CommonSpirit

Implementation Lessons: Community Health Integration and Principal Illness Navigation Services

Final Report | July 2026

Prepared by
Center for Community Health & Evaluation

Prepared for
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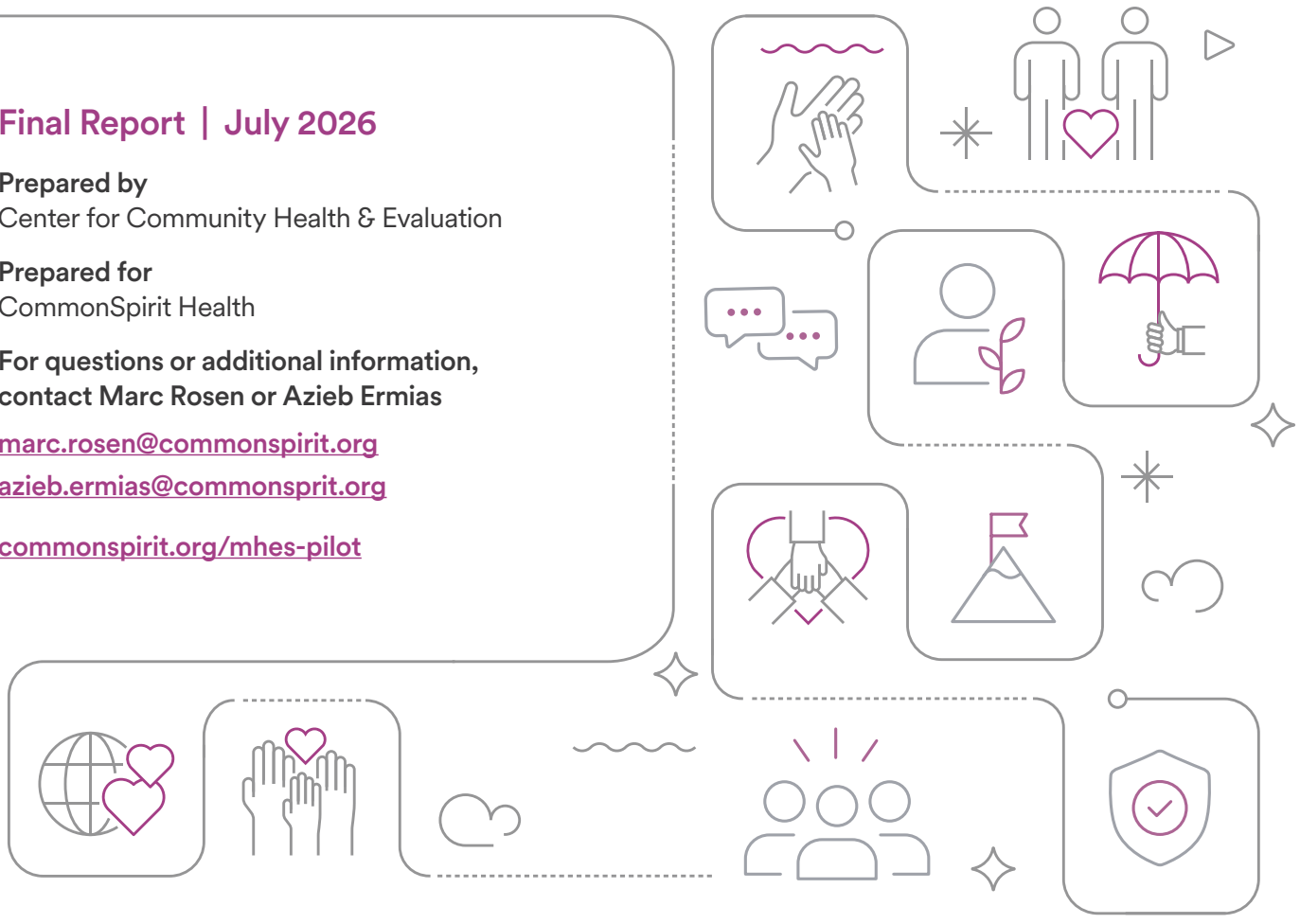

CommonSpirit Health®. (2026). Implementation Lessons: Community Health Integration and Principal Illness Navigation Services: Final Report. Prepared by the Center for Community Health and Evaluation.

Executive Summary

From September 2024 through March 2026, CommonSpirit Health implemented the Medicare Health Equity Services Pilot across eight clinics in six markets to better understand how Community Health Integration (CHI) and Principal Illness Navigation (PIN) services could be operationalized, reimbursed, and sustained within routine health-care delivery. Participating sites entered the pilot with established Community Health Worker (CHW), Patient Navigator, care coordination, or social care programs. Rather than creating new services, the pilot focused on adapting existing programs to meet Medicare reimbursement requirements.

The evaluation found broad agreement that CHI and PIN services addressed important patient and community needs and aligned closely with CommonSpirit's mission and commitment to whole-person care. However, the pilot demonstrated that readiness to deliver CHW and Patient Navigator services was not the same as readiness to sustain those services through Medicare reimbursement. While participating organizations already had experience providing social care coordination, many lacked the operational infrastructure needed to support reimbursable service delivery, such as documentation workflows, provider engagement, governance processes, EHR functionality, billing operations, revenue cycle integration, and cross-functional coordination. As a result, the pilot became less a test of whether CHW and Patient Navigator services were valuable than whether existing programs could successfully be adapted to a Medicare reimbursement model. Implementation challenges were driven primarily by the work required to build new operational and reimbursement infrastructure rather than by delivering the services themselves. The evaluation generated practical lessons about the organizational, operational, and reimbursement conditions needed to support sustainable implementation of CHI and PIN services.

Key Findings

1. Program benefits were clear; long-term sustainability remained uncertain.
2. Service delivery readiness did not equal reimbursement readiness.
3. Organizational agility mattered as much as staffing and infrastructure.
4. Implementation worked best when key operational partners were involved early.
5. Billing aligned best with intensive, longitudinal CHW and Patient Navigator services.
6. Community organizations were essential, but formal integration remained difficult.
7. Several reimbursement requirements complicated scale and sustainability.

Although the pilot did not establish long-term financial sustainability, it generated practical implementation guidance, operational workflows, readiness resources, and organizational learning. These resources can inform future CHI and PIN implementation, and CHW sustainability more generally, within CommonSpirit and by other health systems seeking to integrate social care services into routine healthcare delivery.

