scaled across regions and is an important demonstration of our evolution as a team. In 2026, we’ll continue to expand MIHP into the Southwest and Southeast regions.



Impact snapshot Building healthy futures starts at home January-September 2025

6.4
fewer low-birth-weight infants

per 100 live births

2.1
fewer preterm births

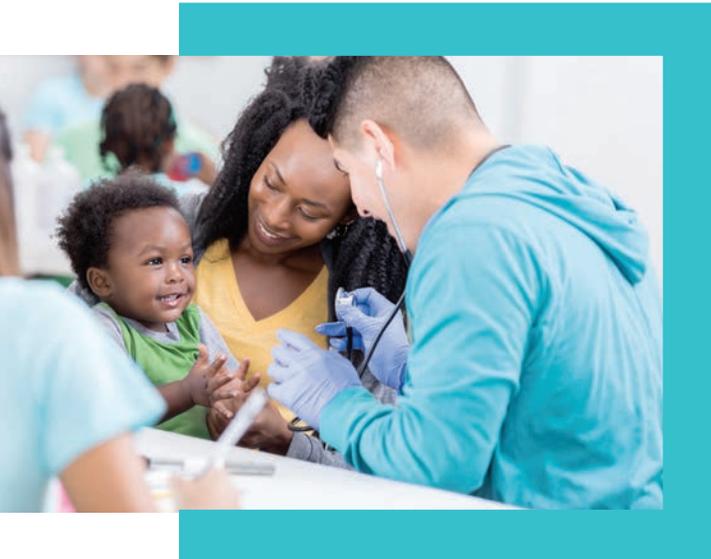
2,749
maternal support visits

3,823
infant support visits

142
mothers
attended 6-week postpartum check

111
mothers
exclusively breastfeeding

397
mothers
initiated breastfeeding



Strong starts, healthy beginnings

The foundation for lifelong health and resilience is built within the family unit. That's why we partner with parents and caregivers, delivering intentional and inclusive support that promotes emotional well-being, strengthens relationships and fosters meaningful connections. We want to empower every family to navigate life's transitions with confidence. Our approach focuses on four pillars:

- 1 Family-centered education:** equipping caregivers with the practical knowledge and tools they need to support child development, health and emotional well-being.
- 2 Emotional support across life stages:** nurturing mental health and strengthening family resilience through compassionate, trauma-informed care.
- 3 Building connection and community:** fostering trusted relationships and inclusive networks to empower families and reduce isolation.
- 4 Equity in family health access:** ensuring culturally responsive services and resources are accessible to all families, regardless of background or circumstance.

Our vision is that all babies, families and communities in Michigan are healthy and thriving.



Maternal and caregiver empowerment at healthier communities Corewell Health in West Michigan

Collaborating with clinical team members and certified educators, our healthier communities team helps expectant parents gain confidence in childbirth, make informed health decisions and start an empowered breastfeeding journey with evidence-based support. Through two key services, childbirth education and lactation support and prenatal education, we aim to improve the health of mom and baby by teaching families about prenatal care, pregnancy warning signs, labor options, lactation and postpartum recovery to reduce the risks of poor outcomes. We offer in-person and virtual classes to all pregnant and parenting families, including expectant teen parents, first-time parents, low-income families, and individuals with limited access to health care, regardless of payer or geography, within our service area.

Supporting the early parenting journey: together we grow

After baby is born, it's crucial to continue supporting parents. As children grow and family dynamics evolve, ongoing support ensures parents have the knowledge and resilience to navigate new developmental stages and challenges, preserving the strong foundation built in the early years.

» At a glance:

In the first three quarters of 2025, Mom's Support Group had 31 unique clients with 92 total logged visits for the classes.

92
visits

31
unique clients

18
group sessions held



Impact snapshot

Prenatal Education

January-September 2025

544
total classes held

4,300
total pregnant client visits

7,900
total support persons visits

82%
of respondents
will utilize the knowledge and/or skills
that they received from this class

75%
of survey respondents
would recommend this class to others

73%
of survey respondents
received the knowledge or skills that
they needed from their class

Healthier communities in Southwest Michigan: childbirth education and lactation support

At 32 weeks pregnant, a mother attended one of our Childbirth Education and Lactation Classes without having received any prenatal care. Recognizing the urgency, our team at the Corewell Health Center for Wellness immediately connected her with a nurse practitioner on-site the very next day. To ensure she received the specialized care she needed, one of our community health workers accompanied her to the hospital, where she was seen in the Labor and Delivery unit. This mother had previously experienced the devastating loss of a baby, and our community health worker provided comfort and emotional support throughout the process. Through our collaborative efforts with InterCare, a local, federally qualified health center, we were able to bridge critical gaps in care, ensuring she received timely medical attention, trauma-informed support, and compassionate guidance, demonstrating the power of partnership, trust and community-centered care in action.

141
visits

38
unique clients

In the first three quarters of 2025, Triple P® in Corewell Health in Southwest Michigan logged:

198
visits

65
unique clients

“This program gave me tools to respond with patience instead of frustration. My child is learning to talk about feelings instead of acting out.”

— Triple P® parent participant

Healthier communities in Southeast Michigan and Southwest Michigan: parenting skills and child resilience programs

Our Raising Resilient Children program in Southeast Michigan helps caregivers build parental skills and positive relationships with their children. The program provides a system of support that ranges from education to more intensive interventions through group sessions, online modules and individual consultations. Our Triple P® program (Positive Parenting Program) in Southwest Michigan helps parents develop confidence and parenting skills that they can utilize to parent positively. It also supports parents to manage challenging behaviors with calm and consistency, often preventing issues such as mental health, substance abuse and family conflict before they start.

“The class opened my eyes to how some of my behaviors, the ‘parent traps’ I was falling into, were negatively affecting my children. I learned so much about how to shift my focus from what’s going wrong to what’s going right.”

