2024 Community Health Impact Report

West Michigan • Southeast Michigan • Southwest Michigan

Corewell Health™

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The 2024 Community Health Impact Report highlights the remarkable strides we have made in advancing health equity and addressing the social determinants of health for our patients and communities. In the pages below you will get a glimpse of the impact our teams make each day to improve the lives of people across our state. This is only possible through collaboration, and through a commitment to our mission to improve health, instill humanity and inspire hope.

Our commitment to advancing health equity and creating a culture where all team members feel they belong is strong. We take seriously the role we play as a community partner and anchor institution across the state of Michigan. I hope you find the stories and the data in this report compelling, and reflective of that commitment and our organization's journey. Let them serve as a reminder of our collective responsibility and the impact we can achieve together.

Carlos Cubia

Chief Community Health Impact
and Belonging Officer

"I am not only excited about our 2024 report but deeply proud of what it represents. It reflects our collective effort and measurable impact in improving health outcomes while addressing the root causes of inequities to make optimal health attainable for all. This report is a testament to Corewell Health's unwavering commitment to health equity and our dedication to building healthier communities through purposeful investments and action."

Vanessa B. Briggs
MBA, RD, Vice President, Healthier Communities (she/her/hers)
Corewell Health

"This 2024 Community Health Impact Report is a testament to Corewell Health's commitment to its mission, vision and values, and to the work that is being done to ensure that all of the individuals and communities we serve are able to be their healthiest. This report demonstrates how Corewell Health's health equity work has evolved and grown over the last year, and the promise that the work holds for the future."

Lynn C. Todman, Ph.D.
Vice President, Community Health Impact (she/hers)
Corewell Health

"This report is about how far we've come, and how far we must go. As a runner, I know improvement is not just about speed, it is about endurance, consistency, and learning from every challenge. Our impact is not measured by a single moment but by the strides we take every day to drive toward our vision of a future where health is simple, affordable, equitable and exceptional."

Valissa Armstead, CDP (Certified Diversity Professional)
Sr Director, Belonging (she/her/hers)
Corewell Health

Welcome to a year of transformation

In 2024, our communities navigated profound changes during a time of evolving healthcare needs and heightened inequities. Corewell Health's commitment to providing accessible, compassionate and equitable healthcare has never been more urgent. Guided by our mission to improve lives through better health and greater humanity, we are actively dismantling inequities in internal processes, bridging community health and clinical functions, and addressing widening health gaps with actionable solutions. This is our labor of love.

Achieving health equity requires an organizational commitment embedded in leadership and vision. Although our strategies provide a solid foundation, our tailored regional programming for maternal-infant health — with a focus on mental health and cardiovascular disease prevention and management — prepare us to effectively respond to the unique needs of our diverse communities and translate our strategies into impact.

Health equity is gaining momentum at Corewell Health, attracting leaders and team members eager to better serve patients, communities, and plan members. To deepen this commitment, we must show equity in practice — not always in large-scale changes or new programs but more often in small, manageable steps that refine processes and test new approaches. These efforts can dispel myths about equity being too abstract or unachievable and support the thriving, culture of equity across our organization.

We partnered with trusted community leaders and leveraged collaborative expertise to strengthen our programming and align each initiative with our equity goals. What we know for sure is that health equity isn't just an aspiration — it's a concrete commitment to ensuring all communities have an equal opportunity to achieve their optimal health.

A note on impact

This report describes the impact of our work over the course of 2024. We use the following definition of impact:

One or more consequences, intended or unintended, of an action or actions[1].

Tackling deep rooted inequities is a process of experimentation and reflection. These problems are not solvable through implementation of single programs, but require a collection of complimentary efforts that get at root causes.

The definition shared here accounts for this idea, recognizing that impact reflects a variety of **consequences of the action we take as an organization** be it on the lives of individuals, shifts in organizational processes or practices, or the emergence of new partnerships to address the community conditions that effect health. Impacts are not an endpoint, but milestones on a path toward addressing the inequities we aim to eliminate.

1 McLean & Gargani, 2019

Following the Transformation Compass to develop strategic portfolios

In 2024, we adopted a portfolio-based approach to actualizing health equity, moving from siloed programs to unified, organization-wide strategies. To do this we adopted the **Transformation Compass** to guide our design of portfolios that address inequities across four interconnected levels:

- **Individual:** Initiatives such as health education and chronic disease management.
- **Organizational:** Equity-focused practices in health care delivery, employment and contracting.
- **Community:** Addressing social determinants like food access and transportation.
- **Social structures:** Advocacy for policy reforms to advance systemic justice.

This shift, powered by a robust evaluation of our existing initiatives, ensures our resources are strategically allocated. It reflects an integrated, multi-level strategy that cultivates collaboration across teams and stakeholders to create lasting, systemic change, ensuring that health equity remains central to our mission.

The Transformation Compass offers a way to plan how we tackle inequities through establishing balanced portfolios made up of mutually supportive investments across all four levels.

Applying a portfolio-based approach reflects an important shift in how Corewell Health is approaching health equity. The intent behind this is two-fold; first it ensures we are focused in our use of resources to achieve our goals, and second acknowledges the reality that impact will come through a collection of initiatives as we work towards those goals.

Between January and June 2024, the Health Equity Evaluation, Analytics and Assessment Team (HEEAAT) assessed 34 Healthier Communities programs across each of our three regions using a tool called the Portfolio Alignment Rubric (PAR) to better understand our portfolios. This evaluation measured each program's alignment with our strategic goals and the Transformation Compass framework, revealing significant achievements:

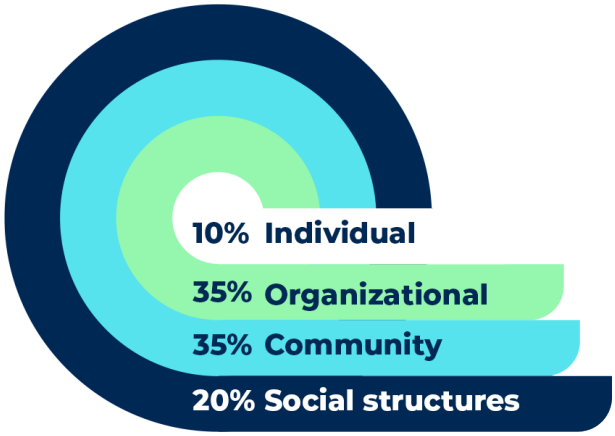
Median age of community health programs is four years.

More than half of these programs drive policy change at local, state or national levels.

183,700+ individuals were served annually through community health programs.

The results revealed that most initiatives are concentrated at the individual behavior level of the Transformation Compass. In August, the health equity leadership team set resource allocation targets for each level of transformation to create a balanced portfolio and guide progress over the next three to five years. Moving into 2025, we'll focus on shifting our spending to better align with these targets.

Portfolio investment targets



Each of our health equity initiatives is an investment and the strength of our portfolios relies on the quality of those individual investments. HEEAAT's evaluation of each programs' health equity alignment and efficacy enhanced our analytical frameworks to refine impact and support ongoing improvement, connecting on-the-ground insights to long-term decision-making. Collaboration with frontline team members ensures our health equity efforts remain grounded in the real experiences of our patients and communities, driving value and expanding their opportunities to live the healthiest lives possible.