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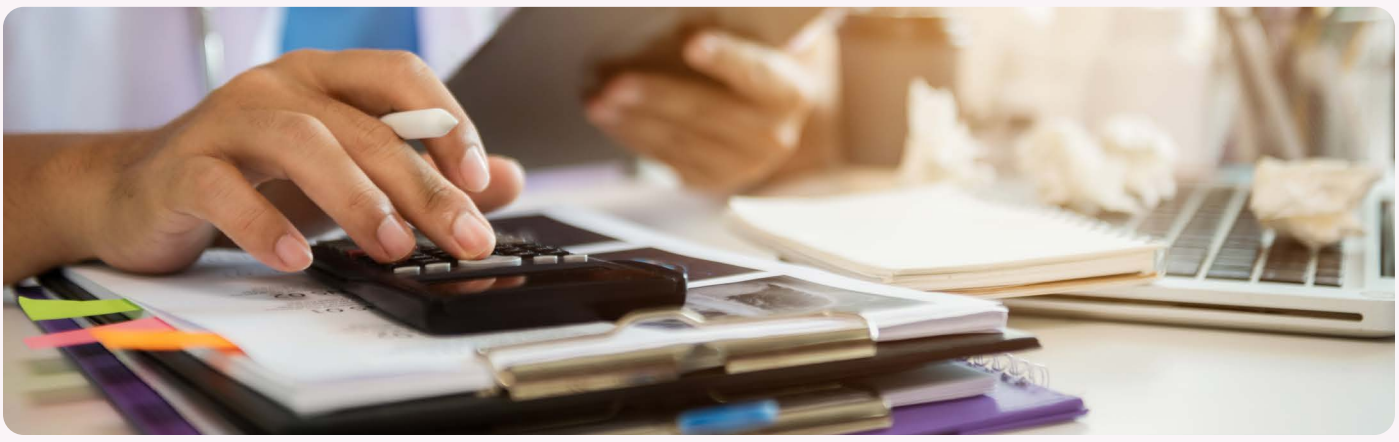
Tables and Figures



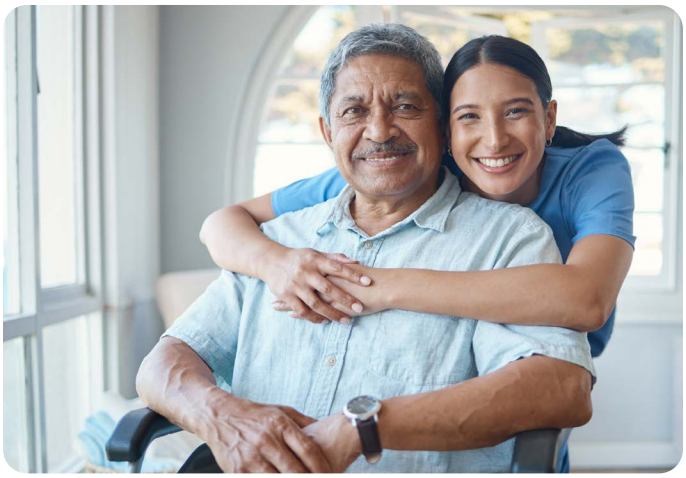
Introduction

Background

Medicare Health Equity Services Codes

Health-related social needs (HRSNs), such as challenges related to food, transportation, housing, and social support, can affect an individual's ability to access care, manage chronic conditions, and maintain health (Gottlieb et al., 2017). In November 2023, the Centers for Medicare & Medicaid Services (CMS) introduced Community Health Integration (CHI) and Principal Illness Navigation (PIN) services as part of Medicare Health Equity Services (MHES), creating new reimbursement opportunities for activities such as patient navigation, resource connection, and social care coordination (CMS, 2023). Historically, many of these activities were supported through grants, community benefit investments, operational budgets, and/or other non-reimbursable funding sources (Buck et al., 2021; Lau et al., 2021). CommonSpirit Health, the nation's largest nonprofit Catholic health system, views CHW and Patient Navigator roles as critical to achieving their mission to improve health and advance social justice for all, and therefore is committed to building and strengthening this workforce. The introduction of CHI and PIN services presented an opportunity to explore whether CHW and Patient Navigator services could be partially sustained through healthcare reimbursement mechanisms.

While many organizations have experience providing social care coordination and navigation services, less is known about how these activities can be integrated into existing clinical workflows and reimbursement systems (Kokorelias et al., 2021). To better understand these implementation challenges, CommonSpirit's System Office Community Health team (System Office) launched the MHES Pilot to develop and test the operational, financial, and organizational systems needed to implement CHI and PIN services.



The System Office began by raising awareness of the new Medicare reimbursement opportunities, working with interested markets to identify potential use cases, and facilitating a competitive internal application process. Participating sites were selected based on their organizational readiness, including existing CHW, patient navigation, social care coordination, care management, or community resource referral infrastructure that could support CHI and PIN implementation. Before implementation began, sites also participated in planning activities designed to strengthen operational readiness.

Throughout the pilot, the System Office served as the central coordinating body for implementation. In addition to providing technical assistance and billing guidance, the team developed practical tools and resources, supported sites as implementation challenges emerged, and facilitated regular opportunities for cross-site learning. Together, these activities helped participating sites build implementation capacity, share lessons learned, and address common operational challenges associated with CHI and PIN services.

Pilot Overview

The goal of the MHES Pilot was to advance sustainable care models that address holistic patient needs across settings where older adults seek care. Participating sites tested implementation of CHI and PIN services using auxiliary personnel employed by the health system, local community-based organizations, or both.

The pilot was designed to achieve three primary objectives:

1. Demonstrate the benefits of integrating social and care navigation services into care delivery systems;
2. Generate billable revenue to help sustain CHW and Patient Navigator services; and
3. Establish implementation approaches that could be replicated across CommonSpirit.

From September 2024 through March 2026, CommonSpirit led the MHES Pilot. This evaluation of the pilot examines how participating sites implemented the services, the operational, documentation, workflow, and billing requirements needed to support Medicare reimbursement, and the factors that influenced implementation and sustainability.

Participating sites entered the pilot with existing CHW, patient navigation, care coordination, or social care infrastructure. Rather than creating entirely new programs, sites were challenged to adapt existing social care coordination activities to meet CHI and PIN requirements. Implementation frequently required the development of new processes and procedures to support Medicare reimbursement.

