CommonSpirit

Community-Centered Care Impact Report

COMMUNITY HEALTH

“As stewards of our communities, we are called not only to heal the sick but to also restore the heart of every neighborhood we serve. True health is found in the relationships we build, the care we give, and the well-being we nurture. With community-centered care as an expression of our mission, let us invest in a future where every life is valued, and health flourishes beyond the treatment of disease – where care is an act of love, kindness, and a commitment to the whole person – body, mind, and spirit.”

– Tom Kopfensteiner, STD
Chief Mission Officer, CommonSpirit Health

WELCOME

A fresh approach to healthcare is not just an option – it's an urgent necessity. We must rethink what defines health and how we deliver care. The United States healthcare system continues to overemphasize service provision for urgent and acute health needs. Significant investments are deployed to create a system that can more efficiently treat a condition or disease that is already present, yet still struggles to prevent it from occurring in the first place.

The truth is, more than 80% of a person's health is driven by nonclinical factors – a zip code is more predictive of health outcomes than genetics. It is imperative the healthcare sector includes this in the equation when designing and issuing remedies for health.[1]

These hyperfocused efforts on treating diseases have overshadowed what also matters to consumers of healthcare – well-being. The presence of physical, mental, and social well-being, and not just the ability to effectively treat disease, matters to individuals, their families, and the communities in which they live. As an industry, we need to focus on the fundamentals of what health is and what care should mean, to focus on the true conditions that impact health and, in turn, rebalance investment.

The truth is, more than 80% of a person's health is driven by nonclinical factors – a zip code is more predictive of health outcomes than genetics.[1] It is imperative the healthcare sector includes this in the equation when designing and issuing remedies for health.

Collectively, we need to reset and acknowledge that we have problems, and we must fix these problems in order to improve health and restore consumer and community faith.

At CommonSpirit Health, we have made a deliberate effort to prepare ourselves for the future – building a culture and practice around health. The Community Health department has been on a journey to recenter and invest in care where health largely happens – in communities.

Specifically, our system office Community-Centered Care team catalyzes the shift from reactive to proactive care, reaching people where they are – where they live, work, and play. Successfully making this shift depends on collaboration across sectors, shared commitment and accountability from both healthcare systems and communities, and most importantly, it cannot be done without genuinely caring for the well-being of the people and communities we are a part of. Community is an integral and necessary component of patient-centered care.

The corresponding achievements described in this report are possible because of the leadership, integrity, and relationships that exist among CommonSpirit Health's local and regional community health and mission leaders, colleagues across functional areas, and the individuals and organizations in communities with whom we collaborate on a daily basis. Patients and communities demand and deserve more than "care as usual". We invite you to partner with us as we learn and design health-plus-care as it is meant to be.

[1]Institute for Clinical Systems Improvement. Going beyond clinical walls: solving complex problems. 2014.

Ji Im, MPH, System Senior Director for Community and Population Health

Brian Li, MBA, System Director for Community Health Strategic Initiatives

Jurema Gobena, MPH, System Director for Social Care Integration

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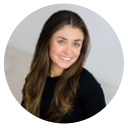

Megan Surace, MPH, System Manager for Community Health Strategic Initiatives

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Introduction to Community-Centered Care

Community-Centered Care extends prevention and treatment approaches in communities with the goal of achieving the vital conditions for health and well-being. Through these recentering efforts, we aim to accomplish the following:

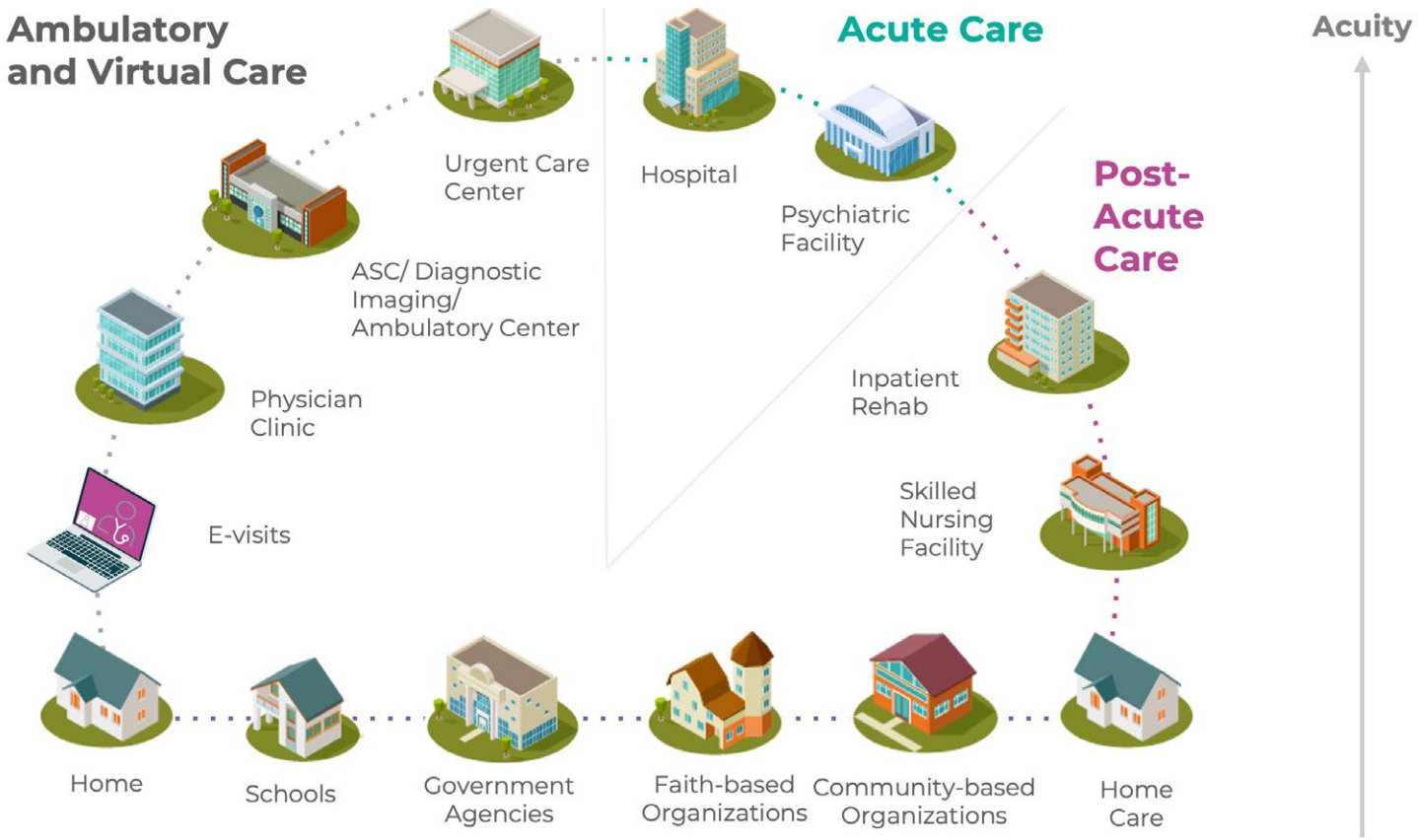
ACCESS
Add conduits in clinical and community settings to vital community-based supports so there is no wrong door to getting support.

AVAILABILITY
Increase the number of available services and workforce that individuals need to live their healthiest lives.

INTEGRATION
Expand the meaning of a "care team" to include individuals and community-based workforce.

SUSTAINABILITY
Accelerate the shift from limited-term and siloed funding for social services to sustainable financial support.

QUALITY
Co-design care with community voices and experiences to promote whole person care.