Restructuring for the future

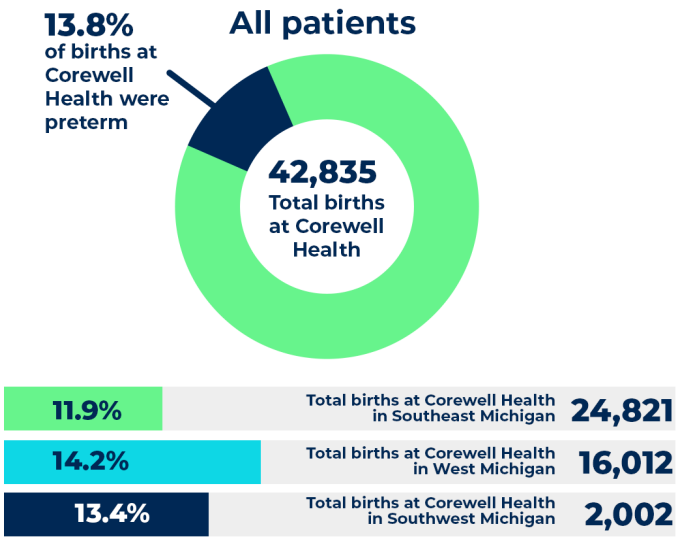
Regulations set by the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission have been pivotal in shaping Corewell Health's approach to health equity. These mandates require hospitals to appoint dedicated leaders, collect and analyze patient demographics and social needs and implement strategies to identify and address inequities. In 2024, CMS introduced regulations requiring hospitals to screen all admitted patients for health-related social needs. These measures not only enhance our understanding of how social determinants effect health inequities but are also essential for hospitals to maintain accreditation and receive reimbursements.

To ensure our initiatives are strategically aligned with these insights, we restructured our Health Equity Leadership Team under the guidance of Carlos Cubia, Chief Community Health Impact and Belonging Officer. This restructure reflects our commitment to tackling inequities in clinical care while developing community-based solutions to help all people achieve their optimal health.

Outlining maternal-infant health inequities

In Michigan, preterm and low birth weight babies account for 41% of infant deaths and face increased risks of developmental delays and chronic health conditions. **Since January 2023, 13.8% of babies born at Corewell Health were delivered preterm, exceeding the state average of 10.3%. These outcomes look different when we stratify by race/ethnicity.**

Rates of preterm birth by region, January 2023 through June 2024

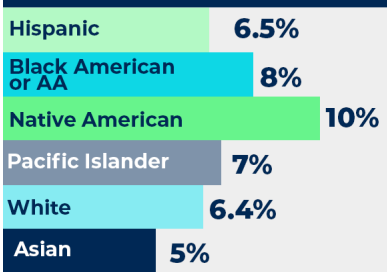


For every 100 within-race births, we see 15 more Native American babies delivered preterm than Pacific Islander babies delivered preterm.

20.6%	Total number of Native American births	149
17.6%	Total number of Black or AA births	6,124
14.4%	Total number of Hispanic births	3,437
13.4%	Total number of White or Caucasian	25,328
12.9%	Total number of Asian births	1,666
5.9%	Total number of Pacific Islander births	29

We use a portfolio-based approach to address the racial, ethnic, geographic and socioeconomic inequities that contribute to poor maternal and infant health outcomes. This means we focus on reducing inequities by addressing multiple determinants of health, targeting key clinical risk factors such as hypertension, preeclampsia, anxiety and depression, and reforming clinical practices, policies and care delivery models to better identify and respond to social stressors. Beyond the walls of our health system, we invest in initiatives that improve community conditions influencing health outcomes.

From January 2023 to June 2024, for every 100 within-race births, we see five more Native American people who gave birth diagnosed with preeclampsia than Asian people who give birth at Corewell health.



Total number of births at Corewell Health:

42,835

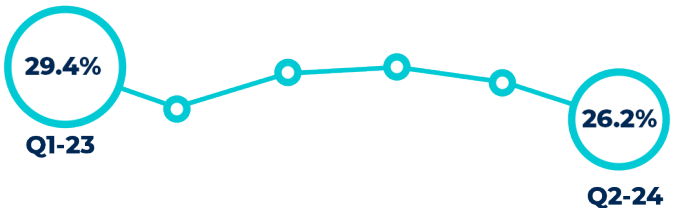
Understanding the impact of cardiovascular and maternal mental health

Research shows a clear link between maternal mental health and cardiovascular disease and adverse birth outcomes. Research shows that people who experience depression, anxiety and chronic stress during pregnancy are at higher risk of delivering low-birthweight babies[1]. These adverse birth outcomes can also increase the likelihood of people experiencing postpartum depression. Between January of 2023 and June of 2024, approximately one in four pregnant individuals cared for at Corewell Health were at medium or high risk for postpartum depression. Black and Hispanic women were disproportionally at risk compared to other racial and ethnic groups. Maternal mental health, which encompasses emotional, social and psychological well-being, is a critical factor influencing pregnancy and postpartum outcomes[2].

Maternal mental health, which encompasses emotional, social and psychological well-being, is a crucial factor in pregnancy and postpartum outcomes. Depression and anxiety are leading contributors to maternal morbidity and mortality, yet nearly half of all women with postpartum depression go untreated. Latino patients are most likely to be at medium or high risk for postpartum depression, followed by Black and Native American patients.

1 Matsas A, Panopoulou P, Antoniou N, Bargiota A, Gryparis A, Vrachnis N, Mastorakos G, Kalantaridou SN, Panoskaltsis T, Vlahos NF, Valsamakis G. Chronic Stress in Pregnancy Is Associated with Low Birth Weight: A Meta-Analysis. J Clin Med. 2023 Dec 14;12(24):7686. doi: 10.3390/jcm12247686. PMID: 38137756; PMCID: PMC10743391.
2 Gelaye B, Sanchez SE, Andrade A, Gómez O, Coker AL, Dole N, Rondon MB, Williams MA. Association of antepartum depression, generalized anxiety, and posttraumatic stress disorder with infant birth weight and gestational age at delivery. J Affect Disord. 2020 Feb 1;262:310-316. doi: 10.1016/j.jad.2019.11.006. Epub 2019 Nov 4. PMID: 31733923; PMCID: PMC7048002.

Over six quarters, an average of 28% of people who gave birth at Corewell Health facilities were screened with medium to high risk of postpartum depression (PPD) in all races.



For every 100 within-race births, we see 16 more Hispanic patients with medium-high risk of PPD than Asian patients.

40.9%	Total number of Hispanic births	3,437
35.6%	Total number of Black or AA births	3,222
33.7%	Total number of Native American births	147
30%	Total number of Pacific Islander births	31
27%	Total number of White or Caucasian births	28,507
24.9%	Total number of Asian births	833

Cardiovascular disease is the leading cause of death among women, responsible for one in three lives lost annually—equivalent to one woman dying every 80 seconds. Pregnancy complications like preeclampsia or gestational diabetes significantly increase a woman's risk of developing cardiovascular disease later in life[1]. For example, women with two or more complicated pregnancies face double the risk of stroke before age 45 compared to women without serious complications.[2]

The link between cardiovascular health and healthy births is well-documented[3]. Patients who experience hypertension and diabetes, both risk factors for cardiovascular disease, are more likely to experience a preterm birth compared to patients without these conditions. Our solution targets two of the primary drivers of maternal morbidity and mortality: mental well-being and cardiovascular health. By focusing on these critical areas, we're reducing inequities and improving outcomes for birthing people and infants across Michigan.

To address maternal-infant health equity

Reforming clinical practices and organizational policies to address hypertension, preeclampsia, anxiety and depression among pregnant individuals.

Implementing an integrated care delivery model that better accommodates the diverse cultural, economic and social needs of pregnant people.

Ensuring more accurate identification and effective mitigation of social needs and psychosocial stressors.

Aligning community benefit programs with local needs to have a greater impact on the community conditions that affect health.

Advocating for policies at the local, state and national level that can improve the health of birthing people and their babies.