Implementation approaches varied based on organizational structure, patient population, staffing model, governance processes, and community partnerships. Services were delivered by auxiliary personnel, such as CHWs and Patient Navigators. These staff were responsible for patient outreach, assessment of HRSNs, care navigation, connection to community resources, and ongoing engagement. While implementation differed across settings, sites worked toward implementing the following universal steps critical to the services: identifying eligible patients, delivering CHI and PIN services, and integrating the documentation and billing processes required to support Medicare reimbursement.

Although the pilot included both CHI and PIN services, participating sites varied in which codes they implemented based on their patient populations, care models, and organizational priorities. Consequently, some implementation findings presented in this report reflect experiences primarily associated with CHI because those services were implemented more broadly across participating sites than PIN. Where implementation lessons are specific to one service, this is noted in the text.

Participating Sites

The pilot included eight clinics across six CommonSpirit markets (Table 1). Participating sites represented a range of care settings, patient populations, organizational structures, and implementation approaches. Pilot sites included primary care clinics, residency programs, geriatric care settings, oncology navigation programs, and community-based organizations (CBOs) offering service delivery models.

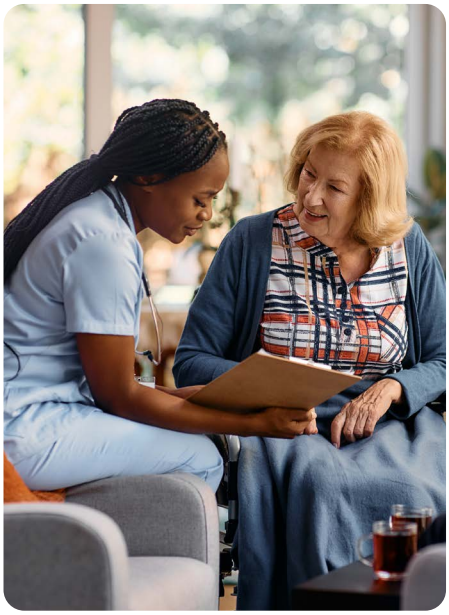
This diversity created an opportunity to examine how CHI and PIN implementation unfolded across different organizational contexts and to better understand which partners needed to be engaged to support implementation and sustainability.

Table 1: Participating Sites

Participating Site	Use Case
Rainier Health Network/Virginia Mason Franciscan Health Bremerton, WA	**Accountable Care Organization Beneficiaries:** Integration of CHWs within a primary care and residency clinic setting as part of a Clinically Integrated Network care model.
Dignity Health Connected Living Redding, CA	**CBO Service Delivery:** Subsidiary CBO of Dignity Health partnering with a residency/Family Practice clinic.
Mercy Medical Group/Dignity Health Medical Foundation Sacramento, CA	**Build vs. Partner:** Decision to use internal CHWs, partner with external CBO CHWs, or a hybrid of both.
Dignity Health St. Joseph's Medical Center Community Health Department Stockton, CA	**Cancer Care Navigation:** Partnership with the cancer center to provide care navigation and social needs support for oncology patients during and after treatment.
Senior Health First St. Anthony/ St. Anthony North Lakewood, CO; Westminster, CO	**Geriatric Clinic:** Delivery of CHI services within a geriatric clinic that has a care management delivery model.
CHI St. Alexius Health Mandan Primary Care/Pinehurst Clinic Mandan and Bismarck, ND	**CHWs within Physician Enterprise:** CHWs employed within the Physician Enterprise functional area.

Purpose of the Evaluation

This evaluation aimed to **examine implementation** of CHI and PIN services across participating sites and to identify lessons learned from those implementation experiences. The evaluation focused on how sites adapted existing social care coordination activities to meet CHI and PIN reimbursement requirements, how those activities were integrated into routine operations, and the organizational conditions that supported or challenged implementation.



Areas of inquiry included governance and decision-making processes, staffing models, technology and systems for managing patient panels, cross-functional coordination, community partnerships, and perceptions of sustainability. The evaluation also explored how implementation experiences differed across sites and what factors appeared to influence implementation progress.

Findings from this evaluation are intended to inform future efforts to sustain CHW positions, including the delivery of CHI and PIN services.

Evaluation Questions

The evaluation was guided by a set of questions (Appendix A) examining implementation, patient reach and participation, staff and patient experiences, health outcomes, costs, and disparities. These questions informed data collection, analysis, and interpretation throughout the evaluation. However, the pilot ultimately generated much stronger evidence about implementation than about outcomes.

The available data supported analysis of the pathway from referral to enrollment across participating sites but were generally insufficient to assess healthcare utilization, total cost of care, or disparities. Many sites were still refining workflows and documentation processes during the evaluation period, and implementation had not progressed far enough to evaluate longer-term outcomes consistently across sites.

As a result, this report focuses primarily on:

- How sites implemented CHI and PIN services.
- How patients moved through the referral and enrollment process.
- What staff experienced during implementation.
- What organizations learned about sustaining these services.