— Triple P® parent participant



Nurturing potential: school- and youth-based wellness

Healthier communities is empowering students to thrive by partnering with school communities to create healthier, more equitable learning environments, and impacting the policies, systems and environments within school spaces. Our innovative programs embed physical, emotional and social well-being directly into the fabric of the education system by focusing on four core areas:

- 1 Whole child wellness:** prioritizes mental, emotional and physical health as the essential foundation for long-term success.
- 2 Equity in access and outcomes:** ensures all students receive culturally responsive care and equitable opportunities.
- 3 Collaborative school-community partnership:** strengthens connections with families and local organizations for comprehensive, wraparound support.
- 4 Empowering learning through health:** promotes health literacy and emotional well-being as vital tools for lifelong achievement.

Through integrated wellness programming and inclusive education, Corewell Health is laying the foundation for healthier futures inside and outside the classroom.

Campus care collective

These unique healthier communities services are truly about eliminating barriers to access by delivering physical and mental health services directly to students where they are. Through in-school and local health centers and teen centers, we provide a wide range of primary and emotional preventive and intervention treatment and referrals, and staff education.

Expanding, Enhancing Emotional (E3) Health

This unique program from healthier communities in Southeast Michigan promotes the emotional health and well-being of children, adolescents and their families by providing on-site, year-round comprehensive mental wellness services for mild to moderately severe needs, including prevention and intervention.



Impact snapshot

E3

October 2024-September 2025

369

youth received services

8

service locations across Metro Detroit



Impact snapshot
School-based clinics and teen centers
 October 2024-September 2025

18
 clinics:

10
 offering physical and mental health

8
 mental health specific

3,361
 unique students
 seen in the 2024-2025 school year

559
 unique students
 specifically sought mental health services

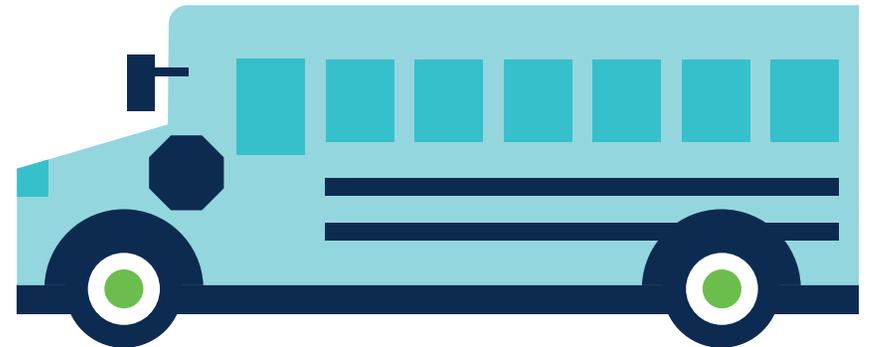
Healthier communities in Southeast Michigan: school-based clinics and teen centers

Through our Corewell Health Child and Adolescent Health Centers (CAHCs), our team provides comprehensive medical and mental health services during and after school hours at in-school clinics and nearby Teen Centers to youth ages 5 to 21, and to special education students receiving services through age 26. By strategically offering services in areas with high poverty and that have experienced disparities in health outcomes, we can reduce barriers to health care and absenteeism, ensure children of working caregivers can easily access care, and improve health outcomes in underserved communities.

Corewell Health in Southeast Michigan has been operating and providing CAHC programs through state funding for more than 30 years in the Detroit Metro area of Wayne County, Michigan, at no cost to residents.

“I like that you make us feel good about being here and making sure that our appointments are confidential; you don’t make us feel scared.”

— Student, Taylor Teen Health Center



Healthier communities in West Michigan: school nursing program

Students with chronic health conditions or health needs face significant barriers to academic success due to inconsistent access to essential health services within schools. By integrating accessible, on-site health services through a team of registered nurses and health aides, we can support schools in managing acute illnesses, injuries and chronic health conditions and enable students to stay healthy and engaged in their learning.



Impact snapshot

School nursing program | July 1, 2024-June 30, 2025

Serving:

10

counties and

32

school district partners

80,000

students

served by nurses across West Michigan

14,909

hours of care

delivered for students helping manage illness, chronic disease or medication adherence

Here is what the school leadership shared when they were surveyed.

88%

of respondents

reported that the program has improved management of chronic conditions in students

93%

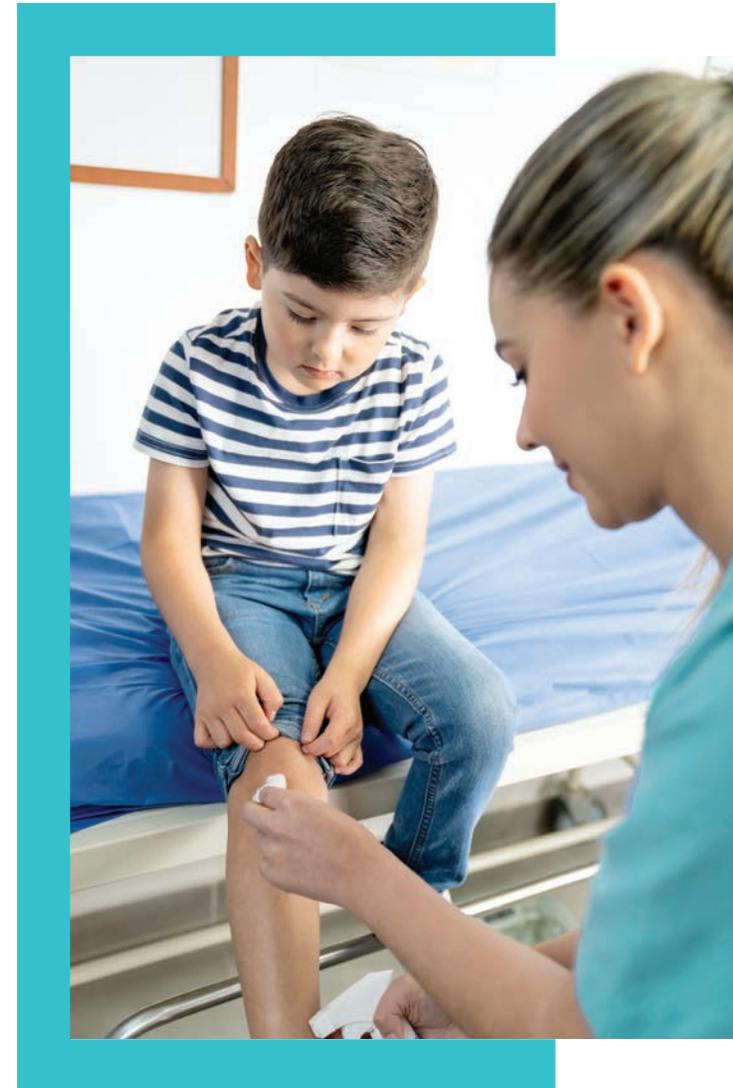
of respondents

reported that the program has improved staff knowledge based on the trainings provided