1 ahajournals.org/doi/10.1161/CIR.0000000000000961#sec-1
2 ncbi.nlm.nih.gov/pmc/articles/PMC8678921/
3 pmc.ncbi.nlm.nih.gov/articles/PMC5308562/#:~:text=CVD%20remains%20the%20leading%20cause%20of%20morbidity%20and%20mortality%20in%20women.&text=A%20growing%20body%20of%20literature,risk%20of%20future%20CVD%20events.&text=However%2C%20it%20is%20unknown%20whether,T2DM)%2C%20and%20BMI)

A year in review:

Regional highlights

Corewell Health's regional programs, led by our healthier communities teams, demonstrate our commitment to addressing health inequities where they are most acute. Grounded in the unique needs identified through the Community Health Needs Assessments (CHNA), we're creating locally tailored pathways to health equity that resonate and deliver measurable impact.

Corewell Health in West Michigan

The Corewell Health Healthier Communities in West Michigan team serves urban and rural communities across West Michigan, developing strategies to prioritize health needs identified from the CHNA. They work closely with local leaders to define what matters most and guide impactful initiatives that address inequities.

Because we value maternal health as a cornerstone of community well-being, Corewell Health in West Michigan is tackling inequities for birthing individuals and their infants with a comprehensive approach designed to improve life expectancy and reduce preventable risks. By breaking down barriers with culturally responsive care, expanding access to mental health support and leveraging partnerships to dismantle systemic inequities, the Healthier Communities West team aims to meet families where they are — at home, in clinics, through virtual education — to ensure healthier beginnings for children and close health equity gaps.

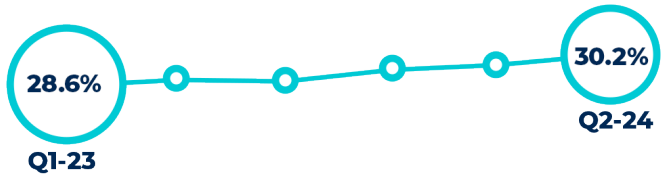
Improving maternal-infant health for patients and communities

The healthier communities team invested **$300,000** in Our Mental Health Collective to strengthen access to culturally relevant mental health care and integrate behavioral health services to improve care for pregnant individuals. This partnership is a significant step toward connecting Corewell Health clients with culturally diverse therapists to provide inclusive mental health care and stay responsive to diverse needs.

Since its launch in July 2024, 21 referrals have been made and the initiative represents a growing collaboration that builds meaningful relationships with therapists and expands access to equitable care. While still in its early stages, **this partnership lays the foundation for long-term impact for our patients and communities by fostering a more inclusive approach to mental health services.**

Corewell Health uses the Edinburgh Postnatal Depression Scale to assess pregnant individuals and new parents. The results help us connect patients with vital support services, including free therapy sessions through partnerships with Arbor Circle and Our Mental Health Collective, as well as referrals to Corewell Health's Maternal-Infant Health Program (MIHP). The Edinburgh screening also identifies breastfeeding challenges and connects patients to support groups for additional help.

Over six quarters, an average of 28.4% pregnant people were screened with medium to high risk of postpartum (PP) depression in all races at Corewell Health in West Michigan.



Rate of med-high risk of PPD

Total number of pregnant people screened: 4,303

The **Tobacco Nicotine Treatment (TNT) program** worked to address these challenges by screening pregnant individuals for tobacco use, providing prenatal and postpartum support and connecting them with evidence-based resources to permanently stop smoking. This proactive approach is yielding promising results, with program referrals steadily increasing in recent months.

In 2024, 73 patients were seen for one or more appointments by the TNT program.

Focusing on meeting people where they are

The **Maternal Infant Health Program (MIHP)** uses an evidence-based home visiting approach to support better health outcomes for birthing people and babies. The Maternal Infant Health Program offers personalized, home-based care management for high-risk, Medicaid-insured pregnant individuals and their babies in Kent and Montcalm counties.

GREAT MOMs (Grand Rapids Encompassing Addiction Treatment with Maternal Obstetric Management) is a collaborative program that provides integrated, high-quality support to pregnant individuals living with substance use disorder, including outpatient services, prenatal care and a referral to a community provider for postnatal addiction treatment medication. We had 70% of GREAT MOMs show up for visits throughout pregnancy, childbirth and six-week postnatal checkups.

Investing in better access to culturally responsive care

Doula services play a vital role in promoting birth equity and reducing health and racial inequities. **Corewell Health Healthier Communities in West Michigan** has partnered with the **Day One Doula Collective** to certify doulas through a 12-week course. This initiative, supported by a $75,000 grant, has enabled Medicaid clients to access doula services, resulting in 12 newly trained doulas ready to provide culturally responsive care. To further expand support, MIHP is hiring 4.5 full-time equivalent doulas dedicated to serving Medicaid populations.

Among MIHP participants in 2022 - 2023:

Initiated breastfeeding

89.5%	81.5%
MIHP	Medicaid statewide

Breastfed for three months

66.5%	43.4%
MIHP	Medicaid statewide

Additionally, MIHP participants experienced 6.4 fewer low birth weight births and 2.1 fewer preterm births per 100 live births compared to similar groups.

In 2024, 298 infant and pregnant people graduated from the MIHP program in Kent and Montcalm counties.

Giving expecting parents opportunities to learn and connect

Research shows that social support reduces maternal anxiety and depression, improves birth weight and enhances immune factors in breast milk. Corewell Health's **Prenatal Education Program** combines evidence-based practices, peer support and cultural responsiveness to meet prenatal and postpartum needs. Classes are offered both in person and online, covering 18 topics across six categories with an emphasis on infant health, care and safety to reduce inequities and improve outcomes for pregnant women and their babies.

Corewell Health in West Michigan also connects new mothers to breastfeeding support groups through prenatal education classes offered three times a week. These classes provide education and skills to help breastfeeding individuals succeed.

Prenatal education program had over 8000 visits by pregnant people, infants and supports persons in 2024.

From January to December 2024, over 8000 repeat participants attended, including new moms, babies and members of their support network. The classes are a space for people to foster connection, build bonds and develop support networks that can improve mental health outcomes after delivery.

Embedding health equity by transforming clinical care

A multidisciplinary team at Corewell Health in West Michigan initiated a plan to support patients who relied on the emergency department as their primary health care source, often because of complex social determinants. An environmental scan identified Corewell Health Ludington Hospital as an optimal location to pilot the placement of a community health worker in the emergency department to support patients with complex needs. The pilot site launched in April 2024 with a focus on developing foundational elements, including new pathways in Epic, standard workflows, team members training and collecting better data about patient needs.

71 patients were referred for a social need from April to October.

More than half of them for health-related social needs; of those, **51 patients enrolled** and received services. This collaborative effort includes community health leadership, clinical leaders, finance teams and public health partners. The program plans to expand to five days per week in Ludington and launch at Corewell Health Pennock Hospital in early 2025, where a patient cohort will help evaluate outcomes and cost savings from these interventions.

Corewell Health Maternal Fetal Medicine delivers comprehensive, one-of-a-kind care for high-risk pregnancies, supporting patients from preconception through delivery. Corewell Health's team of health care providers and Health Equity Champions exemplify diversity across race, ethnicity, gender and sexual orientation, creating an inclusive, culturally competent environment just by being themselves and inviting patients to do the same. All team members are trained in cultural sensitivity to ensure respectful, equitable care for every patient.

Patients with severe fetal conditions often face unique challenges, including higher risks of perinatal depression, anxiety and PTSD, along with limited time and resources to undergo frequent ultrasound monitoring, procedures requiring bed rest, or relocation to specialized hospitals for surgery. Our new **Corewell Health Maternal Fetal Medicine** serves families by offering cutting-edge therapies and surgeries. Through targeted outreach, community partnerships and tailored support services, we're committed to reducing inequities and providing exceptional maternal fetal care for all.