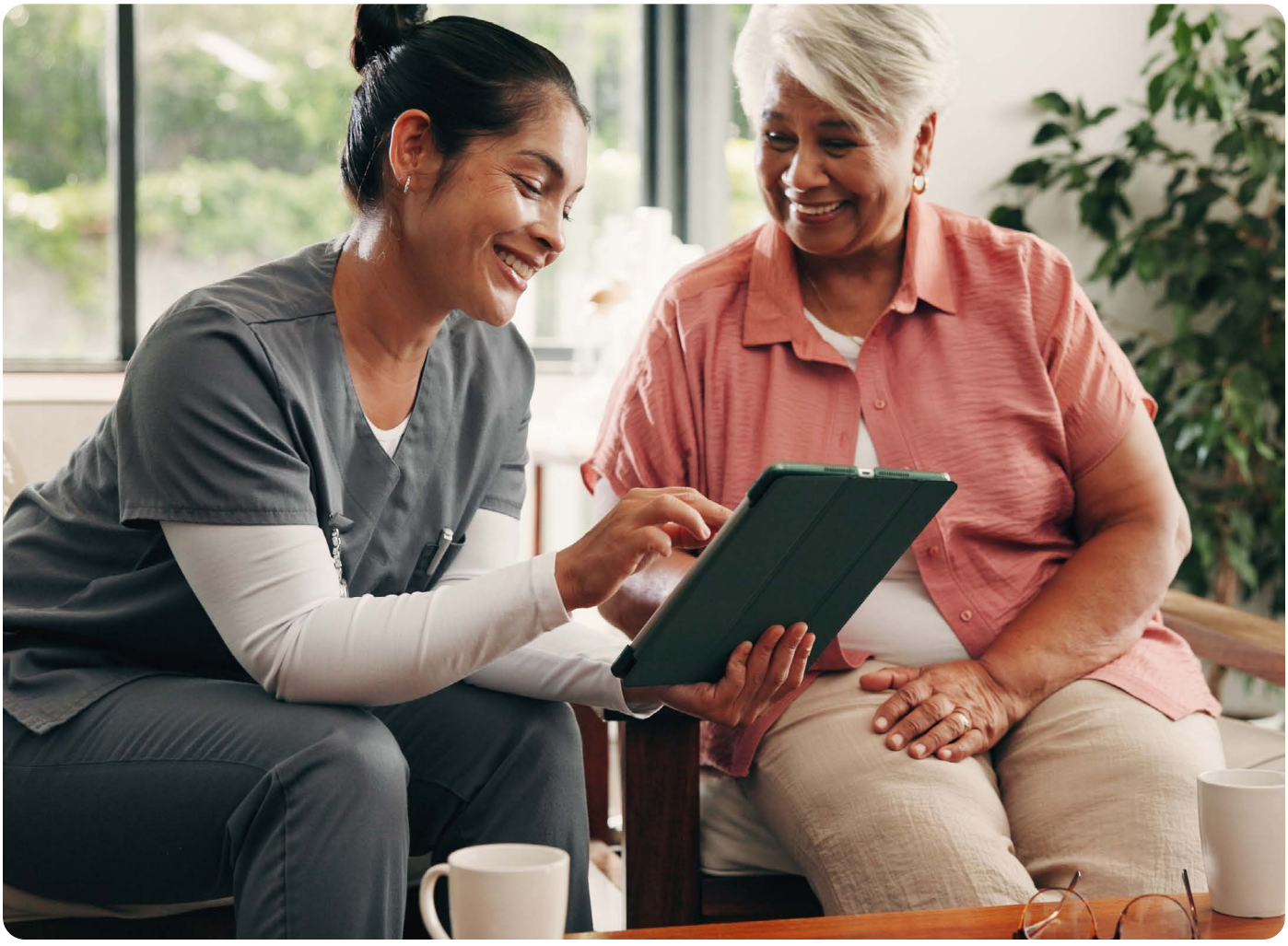
Findings related to patient outcomes, healthcare utilization, total cost of care, and disparities are more limited and should be interpreted cautiously.

Methods

Evaluation Design

The evaluation was conducted by the Center for Community Health and Evaluation (CCHE), an external evaluation partner supporting the MHES Pilot. The System Office also partnered with DoTank, a human-centered design agency that supported planning for future phases of the work. While DoTank participated in selected pilot activities and facilitated midpoint project lead focus groups, CCHE was responsible for the independent evaluation described in this report.

A mixed-methods approach was used to combine qualitative and quantitative sources of information. Qualitative data served as the primary source of information regarding implementation experiences, while quantitative data were used to provide context regarding referrals, outreach, enrollment, and service utilization.



Data Sources

Interviews and Focus Groups

The evaluation primarily drew upon qualitative data collected through interviews and focus groups with individuals who played a role in advancing CHI and PIN service delivery. Participants included Executive Sponsors, Project Leads, Billing and Coding staff, CHWs and Patient Navigators, and CBO partners. Together, these groups represented strategic leadership, implementation management, frontline service delivery, reimbursement operations, and community partnerships. Including multiple perspectives allowed the evaluation to examine how implementation experiences varied across organizational roles and settings. Table 2 summarizes participant groups, their primary implementation roles, and their participation in interviews and focus groups.

Table 2: Interview and Focus Group Participants by Role

Implementation Group	Primary Role in Pilot	Interviews	Focus Groups	Participants
Executive Sponsors	Strategic oversight, organizational alignment, sustainability planning	11	0	11
Project Leads	Implementation management, workflow development, coordination	1	3	12
CHWs and Patient Navigators	Patient engagement, navigation, resource connection, follow-up	1	1	3
Billing and Coding staff	Compliant documentation, coding, reimbursement, revenue cycle support	1	1	5
CBOs	Community resource connections, referral partnerships, patient support	4	0	4

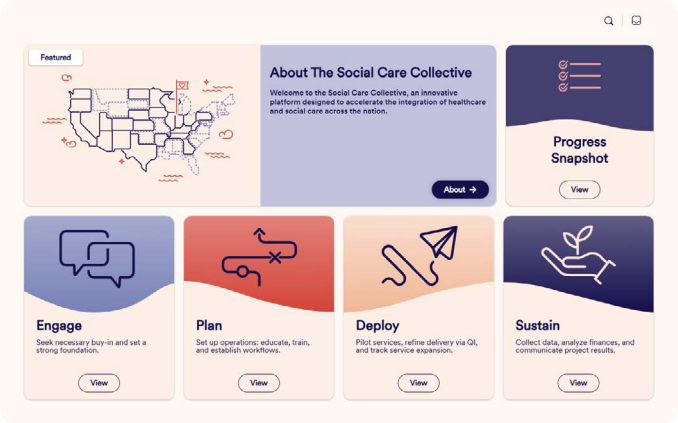
Panel Management Tool and Site-Reported Data

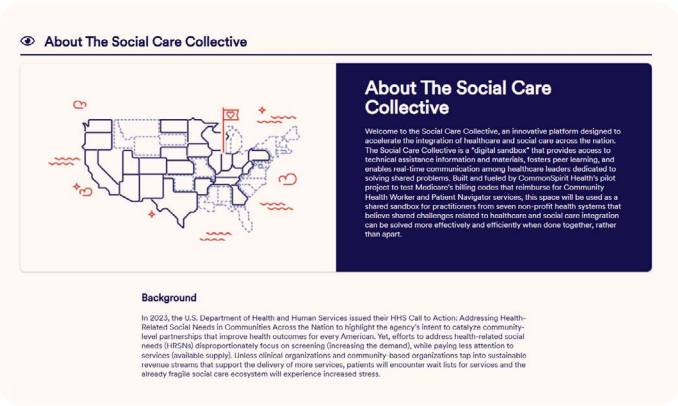
Quantitative data included referral, outreach, and enrollment information collected through a standardized Panel Management Tool developed by the System Office. The tool was implemented across participating sites to support consistent tracking of patients as they progressed from referral through enrollment while also documenting identified HRSNs, outreach activities, and service delivery. Participating sites also reported descriptive implementation information. Together, these data were used to describe referral activity, patient outreach, enrollment patterns, service utilization, and the needs addressed through CHI and PIN services. Patient surveys were also planned as part of the evaluation; however, participation was insufficient to support meaningful analysis, and those data were not included in the final evaluation.