89%

of respondents

reported that the program has increased access to care for students





Impact snapshot
CATCH

Over two years of implementation (2023-2025), CATCH has measurable progress:

2,497
students engaged

across Barry and Ottawa counties in the 2024-2025 school year

96%
of teachers

reported an increase in awareness of the importance of good nutrition among their students who participated in CATCH

93%
of teachers

either strongly agreed or agreed that they could motivate their students to be physically active through modeling and encouragement after participating in CATCH

96%
of teachers

said they saw an increase in their students engaging in physical activity since participating in CATCH

Thriving Spaces for Growing Minds

Our “Thriving Spaces for Growing Minds” initiatives are focused on impacting the policies, systems and environments within the school space. These programs may happen through our Coordinated Approach to Child Health (CATCH) program, which aims to impact nutrition policy in schools, or the Whole Child County Collaborative that strives to improve belonging in schools.

We’re helping to optimize wellness to fuel academic achievement.

Healthier communities in West Michigan: CATCH

The CATCH school-based program is a dynamic, evidence-based initiative that fosters healthy habits in pre-K-8 students by transforming school environments and policies. Through engaging in-person and virtual lessons, taste tests, and grade-specific activities, CATCH makes healthy choices easy and sustainable. It helps schools meet wellness policy requirements while reducing chronic disease risk and boosting lifelong health. Thanks to Corewell Health and foundation support, the program is free and prioritizes underserved schools — though any school can join.

“I started drinking more water and have fruits and vegetables with every meal.”

— Upper Elementary Student

“I have more students talking about trying new fruits and vegetables at lunch and encouraging parents to try new dishes at home. They have also encouraged each other in trying to be more active.”

— Elementary Teacher

**Healthier communities in Southwest Michigan:
Berrien County Whole Child Collaborative**

The Whole School, Whole Community, Whole Child (WSCC) model unites education, health and community-based organizations around a shared mission — nurturing every child’s cognitive, physical, social and emotional development. In Berrien County, superintendents have rallied around a shared goal to build educator capacity to foster belonging and engagement, where every student feels connected and accepted. Recent community health assessments echoed the need to prioritize mental wellness. The Whole Child Collaborative is answering with a multitiered approach — promotion, prevention and intervention strategies that strengthen psychological safety, build social capital, and drive change at every level, from the individual to the community to the institution.

Together, we’re creating school environments where students and staff truly belong.



**Impact snapshot
Whole Child Program**

3,766

attendees

participated in Whole Child Collaborative (WCC) programming in 2025

173

individuals

attended the Suicide Risk Assessment Workshop in September

122

individuals

attended the WCC Fall Summit in October

40

student advisory members and

29

belonging ambassadors

(representing 100% of school districts within Berrien County) oversaw the completion of **10 student projects in 6 different Berrien County school districts**



Community building and civic engagement



The Community Building and Civic Engagement portfolio is a favorite because it highlights how health extends beyond health care. It demonstrates how investing our time, talent and partnerships creates lasting change in the communities we serve.

— **Nicki Britten, MPH**, Director, Healthier Communities Southwest Michigan, Corewell Health Center for Wellness — Benton Harbor



True partnership between communities and health care systems is vital to engage residents, advance health and foster lasting wellness.

When it comes to community health care, moving beyond our clinic walls isn't secondary — it's the critical foundation for how our healthier communities teams reduce health disparities. When we invest in communities and engage residents as trusted partners, we can help ensure that health care interventions and programs are relevant and culturally competent and address the unique barriers our communities face.



Together we thrive: belonging and collective action

Our approach to community health care shifts the paradigm from top-down interventions to those rooted in the communities we serve. Our healthier communities teams commit to growing neighborhood capacity — ensuring that residents themselves are helping to identify, prioritize and support solutions to their most pressing health-related concerns within their own communities.

Healthier communities in Southeast Michigan: Racial and Ethnic Approaches to Community Health (REACH) Coalition

Healthier communities in Southeast Michigan created the Community Health Coalition of Greater Detroit — a grassroots initiative funded through our Centers for Disease Control and Prevention (CDC) REACH grant — to drive policy, system and environmental change in Wayne County. Our goal is to coalesce local organizations





Impact snapshot
REACH opportunity

1 in 5

mothers in Michigan

have at least one basic need (food, housing or transportation) that was unmet during pregnancy, and the majority of mothers who stopped breastfeeding did so because they were not producing enough milk

250,000

people in Wayne County
are affected by food insecurity

Wayne County SNAP recipients:

45%

children

32%

single mothers

92%

of retailers

accept SNAP benefits in Detroit but carry little to no fresh fruits or vegetables

to help improve community health and reduce disparities among populations with the greatest burden of chronic disease. REACH’s four strategic focus areas include breastfeeding continuity, food policy systems, fruit and vegetable systems, and safe physical activity.

In 2025, we led our first chronic disease assessment in Wayne County that identified food insecurity and breastfeeding challenges as two of the most critical issues. The findings related to breastfeeding led Corewell Health East to review their processes and procedures surrounding birth and engage coalition member organizations, like [Birth Detroit](#) and [J.O.B. Lactation](#), who are helping to improve breastfeeding initiation and duration rates. With regard to food insecurity, organizations like [Metro Food Rescue](#), Detroit With Love, and [The Youth Connection](#) are helping to encourage urban agriculture and advocate for policy changes that reduce food waste while improving access to food for those who need it most.



“Programs like REACH are great! I didn’t know some of the things that could be resolved if I just showed up at community meetings. I enjoyed how we came together collectively and figured out how we can do better as individuals and how we can implement change as a community.”