Photo description: The Corewell Health Sickle Cell Expert Improvement Team

The Corewell Health Sickle Cell Expert Improvement Team (EIT) exceeded its goal for improving patient perceptions of pain management in 2023, surpassing the target of 60.2% by achieving 72.6% of patients who reported their pain was being managed effectively. This improvement was driven by collaboration between health care teams, patients and caregivers, including the development of a standardized emergency department sickle cell crisis pathway and an inpatient action plan within Epic. In addition, an updated sickle cell order set and improved education on patient-controlled analgesia pumps contributed to positive outcomes.

Strengthening community partnerships

Local partnerships to address food insecurities

Access to healthy food remains a significant challenge for low-income individuals, contributing to chronic conditions such as obesity, diabetes and heart disease. **In February 2024, Corewell Health in West Michigan partnered with the American Heart Association (AHA) to invest $40,000 into enhancing food options at Montcalm County food pantries.** In this collaborative partnership, Corewell Health is expanding access to nutritious food and promoting healthier eating habits in the community. A registered dietitian is central to this initiative to enhance pantry infrastructure, promote health-focused food policies and provide nutrition education.

Another tangible outcome of this partnership was the installation of a new refrigerator/freezer combo unit at a participating pantry, enabling team members to stock fresh and frozen produce more effectively. This upgrade not only increases the availability of fruits and vegetables but also reduces utility costs, supporting both health and sustainability goals. By working with five established food pantries and exploring a sixth partnership, Corewell Health is building a foundation for impactful, health-focused food policies to improve community nutrition by December 2025.

Photo description: The refrigerator/freezer combo unit at a pantry.

More Life Más Vida through cancer screenings

In partnership with cancer care services, Corewell Health's More Life Más Vida has worked to reduce cancer inequities by increasing access to prevention, screenings and equitable care for uninsured or underinsured individuals. This collaboration provided access to free or low-cost cancer screening resources, including early detection mammograms, colon cancer at-home kits, HPV vaccinations and cervical cancer screenings.

These services were made possible with philanthropic funds from cancer care services as well as the MDHHS Breast and Cervical Cancer Navigation Program (BC3NP), which provides cervical cancer screenings for individuals aged 21 to 64 and breast cancer screenings for individuals aged 40 to 64 (or 21+ for diagnostic mammograms) who meet income eligibility.

Photo description: The More Life, Más vida and cancer care services team serving the community

Community health workers are integral to the program, addressing social determinants and providing follow-up care, financial counseling and patient assistance. Since its inception in 2023, the community-driven program has hosted two cancer screenings, **distributed 10 colon cancer screening kits, administered 26 HPV vaccinations and completed 105 mammograms.**

Aspen Institute's justice and governance partnership

Photo description: The Leadership Council members of A Just GR with the Corewell Health team.

Launched in 2023, A Just GR is guided by a diverse leadership council—55% Black/African American, 35% White and 60% holding graduate degrees—with representation from law enforcement and public safety, education, local government and nonprofits. Rooted in listening, embracing complexity and data-driven decision-making, the initiative acknowledges historical inequities and works toward equitable outcomes. Its mission is to enhance safety and opportunity for all while serving as a national model for justice reform.

The Corewell Health Healthier Communities team in West Michigan was selected and funded to lead this effort through 2027, positioning Grand Rapids as the first pilot city in the nation. Powered by the Aspen Institute's Justice and Governance Partnership, A Just GR is a groundbreaking initiative promoting equity-centered public safety and justice in Grand Rapids. This first-of-its-kind project brings together community voices to create a shared vision for justice and safety, prioritizing cross-sector collaboration to tackle systemic inequities while fostering community leadership and ownership. Our team was selected and funded to lead this effort through 2027, positioning Grand Rapids as the first pilot city in the nation.

Corewell Health hospitals in West Michigan tackle health care equity

Our Corewell Health hospitals in West Michigan are responding to emerging The Joint Commission requirements by implementing health equity action plans. These hospitals are analyzing social determinants and stratifying data to better understand patient outcomes and launch projects to address

Postpartum depression: Corewell Health Zeeland and Greenville hospitals

Zeeland Hospital: Focused on postpartum patients at medium-high risk of PPD. In 2023, 59% of MIHP clients who were pregnant said they experienced stress and depression, while 69% of clients who had an infant reported these experiences.

Focused on increasing referrals of pregnant people at risk of PPD into the MIHP from 9% to a target referral rate of 30% by 6/2025. And, increase the provision of educational materials to these patients from 41% to 95% in the same time frame.

Increased referral rate for MIHP to 33% by December 2024. Delivery of educational resources had increased to 60% by December 2024.

Greenville Hospital: Focused on post-partum patients who are high risk for depression. The ratio of mental health providers to residents in the community is 1:477. Adults aged 18 - 34 are twice as likely to experience mental distress, and 75% of moms who give birth at Greenville Hospital fall within this age group.

No referrals were being made into supportive programs which included the Welcome Baby Program and the MIHP. Set a target to increase referrals from 0% to 10% by December 2024.

Exceeded the target by increasing referrals to 100% of all eligible patients. The OB team has adopted new workflows to maintain the referral pathway.

Tobacco cessation: Corewell Health Big Rapids, Reed City and Ludington hospitals

Big Rapids and Reed City hospitals: Focused on admitted patients between age 18-65 at high risk of tobacco use. In 2023 21.2% and 30.2% of these patients admitted to Big Rapids and Reed City hospitals were at high risk for tobacco use, respectively.

Only a fraction of those patients were referred to the Tobacco Cessation Program.

Increase referrals to the Tobacco Cessation Program to or above 85% by June 2025.

Ludington Hospital: Focused on admitted male patients at high risk of tobacco use. Male patients between 25 - 55 had an 8% higher risk of tobacco use.

Focused on increasing referrals for male patients between the age of 35 - 55 who were at high risk of tobacco use into the Tobacco Cessation Program from 0% to 50% by July 2025.

Exceeded the target by November 2024 with 60% of target patients being referred to the program.

Tobacco cessation at Corewell Health Gerber Hospital

Focused on White patients between the ages of 50 - 80 in the medical surgery unit and ICU at high risk of tobacco use. Cardiovascular disease was a leading cause of death in Newaygo County in 2023.

Focused on increasing referrals of the target patient population to Tobacco Specialist from 0% to 50% by December 2024.

Increased referrals to 60%, and increased contact rate with patients at high risk of tobacco use to 86% by Tobacco Specialist.

Shelly Klochack, RN, MSN, testified before the Senate Regulatory Affairs Committee in October 2024, to support the Protect MI Kids bill package.

Addressing food insecurity at Corewell Health Pennock Hospital

Focused on patients between the ages of 51 - 70 who screened positive for food insecurity. Patients in the Medical Surgery and ICU units had the highest needs.

Focused on increasing referrals to the Fresh Food initiative prior to patient discharge from 0% to 40% May 2025.

Increased referrals to the Fresh Food Initiative to 66% by November 2024 with 40% of those being referred attending the program.

The screening rate for social driver of health (SDoH) at Corewell Health hospitals in West Michigan for 2024 was 87%.

Patients with a SDoH need at Corewell Health hospitals in West Michigan.

6.0%
Indicated transportation needs

2.4%
Indicated utilities needs

6.4%
Indicated housing needs

5.4%
Indicated food insecurity

Corewell Health in Southwest Michigan

The key to improving maternal and infant health outcomes at Corewell Health in Southwest Michigan begins when we earn the trust of families. In March 2024, the Corewell Health Center for Wellness expanded its community reach by moving into a new and significantly larger location in downtown Benton Harbor. At the Corewell Health Center for Wellness, the Corewell Health Healthier Communities team has created a cohesive portfolio of programming that centers maternal-infant health, cardiovascular health and mental wellness in an easy-to-access location.

Addressing the complex maternal and infant health inequities in our communities requires a multi-faceted approach. At the center, families can access a portfolio of programs designed to have a lasting impact and improve outcomes during some of the most critical years of their lives.