Community-Centered Care

Availability of services across the continuum vary by community

Community-Centered Care Initiatives Cumulative Impact

$19.5 million
external funding leveraged to build community infrastructure and capacity

34 funding partners
investing in Community-Centered Care approaches and models

79 CommonSpirit Health hospitals and clinics in **11** states

78,583 individuals
issued **173,963** referrals to services to address social needs

14 contracted community service organizations to sustain growth

5,126 organizations
in partnering networks

95 community partners
co-creating community solutions

750+ individuals
(pregnant, postpartum, and/or living with chronic conditions) supported by Community Health Workers to address an average of **6+** social needs to reach self-sufficiency

30 community health workers
focused on multiple populations including chronic conditions and maternal health

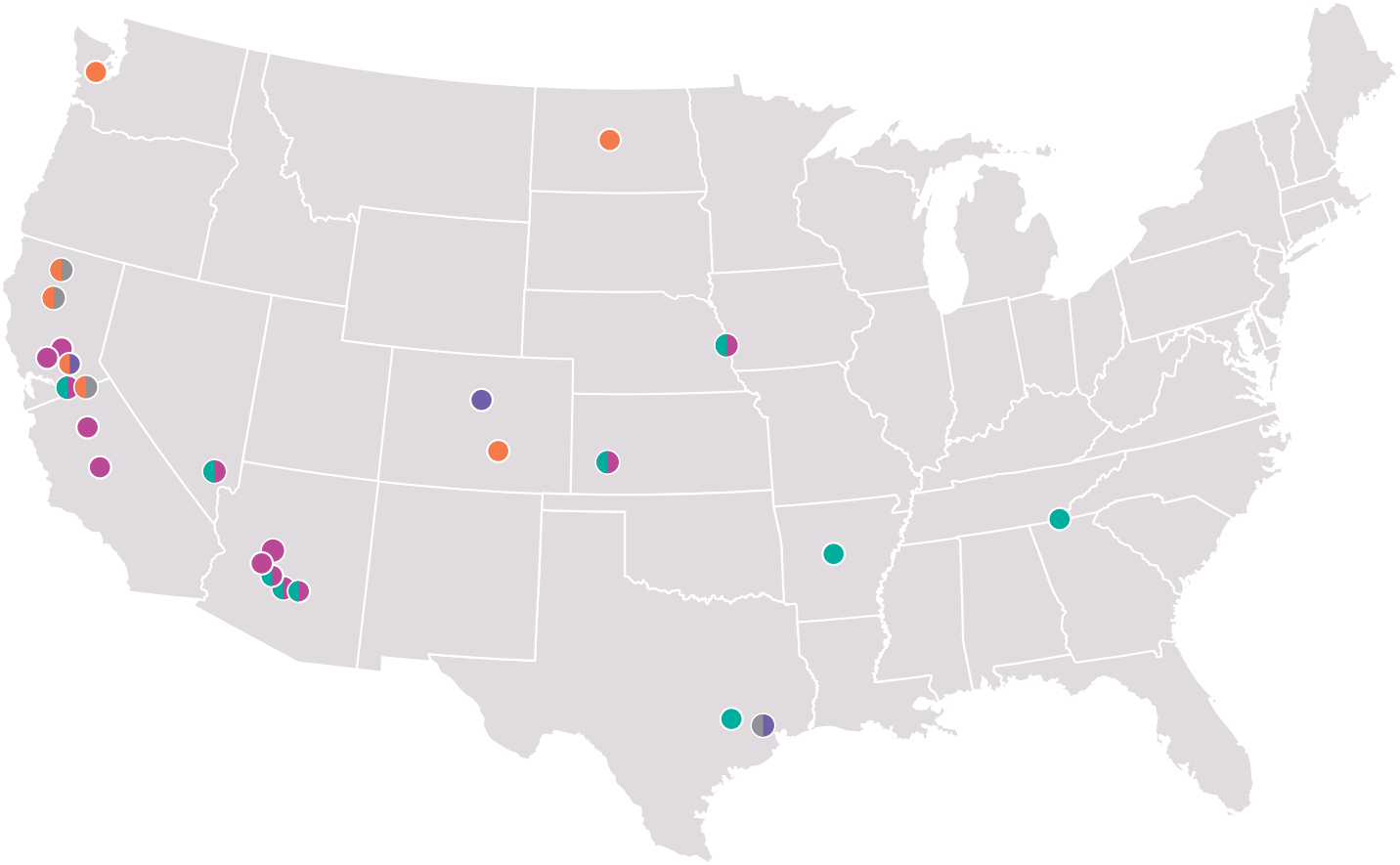
4 social needs analytics dashboards giving insight to the impact of community programs

10 years
since launching the first community network

42
industry publications and presentations

6 community learning series bringing partners together to learn about community-centered care models

Community-Centered Care Initiatives



LEGEND

- Pathways Community HUB
- Connected Community Network
- Community Care Hub
- Community-based Care Transitions
- Medicare CHW Reimbursement Pilot

Community-Centered Care Initiatives – Locations

ARKANSAS
- CHI St. Vincent

ARIZONA
- Chandler Regional Medical Center
- Mercy Gilbert Medical Center
- St. Joseph's Westgate
- St. Joseph's Hospital & Medical Center
- Yavapai Regional Medical Center

CALIFORNIA
- Bakersfield Memorial Hospital
- Cancer Institute at Dignity Health - St. Joseph's Medical Center
- Dignity Health Management Services Organization
- Mercy General
- Mercy Hospital of Folsom
- Mercy Hospitals of Bakersfield – Southwest/Downtown
- Mercy Medical Center Merced
- Mercy Medical Center Mt. Shasta
- Mercy Medical Center Redding
- Mercy Medical Group
- Mercy San Juan Medical Center
- Methodist Hospital
- St. Joseph's Behavioral Health Center
- St. Joseph's Medical Center
- Woodland Memorial Hospital

COLORADO
- Centura St. Anthony North
- Southern Colorado Family Practice

KANSAS
- St. Catherine Hospital

NEBRASKA
- CHI Health

NEVADA
- St. Rose Dominican Hospital

NORTH DAKOTA
- CHI St. Alexius Health Pinehurst Clinic
- CHI St. Alexius Health Mandan Primary Care

TENNESSEE
- CHI Memorial

TEXAS
- CHI Baylor St. Luke's Medical Center
- CHI St. Luke's Health Sugar Land Hospital
- St. Joseph Regional Hospital

WASHINGTON
- FMG Primary Care in East Bremerton
- NW Family Residency in Bremerton

LEGEND
- Pathways Community HUB
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01
AREA OF FOCUS

Understand and Address Health Disparities

Health disparities, the preventable differences in disease burden, represent a profound moral and public health crisis undermining societal well-being. Our team seeks to deeply understand and address health disparities through quantitative data and qualitative feedback on what communities themselves identify as priority needs. Our work recognizes that social structures and conditions significantly impact how different groups and communities interact with larger systems. Addressing health disparities within our framework has two key dimensions: first, adopting a comprehensive view of individuals that goes beyond medical data, and second, identifying and addressing the root causes of these disparities through effective collaboration. Our Community-Centered Care approach ensures co-designing solutions, amplifying community voices and expertise, and defining the healthcare system's appropriate role in supporting community-driven efforts.

- **Understanding health disparities:** Historically, there has been a lack of insights into patients' social needs due to difficulty collecting and integrating social needs data. The Community-Centered Care team, in collaboration with partnering teams in IT, Quality, and Payer Strategy, built the **Social Needs Analytics (SoNA)** platform to assess the impact of community health programs and understand patients' health-related social needs. We use these dashboards to identify disparities in needs and resource gaps the communities need to fill in order to thrive. Until recently, hospitals and health systems did not collect standardized health-related social needs data as part of care standards. Promoting the collection of clinical and nonclinical information critical to health and integrating these historically disparate datasets provides a holistic view of individual and community health. This enables development and implementation of tailored interventions that address the social drivers of health (SDoH) and will facilitate more effective resource allocation, improve care coordination, and lead to more equitable health outcomes for underserved populations.

- **Addressing health disparities:** Nationally, black women are three times more likely to die from pregnancy-related causes than white women[2]. Communities in Nebraska, Texas, Nevada, and California identified this disparity as a critical need and enrolled black pregnant individuals into the **Pathways Community HUB (PCH) initiative**. As part of the PCH initiative, community-based organizations (CBOs), local government agencies, health plans, and other community partners convene to identify communities' highest health priorities. This advisory group reviews community data from Community Health Needs Assessments, public health trends, and health plan claims data to help identify a population to focus on. The initiative relies on community health workers (CHWs) to help black pregnant women navigate health and social services during and after their pregnancies.