Program Materials and Implementation Documents

The evaluation also incorporated implementation materials and tracking tools developed by the System Office and participating sites throughout the pilot. To support consistent implementation monitoring, the System Office created a standardized Excel-based evaluation workbook aligned with the pilot logic model (Appendix A). The workbook established a common set of measures and reporting processes across participating sites and was used to monitor implementation progress, operational milestones, and evaluation metrics. Collectively, these materials provided important context for understanding how implementation unfolded at each participating site.

The System Office also partnered with DoTank to launch a "digital sandbox," the Social Care Collective (SCC), to support cross-site learning and provide access to technical assistance materials and implementation resources. The SCC promoted shared visibility into implementation challenges and solutions, allowing participating sites to learn from one another as barriers emerged. The platform continues to be refined with pilot sites and is also

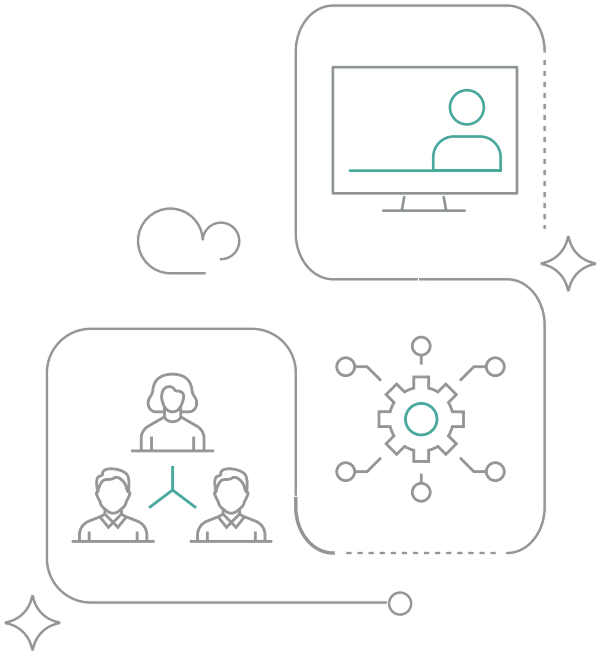




being used by participants from other nonprofit health systems involved in a CommonSpirit-sponsored Community of Practice focused on advancing CHI and PIN implementation.

Supplemental Kentucky CHI Program Data

Billing and operational data from CommonSpirit sites in Kentucky implementing CHI services outside the pilot provided additional contextual information regarding CHI service utilization. These data were obtained during the latter stages of the evaluation and reviewed descriptively to provide supplemental context regarding service delivery, billing patterns, and implementation approaches. Because the data were not collected as part of the pilot and became available late in the evaluation period, analyses were limited to descriptive review.



Interview Recruitment and Data Collection

The System Office and local implementation teams identified and recruited participants for interviews and focus groups. Recruitment occurred across multiple CommonSpirit markets and required coordinating around participants' schedules, which contributed to logistical challenges. Individuals were purposefully selected because they fulfilled one or more implementation roles defined as accountable, responsible, consulted, or informed. This recruitment approach ensured representation from different organizational functions, implementation responsibilities, and participating sites.

Separate semi-structured interview and focus group guides were developed for each participant group. Questions addressed implementation planning, workflow integration, staffing approaches, documentation and billing processes, community partnerships, operational supports, implementation challenges, perceived impacts, and sustainability. Although each discussion guide was tailored to the participant group, core topics were explored consistently across interviews to support comparisons across roles and sites.

Three midpoint Project Lead focus groups were facilitated by DoTank in August 2025. All remaining qualitative data collection, including endpoint Project Lead focus groups, was conducted by CCHE between February and April 2026.

Data collection was conducted virtually using Zoom or Microsoft Teams. Focus groups lasted approximately 45 to 60 minutes, while interviews generally ranged from 15 to 30 minutes. Discussions were documented through detailed notes and transcripts when permission was granted.

As shown in Table 2, Executive Sponsors and Project Leads represented the largest participant groups. This distribution reflected the practical realities of engaging different stakeholder groups rather than the relative importance of any perspective. Executive Sponsors participated through individual interviews because of scheduling constraints, whereas Project Leads, Billing and Coding staff, and CHWs and Patient Navigators primarily participated through focus groups.

Findings were developed through synthesis across all participant groups, with particular attention to areas where strategic, operational, and frontline perspectives converged or differed.

This project was reviewed by the CommonSpirit Health Research Institute Institutional Review Board and received a determination of Not Research.

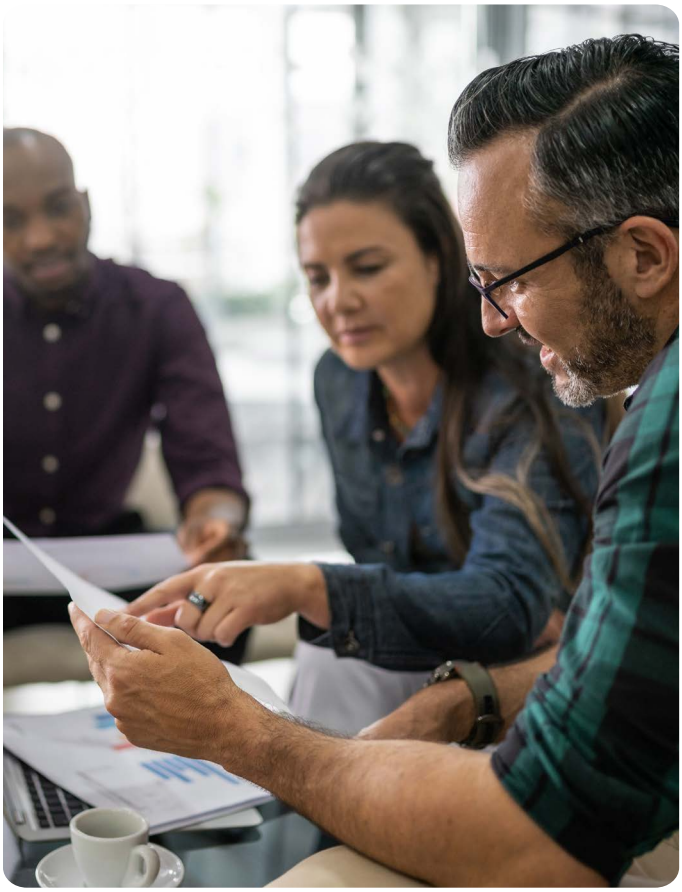
Data Analysis

Qualitative and quantitative data were analyzed separately and synthesized during interpretation. Qualitative analysis used a structured summary and synthesis approach. Interview notes, transcripts, recordings, and Project Lead focus group materials facilitated by DoTank were reviewed using standardized Excel templates aligned with the evaluation questions. Although qualitative data were collected by multiple facilitators, all materials were reviewed by CCHE using a consistent analytic approach.