In 2024, the Corewell Health Center for Wellness served nearly 1,500 clients across more than 8,000 visits.

Photo description: The opening of the Corewell Health Center for Wellness in March 2024.

Engagement through community diaper distribution

Photo description: Diapers stocked at the Corewell Health Center for Wellness

In 2024, the Corewell Health Center for Wellness distributed more than **165,000 diapers to families in Berrien County.** By alleviating a critical household expense, the program helps reduce family stress and builds trust between caregivers and team members Interactions also create opportunities to connect families with additional services and foster long-term engagement.

People who received diapers reported

93%
could care for their children in new ways.

92%
felt happier.

90%
were able to pay for other necessities.

82%
reported feeling less stressed or anxious.

80%
felt an increased connection to others.

Bridging community and clinical care for holistic wellness

The Corewell Health Center for Wellness is redefining primary care by integrating innovative staffing, recruitment and care models. While awaiting an Epic build, the center has collaborated with the medical group to include offerings such as cooking classes, mental health support and lifestyle medicine as part of its care framework. Partnerships with Intercare, a Federally Qualified Health Center (FQHC), further align our efforts to create a cohesive, community-focused system.

The Corewell Health Center for Wellness also offers the Inspire and Connect programs that jointly create a seamless connection between community and clinical care. Inspire combines lifestyle interventions and home blood pressure monitoring to support hypertension management; Connect enhances blood pressure control by providing in-home education and resource navigation to help patients overcome social and structural barriers. Additionally, Centered: Cooking for Better Health, is a food focused initiative designed to empower patients to manage hypertension by providing hands-on culinary instruction focused on preparing low-salt, plant-based meals. This collaboration extends care beyond traditional medical treatments, fostering a deeper connection between nutrition education and chronic disease management.

Photo description: Participants of the Centered: Cooking for Better Health class.

Participants report high levels of satisfaction with the program, with **90% expressing that they "learned a lot" about healthy eating for hypertension and appreciated being treated with respect throughout the classes.** The program equips individuals with practical skills, such as preparing nutritious meals and ordering low-salt options when dining out. Many participants have already applied these new recipes and techniques at home, enhancing their daily lives.

Additionally, **80% of participants gained a better understanding of how untreated hypertension affects their health and how nutrition can reduce its impact.** The program also nurtures a sense of community, with **80% feeling connected to fellow participants,** further reinforcing the importance of shared support in making lasting lifestyle changes. This partnership highlights the transformative impact of integrating clinical referrals with community-based education to promote healthier living and we continue to be electrified around developing similar community-serving partnerships.

Photo description: Cooking heart friendly food at the Centered: Cooking for Better Health classes

Providing care for the whole person

The HOPE program provides medical care and education for pregnant patients with hypertension or preeclampsia, including up to 12 visits with a community health nurse focused on heart health. Since launching in August 2023, HOPE has supported more than **20 expecting families**, helping them improve heart health for safer deliveries.

In 2024, Corewell Health in Southwest Michigan launched Labor of Love, a series of childbirth and breastfeeding education classes designed to ensure equitable access to prenatal and postnatal care. Funded by a grant from the Southwestern Michigan Perinatal Quality Collaborative, the program's goal is to educate 250 participants annually on pregnancy-related conditions, risks and resources. In its inaugural year, a five-cohort series enrolled and supported **59 participants with a 100% retention rate.** Families consistently reported improved birthing experiences compared to previous pregnancies and continued seeking additional resources beyond pregnancy and breastfeeding support.

Photo description: Child birth and breastfeeding classes at Corewell Health Center for Wellness.

Highlights of the childbirth and breastfeeding class from June – December 2024.

17
support partners and children attended.

14
car seats installed.

100%
breastfeeding initiation.

5
cohort series (June 2024 - September 2024) 20 classes total.

72%
continue to exclusively breastfeed (exclusive breastfeeding means only breastmilk is fed to new babies) at two weeks compared to national average of 59.2% (NIH study).

After birth, the center provides free essentials like diapers, wipes and car seats. These services are an entry point for building trusting relationships and connecting patients to additional resources, including parenting support through **Triple P (Positive Parenting Program)**, a community-centered intervention that equips new parents with tools to manage stress, build stronger family relationships and foster positive behaviors in children. By offering these services within an accessible and supportive community framework, **Triple P provides families with "guardrails" to strengthen resilience and dismantle toxic stress, a contributor to hypertension and heart disease.**

Photo description: The Triple P team ready to empower pregnant people.

In communities like Benton Harbor, where chronic stress compounded by economic instability, racial inequities and social disinvestment is a significant risk factor for cardiovascular disease, parenting can exacerbate stress in an already high-stress environment. Where resources are scarce, the absence of support can exacerbate this dynamic to deeply impact both caregivers and the children under their care.

Enhancing community-centered OB care

Corewell Health in Southwest Michigan is transforming its obstetric care model to prioritize health equity and address gaps in local services.

A key advancement is the establishment of a Level 2 nursery, enabling families with preterm births to receive specialized care close to home. This addition reduces the need for transfers to other hospitals, a challenge that previously contributed to a 2% loss in the birthing market share to providers like Bronson and Beacon Health.

To further reduce inequities, we launched a dedicated OB Emergency Department (OBED), ensuring pregnant patients receive immediate, specialized care upon arrival. Together, the OBED and Level 2 nursery enhance equitable access while supporting the hospital's strategic goals, illustrating a commitment to value-based care that aligns patient needs with sustainable growth.

Investing in community partnerships

Partnerships like the ones we've developed with Karissa White of Birthmark Doula and Mistel de Varona from the Michigan Breastfeeding Network **provide Benton Harbor families with culturally relevant childbirth education and breastfeeding support.** Collaborating with providers who have lived experience and deep community ties ensures services are both medically sound and culturally sensitive, which is crucial for delivering equitable and accessible care.

Social determinants such as economic stability, education, healthcare access and social connections significantly affect cardiovascular health.

The Achieving Birth Equity Through System Transformation (ABEST) Taskforce, a coalition of community partners including Corewell Health Healthier Communities in Southwest Michigan, is addressing the root causes and long-term risks of cardiovascular disease by focusing on birth equity and maternal health.

In Benton Harbor, where distrust in the health care system is rooted in historic disinvestment, the taskforce bridges the gap between families and healthcare providers, promoting early and regular care to prevent, detect and manage cardiovascular disease. By confronting racism as a root cause of inequity and advocating for better access to care, particularly for Black and Native American people, the taskforce reduces the stress burden these communities face.

Improving youth mental health through school and community engagement

The Berrien Whole Child County Collaborative, co-led by Berrien RESA and Corewell Health in Southwest Michigan, fosters belonging and engagement in schools using the Whole School, Whole Community, Whole Child framework. **The collaborative offers shared services like Youth Mental Health First Aid and Community Resiliency Model training, already implemented by eight districts with two more trainings scheduled in 2025.**

In 2024, Abbie Benfield, the Whole Child Consultant for Berrien Regional Education Services Agency and Ashlee Offord, Supervisor of Community Programs at Corewell Health in Southwest Michigan presented at the American Hospital Association's Accelerating Health Equity Conference about the partnership between the health system and local schools to advance a whole child model with a focus on addressing mental health. They were also invited to present at the Collaborative for Academic, Social and Emotional learning (CASEL) Exchange National Conference. **Their work highlights the importance of authentic partnerships between education systems and health care to improve the mental wellness of young people.**

In Berrien County, Brave Talks bring community members together to explore structural racism and its impact on health. This initiative has been integrated into local schools to promote belonging and help students build a healthy, informed identity. Brave Talks has expanded to Berrien RESA's leadership team, team members and two school districts with plans to include a county-wide advisory in 2024 – 25 to sustain advocacy and action on equity.