[2]Howell, Elizabeth. Reducing Disparities in Severe Maternal Morbidity and Mortality. June 2018. National Library of Medicine

64,212 (21%)
patients screened with at least one identified need

108,280
total identified needs

1.69 average identified need per positive patient

INSIGHT: Approximately 20% of inpatients screened positive for health-related social needs. In 2024, there were 108,280 needs identified in 64,212 patients who screened positive for needs – an average of 1.69 needs per positive patient.

Community Health Worker Services in Texas Help a Pregnant Mother with Housing

A young mother in her second pregnancy was referred to the Texas Pathways Communities HUB by a family member. She needed help applying for Medicaid and securing stable housing, as she was behind on rent. With Spanish being her primary language, she encountered language barriers that made it difficult for her to navigate the application process. The CHW assisted her with the Medicaid application and it was subsequently approved. She has since attended prenatal appointments and received medical support. The CHW also coordinated rent assistance through Catholic Charities, covering three months of rent and utilities. In December 2023, she safely delivered an 8-pound baby boy, and her husband has since secured employment. The following Pathways were successfully completed:

- Healthcare coverage (enrolled in Medicaid)
- Food security (enrolled in WIC and SNAP)
- Social services (received a car seat, diapers, baby items, clothing, and hygiene supplies)
- Housing security (rent and utility assistance)
- Pregnancy and postpartum (healthy delivery and received postpartum care)

Community Health Worker Services in Nebraska Help a Pregnant Mother Obtain Employment

Kara* (name changed) joined the Omaha Pathways Community HUB after she learned about the program from her local health clinic. When she enrolled, she was 18 weeks pregnant. With the support of her CHW, Arnetta, she was able to obtain employment and complete her first semester of interior design school. She was also able to secure financial resources to help supplement income while on maternity leave. She had a healthy 7.6-pound baby girl and is now two months postpartum and thriving. Kara shared that she suffered from postpartum depression during her last pregnancy. She believes that the support of the CHW during this pregnancy prevented her from developing those conditions again.

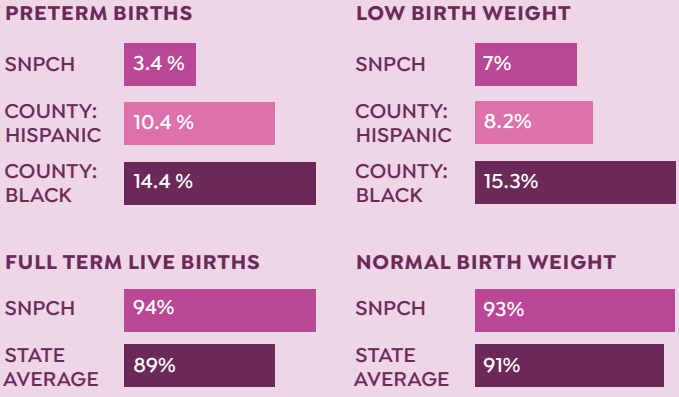
Improving Preterm and Birth Weights Rates for Babies in Nevada

Comagine Health is collaborating with local partners to improve health and health equity in Clark County, Nevada, by establishing the Southern Nevada Pathways Community HUB (SNPCH). SNPCH implemented a one-year maternal health pilot with support from a 2023 SilverSummit Community Reinvestment Grant and CommonSpirit Health grant to demonstrate the effectiveness of the PCH Initiative for high need SilverSummit Medicaid members. An evaluation demonstrated that the percentage of live births from the priority population of focus (Hispanic and/or Black) that were preterm was lower than the rates for Hispanic and Black infants in Clark County (3.4% compared to 10.4% and 14.4%, respectively) and the LBW rate for the priority population of focus was lower as well (7% compared to 8.2% and 15.3%, respectively).[3] This success has fueled further investment to expand services and populations.

[3]Southern Nevada Pathways Community HUB. Silver Summit Pilot Final Report. 2024. Comagine.

PRETERM AND LOW BIRTH WEIGHT RATE IMPROVEMENTS

Preterm births and low birth rates for our priority populations were significantly lower than the county averages for Hispanic and Black people.



SNPCH = Southern Nevada Pathways Community HUB
County = Clark County, NV

02
AREA OF FOCUS

Engage in Authentic Community Partnership

Effective community engagement relies on intentional partnerships and recognizes the unique strengths of diverse organizations. The most impactful initiatives convene diverse groups – governmental agencies, CBOs, faith-based organizations, healthcare and anchor institutions, and community members and coalitions – to create an inclusive approach to address community challenges.

In alignment with one of CommonSpirit Health's core values – collaboration – we pursue each community relationship with the intent to accompany our partners, build trust, and shift power to communities.

Community-Centered Care Partners

34 Funding Partners
Funding partners invest more in community infrastructure, workforce development, and innovative care models that prioritize community involvement and ownership. This strategic shift in funding will support vital community conditions and break down organizational silos.

105 Collaborative Partners
Collaborative partners co-design and co-implement programs, sharing power and building trust to best serve marginalized communities. We prioritize community voices and participation, focusing on long-term positive impact while anticipating unintended consequences and addressing barriers to access.

14 Contracted Partners
Contracted partners are external collaborators whose partnerships are built on mutual accountability or achieving shared goals and a commitment to equitably compensating for the valuable work.

Some of our regional and national partners include, but are not limited to:

- American Hospital Association
- America's Physician Groups
- Blue Shield of California
- Brookings Institution
- California Health Care Foundation
- Camden Coalition
- Catholic Charities
- Convergence Center for Policy Resolution
- Episcopal Health Foundation
- Health Begins
- Health Leads
- Hold.Health
- Intrepid Ascent
- National Academy of Medicine
- New York Fed Community Development
- Partnership to Align Social Care
- Partnership Foundation
- Pathways Community HUB Institute
- Rippel Foundation
- USAging
- United Healthcare
- United Way Worldwide
- Uncommon Solutions
- Urban Institute

We acknowledge the invaluable contributions of our partners – locally, regionally, and nationally – in our pursuit of health equity.

Accompaniment

Walking alongside partners, providing support and resources, and recognizing that each partner has unique strengths and contributions to offer. An acknowledgement that each brings distinct leadership, voices, and skills at different times to fulfill a collective need.

Trust Building

Trust is the foundation of successful partnerships for diverse groups to feel confident that they can rely on each other to fulfill their commitments. It requires transparency, accountability, and consistent communication.

Power Shifting

Requires a conscious effort to challenge existing power dynamics and create a more equitable partnership.

A Community Care Hub Gets off the Ground in Houston

The Community Assistance and Transition Care of Houston (CATCH) is an emerging Community Care Hub that convened community partners in 2023 to assist in its Hub planning efforts. CommonSpirit Health joined these early efforts alongside other community organizations. Since then, our team has participated in regular planning efforts that have furthered CATCH's ability to establish organizational governance, understand needs in the local marketplace, and secure seed funds to hire initial staff. With the support of partner organizations including CommonSpirit Health, CATCH was selected as one of 20 Community Care Hubs to receive infrastructure and innovation grants by the Center of Excellence to Align Health and Social Care and is also preparing to launch services as part of its first contractual agreement.

> "It has been an honor to work with CommonSpirit to advance Community Care Hub efforts locally and to be a part of the work the organization is doing nationally. We hope to continue to build upon these initial efforts to expand much-needed health and non-medical care to our community members who need it most."

– Janice Sparks, PhD, CATCH Director

Local Partnerships in Action Across Eight States

Connected Community Networks (CCN) support social services providers in their network self-organization. A local, trusted backbone community entity helps convene local partners towards collaboration and collective impact. Each CCN establishes a community advisory group to co-steward the needs of community partners and the clients they serve, independent of healthcare interests. By rooting governance in the community, health systems like CommonSpirit Health participate as an active stakeholder, and are better positioned to understand the real-time needs of local providers and intentionally "show up" in ways that the community identifies versus crafting solutions to solely suit acute business needs. CommonSpirit Health has established five governance models in its networks and counting, with plans to incorporate direct community voice.

03

AREA OF FOCUS

Build Community Infrastructure

Community-based organizations belong to a sector that has historically encountered challenges in harnessing sustainable funding and delivering services in coordination with organizations across the community. Trying to solve these challenges without the active support of local, influential organizations like hospitals can be difficult. Our team recognizes this and believes we can play a supportive role in overcoming these challenges. We help CBOs with the resources, capacity, and readiness to partner, from a place of agency, with healthcare organizations to better serve clients, together.