— **Nicole C.**, Inkster Resident, REACH Focus Group

Healthier communities in Southwest Michigan: interconnected systems framework — whole child model

As community leaders, we believe it's our responsibility to understand the people within our service areas and leverage all our resources to yield sustainable health and well-being.

We know many of our communities lack sufficient mental and emotional health services, leading to untreated conditions, higher acuity and more complex medical issues. This gap is most acute in our rural communities that struggle to recruit on-site clinicians. To address this, our Interconnected Systems Framework (ISF) team collaborates with local leaders and school systems. We begin with an assessment to identify the greatest needs, and then deploy a targeted, tiered support system:

- **Tier 1:** Universal strategies to build resilience
- **Tier 2:** Targeted interventions for students showing signs of need
- **Tier 3:** Individual one-on-one services, often involving specialized clinicians

“This is a way to help our kids and our families, giving them another way to connect with the needs that they have. Our kids can stay in school, still continue to get those services. That's what's best for kids.”

— Jeff Mount, Superintendent, Mason County Central Schools



Impact snapshot ISF Whole Child Model

- The Interconnected Systems Framework leadership collaborative came together to explore responses, with Corewell virtual mental health selected for pilot.
- A Corewell Health virtual mental health solution was selected from a number of responses.
- The program started in one rural area and has now expanded to 18 schools.

15-20%

of students

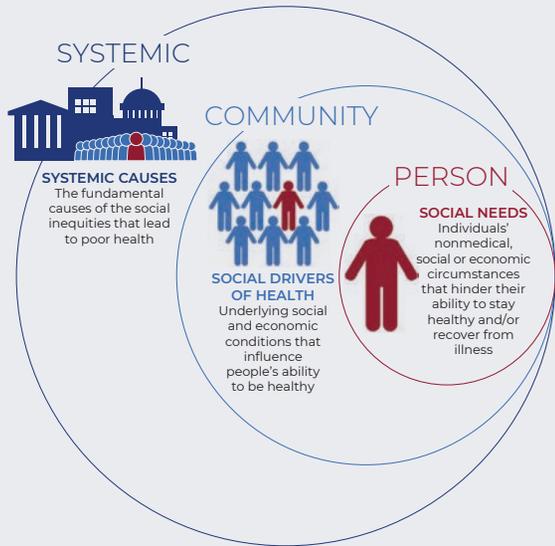
come into high school with mental health needs (per Mason County High School director of state and federal programs)

783

unique students

were served in 2025

Societal factors that influence health



Credit: American Hospital Association

We piloted our first ISF program in **Mason County** during the COVID-19 pandemic, introducing school-based suicide prevention protocols, opening clinics in high-need schools and implementing substance misuse prevention. Our role is multifaceted: we act as a **key partner** in the local ISF leadership collaborative, convene partners, fill resource gaps and track success. We have since introduced the ISF program to **Ottawa and Zeeland** and plan to expand to more schools in 2026.

“There’s so much more that a community needs beyond what is served in the hospital. And as health care providers, we’re responsible to make sure those needs are met. In the most broad sense, that’s what’s important to me, is that our families, our students and our schools are seeing the benefit of this.”

— Brandon Holmes, Director, Care Management, Corewell Health

 **Empowering local leadership**

Locally led, community-based health care programs succeed because residents are the true experts on their cultural, environmental, social and economic needs.

That’s why the office of community health impact and belonging invests so heavily in community collaborations and community-driven policy, program and system changes. To ensure these initiatives are successful and sustainable, we also provide residents with the knowledge and operational foundation they need to lead.





**Collaboration, education, results:
18th Annual Community Health
Worker Conference**

Community health workers (CHWs) are trusted partners who bridge the gap between health care systems and underserved communities facing poverty and historical mistrust. By sharing lived experiences, CHWs address social determinants of health and advocate for equity, significantly impacting community empowerment and long-term health outcomes. They are embedded professionals who understand our patients, multiply system capacity and help improve outcomes while driving down costs.

Recognizing their critical role, 18 years ago Corewell Health launched an annual conference. Now national, the most recent conference celebrated and elevated CHWs, highlighting their role and benefits and demonstrating how collaboration with the interdisciplinary team improves health.



**Impact snapshot
CHW Conference**

200
survey responses:

87%
of respondents
would recommend the
conference to others

86%
of respondents
will use the knowledge and skills
they learned from the conference

Feedback from attendees emphasized the valuable information/messages and speaker quality as what they liked best about the conference. Attendees also expressed that they liked the opportunity to engage and network with other community health workers.



“The Academy is more than a training program — it’s a launchpad for civic engagement, neighborhood transformation and long-term wellness. We’re investing in residents who live the realities of our community every day. Their leadership is key to building a healthier, more connected Berrien County.”

— Dawn Marie Smith,
Director, Be Healthy Berrien

Community health worker training at Corewell Health

Corewell Health has been training CHWs for over 10 years. Initially in-person, the program pivoted to a virtual delivery in 2020, achieving statewide reach across Michigan. Cohorts include a diverse mix of 25-30 candidates, fostering a broad learning environment.

“For me, being a CHW is purpose, passion and profession all in one. The work feels less like a task and more like a guided mission toward the future my community deserves. This role is beyond metrics or theoretical equity — it is lived expertise, heart work and community stewardship. CHWs don’t just talk about it, we walk the path. We are the architects advancing community-centered policy and practice.”

— Steph Thornton, BS, CCHW

Healthier communities in Southwest Michigan: Community Leadership Academy

The inaugural cohort of the Community Leadership Academy officially launched its dynamic, 10-week pilot program in September 2025 at the Corewell Health Center for Wellness in Benton Harbor. Led by [Be Healthy Berrien](#) — a collaborative initiative of United Way of Southwest Michigan and Corewell Health — the Academy is designed to transform passionate local residents, including parents, young adults and educators, into effective neighborhood changemakers. The program achieves this by providing workshops and leadership development sessions focused on equipping participants with the knowledge and tools needed to lead change, specifically by addressing local health and well-being. The first session introduced core concepts such as environmental and social health influences, neighborhood design, local food systems and community improvement project planning.