Corewell Health in Southeast Michigan

Advancing well-being

Corewell Health in Southeast Michigan team covers the Detroit metro area of Wayne, Oakland and Macomb counties. Their health equity efforts advance maternal-infant health, address chronic disease and support students and their families through their network of 17 school-based clinics. With a focus on building local partnerships, the Corewell Health Healthier Communities in Southeast Michigan team has been revamping their portfolio of health equity and community health investments to drive impact and outcomes for patients, communities, team and plan members.

Tackling systems change with CDC reach funding

According to the 2023 County Health Rankings and Roadmaps, Wayne County is Michigan's least healthy county, ranking last for health outcomes and factors such as behaviors, socioeconomic conditions and physical environment. To support programming in communities experiencing these health gaps,

Corewell Health in Southeast Michigan has received a $3.4 million CDC REACH grant. This funding will promote breastfeeding, physical activity, healthy food access and food service guidelines to low-income Black/African American families in Wayne County over the next five years.

The REACH grant is significant as one of the few health system-based awards in the program and Corewell Health will leverage it to collaborate with a cross-sector network of community partners to tackle key health inequities and implement proven public health programs focused on physical activity, access to nutrition and healthy foods and breastfeeding continuity of care. During the CDC team's site visit in summer 2024, much of the discussion centered on the potential of implementing the REACH model through a healthcare system, highlighting the novelty of this approach. This opportunity positions Corewell Health in Southeast Michigan at the forefront of advancing equitable community health.

Building resiliency for healthier families

Corewell Health's Raising Resilient Children (RRC) program in Southeast Michigan helps parents build practical skills for managing children's behavior while fostering peer support and connections with other caregivers. Rooted in the Triple P system, RRC combines structured guidance, collaborative learning and free online access to resources for families in Wayne, Oakland and Macomb counties. In September, the program expanded its reach with a website offering free access to expert tools for 1,000 families, ensuring parents have the support they need to create nurturing, resilient environments for their children.

Increasing community engagement through partnerships

Corewell Health in Southeast Michigan signed on as a community partner to **Black Birthing people Breastfeeding Association's** $4.8 million Triple Crown Initiative, funded through the Office of Minority Health. As a partner on this grant, Corewell Health in Southeast Michigan has committed to transforming internal processes and practices to better support and improve maternal and infant health outcomes for Black birthing families in metro Detroit.

Since 2014, Corewell Health in Southeast Michigan has partnered with the **National Kidney Foundation of Michigan (NKFM)** to provide evidence-based workshops, including Diabetes PATH and Chronic Pain PATH. Facilitated by NKFM staff, these programs have reached hundreds of community members with Type 2 diabetes or chronic pain. Corewell Health in Southeast Michigan further strengthens community health by connecting local patients and residents to these valuable resources through collaboration.

In March 2024, Corewell Health in Southeast Michigan was awarded a $100,000 grant from the **Children's Miracle Network Hospitals** that will support programming and training to enhance care and outcomes for children in the region.

Embedding health equity

Projects such as Maternal Hypertension Pathways (HyperPath) illustrate how internal collaborations drive equity-focused care. This initiative, supported by the Michigan Maternal Mortality Surveillance Mini Award, addresses pregnancy-related hypertensive disorders, social determinants screenings, postpartum follow-ups and educational resources for patients and providers. Through sustainable, systemic solutions, the project reduces inequities and improves maternal outcomes for underserved communities in Wayne, Oakland and Macomb counties.

In tandem, Corewell Health in Southeast Michigan strengthened its commitment to community health via the convening of coalitions addressing critical needs like substance abuse prevention, youth mental health and food insecurity. Key initiatives include the Downriver Igniting Youth Coalition's work with LGBTQ+ youth and the Western Wayne Food Policy Council's advocacy to combat food deserts. These partnerships amplify the organization's health equity mission by uniting community voices, aligning local efforts with clinical priorities and driving impactful policy changes.

Improving access by meeting families where they are

Photo description: The Corewell Health in Southeast Michigan Child and Adolescent Health Center team.

Corewell Health in Southeast Michigan has been providing Child and Adolescent Health Center (CAHC) programs in metro Detroit schools for more than 30 years, starting with the Taylor Teen Health Center in 1988. These clinics are made possible through partnerships with schools that provide

space and invite Corewell Health in Southeast Michigan in to serve students. Fully funded by grants from the Michigan Department of Health and Human Services, Corewell Health in Southeast Michigan operates 17 total clinics—eight dedicated exclusively to mental health services—and served more than 3,000 patients in 2024.

These clinics provide medical care, mental health support and health education, specifically targeting high-risk, underserved youth. Located in regions with healthcare provider shortages, they offer convenient access for students and their families. Services are available to everyone, regardless of their ability to pay. The clinics accept all insurance types, provide the same range and quality of services to uninsured individuals and ensure families never receive a bill.

On Jan. 12, 2024, Corewell Health in Southeast Michigan opened its first school-based clinic in Detroit at the Detroit Edison Public School Academy (DEPSA), a public charter school serving 1,425 pre-K through 12th-grade students, with 72% from low-income households and 98% identifying as Black.

Photo description: The grand opening of our first School-Based clinic in Detroit, at Detroit Edison Public School Academy, January 2024

As the first charter school in Michigan to achieve Blue Ribbon status, DEPSA emphasizes academic excellence in a supportive environment, bolstered by strong family, team members and community partnerships.

The Corewell Health in Southeast Michigan clinic is staffed with a nurse practitioner, medical assistant and social work therapist to provide medical services, mental health counseling, sports physicals, immunizations and health education. Additionally, it's a space where students have the opportunity to learn more about medical and social services careers. The school prioritizes the health and wellbeing of its students, understanding that healthy students are more likely to succeed academically, contribute to their community and become global citizens and lifelong learners.

Expanding HIV prevention access for youth

After years of preparation, the Taylor Teen Center's reproductive health clinic has officially launched HIV pre-exposure prophylaxis (PrEP) services to address a critical need in the Downriver area south of Detroit, identified in 2018 as a PrEP desert. A highly effective preventative medication, PrEP reduces the risk of contracting HIV from sexual transmission by up to 99% and at least 74% from injection drug use. **Nurse practitioner Katherine Kristoff, in collaboration with a Doctor of Nursing Practice (DNP) student, developed the clinic's policy to bring this life-saving service to underserved areas.**

Title X funding has been instrumental in launching PrEP services, enabling affordable and confidential reproductive health care for adolescents without requiring parental consent. The Family Planning Program further expands access to birth control, STI testing and treatment. With decreasing costs of PrEP, the clinic aims to combat health inequities in Black and Latino communities disproportionately affected by HIV in Michigan.

Corewell Health

As a system, Corewell Health is taking critical steps to advance key focus areas of our health equity strategy. Our accomplishments in 2024—many of them highlighted below—illustrate how health equity is being operationalized within the organization.

Priority Health embeds health equity into population health

In 2024, Priority Health's Population Health and Health Equity (PHHE) department adopted a "leverage-while-build" approach to equity, optimizing existing programs while strengthening data systems to address gaps in race, ethnicity and language information. This dual strategy enabled teams to integrate an equity lens into current initiatives while building future capacity to tackle health inequities.

Key efforts included partnering with the Michigan Public Health Institute to embed equity into the organization's culture, beginning with the Medicaid line of business. Team members engaged in workshops, self-assessments and consultant-guided planning to evaluate organizational strengths and barriers. These efforts will extend to the Medicare line of business in 2025, with a comprehensive equity report and recommendations to inform future strategy.

Population health assessments conducted in 2024 revealed inequities in maternal health and chronic diseases. In response, Priority Health launched a maternal and infant health strategy in Southeast Michigan, focusing on Black pregnant members in Detroit. This initiative employs community health workers to address unmet social needs and provide targeted support. Progress will be tracked in 2025 to guide a potential statewide rollout.