Our team works with communities to develop and improve systems of care that support a community's well-being and functioning. This encompasses a wide range of activities aimed at strengthening the community's capacity to thrive.

Our unique approach to accelerating CBOs' capacity and infrastructure includes:

CATALYTIC INVESTMENT

We believe that community challenges require community-level action. As such, we play an intentional role in engaging other anchor and healthcare organizations in communities to leverage collective investments. To date, CommonSpirit's initial investment of $2.2 million in local efforts has spurred an additional $19.5 million in funding from partners, including competitive healthcare organizations, health plans, government agencies, and foundations. The dollars funded investments needed to build community infrastructure, capacity, and community-based organization readiness to serve individuals in our local service areas.

THOUGHT PARTNERSHIP AND TECHNICAL ASSISTANCE

We recognize the importance of having healthcare organizations walk alongside the community sector as we collectively improve our systems of care. We put this into practice by providing technical assistance and thought partnership in 26 communities, and have helped to secure local buy-in to support community-driven initiatives from 13 health plans and an additional five health systems.

We help CBOs with the resources, capacity, and readiness to partner, from a place of agency, with healthcare organizations to better serve clients, together.

Our team works with communities to develop and improve systems of care that support a community's well-being and functioning.

Accompaniment in Action as Community Organizations Lead

"During our organization's early stages of formation and strategy development, CommonSpirit Health provided resources, peer learning opportunities, and sourced impact models as we designed how best to serve the needs of our greater Chattanooga community. They [CommonSpirit Health] understand that there is no one-size-fits-all approach to building lasting initiatives. We know we have a trusted partner who will support whichever direction our community and organization chooses and catalyze ways to help get us there."

— Tracy Wood, MPH, MHA,
CEO Journey Health Foundation

CommonSpirit Catalytic Investment Ignites Action to Address Maternal Health Disparities

"In Southern Nevada, CommonSpirit granted us [Comagine Health] a catalytic $249,000 investment to design and build a care coordination hub. This funding, coupled with technical assistance, has ignited action to address maternal health disparities in our community. As the hub, we were able to secure an additional $6.7 million in funding from others to increase community-based organization capacity, expand the care network, and evaluate health and financial outcomes."

— Tracy Carver, MPA, Senior Director,
Community Health, Comagine Health

04
AREA OF FOCUS

Foster Innovation

As Community and Public Health practitioners with expertise in bridging clinical and community sectors, our Community-Centered Care team plays a unique role within CommonSpirit Health by testing new ways to address a person's whole health needs through an extended care continuum.

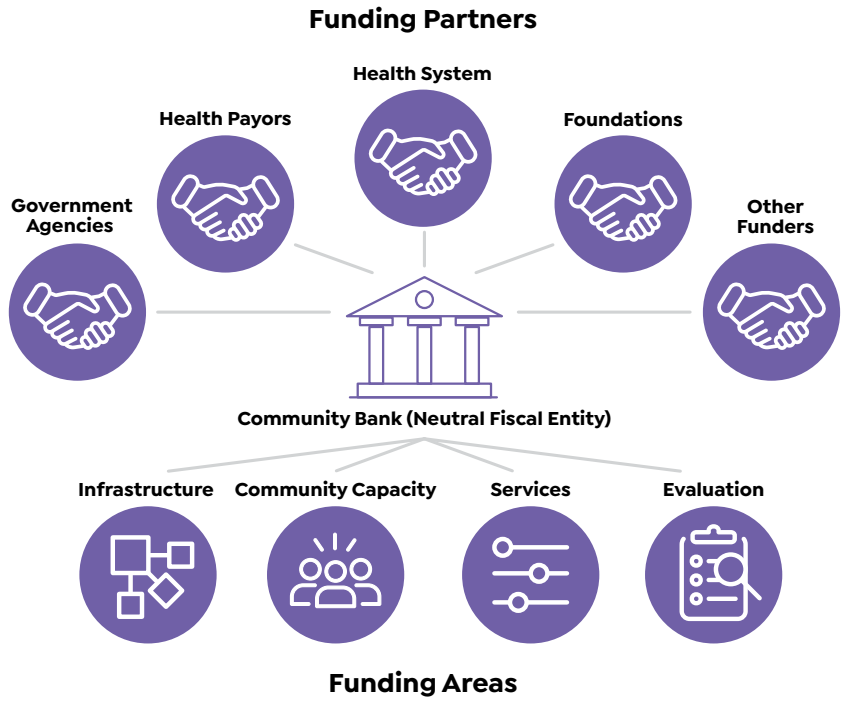
The team sources creative and promising approaches, frameworks, and models that can be replicated and scaled across diverse communities. Sometimes, innovation involves exploring new, untested opportunities that are guided by our values of reciprocity and collective vision to improve communities. At other times, innovation means bringing the community together to prioritize both individual and community goals, rather than focusing solely on immediate needs or optimizing existing systems.

The following Community-Centered Care innovations are currently being tested.

- **Community Bank and Community Governance:** Our organization views the community networks we build as public goods because they benefit different people and sectors, including those who don't pay directly for them. The community bank concept was born to encourage stakeholders like other health systems, payers, government, philanthropy and nontraditional funders to pay into their net benefit and catalyze additional funding through pooled investment. Establishing local governance permits community ownership of the networks and its funding, allowing communities to steward how to appropriate investment.

- **Community Health Worker reimbursement:** We lead pilot projects to implement new Medicare and Medicaid reimbursements for CHWs' time providing health and social care navigation inside and outside of clinical settings. These services will play an important role in sustaining CHW positions in healthcare and CBO settings that are otherwise grant-funded and difficult to finance. For example, CommonSpirit's **Medicare CHW Reimbursement Pilot** is one way we're leading by example for the field. It is the largest and most advanced effort of a multi-market implementation of these services by a health system to date.

The implementation tools developed as part of this effort are being requested by collaborating organizations across the field, and CommonSpirit plans to share these tools to enable successful replication within and outside of CommonSpirit service areas once the pilot projects conclude.



- **CBO inclusion in care delivery design:** CBOs in California were on the receiving end of information to encourage their participation in California's Medicaid transformation (CalAIM), but their perspective as active agents in the design and decision-making process was not sufficiently heard. As such, CommonSpirit funded a study to understand CBOs' awareness, experience, and infrastructure readiness for CalAIM participation. CBOs in 60.3% of the counties in CA received compensation for their time participating in key informant interviews. Those interviews yielded findings which highlighted the need for intentionally including CBOs as partners in all phases of designing CalAIM implementation; more support for CBOs thinking about or taking steps to become CalAIM providers, such as peer-to-peer mentoring and earlier community level engagement; and shared services among CBOs who are taking steps or are already providers to alleviate administrative burden. These findings were among many influencers that led to changes in the CalAIM initiative to more directly center CBOs.

- **Health systems as agents of change for cross-sector collaboration:** CommonSpirit is not only a founding funder of the Partnership to Align Social Care, but has team members in leadership roles within this cross-sector collaborative whose aim is to advance alignment between the health and social care ecosystems. Through our efforts alongside others, practical tools have been developed, such as a template agreement for clinical and CBO partners, and guides on paying and contracting for CBO services. These technical assistance tools help emerging partners overcome challenges that can impede their ability to formalize a partnership. Similarly, alongside other collaborating organizations in the Convergence Collaborative on Social Drivers of Health, our team has helped fund and develop "A Blueprint for Action" at federal, state, and local levels to mitigate the impact that inequities in social drivers of health have on communities.

CommonSpirit Health is a foundational and essential partner in advancing the cross-sector collaborative work of the Partnership to Align Social Care to co-design value-based, community-focused, and person-centered social and health care delivery system solutions. CommonSpirit's early financial commitment to the collaborative catalyzed critical work to identify, define, and develop capacity-building resources enhancing the evolving landscape of community care hubs across the country.

– June Simmons, MSW, Co-Chair, Partnership to Align Social Care, President & CEO, Partners in Care Foundation

"CommonSpirit Health's approach to community collaboration is exemplary and exactly what our country needs now. The range of engaged partners and the depths of their commitment to Community-Centered Care as defined by CommonSpirit is unmatched. The key seems to be taking their own words seriously. They accompany, not direct, local partners to enable them to contribute more effectively to community goals. They build trust, the essential asset of community collaborations, by recruiting, listening to, and empowering partners to feel secure enough to share what needs to be done and how it could be done successfully, here. And they constantly strive to share and shift power so that authentic community voices are elevated and the co-designed Community-Centered Care solutions work for all."