 **Equitable resource mobilization**

We're making direct, targeted investments in our local ecosystems to boost community health.

We know we can't solve every problem alone, so our strategy is to **build local capacity** by providing financial resources to key organizations and partner institutions that support our communities. In 2025, we began strategically focusing these investments to advance health and well-being across our entire service area.

Healthier communities in West Michigan: funding community priorities

Focusing on mental health and access to care, in 2025 our healthier communities in West Michigan team evolved their grantmaking model to drive systems-level change through strategic alignment with community health needs assessment (CHNA) priorities. The multiyear grant program is the office of community health impact and belonging's largest funding initiative in Kent County, offering substantial financial support to local organizations. The team now uses a more intentional approach to drive necessary resources to communities that have used the CHNA process, further aligning our programming and grantmaking work to community needs.

Supporting strategic alignment through regional grantmaking

In 2025, the office of community health impact and belonging enhanced its grantmaking approach by using a regional lens. Learning from the strong legacy of the healthier communities in West Michigan team in Kent County, we're seeking opportunities to support critical partners who can advance our shared goals in food access and maternal-infant health, while bolstering the infrastructure needed to align communities around priority health needs.



Impact snapshot
 2025 funding
 community priorities

across Kent County:

\$1,716,900
 granted to

11
 organizations

7
grants
 supporting
 community health
 needs assessment
 prioritized access
 to care needs

4
grants
 supporting
 community health
 needs assessment
 prioritized mental
 health care



Impact snapshot
 2025 partner funding

\$250,000
 granted across our
 service area to

7
 organizations



Strategic sponsorships that advance health

Community sponsorships are a strategic investment that builds trust, increases brand awareness, advances health equity and strengthens relationships. By partnering with local organizations, we demonstrate our commitment to improving health outcomes, tackling social determinants of health and building sustainable partnerships that amplify impact. To date, we've invested over \$1 million in sponsorships and direct support across 42 organizations serving our state. Here are two great examples of the power of sponsorships:

Michigan Men's Health Foundation

Since 2009, the [Foundation](#) has delivered measurable results by conducting thousands of free preventive screenings through the Men's Health Event. Our investment will build on this success by supporting the new Mobile Men's Health Clinic, which will bring screenings, education and resources directly to communities throughout Michigan.

DABO Detroit Inc.

[DABO Detroit Inc.](#) has established trusted pathways to reach underserved populations through culturally responsive programming that addresses social determinants of health. Our investment of \$100,000 will help DABO create a micro urgent care facility and build capacity to serve more residents in northwest Detroit.

This funding is part of a broader effort to deepen our engagement in Detroit, where Corewell Health currently has minimal physical presence. We're committed to following the lead of trusted local partners to determine the best ways we can support the health of Detroiters.



Investing in sustainable community health

Our community investments move beyond treating acute needs and simply delivering services; we focus on creating lasting policy, systems and environmental changes. This helps build a foundation for sustainable community health.

Healthier communities in West Michigan: expanding food bank capacity, quality and access

People with low income often lack access to healthy food, which has led to growing socioeconomic disparities in diet quality. Corewell Health in West Michigan partners with three local **choice-based food clubs** — Ottawa County Community Action House, Mason County Lakeshore Food Club and Kent County GR Food Club. This innovative model, distinct from traditional food pantries, utilizes a low-cost, membership-based system where clients use a point system to shop for groceries. To encourage healthy eating, nutritional foods are assigned lower point values, effectively incentivizing the selection of healthier items. Corewell Health in West Michigan supports these partners through community grant making, collaborates directly with the food clubs on various health and social needs programs, and maintains a close connection with them regarding policy and advocacy opportunities.

Additionally, we're partnering with the American Heart Association to deploy our registered dietitians in the Greenville, Big Rapids and Reed City communities. They are working directly with food pantries to optimize food display and provide educational materials, focusing on how food choices align with managing chronic conditions to support increased healthy food consumption. In 2025, we helped fund equipment to properly stock and store fresh food and enhance volunteer and client education to promote healthier food choices. We also supported programs to increase the availability of fresh, local produce and reduce refined grains and high-sugar items.



Impact snapshot Food systems

\$100,000
in funding to local pantries

7
pantries
received funding

3
food clubs
who partner with Corewell Health



Together, we're building a culture where everyone can thrive.

Our belonging team, a central part of the office of community health impact and belonging, works systemwide to build bridges across differences and create environments where everyone can thrive.

Belonging shapes how we deliver care, how we work and how we show up for our communities. When patients feel seen, valued and respected, care and outcomes improve. When team members feel valued, heard and empowered, collaboration strengthens. When communities trust us, access expands. To build a culture of belonging within our organization and across the communities we serve, we strive to:

- Cultivate trusted patient partnerships and foster value-based supplier relationships
- Ensure equitable access for — and adapt quickly and appropriately to the evolving needs of — our communities
- Ensure our policies, practices and decisions reflect fairness and compassion
- Listen actively to the voices and experiences of our communities and team members
- Promote a work environment rooted in respect, integrity, compassion and collaboration
- Create opportunities for team member growth and meaningful contribution



Corewell Health was named to Seramount's 2025 Inclusion Index for the fourth consecutive year in recognition of leadership accountability, equitable talent management, inclusive culture and community engagement.



Additionally, Corewell Health achieved a top score on the 2025 Disability Equality Index for the third year running, affirming its ongoing commitment to accessibility and inclusion for individuals of all abilities.



Impact snapshot
Learning and development
 January-October 2025

12
 belonging training
 programs offered

15,000
 team members
 completed belonging
 courses and training

11,500+
 team members
 completed Foundations
 of Unconscious Bias



Building belonging: learning and development

Our belonging learning and development curriculum helps our team members better understand and respond to one another and the diverse communities we serve across our service area. To support our belonging efforts, we offer a wide range of training and courses on topics ranging from unconscious bias and managing microaggressions to understanding generational differences, advancing maternal health equity, and creating environments of psychological safety and belonging.

Our evidence-based courses help create understanding and provide team members with strategies to adapt their behaviors. For instance, our implicit bias courses aim to help team members understand how bias in health care leads to differences in pain treatment, diverging assumptions about medical compliance and diagnostic disparities. Through our training programs, team members learn strategies to mitigate the effects of bias in their work.