To ensure measurable outcomes, Priority Health introduced equity dashboards to track performance on key metrics in four focus areas: diabetes, hypertension, maternal-infant health and behavioral/mental health. These dashboards provide actionable insights, inform efforts to reduce inequities and deliver regular updates to the Health Equity Council and senior leadership.

Embedding health equity in quality, safety and experience

In 2024, Corewell Health's Quality, Safety and Experience (QSE) team took another step toward embedding health equity as a core priority by launching the Equitable Outcomes team led by Kania McGhee, Dr. This team will integrate health equity into QSE processes, identify inequities, and ensure quality improvement efforts are focused on closing gaps in patient outcomes. Collaborating closely with other health equity teams, including HEEAAT, the group will align efforts to avoid duplication and leverage diverse expertise.

Combatting unconscious bias from the inside out

Research shows that a diverse and representative health care workforce improves patient access to care, perceptions of care quality and most important, health outcomes. When health care teams reflect the characteristics of their patients, outcomes improve significantly.

Our Corewell Health Diversity, Equity and Inclusion Learning and Development team provides resources and courses designed to enhance cultural competence, address unconscious bias and build cultural intelligence among team members. The implementation of our mandatory, organization-wide Unconscious Bias training was a major milestone. **From January 2021–March 2024, 68,578 team members finished the training, resulting in an impressive 102% completion rate.**

To sustain this progress, the training is now integrated into employee orientation systemwide, ensuring all new hires complete it within their first 90 days of employment—in fact, 9,147 additional new hires had already finished the program by Sept. 30, 2024. This initiative has further embedded DEI principles into Corewell Health's culture.

Solving inequities when flagging violent patients

We remain committed to reducing harm from workplace violence. Documenting a patient's potential for aggression in their electronic health record (Epic) is a critical part of this effort. In 2023, Corewell Health introduced new tools in the West Michigan to ensure a more equitable, objective way to record a patient's history of aggressive and violent behavior. This update has standardized processes and terminology, reducing potential bias in risk assessments.

An Epic dashboard was developed to continuously track and analyze data, monitoring trends in violence-related flags across patient populations and demographics (such as race, age and gender). With the rollout of the One Epic Ecosystem (OEE), these tools and processes have been expanded to Southwest and Southeast Michigan regions to create a unified, systemwide approach.

Moving forward, a multi-disciplinary committee will convene in the first quarter of 2025 to review the data, refine tools and processes and guide decisions on training and education to further support team members in effectively managing violent incidents.

Strategizing to better serve the LGBTQIA+ community

Corewell Health in West Michigan has earned the LGBTQ+ Healthcare Equality Leader designation with a **score of 90 out of 100 on the 2024 Healthcare Equality Index (HEI)**, up from 65 in 2020. The HEI evaluates health care organizations on non-discrimination policies, LGBTQ+ patient services, employee benefits and community engagement. In 2024, Corewell Health met more rigorous criteria, reflecting its commitment to inclusive, patient-centered care.

Key updates include non-discrimination policies, active collection of sexual orientation and gender identity data and a dedicated LGBTQIA+ patient navigator, who has assisted over 1,111 patients since 2022. Additionally, **429 physicians completed "Safe and Affirming" training and 33 practices in the Corewell Health ecosystem have now received the designation.** Policies ensuring the use of chosen names and pronouns extend to maternal and infant care, ensuring respectful treatment for transgender and gender-nonconforming individuals during labor and delivery.

Community health needs assessments

Bridging community health and clinical teams' implementation strategies

The CHNA and Implementation Strategy (IS) are essential to identifying and addressing health inequities in the communities that we serve. Through a data-driven process that includes community input and analysis of public health data, the CHNA reveals the health needs of each community to guide future initiatives and strategies. Although each region has its own CHNA and IS process, our goal is to establish a systemwide framework that allows for regional flexibility and hospital-level autonomy. Ultimately, the CHNA bridges community health and clinical functions, educates stakeholders and fosters partnerships to sustain the impact of clinical and community health interventions.

In 2024, we made significant strides in aligning the CHNA process with health equity and clinical priorities. For instance, the Maternal Infant Health Program was added to the Grand Rapids and Zeeland hospitals IS reports and we established referral pathways between community health programs and clinical service lines, which were previously lacking. Additionally, the integration of the HealthBegins Transformation Compass into IS reports helped foster meaningful discussions around the continuum of health interventions—from individual behavior to social structures—guiding the development of targeted implementation strategies.

Tracking partnerships and impact

The 2024 CHNA process also saw the continuation and expansion of partnerships across the system. Corewell Health in Southeast Michigan issued a request for proposals (RFP) to identify CHNA contractors and focus on local collaborations with health departments and community organizations. Corewell Health in West Michigan maintained long-standing partnerships with Kent and Ottawa County Health Departments, while Corewell Health in Southwest Michigan worked closely with the Berrien County Health Department to write the mortality statistics chapter for the 2025 – 2027 CHNA. Southwest Michigan also engaged its Health Equity (HE) Committee in prioritizing and ranking community health needs.

In parallel to the CHNA reports, our work continued to assess the impact of ongoing IS initiatives. In West Michigan, data collection occurred quarterly to track the progress of interventions, such as supporting telehealth therapy in Kent County school districts and expanding the School Blue Envelope program in Ottawa County. This data was compiled into summary documents and presented at quarterly Community Board meetings for discussion and feedback.

Building awareness and buy-In

Advancing healthy births through stories and action

Photo description: The Corewell Health team at the 2024 Michigan Maternal and Infant Health Summit.

The 2024 Michigan Maternal and Infant Health Summit brought national and state stakeholders together to examine inequities, challenge systemic barriers and create actionable solutions. This inclusive event emphasized collaboration and positioned families as changemakers in maternal and infant health.

As a premier sponsor, Corewell Health had the opportunity to showcase its vision for a maternal health care continuum grounded in community-based innovations and holistic care. Presentations highlighted advancements in maternal-fetal medicine, home visiting programs and community health partnerships, reinforcing the idea that healthy pregnancies begin in homes and neighborhoods.

Galvanizing board members through health equity education

In summer 2024, all 15 members of the Health Equity Committee of the System Board of Directors toured The Corewell Health Center for Wellness in Benton Harbor, exploring its funding model, programs and impact on the community. In August, the committee toured the school health clinics at Detroit Edison Public School Academy, followed by a presentation about school health programs' response to health care access, a need highlighted in all nine hospital CHNAs across Corewell Health's service area.

Corewell Health in Southeast Michigan Board of Directors symposium featured a presentation on the Corewell Health in Southeast Michigan health equity strategy and programming; a health equity committee for the board is currently in development. The Corewell Health in West Michigan Board of Directors also received a presentation on the CHNA and its implementation strategy and a health equity committee for that board is currently in development as well. The Health Equity Committee of the Corewell Health in Southwest Michigan Board of Directors regularly meets to discuss key health equity projects, programs, initiatives and events.

Introducing transformative thinking through Community Grand Rounds

In October 2024, Rishi Manchanda, Dr, CEO of HealthBegins, delivered an insightful presentation on health equity at the Community Grand Rounds event hosted by Corewell Health. Speaking to nearly 200 in-person and virtual attendees across all three regions, Dr. Manchanda highlighted the importance of a "balanced portfolio" approach to health equity, covering medical interventions, policy reforms, social determinants of health and advocacy for key policy changes.

Monitoring, assessing and sustaining health equity

Assessing community benefits to sustain health equity

Community benefits investments are defined by the Catholic Health Association (CHA) as "activities or programs that provide treatment and promote health and healing in response to identified needs." For Corewell Health, they are an important mechanism for intentionally allocating resources to community needs.