- Len M. Nichols, MA, PhD,
Non-Resident Fellow, Urban Institute,
Health Policy Center

Community Bank, a Foundation for Collective Impact Funding

San Joaquin County, CA, launched a Connected Community Network in 2020 with United Way of San Joaquin (UWSJ) serving as the network convener. In its inception, UWSJ received commitment from 11 funding partners, including Dignity Health St. Joseph's Hospital and Medical Center, to pay into the community bank and sustain efforts that build an innovative public health infrastructure. The CCN represented by health providers, healthcare payers, government agencies, and foundations financially contributes $200,000 annually for this work. In one case, a funding partner had already selected a different technology for their organization, however seeing the community's desire for a single technology solution and the number of partners committed, the organization decided to side with the community's selection, not their own. The San Joaquin County CCN's funding success coupled with consensus with the community demonstrates the strength of this model towards sustainability and driving engagement while reducing burden to CBOs.

05
AREA OF FOCUS

Collaborate Across Sectors

We recognize that advancing shared aims across and within sectors is not only achieved at the programmatic level, but also through advocacy as well. When it comes to community health, CommonSpirit hospitals and practices are one among many local organizations seeking to improve local community conditions and outcomes. As such, we recognize that CommonSpirit and other like-minded organizations seeking to advance community health are better together than apart. We actively participate in key cross sector collaboratives with national influence in order to catalyze a shift towards upstream investments and interventions.

- **Influencing SDoH Policy & Practice:** Our work has been presented and featured in federal efforts and toolkits to design policy and influence practice, including the Office of the National Coordinator SDoH Information Exchange, the Administration for Community Living, and the White House's U.S. Playbook to Address Social Determinants of Health. Highlighted throughout is our stance on the need for trusted backbone entities to steward SDoH initiatives at the community level and pooled investment for collective ownership and impact.
- **Community Care Coordination:** CommonSpirit was among 14 local organizations that collectively explored and launched the **Pathways Community HUB Initiative** in Omaha as a new way to collaborate, leverage resources, and effectively address the social drivers of health in order to build a healthier community. These organizations include health plans, health systems, community-based organizations (housing, food assistance, etc.), academia, and state and local public health agencies committed to create a sustainable care coordination network in the region.

We recognize that CommonSpirit and other like-minded organizations seeking to advance community health are better together than apart. We actively participate in key cross sector collaboratives with national influence in order to catalyze a shift towards upstream investments and interventions.

"CommonSpirit Health catalyzed the Pathways Community HIUB initiative in Omaha. After 9 months and serving our first 84 pregnant individuals, the hub has been able to demonstrate a powerful commitment to community health and well-being. This initiative showcases not only innovative approaches to care but also a remarkable level of collaboration, uniting health plans, healthcare providers, and community-based organizations in a shared goal of improving maternal health outcomes. The collaborative spirit and innovative approach of the model are a testament to the community's dedication to creating a healthier future for all."

– Kelly Nielsen, MPH,
Director of Omaha Pathways
Community HUB

Removing Barriers to Implementing Community Partnerships

Some success stories don't directly involve patients, but improve our ability to serve them. Members of our team serve in leadership roles within the Partnership to Align Social Care, including its Contracting Workgroup. This workgroup created a template agreement, along with other guides – Partnerships with CBOs: Opportunities for Health Plans to Create value; A Health Plan's Guide to Paying CBOs for Social Care; A Health Plan's Guide to Developing CBO Contract Scopes of Work; Operationalizing Contracts: How Payers Can Improve Collaboration with CBOs – that healthcare providers and CBOs can use to partner on the delivery of CHW services. These technical assistance tools provide guidance on the numerous and often complex issues partners should address when formalizing a partnership.

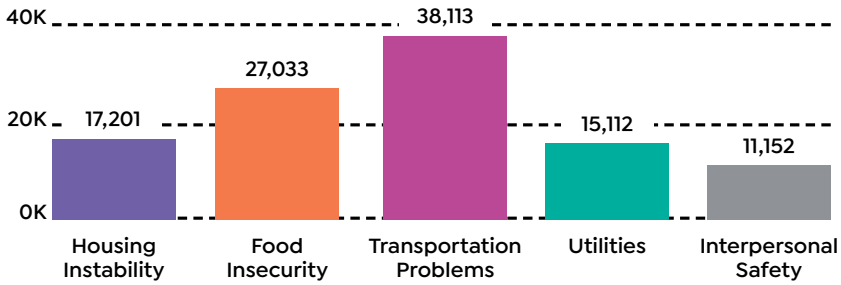
06
AREA OF FOCUS

Translate Policy into Practice

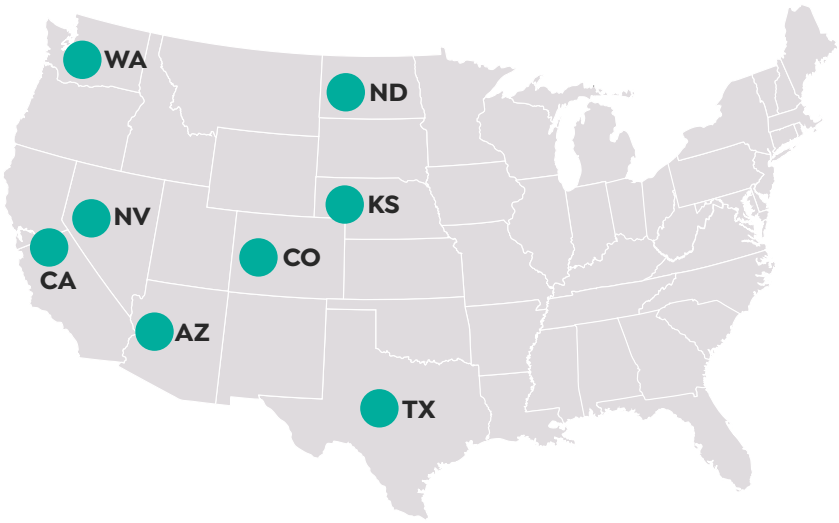
Federal and state policies increasingly promote the integration of medical and social care through regulatory and legislative processes. Yet, it is often challenging for community health leaders across healthcare and community sectors to make meaning of these changes because they are already responsible for monitoring their community context and advancing initiatives that improve conditions in their locales. Our team complements our colleagues across sectors that lead change locally. We regularly track and assess how this evolving landscape may impact the work we collectively do, and seek opportunities to pilot implementations of the policies in ways that are equally beneficial to our community-based partners and the individuals we collectively serve.

- **Regulatory and accreditation requirements**: We serve as subject matter experts in CommonSpirit's cross-functional advancement of social needs screening and referral solutions that comply with federal regulatory and third-party accreditation requirements for our hospitals. As a result, CommonSpirit now has standard screening and referral operations for all patients 18 years and older admitted to our hospitals and the corresponding **social needs analytics (SoNA)** dashboard to track the prevalence of various needs. Over one-fifth of the 313,159 patients screened in our hospitals in the calendar year 2024 had at least one identified social need. These needs included: transportation (53%), food insecurity (36%), utilities assistance (21%), housing instability (20%), and interpersonal safety (12%). While we worked to establish CommonSpirit's internal infrastructure for screening and referring, we simultaneously advanced network-based approaches in 18 communities to support sustainably scaling social care service readiness and capacity to serve the patients that are referred.

CommonSpirit Health
Patient Social Needs in 2024



States Where the Community-Centered Care Team Pilots CHW Reimbursement



- **Reimbursement for social needs interventions**: Growing momentum to address patient's social needs has resulted in new reimbursement opportunities at both federal and state levels that support clinical and community-based workforces working with patients. Our team has active pilot projects and implementation efforts to advance Medicare and/or Medicaid CHW reimbursement in 11 CommonSpirit markets across the following states: Arizona, California, Colorado, North Dakota, Nebraska, Nevada, Texas, and Washington. These projects will bring in new revenue to support existing and new CHW positions, and also establish repeatable processes that extend the care continuum in additional markets.