We want to develop a workforce that leads with empathy and understanding, providing tools for our team to identify and correct unintentional slights and exclusion to ensure a truly inclusive environment.

Five areas of belonging

 Cultural Competence	 Equity of Care	 Community Engagement	 Supplier Diversity	 Workforce Diversity
<p>GOAL Deliver a variety of interventions aimed at removing systemic barriers that affect people's behavior and the quality of health care provided. This includes interpersonal interactions among team members, providers, patients and consumers.</p>	<p>GOAL Improve systematic collection of data for various dimensions of diversity and use of quality measures to develop targeted interventions that help eliminate health care disparities.</p>	<p>GOAL Increase and strengthen community partnerships that bring awareness and involvement in improving health outcomes and reducing health inequalities within our community.</p>	<p>GOAL Improve the economic health of our community through inclusive sourcing that leads to cost savings, drives innovation and benefits our local community.</p>	<p>GOAL Increase and sustain diversity (e.g., race and ethnicity) of our workforce at all levels to help improve access to health care for all communities.</p>



Leading with integrity: policies and practices

We create spaces where everyone feels seen, supported and valued — from our team members and patients to our health plan members and communities.

To embed our principles of belonging into the way we operate, our belonging team reviews policies and practices across Corewell Health, ensuring alignment with the organization’s belonging principles. Our belonging team uses targeted universalism to identify and help to eliminate barriers that impact underserved and marginalized groups in clinical and nonclinical settings to ensure optimal health for everyone. Leading with compassion, empathy and self-care for all, our approach fosters a deeper sense of inclusion, promotes a culture of fairness, strengthens community trust and encourages a supportive work environment across our system.



Shaping our culture: workforce and workplace development

Business Resource Groups (BRGs) are team member led and formed around common demographics and characteristics or shared interests. Our BRGs provide team members with opportunities for connection and education while serving as key partners to drive change. They are essential partners in achieving Corewell Health’s mission and instrumental in achieving the following four outcomes:

- 1 Engaging our workforce:** connecting team members across our system and providing them a forum to network and learn together.
- 2 Developing leaders:** cultivating a pipeline of diverse, high-potential future leaders.
- 3 Recruiting and retention:** attracting and retaining top talent.
- 4 Community connection:** deepening our engagement with the diverse communities we serve.



Impact snapshot Policies and practices January-October 2025

Across our system, belonging team advisers collaborated with

45

departments
in 2025 and continue to expand on their work





Impact snapshot
Workforce and workplace development
 January-October 2025

nearly
38%
 increase in BRG members

75
 events coordinated

more than
27,000
 people reached

All Corewell Health team members are eligible and encouraged to participate in any Business Resource Group (BRG) to learn and network whether they are a member of that BRG community or an ally.



The wide spectrum of events sponsored by our BRGs in 2025 ranged from recurring book clubs and professional development webinars to networking and social hours, and externally sponsored events like participation in local parades and community volunteering activities. Each unique format is designed to promote our business goals, foster a culture of belonging, advance inclusion and inspire hope.

» **At a glance:** BRG membership has increased a great deal over the past year.





2025 BRG Summit

The 2025 BRG Summit brought 123 BRG members together from across Corewell Health’s service area. The BRG Summit aimed to show the value BRGs bring to the Corewell Health organization and all team members. Attendees had the opportunity to connect, learn and explore how BRGs can support team members’ experience and development. Those that attended the BRG Summit shared that they receive a lot of benefit from their BRG membership.



Impact snapshot Business Resource Group Summit

93%

of respondents

stated their Business Resource Group membership provides either “a fair amount” or “a lot” of benefit to their feelings of belonging and connection at Corewell Health

90%

of respondents

said their membership provides either “a fair amount” or “a lot” of benefit to their ability to impact the group of team members their Business Resource Group represents

Community benefits and community health needs assessment



We do amazing, life-changing work that most of the general public doesn't know about. We should celebrate it and share it with our communities to demonstrate we truly are here for them.

— Tom Warnshuis, Director, Tax and Finance, Corewell Health



The powerful partnership between Community Benefits and CHNA enables us to respond to the unique needs of the communities we serve with greater precision and impact.

Community Benefits (CBs) are programs or activities that provide targeted treatment or promote health and healing as a response to a documented need. The **Community Health Needs Assessment (CHNA)** is a systematic process that identifies specific community health needs and issues by listening directly to the voice of the community through robust community engagement methods. Together, these powerful frameworks help us to uphold our fundamental responsibility to provide measurable benefit, promote transparency and continuously advance health equity across all the communities we serve.



The purpose and power of community benefits

CB is the tangible result of our commitment to invest in the health of every person and community we serve. Our efforts are rooted in three core objectives: improving access to care, enhancing community health and advancing medical knowledge. Our CB investments help to ensure we reduce burdens on public resources and directly address critical needs identified in our CHNAs. Fulfilling this strategic commitment is essential to advancing Corewell Health's mission to "improve health, instill humanity and inspire hope." It also affirms our health equity pledge to achieve "no avoidable gaps in health outcomes."





The CHNA helps us systematically determine how best to focus our CB efforts. This rigorous process involves two critical steps:

1 Needs identification: We synthesize publicly available, preexisting data (secondary data) and our own collected research and insights (primary data) to pinpoint the most significant unmet health needs facing our residents.

2 Implementation strategy: A diverse team of organizational stakeholders collaboratively develop a strategic three-year plan. Each stakeholder identifies their specific role in addressing the identified needs, detailing comprehensive interventions at the individual, system and community levels.

Ultimately, the CHNA is the indispensable asset that provides the community-specific health data necessary to make impactful and efficient strategic investments in our programming.

It's not just about compliance; it's about maximizing our positive impact where it matters most.



Strategic momentum across our CHNA cycle

All regional hospitals are in full compliance with CHNA regulations, maintaining current implementation strategies and required reporting, and securing all necessary key stakeholder and board approvals across every stage of the cycle.