Analysis occurred in two stages. The first stage focused on each participant group independently to identify recurring implementation experiences, barriers, facilitators, areas of agreement, and areas where experiences differed. Separate summaries were developed for Executive Sponsors, Project Leads, CHWs and Patient Navigators, Billing and Coding staff, and CBO partners before findings were compared across groups.

The second stage synthesized findings across participant groups to identify broader implementation lessons. Analysis examined where perspectives converged or differed and explored the organizational conditions associated with successful implementation of CHI and PIN services. Particular attention was given to workflow redesign, implementation tools, decision-making processes, change management, sustainability, and community partnerships. These cross-site findings form the basis of the key findings presented in this report.

Quantitative data were analyzed descriptively to characterize referral activity, patient outreach, enrollment, and service utilization. These findings were interpreted alongside the qualitative results to provide additional context regarding implementation experiences across sites. Because implementation remained in its early stages and patient volumes were relatively low, quantitative analyses were not sufficient to evaluate health outcomes, cost of care, or disparities. Supplemental Kentucky billing data were also reviewed descriptively to provide additional context regarding CHI utilization rather than to support comparative or outcome analyses.



Following preliminary analysis, CCHE facilitated a sense-making session with System Office leaders involved in the pilot. The purpose of the session was to review emerging findings, assess their alignment with implementation experiences across participating sites, and identify contextual factors that informed interpretation. Information from this session contributed to interpretation but was not treated as a primary source of evaluation data.

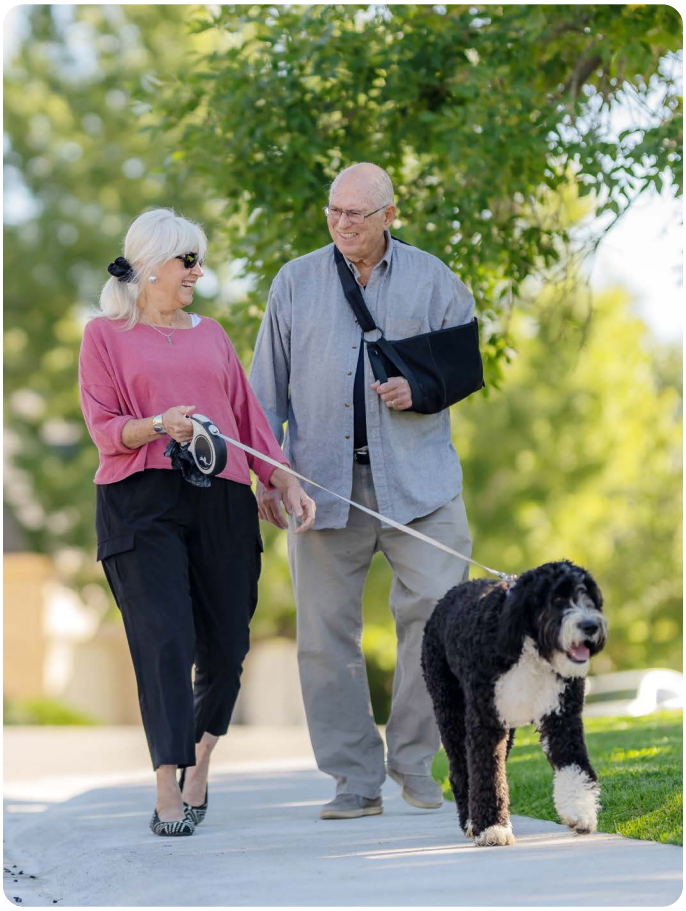
Limitations

This evaluation was designed to examine implementation of CHI and PIN services and was conducted during the early stage of pilot implementation.

While the original evaluation framework included questions related to healthcare quality and cost outcomes, the pilot generated substantially more information about implementation than about outcomes. As a result, findings primarily reflect experiences related to planning and implementing CHI and PIN services.

Implementation approaches varied across participating sites. Although all sites entered the pilot with existing CHW, Patient Navigator, care coordination, or related infrastructure, they differed in staffing models, governance structures, technology systems, patient populations, community partnerships, implementation timelines, or decision-making processes. In addition, implementation of the two MHES codes was not evenly distributed across sites. While the pilot included both CHI and PIN services, more sites implemented CHI than PIN, and some sites did not progress to PIN implementation during the evaluation period. Consequently, implementation findings related to PIN reflect experiences from a smaller number of sites and may not capture the full range of operational challenges or implementation approaches that could emerge with broader adoption. These differences influenced how CHI and PIN services were implemented and may limit the extent to which findings are transferable to other healthcare settings.

The evaluation relied heavily on interview participant perspectives and self-reported experiences. To strengthen interpretation, findings were triangulated across interviews, focus groups, implementation documents, panel management data, pilot tracking tools, and other descriptive implementation data.



However, findings should be interpreted within the context of the sites and individuals who participated in the evaluation. Participation varied across participant groups and sites, and the System Office and local implementation teams purposely identified individuals involved in implementation. Participation was also dependent on staff availability and willingness to participate. CHWs and Patient Navigators were less represented than originally anticipated due to the demands of providing direct patient services. As a result, findings may not capture the full range of experiences across all participating sites and roles. Qualitative data collection was conducted by both DoTank and CCHE. Although discussion guides were aligned around common evaluation questions and all qualitative data were

reviewed using a consistent analytic approach, differences in facilitation style may have influenced how some topics were explored during interviews and focus groups.

The evaluation did not include a dedicated interview group of physicians or other ordering providers. Provider perspectives were represented indirectly through Executive Sponsors, Project Leads, CHWs and Patient Navigators, and Billing and Coding staff who frequently discussed provider engagement, referral processes, supervision requirements, and implementation challenges, and only one interviewee was also an ordering provider (physician). As a result, findings may not fully reflect the perspectives of clinicians responsible for ordering or supervising CHI and PIN services.