- **Community-based care transitions**: The passage of the Affordable Care Act in 2010 underscored CMS' interest in reducing hospital readmissions through programs like The Hospital Readmissions Reduction Program and the **Community-based Care Transition Program** (CCTP). Learnings from the CCTP continue to be leveraged by the Administration for Community Living via national learning collaboratives and hospital and CBO partners around the country. Since then, our team has identified an opportunity to support replication of **Community-Based Care Transition** models between a CommonSpirit Health hospital and local CBO. These models assist patients around their non-medical needs once they are back at home, avoiding readmissions to the hospital, and improving quality of life. To date, two CommonSpirit service areas already leverage the model with a third on the way. We have also developed more than 20 template tools as part of a guide to help accelerate replication of the model within CommonSpirit hospitals, as well as other hospital and CBO partners across the country.

20+ template tools **available to accelerate model replication**

$80,000 in external funds **raised to support community-based care transitions in a new CommonSpirit market**

11 states actively **piloting Medicare and/or Medicaid CHW reimbursements**

Perspectives From Two Markets Participating in the Medicare CHW Reimbursement Pilot

"The Medicare CHW Reimbursement Pilot directly aligns with Mercy Medical Group's clinical goals and enhances our ability to address health-related social needs for our expanding Medicare population, while empowering community health workers, social workers, and community-based organizations who play such a vital part in patient care. By learning from the different ways the other CommonSpirit markets are tackling similar roadblocks, I have been able to come up with my own unique solutions tailored to my market. I am incredibly grateful for the leadership from the Community-Centered Care team and their hands-on approach with us through this pilot. This experience definitely makes me look forward to collaborating again in the future."

– Kellen Na, MD, Mercy Medical Group, Family Medicine, Medical Director for Social Determinants of Health

"This project exploring reimbursement opportunities for our CHWs is essential to our social care integration strategy. As we continue to look at the patient as a whole, especially knowing the SDoH insecurities they go through, resources and services to treat the patient as a whole are significant and require sustainability evaluation. The Community-Centered Care team has been instrumental to this sustainability evaluation through navigation, advocacy, and providing tremendous resources and technical assistance to our local team so we have all the correct information and keep us on track with administrative and engagement aspects of the project."

– Kandy Truong, MPH, Market Director (NE/IA, CAH, Bismarck), Patient Transformation & Practice Integration

"Effective community-centered care requires close, local collaboration between social services and health sectors. That's difficult and requires mutual trust and a willingness to share leadership. The CommonSpirit team understands that. The team also appreciates the key importance of creating the right policy environment to foster innovative partnerships and has been a dedicated partner in identifying and supporting needed reforms."

– Stuart M. Butler PhD, Scholar in Residence, The Brookings Institution

07

AREA OF FOCUS

Shift Focus to Overall Health

Dr. Braverman et. al's paper "The Social Determinants of Health: Coming of Age" in the American Journal of Public Health provides extensive evidence demonstrating the strong association between social drivers of health (like poverty, education, and access to resources) and a wide range of health outcomes, including chronic disease prevalence and life expectancy. This evidence supports the urgency behind shifting from reactive, illness-focused care to a proactive, holistic approach that addresses upstream drivers to improve health.

While there is broad recognition and support among organizations in the healthcare sector to play a role in addressing SDoH, the methods for doing so can vary. CommonSpirit embraces the meaningful roles that we can play in advancing individual, patient-level interventions. Yet, we also understand that if we do not pursue interventions at the organizational and community levels that seek to recalibrate how communities collectively invest and support well-being, then we will inadvertently revert to "care as usual." That's why we're among a small number of health systems across the country that aim to adopt a unique framework that doesn't only focus on mitigating the impact of social drivers of health, but moves focus further upstream, to activating the protective factors that promote well-being.

- **Adopting the Vital Conditions framework**: Through the Vital Conditions framework, we rethink the factors that impact health to make more intentional community investments that promote long-term well-being. These investments address both immediate needs and the underlying social drivers of health. The **Pathways Community Hub** and **Community Care Hub** models serve these vital conditions. They deploy CHWs who have similar lived experiences to work with underserved and underresourced communities and address their vital conditions which are fundamental building blocks for a person to flourish, such as safe and stable housing, economic security, and access to quality education. In the last year, the PCH initiative alone has hired 30+ CHWs across six communities and has supported over 700 individuals to self-sufficiency by closing 3,500 identified needs.

Vital Conditions for Health and Well-Being

Moving the Needle: Community Health Legacy and Today

"Even with all we know about health and well-being, our environment is always evolving and health needs are always changing. Therefore, we must continue to ask and learn what individuals and communities really need to be healthy and well. In doing so, we may discover the root causes of poor health outcomes and better invest time and resources in what is vital to them for safety and health. And we will renew our understanding that people who live in the communities we serve need a combination of clinical care and social care – care that is multidimensional and place-based – to be healthy in body, mind and spirit.

At CommonSpirit Health, we believe we, like others in health care, must also continue to be "learning organizations" open to the knowledge and expertise of people who are dedicated to improving community health. Listening to them will help health care leaders shape and improve how they support change and growth.

– Ji Im, MPH, Does Your Organization Adapt as Health Needs Evolve? Catholic Healthcare Association

Community Health Worker Services and CBOs Help a Patient Reclaim His Health in Arizona

Roberto was admitted to Chandler Regional Medical Center in July 2023 for an avoidable visit. He visited the hospital frequently for his uncontrolled diabetes. Brandi, a PCH CHW, enrolled him into the Pathways to Wellness program. Since enrollment, Roberto has made significant progress in managing his health. He has not had any hospital visits in six months, is attending monthly medical appointments, and takes his prescription medications daily.

As a result, his blood sugar is under control and his diabetic ulcer has completely healed. He is now able to receive eye surgery, which will allow him to return to work. Brandi has also collaborated with Mutual Aid Diabetes and Live Love, two community-based organizations who were able to provide free diabetic testing supplies and transportation to medical appointments. These are just two of the many CBOs that have been instrumental in supporting Roberto's journey to wellness. The partnerships demonstrate how integrated support can contribute to overall well-being.

Industry Leadership and Expertise

Our team provides thought leadership and strategic guidance to advance and scale Community-Centered Care efforts across the broader field through our roles as committee members and advisors at different organizations. Fulfilling these roles promotes shared visions and agendas within and across sectors that lead to amplified impact. Our team also facilitates cross-state learning and collaboration so that resources and tools, opportunities, and lessons learned can be shared. We leverage our network of industry experts and partners to enrich and accelerate the work locally.

For example, our team members contribute to the field through the detailed examples and broader portfolio of thought leadership roles described below.

1. Strategic advisory group and workgroup leadership positions within the **Partnership to Align Social Care**, which relies on health system, health plan, community-based organization, and government agencies co-designed solutions that aim to create equitable, community-focused, and person-centered health and social care.
2. Advisory and review committee roles in organizations like the **American Hospital Association**, which entrust our team members to provide advisory guidance and review of competitive applications for American Hospital Association.
3. Our contributions don't just include advisory roles, but also create new assets for the field. We serve in leadership roles in the **National Academy of Medicine's** (NAM) Commission on Investment Imperatives for a Healthy Nation and other NAM activities which produce publications addressing the alignment challenges, opportunities, and impacts related to meaningfully engaging individuals and communities in all health-related decisions that affect them.

SIX ADVISORY ROLES We serve as thought partners to guide strategic direction on initiatives that aim to advance health equity and medical-social care integration within a variety of industry associations, philanthropic, and multi-sector collaborative organizations.

EIGHT COLLABORATIVE WORKING GROUP ROLES
We contribute operational support and thought leadership to co-designed tools and products whose purpose is to advance Community-Centered Care across the industry.

SEVEN REVIEW COMMITTEE ROLES
We apply our expertise and working knowledge of successful community health practices by serving as third-party, impartial guest reviewers of competitive review processes that aim to ignite Community-Centered Care projects.

THREE CO-CHAIR ROLES
We lead by example within multi-sector collaboratives by serving as co-chairs of working groups.

Our participation in the above-mentioned roles with the following organizations has advanced alignment across the industry and furthered CommonSpirit Health's reputation as a valued thought partner.