 **Shared focus, local impact: systemwide priorities for health equity**

The office of community health impact and belonging drives systemwide alignment, efficiency, collaboration and shared best practices to maximize CB and CHNA impact. For example, teams in Southeast and Southwest Michigan are combining their resources to address two critical needs: access to health care and mental health. This partnership allows us to optimize investments in areas such as financial counseling services to support patients with insurance and affordability challenges. We're also developing a systemwide strategy to standardize the identification of social determinants of health (e.g., food insecurity) and support the development of care coordination hubs for more efficient referrals.

While we relentlessly pursue strategies that achieve our shared statewide priorities, we ensure individual hospitals have the flexibility to address unique local and regional health issues.

 **Continuous evolution: transforming the CHNA from compliance to strategic value**

Corewell Health is deeply committed to the iterative evolution of its CHNA process, deliberately transforming a compliance exercise into a tool for strategic investment. For example, in Southeast Michigan, we're dividing our report into at least three separate county-level reports (Oakland, Macomb, Wayne), enabling better-informed investment decisions with greater local impact. The office of community health impact and belonging is focused on three major goals: innovating data collection; aligning CHNA findings with CB investment; and enhancing external partnerships to ensure collaboration building trust within our service areas. This commitment ensures each cycle brings incremental changes that maximize the CHNA's impact and utility across the entire system.





Impact snapshot
Community benefit data integrity

~48%

increase
in reporters trained since 2024

117%

increase
in occurrences reported since 2023



Enabling data for strategic investment

Our overarching goal for 2026 is to ensure CB investments are fully aligned with the priorities identified by the CHNAs. This effort will convert our robust data into a strategic asset, empowering hospital, healthier communities leaders and Health Equity Evaluation, Assessment and Analytics Team (HEEAAT) leaders to make informed funding decisions for community health initiatives and guiding clinical teams in providing more culturally responsive care. To achieve alignment with CHNA and to facilitate enhanced reporting quality, HEEAAT entered into a partnership with Corewell Health Tax and Finance. This partnership will lead to increased communication between stakeholders, improved role clarity and the creation of shared processes.



Enhancing CB data integrity: standardizing reporting and maximizing impact

In 2025, HEEAAT initiated a focused effort to standardize CB reporting systemwide and engage more reports across the system to obtain better quality data. Our new rigorous reporting process not only ensures the integrity of our reporting, it enables more accurate and impactful goal setting.

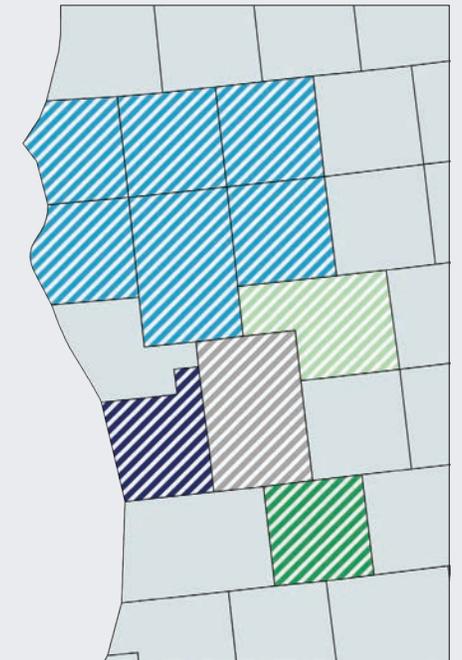
By standardizing practices and strengthening stakeholder engagement, we're paving the way for a more accurate, transparent and strategically valuable CB reporting system.

**Strategic partnerships:
collaborative CHNA for shared community impact**

The office of community health impact and belonging believes the key to advancing CHNA data collection, report writing and shared intervention strategies is collaboration. West Michigan exemplifies this commitment by actively participating in multiorganizational CHNA work groups across its service area. For example, in Kent County, our team collaborates monthly with the Health Department and other major health systems, including Trinity Health and Pine Rest. Together, they produce a shared report, addressing common topics ranging from IRS compliance to data collection and prioritization. Similar robust partnerships exist in Ottawa County (Healthy Ottawa), Montcalm, Barry and six additional counties through the MiThrive collaborative. Our Healthier Community teams are working to replicate these partnership models in the Southwest and Southeast markets to streamline and reduce costs. These vital working relationships ultimately enhance our efforts to improve the health of Michigan residents.



2025 community health worker — community needs health assessment partnerships



-  MiThrive
-  Mid-Michigan District Health Department
-  Healthy Ottawa
-  Barry-Eaton District Health Department
-  Kent County Health Department



Integrating equity into clinical care



We're aligning clinical care, community partnerships, data and governance around health equity to improve patient quality, safety and experience. By integrating equity into everything we do we can deliver equitable outcomes and set a new standard for excellence.

— **Kania McGhee, MD**, Medical Director, Equitable Outcomes, Community Health Impact and Belonging



We're redefining what it means to deliver exceptional care by ensuring that every patient, regardless of circumstance, receives high-quality, culturally responsive care.

In 2025, Corewell Health advanced its bold vision for improving health for all by embedding the equitable outcomes team in the office of community health impact and belonging. This strategic shift, launched in partnership with Quality, Safety and Experience (QSE), allows us to seamlessly align our clinical health equity initiatives with our broader community health and belonging priorities. It's a unified approach that will drive meaningful and measurable impact across the entire system.



Advancing measurement and accountability

Ongoing measurement is critical to transforming aspirational goals into sustainable improvements. Rigorous, standardized data collection allows us to accurately identify disparities, evaluate a range of interventions and ensure accountability. With this in mind, last year we rolled out our first set of systemwide health equity metrics to focus on priority outcomes, closing gaps in community health care, and monitoring our progress and impact. We created three key groups of metrics:

The Enterprise Health Equity Council, made up of clinical and business leaders from across the state, oversees these metrics. The council receives recommendations from a group of subject matter experts (SMEs) that include clinicians and community health leaders. The final level of support in the governance structure is

Metrics:

Maternal-infant health

1. NTSV cesarean delivery rate
2. Preterm birth rate
3. Low-birth-weight rate
4. Hypertensive disorders of pregnancy
5. Med-high risk of postpartum depression at birth
6. Adequacy of prenatal care (Kotelchuck Index)

Quality, safety and experience

1. Up to date on cervical cancer screening rate
2. Hypertension controlled under 130/80 rate
3. Diabetics with A1c in control under 9%
4. Up to date on mammogram rate

Data quality

1. Health-related social need screening rate
2. Sexual orientation and gender identity capture rate
3. Race, ethnicity and preferred language capture rate



the data work group, which analyzes health care needs, outcomes and insights and uses this trove of information to better support subject matter experts in their decision-making.