Quantitative data were used primarily to describe implementation reach, patient engagement, and service utilization. Although patient surveys and healthcare utilization data were originally planned as part of the evaluation, low survey participation and the lack of available utilization data prevented these sources from being included in the final analysis. Accordingly, Communities of Practice and other organizations should interpret these findings primarily as implementation guidance rather than evidence of clinical effectiveness or healthcare utilization and quality impacts. Evaluating those outcomes will require larger numbers of enrolled patients and longer-term follow-up.

Key Findings

1
Key Finding

There was broad agreement on the potential benefits of CHI and PIN services and the reasons for testing them. However, sustainability remained uncertain.

Participants across interview groups consistently described CHI and PIN services as closely aligned with CommonSpirit's commitment to whole-person care, health equity, and addressing HRSNs. There was little disagreement that the services addressed important patient and community needs. Where perspectives differed was in how participant groups defined the pilot's value (Figure 1). Executive Sponsors and Billing and Coding staff primarily viewed the pilot through the lens of sustainability. Their discussions focused on whether CHI and PIN services could be successfully integrated into routine healthcare operations and supported through Medicare reimbursement. In contrast, Project Leads, CHWs and Patient Navigators, and CBO partners more often described the pilot in terms of patient need, service delivery, and day-to-day implementation. Although each group emphasized different aspects of the pilot, all consistently viewed the services as valuable.

These differing perspectives also influenced how participants defined success. Executive Sponsors most often viewed the pilot as an opportunity to determine whether existing CHW and Patient Navigator programs could be sustained through Medicare reimbursement. Frontline and operational participants, however, were more likely to focus on delivering services effectively within existing clinical workflows and meeting patient needs.

Figure 1: Perceived Value of CHI and PIN Services Across Participant Groups

Note: *Symbol placement reflects the relative prominence of each theme within each participant group based on the qualitative synthesis. Symbols positioned farther to the right indicate themes that were discussed more frequently and emphasized more consistently by that participant group. Participant groups for which a theme was not identified are not shown. This figure summarizes qualitative patterns and should not be interpreted as a quantitative measure or a count of participants.*

The most notable finding, however, was not whether participants believed the services were valuable, but whether existing reimbursement mechanisms could adequately support the staffing and operational requirements needed to sustain them over time. Across interviews, participants rarely questioned the patient value of the services. Instead, discussions frequently centered on the operational and financial conditions necessary to support long-term implementation. Executive Sponsors most frequently viewed CHI and PIN services as a potential pathway for supporting the long-term sustainability of CHW and Patient Navigator roles that had historically relied on grants, community benefit funding, or operational budgets. Some CHWs and Patient Navigators also discussed reimbursement as a potential mechanism for sustaining these roles over time, although this theme was less prominent among frontline participants. Executive Sponsors and CBO partners also described the pilot as part of broader efforts to move social care coordination from grant-funded activities into routine healthcare operations supported by more sustainable financing and partnership models.

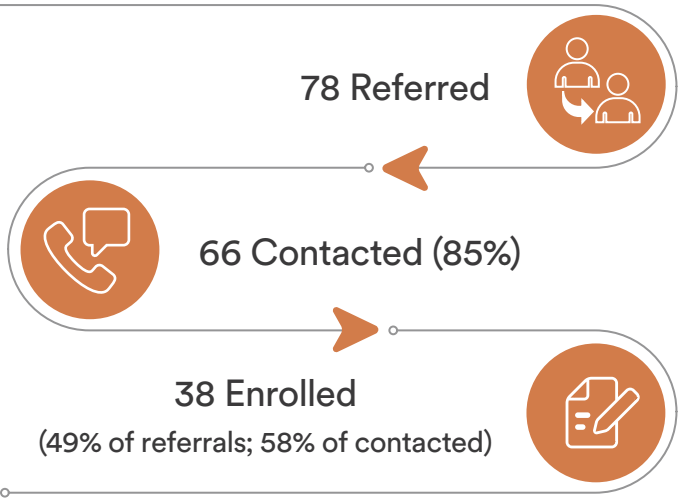
At the same time, uncertainty regarding long-term sustainability remained common across participant groups. Interviewees frequently questioned whether reimbursement levels, documentation requirements, staffing needs, and operational costs could be aligned in ways that would support sustained implementation at scale. As one Executive Sponsor explained,

> *The value is there. The question is whether the model can support itself.*

While Figure 1 summarizes how interview participants perceived the value and sustainability of CHI and PIN services, Figure 2 provides additional context regarding patient flow through the pilot. Referral activity varied considerably across participating sites, reflecting differences in how organizations integrated CHI and PIN services into routine practice. Some sites established referral pipelines early and enrolled patients consistently, while others continued refining referral workflows throughout the pilot. Attrition also occurred at multiple points between referral, outreach, and enrollment, indicating that patient need alone was not sufficient to generate participation. Together, these findings reinforce interview participants' observations that demand for CHI and PIN services existed, while illustrating the operational challenges of moving patients into reimbursable services.

Figure 2: Patient Flow Through the Pilot

Note: *Referred indicates patients referred to a CHW or Patient Navigator for CHI or PIN services. Contacted indicates referred patients who were successfully reached by a CHW or Patient Navigator. Enrolled indicates patients who consented to and enrolled in CHI or PIN services.*



Enrollment

By the end of this pilot, sites were still not fully ramped up as intended. Across all sites, 38 patients consented to and enrolled in CHI or PIN services by April 30, 2026. Enrollment patterns varied substantially across sites (Table 3), reflecting differences in how implementation progressed at each location. Interview participants frequently attributed these differences to local workflows, operational readiness, staffing capacity, and referral processes. Although the evaluation was not designed to determine the specific causes of site-level variation, the findings illustrate how implementation context influenced enrollment throughout the pilot. However, interview participants frequently described factors such as referral workflows, patient outreach processes, staffing capacity, documentation requirements, and operational readiness as influencing whether referred patients ultimately enrolled in services. Rather than serving as performance rankings, these data are most useful for illustrating the variability in implementation experiences across participating sites.