- American Hospital Association
- Association of Maternal & Child Health Programs
- California Collaborative for Long-Term Services and Supports
- Center of Excellence to Align Health and Social Care
- Convergence Center for Policy Resolution
- John A. Hartford Foundation
- National Academy of Medicine
- New York Federal Reserve Community Development
- Partnership to Align Social Care
- Pathways Community HUB Institute
- Rippel Foundation
- The SCAN Foundation

Future State

We are committed to building a culture and practice of health that is better integrated between health systems and social service providers, centered where health largely happens – outside of healthcare facilities and in community – that impacts all the ways in which a person can thrive. Our team is ready to partner with others that can support, integrate, or benefit from the initiatives and priorities described in this report; we invite you to walk alongside us.

THANK YOU

Thank you for learning about our Community-Centered Care initiatives and impact. Our team relentlessly innovates how and where healing can happen and unites with others in our communities to benefit the common good. By working to meet the needs in our communities, CommonSpirit is better positioned to meet the changing healthcare landscape, improve population health, and make progress on the path to greater health equity.

Email the team or find more information here: External website and Internal Google Site

ACKNOWLEDGEMENTS

The achievements described in this report are made possible because of the commitment and collaboration of many individuals that work alongside the Community-Centered Care team.

Without the trust and support of our partners, and without a clear understanding of the local health and social care ecosystem – including its assets, disparities, and health priorities – introducing and implementing new models and approaches to whole person care would not be possible. We remain steadfast in our deep commitment to the well-being of the individuals in our communities.

Our Chief Mission Officer, Tom Kopfensteiner, and System Vice President of Mission Integration and Community Health, Lois Lane, ensure our strategic north star points in the right direction. The CommonSpirit Health community health leaders in markets across our service areas exemplify the practice of servant leadership by collaborating with community partners to prioritize the collective good over individual gain. Our partners in functional areas across CommonSpirit Health make it possible to implement a vision where our efforts to recalibrate care centered more in community do not exist on the fringes of our care delivery system, but become ingrained into the standards of care for years to come. Lastly, individuals and organizations in communities bring their wisdom and know-how to champion systems of care that center the needs and desires of members of our communities, with a focus on serving the most marginalized.

Our work relies on the leadership and integrity of these aforementioned partners. Without their trust and support, and without a clear understanding of the local health and social care ecosystem – including its assets, disparities, and health priorities – introducing and implementing new models and approaches to whole person care would not be possible. We remain steadfast in our deep commitment to the well-being of the individuals in our communities.

Thank you for raising your hands to partner in the work. Together, we have advocated for new opportunities that have resulted in improved health and well-being. We look forward to our collective work ahead.

APPENDIX

A

Glossary of Community-Centered Care Initiatives

AGING INITIATIVES

Launched in 2023, the portfolio of aging initiatives aim to address the health-related social needs of older adults in clinical and community settings. In part, this is accomplished through contractual relationships between CommonSpirit care sites and local CBOs that enable scaling of local services for older adults. This portfolio of initiatives includes:

Community-based care transitions: These programs formalize a contractual relationship between a CommonSpirit hospital and CBO that outlines shared goals, measures, and services to prevent avoidable readmissions to the hospital and improved quality of life for older adults. CBO partners use trained staff to deliver evidence-based, care transition services focused on four pillars: medication self-management; recognizing red flags; accessing medical provider follow-up appointments; and helping patients document questions in a personal health record. To date, the system office has actively supported replication of community-based care transitions in three markets (two in CA and one in TX).

Medicare CHW Reimbursement Services: Six CommonSpirit markets actively participate in a pilot project to demonstrate the benefit of integrating navigation assistance into care delivery systems. The pilot project concluding in December 2025 tests implementation of new Medicare billing codes which reimburse for CHW's time spent providing health and social care navigation for older adults inside and outside of clinical settings. CHWs and Patient Navigators deliver billable navigation services to patients in a variety of settings, including primary care, post oncology care, rural settings, and within medical resident clinics. The impact these services have on patient health outcomes, utilization, cost, and social care will be tracked and assessed. This pilot project is taking place in CommonSpirit markets in CA, CO, ND, WA.

Community Care Hubs (Aging Focused): Community Care Hubs (CCHs) are a new way for providers of healthcare and providers of social services to work together. They enable contracting between healthcare organizations and CBOs that share a goal of addressing health-related social needs. The hubs manage and centralize functions, such as contracting and billing and documentation of services, for participating CBOs so they can better support scaling of social services. Efforts to replicate CCHs have focused on partnering with **aging-focused CBOs** (e.g. Area Agencies on Aging) to serve older adults as an initial population of focus. CommonSpirit supports aging-focused Community Care Hubs in four markets (CA, CO, NV, TX).

COMMONSPIRIT SUPPORTS HUBS IN ESTABLISHING THE FOLLOWING CAPACITIES:

LEADERSHIP AND GOVERNANCE: Establish a legal and operational structure that enable the entity to operate a CBO network and incorporate goals of relevant stakeholders.

OPERATIONS: Manage the flow of data, individual referrals, and services between contracting healthcare entity, hub, and network, as well as continuous quality improvement.

STRATEGIC BUSINESS DEVELOPMENT: Conduct strategic and business planning undertake development of new and expansion of existing partnerships (contractual and non-contractual).

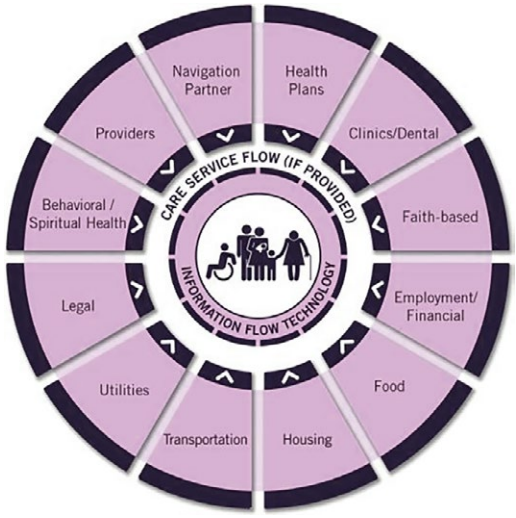
CONTRACT ADMINISTRATION AND COMPLIANCE: Manage the business fiscal cycle, contract administration responsibilities, risk, implementing quality improvements, and relationships with health care entities.

NETWORK, RECRUITMENT, ENGAGEMENT, AND SUPPORT: Recruit, engage, monitor and retain CBO network members to build the network's capacity, train CBO staff, and other capacity-building efforts.

INFORMATION TECHNOLOGY AND SECURITY: Source and use IT tools that facilitate data sharing with healthcare and CBO partners in a secure and healthcare-compliant manner.

CONNECTED COMMUNITY NETWORK

The Connected Community Network is an initiative established in 2016 to create efficient linkages with and among local community service organizations that provide social resources vital to people living in the community. Today, it serves as an approach to promote and standardize social care integration for the system while organizing and supporting community partners to help center care for well-being where people live, work, and play. Moreover, CommonSpirit goes further to organize and build accountable networks of CBOs and healthcare partners to electronically refer and collectively manage an individual's social needs while receiving feedback on whether those needs were met. Connected Community Networks accelerate the establishment of a transparent, accountable, and sustainable social drivers of health ecosystem while centering ownership within the community. CCNs exist, in various forms, within AZ, CA, NE/IA, ND, NV, MN, and TX.



PATHWAYS COMMUNITY HUBS

CommonSpirit partnered with the Pathways Community HUB Institute (PCHI)® in 2022 to establish and implement local Pathways Community HUBs (PCHs) and Pathway Agencies (PAs). The PCHI model, a type of community care hub, contracts with local community-based organizations that employ Community Health Workers (CHWs) providing intensive community care coordination. CHWs support at-risk individuals and their families by helping them access medical, social, and behavioral services, navigating complex health and social systems, and providing essential health education. They also work to identify and remove barriers and risk factors that may prevent clients from reaching their health goals. The PCHI model is sustainable through an outcomes-based payment approach and encourages blending of private and public funding. This model currently operates in more than 35 communities across the United States, including eight CommonSpirit states (AR, AZ, CA, KS, NE, NV, TN, TX).