By embedding a robust data infrastructure, Corewell Health is not only measuring performance, but helping to initiate change and sustain improvements, ensuring that equity itself becomes a measure of quality.



**In pursuit of equity:
Excellent Health Outcomes for All certification**

The Joint Commission has introduced a powerful new tool for health care systems: the Excellent Health Outcomes for All certification. This voluntary, advanced certification is designed to equip health care organizations with a comprehensive framework to identify and dismantle disparities in patient care, treatment and service delivery. We aim to achieve this designation across Corewell Health hospitals, formalizing our equity commitment within national quality frameworks. To reach our goal, we're launching an inaugural cohort, selecting one hospital from each region to assess disparity gaps in health outcomes and implement interventions to close these gaps.



Funding integrated clinical and social care quality improvement

Launched in 2025, the office of community health impact and belonging mini-grant program awards up to \$25,000 to support equity-focused, clinical quality improvement projects to close health disparity gaps. By integrating clinical and social care, our teams promote organizational culture change, enhance community collaboration, and provide technical assistance to advance health equity. Some of the vital projects the mini-grant program supported in 2025 include:

- 1 Health literacy among women’s health regional patients:** This initiative focuses on educating patients and team members about available site-specific resources across all women’s health locations to improve patient safety, enhance health literacy and address health disparities.
- 2 Equity in action: improving maternal mental health outcomes for underserved communities in Kent County:** This project seeks to improve maternal mental health outcomes for Black people, Indigenous people, people of color, low-income families, and rural, immigrant, and refugee women. We will do this by increasing access to culturally responsive mobile/telemedicine services, reducing stigma and enhancing education, training providers and community health workers, and addressing social determinants through community partnerships.
- 3 Community medicine clinic mobile outreach:** This unique effort delivers mobile health care services in collaboration with community partners to reduce social isolation and increase access to care for high-risk patients, especially those facing housing crises.
- 4 Sickle cell expert improvement team:** This health equity initiative improves care for patients with sickle cell disease by focusing on disparities and enhancing clinical outcomes through standardized clinical pathways, a pharmacy stewardship program for pain management, bias education, community collaboration, data collection and short-term outcomes to support long-term goals.

By advancing equitable and measurable outcomes, the office of community health impact and belonging is helping Corewell Health create a more sustainable and effective model of care for everyone.

Integrating community and clinical care

Collaborating with community-based organizations and our clinical partners is critical to our ability to broaden access to care, particularly in neighborhoods with historically little to no local access. As we highlighted in [Whole Health Neighborhoods: Wellness Where We Live](#), healthier communities in Southwest Michigan is working to improve health equity for Benton Harbor residents through a single, easy-to-access location for clinical care and health and wellness education. Programs are tailored to key community needs, including prenatal education, CPR classes, birth basics and breastfeeding support groups. We recently expanded this reach by introducing the [More Life Mas Vida](#) program at Boston Square in Grand Rapids.

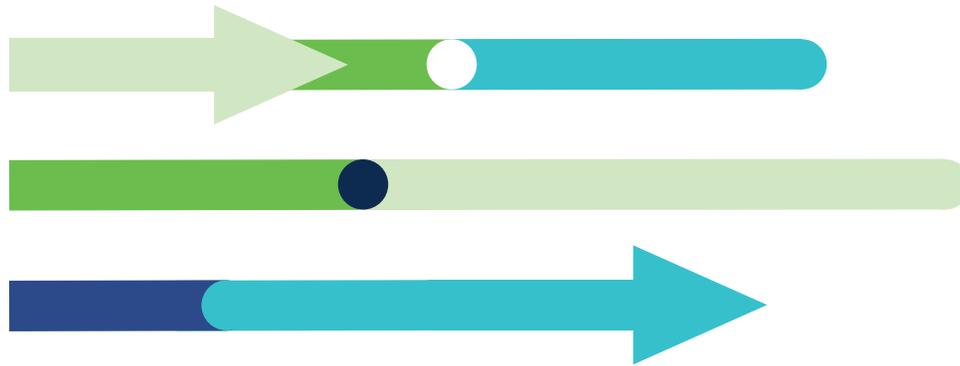
Sustaining our momentum

Our community-based programs, partnerships and advocacy create a bridge between where people live and where they receive care. Strengthening that bridge is how we support healthy lives and build thriving communities.

No matter what changes or challenges we face along the path ahead — and we know there will continue to be many — our shared commitment to make health better for team members, patients and members will continue to guide our way.

While we're proud of the progress we made in 2025, we know there is still more we can do to make health better for every person, every place, every time. As we outlined in this report, we rely on a combination of data and voice of our customers to continuously improve performance across all of our programs and practices. However, in 2026 there are several areas where we are accelerating our efforts, so we can deepen our impact where it matters most:

- Expanding and integrating community-based programs to improve access, prevention and outcomes in key areas.



- Increasing cross-sector partnerships to advance community-based solutions, reduce avoidable emergency use and support patients in more appropriate settings.
- Investing in data-driven innovation to translate clinical data into preventive social services.

As we evolve to continue to meet changing regulations, increased governance and growing community needs, our commitment to accountability remains the same. We'll prioritize required frameworks, such as CHNAs, Community Benefit reporting, and governance bodies that ensure transparency and compliance. We'll rigorously evaluate our programs and practices to ensure measurable impact, and we will reinvest in scalable, evidence-based interventions that demonstrate clear clinical and community outcomes.

By continuing to accelerate, maintain and refine our programs and practices, we can ensure that every community investment strengthens both the health of our patients and the sustainability of our system.





[corewellhealth.org](https://www.corewellhealth.org)

Southeast Michigan
248.898.5000

Southwest Michigan
800.968.0115

West Michigan
866.989.7999