To accurately showcase the impact of our community efforts and ensure community benefit spending remains a reliable success metric, the health equity evaluation, assessment, and analytics team (HEEAAT) established three key goals in 2024: assess the current state of community benefits, implement a standard reporting process and structure and develop education to expand team

members capacity to engage in the reporting process. Thanks to a strong collaboration between the health equity and finance teams, these goals were met in 2024, creating the foundation to continue improving our internal processes and practices in 2025.

In 2024, the team delivered 19 trainings on how to use the Community Benefits Inventory for Social Action (CBISA) platform, equipping 245 reporters to accurately track and report community benefit data. Additionally, nearly 20 presentations were made to key stakeholders, including senior leadership, the Health Equity and DEI Leadership Team and the Health Equity Committee of the system board, to raise awareness and build buy-in to engage in the work required to effectively capture the full investment that Corewell Health makes in communities.

HEEAAT community benefits milestones

Assess current state of community benefit reporting	**100% complete**
Systematize the community benefit reporting structure and process	**100% complete**
Provide education and capacity development	**100% complete**
Provide regular updates detailing community benefit reporting	**50% complete ***

***Projects under this milestone are set to be completed in 2025**

Assessing our Corewell Health Healthier Communities portfolio

We have implemented innovative strategies to evaluate and enhance health equity investments systemwide. A recent Outcomes Statement Analysis reviewed 27 community program logic models—encompassing 422 outcomes across three regions—to assess their alignment with health equity priorities. This analysis revealed that 81% of the outcomes focused on individual-level change, while institutional (8%), community (8%) and policy (3%) changes accounted for the remaining outcomes. These findings will guide future investments in maternal-infant health, chronic disease prevention, behavioral health and other priorities.

Establishing health equity metrics to monitor and assess progress

In July 2024, the Enterprise Health Equity Council approved a governance structure to develop and implement organization-wide health equity metrics, including a working group to collect and visualize data, a subject matter expert group of clinical and health equity leaders and the council itself, which monitors and approves the metrics. This framework ensures accountability in prioritizing our indicators, measuring our inequities and setting benchmarks across our organization. The health equity metrics will serve as a guiding “north star” for Corewell Health to align efforts across teams.

Future goals and vision

As we move forward, our Corewell Health Equity, Evaluation and Analytics Assessment Team (HEEAAT) will continue refining and supporting initiatives across our regions, ensuring that the voices and insights of frontline team members are integrated into our strategic decision-making. Grounded in the lived experiences of patients, communities, teams and plan members, these efforts will drive meaningful investments and build high-performing portfolios with lasting impact.

In 2025, we'll deepen this collaborative approach, leveraging organization-wide insights and rigorous data analysis to create systemic change. By advancing health equity at every level, we'll expand opportunities for all to thrive and move closer to our vision of optimal health for everyone.

Prioritizing metrics and addressing inequities

In 2024, the enterprise health equity council and an associated group of subject matter experts made up of clinicians and community health leaders worked to establish 13 key health equity metrics for 2025. They were selected based on their potential to address significant inequities, alignment with existing organizational strategies, and their actionability for teams. These 12 metrics will form the foundation for setting specific targets and benchmarks in 2025 and qualitative investigations will explore the root causes of inequities.

Establishing these metrics is a step toward formalizing health equity work at Corewell Health by creating a way to measure and report progress, while highlighting critical inequities in health outcomes that are experienced by our patients. The process for developing these metrics brought together clinical and community health experts to ensure diverse perspectives contributed in the decision making process. The metrics offer an organizing framework for health equity efforts and a set of top-line outcomes that can inform the design and development of our portfolios moving forward.

Improving data to uncover health inequities

Capturing comprehensive patient demographic data—including Sexual Orientation Gender Identity (SOGI) and Race, Ethnicity, Preferred Language and Sex (REaLS)—is essential to understand how different populations experience health inequities. Although Corewell Health's enterprise-wide capture rates for REaLS are strong, with more than 80 – 90% completion for most metrics, SOGI capture rates remain under 15%. In 2025, improving the capture of these critical metrics will enable us to disaggregate data across a broader range of demographic groups and identify and address inequities that were previously difficult to pinpoint. This effort will enrich our understanding of patient needs to drive our targeted interventions.

Making health equity real to real people

Our impact as an agent of change and a trusted source of equitable health care is not just measured by metrics. It's defined by the lives we touch and the barriers we dismantle. Impact is a person preparing to give birth who feels less worried and uncertain knowing there's a qualified doula ready to guide them through delivery. Impact is a child who thrives because their family received timely nutritional support in their most formidable years. Impact is communities of color that feel listened to, cared about and empowered to value and invest in their health.

Corewell Health is catalyzing our mission with programs tailored to meet the unique needs of our communities. As we move into 2025, our strategy is clear: balance investments across all levels of transformation, deepen partnerships and address the root causes of health inequities. By leveraging the strengths of each region alongside systemwide initiatives and collaborations, we're maximizing our collective impact.

2024 was a year of progress. Assessments show that we've marked substantial successes in individual behavior interventions. To sustain that advancement into the next year of unknowns as we look to 2025, we'll balance these investments across all levels, with a focus on addressing the root causes of inequities and creating more lasting change. We remain inspired by the profound connections between our mission and the communities we serve. Together, we're not just measuring impact—we're living it.

Appendix

Definitions

Community Health Needs Assessment (CHNA): A systematic process engaging community members and partners to collect and analyze data within a geographic area, assessing health needs, including social determinants, mortality and morbidity The process produces a CHNA report and an Implementation Strategy (IS), detailing priorities, metrics, goals and partnerships.

Community benefits: Programs or activities addressing identified health needs to improve healthcare access, community health and medical knowledge while reducing the burden on government services Essential for non-profits to maintain charitable status and reported annually to the IRS.

Health inequities: Differences in health outcomes linked to social, economic and environmental disadvantages, often among groups defined by race, ethnicity, gender, income and location.

Health equity populations: Groups disproportionately affected by health inequities, such as racial minorities, low-income families and those in underserved areas health equity initiatives aim to ensure fair opportunities for optimal health.

Health equity strategy at Corewell Health: A plan to eliminate inequities by addressing social determinants, engaging stakeholders and embedding equity in organizational priorities It aims to ensure health care access for all, regardless of identity or status.

Health equity outcomes: Measurable results of efforts to reduce inequities, reflecting improvements in health, care access and well-being.

Health equity value pilot: Evaluates the impact of health equity programs through metrics like ROI, VOI and SROI.

Health-Related Social Needs (HRSNs): Social and economic factors affecting health, such as transportation, food and housing insecurity Addressing HRSNs involves connecting patients to community resources.

Portfolio of health equity investments: Coordinated initiatives addressing inequities and promoting equitable outcomes through medical interventions, policy reforms and advocacy.

Portfolio alignment rubric: A tool to assess how programs align with Corewell Health's equity mission, evaluating domains like systems change, strategy alignment and stakeholder engagement.

Return on Investment (ROI): Measures financial benefits relative to program costs, evaluating short-term efficiency.

Social Determinants of Health (SDoH): Environmental conditions shaping health, such as economic stability, education, food security and community support.

Social Return on Investment (SROI): Quantifies social and community benefits relative to resources invested, offering a holistic view of program impacts.

Transformation map: Framework assessing the impact of health equity investments across individual behavior, organizational change, community conditions and societal policies.

Value of Investment (VOI): Considers both financial and non-financial benefits, including long-term outcomes and social impacts, for a comprehensive program evaluation.

Diversity: Individual differences in race, gender, religion.

Equity: Fair, unbiased treatment for all.

Inclusion: Ensuring all populations feel valued, safe and respected.

2024 Community Health Impact Report

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Corewell Health™