SOCIAL NEEDS ANALYTICS PLATFORM

CommonSpirit Health's Social Needs Analytics (SoNA) platform leverages eight years of health-related social needs and referral data to understand patient social needs. Integrating data from electronic health records, census data, and community program data, SoNA provides visual representations of community health, identifying patient needs and measuring the impact of community initiatives. Currently featuring four dashboards (health-related social needs screening, Z Code, Community Health Referrals, and Community Health Programs), SoNA is used by an average of 70 users monthly across various departments. Future development includes additional dashboards (e.g., Chronic Disease Management), data lake expansion, user-friendly tools, and engagement with community partners to enhance health equity efforts.

VITAL CONDITIONS

A common thread throughout the team's initiatives is the Vital Conditions framework. The framework was developed by the Robert Wood Johnson Foundation (RWJF) and the Rippel Foundation, and encompasses factors like economic stability, education, social and community context, healthcare access, and neighborhood and built environment. It moves beyond a solely clinical approach to healthcare, emphasizing the need to address these upstream factors to achieve equitable health outcomes. Adopting this framework is crucial for healthcare systems because it necessitates a shift from reactive, disease-focused care to a proactive, preventive model. By acknowledging the significant impact of vital conditions, healthcare systems can better identify and address the root causes of health disparities, invest in community-based interventions, and ultimately improve population health and reduce health inequities, leading to a more just and healthier society. This holistic approach requires collaboration across sectors and a commitment to addressing social issues alongside medical ones.

APPENDIX

B Industry Insights

CommonSpirit Health's Community-Centered Care team presents on community health, social determinants of health, and health equity. The 2023-2024 presentations and publications listed below explore a range of topics, from innovative community care models and collaborative approaches between healthcare and social services, to innovative care frameworks and funding reforms designed to support holistic care for individuals and communities.

COMMUNITY NETWORKS AND HUBS

Emphasized community-centered care models, hubs, and networks designed to address social drivers of health.

Publications and Articles	Published By
Exploring Emerging Medi-Cal Community Care Hubs **(October 2024)**	California Health Care Foundation
Hospital Guide: Health Equity Through Partnership and Collaboration **(October 2023)**	Pathways Community HUB Institute
1 year later: How CommonSpirit is organizing outcome-based healthcare in underserved communities nationwide **(June 2023)**	Becker's Hospital Review
CommonSpirit sees care navigation networks gain momentum **(March 2023)**	Catholic Health World
Conferences and Webinars	**Hosted By**
Community-Centered Care: A Unique Health System Approach to Supporting Social Care Network Models (April 2024)	RISE Summit on Social Determinants of Health
Community Care Hubs: A Solution for Meeting Patient Social Needs (May 2024)	Scottsdale Institute

> "We all talk about social determinants of health and the importance of screening, but that's just the beginning. Truly understanding an individual's social needs is knowing what's happening within their circles and their ecosystems. This model [PCH] serves not only the individual, but their family members, recognizing that social needs are way just beyond one person."
>
> — Ji Im, 1 Year Later, Becker's Hospital Review

SOCIAL DETERMINANTS OF HEALTH AND HEALTH EQUITY

Focused on addressing broader health disparities, equity, and the social determinants of health that impact health outcomes, and frameworks, strategic approaches, and advocacy for tackling social drivers of health at a national or systemic level.

Publications and Articles	Published By
Does Your Organization Adapt as Health Needs Evolve? **(January 2024)**	Catholic Healthcare Association
The U.S. Playbook to Address Social Determinants of Health **(November 2023)**	The White House
HEALTHCARE 2030: SDoH convener or leader? **(November 2023)**	Healthcare Financial Management Association
Community Health as a Strategic Asset for Redesigning Care Delivery and Accelerating Health Equity **(June 2023)**	American Hospital Association
How Trusted Local Entry Points are Key to Improving Community Health **(April 2023)**	The Journal of the American Medical Association
ONC Social Determinants of Health Information Exchange Toolkit **(February 2023)**	Office of the National Coordinator for Health Information Technology (U.S. Dept of Health & Human Services)
Conferences and Webinars	**Hosted By**
Reimagining Social Care Contracting Models to Address Member's Health-Related Social Needs (March 2024)	RISE National

> **"Understanding the needs and challenges their patients face, combined with better information and referral exchange with community partners, supports CommonSpirit's ongoing efforts to provide equitable and effective care for the whole person, and enhance healthcare's role in cross-sector collaborative efforts to strengthen the social fabric of local communities."**
>
> – Office of the National Coordinator for Health Information Technology

CO-DESIGN AND COLLABORATION BETWEEN HEALTH SYSTEMS AND COMMUNITY SERVICE ORGANIZATIONS

Focused on collaborative efforts between health systems and community service organizations to co-design solutions for social needs.

Publications and Articles	Published By
How Health Care Organizations Should Support Social Services **(November 2023)**	The Journal of the American Medical Association
Community Voices and Perspectives on CalAIM **(2023)**	Stakeholder Health (Hold.Health)
Conferences and Webinars	**Hosted By**
Meeting the Administration's Call-to-Action: Leading Practices to Address Health-Related Social Needs in Communities Across the Nation (February 2024)	Partnership to Align Social Care
Addressing Health-Related Social Needs: The Role of Health Systems (May 2023)	HHS Administration for Community Living

> "Hearing directly from key stakeholders involved in or thinking about becoming involved in the CalAIM initiative provides first-hand accounts of the challenges faced by CBOs. Taking their perspectives and proposed recommendations into consideration increases the likelihood CBOs will continue to participate and engage in CalAIM efforts and help build a sustainable initiative to align and integrate health and social care."
>
> – Community Voices and Perspectives on CalAIM Report

SOCIAL DRIVERS OF HEALTH
PAYMENT AND FINANCING

Addressed the financial mechanisms, payment reforms, and sustainable funding models to support social care systems.

Conferences and Webinars	Hosted By
Engaging healthcare entities to address disparities through sustainable funding (May 2024)	Communities Joined in Action
Health Equity Focus: How Health Plans are Moving the Needle (November 2023)	Becker's Healthcare

> **We argue instead that a collaborative private approach to financing infrastructure – and health-related social services themselves – is better suited to the investment challenge. [CommonSpirit] recently brought together 11 partners, including several health plans, to create a "community bank" to fund a network coordinating services in several communities."**
>
> – Could Health Plan Co-Opetition Boost Action on Social Determinants? Published by the American Journal of Public Health.

FUTURE DIRECTIONS AND EMERGING STRATEGIC FRAMEWORKS OF SOCIAL DRIVERS OF HEALTH

Focused on frameworks, strategic approaches, and advocacy for tackling social drivers of health at a national or systemic level. Examining innovative and evolving approaches to integrating social and healthcare, with a focus on long-term trends and emerging solutions.

Publications and Articles	Published By
Cross-Sector Support for a Policy Framework to Tackle Social Determinants of Health **(November 2024)**	The Journal of the American Medical Association
Exploring Emerging Medi-Cal Community Care Hubs **(October 2024)**	California Health Care Foundation
Valuing America's Health: Aligning Financing to Reward Better Health and Well-Being **(2024)**	National Academy Medicine
Convergence Collaborative on Social Factors of Health Discovery Report **(April 2024)**	Convergence Center for Policy Resolution
Community Health as a Strategic Asset for Redesigning Care Delivery and Accelerating Health Equity **(June 2023)**	American Hospital Association
Healthcare 2030: SDoH Convener or Leader **(November 2023)**	Healthcare Financial Management Association
Conferences and Webinars	**Hosted By**
Reimagining Social Care Contracting Models to Address Member's Health-Related Social Needs (March 2024)	RISE Conference
Meeting the Administration's Call-to-Action: Leading Practices to Address Health-Related Social Needs in Communities Across the Nation (February 2024)	Partnership to Align Social Care

> **"Disruptive change is needed in who, what, and how we finance, pay for, and ultimately value health. If the slow, incremental pace of change continues, we cannot expect significant progress toward greater equity, improved life span, or quality of life."**

National Academies of Sciences, Engineering, and Medicine. 2024. Valuing America's Health: Aligning Financing to Reward Better Health and Well-Being. Washington, DC: The National Academies Press. https://doi.org/10.17226/27141.


CommonSpirit