Table 3: Patient Flow by Site

Site	Referred to CHW/ Patient Navigator	Contacted by CHW/ Patient Navigator	Contact Rate	Enrolled in CHI/PIN Services	Enrollment Rate (of Referred Patients)
Lakewood, CO; Westminster, CO	16	16	100%	16	100%
Mandan, ND	15	12	80%	9	60%
Redding, CA	14	5	36%	0	0%
Bremerton, WA	33	33	100%	13	39%
Total	**78**	**66**	**85%**	**38**	**49%**

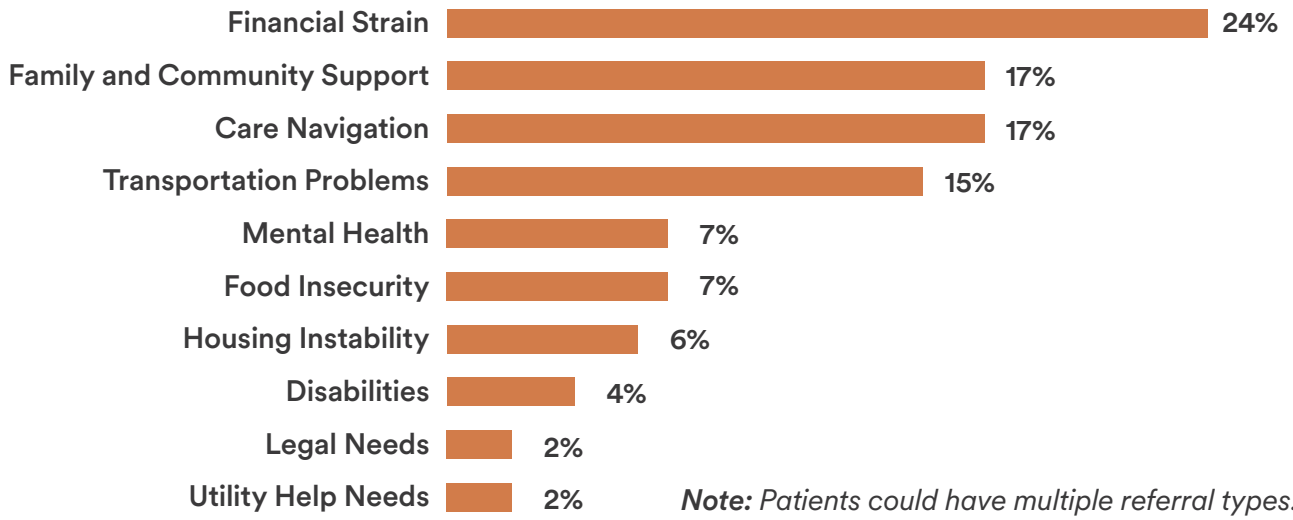
38 Patient Referrals

9 (24%) had two or more referral needs and **5** (13%) had three or more referral needs identified

Note: *Referral data from Sacramento, CA (34 patients referred, 3 enrolled) and Stockton, CA (1 patient referred, 1 enrolled) was sourced from a native system, not the Panel Management Tracking Tool, and is therefore excluded from social needs analysis.*

Referral data further illustrate the complexity of the patient needs that sites were attempting to address through CHI and PIN services. Enrolled patients experienced **multiple types of HRSNs**, including financial strain, transportation barriers, limited family or community support, care navigation needs, and mental health concerns (Figure 3), with approximately one-quarter having more than one HRSN.

Figure 3: Distribution of Referral Needs Among Enrolled Patients (N = 38)



Note: *Patients could have multiple referral types.*

Interview participants consistently described these **needs as interconnected** rather than isolated. Addressing them often required sustained navigation and relationship-building rather than a single referral or brief intervention. CHWs and Patient Navigators commonly described **their role as extending beyond resource referral** to include ongoing engagement and navigation support across multiple service domains.

At the same time, implementation experiences revealed **important variation in how sites structured CHW and Patient Navigator services.**

While interview participants consistently emphasized the complexity of patient needs, **several sites struggled to consistently meet the 60-minute monthly billing threshold.** This tension suggests that identifying complex needs alone may not be sufficient to support CHI and PIN implementation. As discussed in Key Finding 5, sites that emphasized longitudinal engagement with patients appeared to align more naturally with CHI and PIN reimbursement requirements than sites whose models focused primarily on making referrals.

Translation into Practice

Set expectations that early phases will yield far more implementation learning than clinical or cost outcomes, and frame pilot success around operational readiness, patient reach, and workforce sustainability rather than ROI.

2

Key Finding

Readiness for service delivery was not the same as readiness for reimbursement.

Participants across interview groups consistently described CHI and PIN services as **building upon services that already existed** within their organizations rather than introducing a fundamentally new model of care. Participating sites were intentionally selected, in part, because they already had CHWs, Patient Navigators, care coordination programs, referral infrastructure, or other forms of social care coordination in place. As a result, most sites entered the pilot with experience delivering services intended to address HRSNs and support patients with complex needs.

However, interview participants frequently **distinguished between readiness to deliver social care coordination services and readiness to support those services within a reimbursable healthcare model.** The pilot sites discovered that reimbursement required additional processes and infrastructure that were not already in place. Interviewees described needing to develop workflows for documenting billable time, obtaining and tracking patient consent, supporting provider ordering and supervision requirements, coordinating with revenue cycle teams for coding, billing, and reporting activities, and ensuring that EHRs and other systems could support these requirements. For example, several sites described already having CHWs actively helping patients access food, transportation, benefits, and other community resources before the pilot began.

However, those same sites often lacked processes for documenting billable time across a calendar month, tracking patient consent related to Medicare cost-sharing, obtaining provider orders, or integrating CHW activities into existing billing workflows. As a result, sites that were already delivering social care services frequently relied on manual tracking while simultaneously building new operational and reimbursement infrastructures. Several sites reported that these manual processes remained in place through the end of the pilot because implementing the necessary changes proved more complex and time-intensive than anticipated.

Across interviews, participants emphasized that the primary innovation being tested was not the social care coordination itself, but **whether those activities could be successfully integrated** into healthcare financing and operational systems. As one Executive Sponsor explained,

> *We were already doing the work and not getting paid.*

Several Executive Sponsors and Project Leads noted that CHI and PIN services generally fit within existing care delivery models because participating sites already operated CHW, navigation, and social care coordination programs. However, the pilot revealed the additional infrastructure required to access reimbursement for services already being delivered.

Translation into Practice

Continue creating practical tools, workflows, and readiness resources to support implementation teams if the services fit into an organization's future state strategy.

3

Key Finding

Organizational agility and decision-making processes influenced implementation as much as staffing and infrastructure.

Although participating sites were already delivering social care coordination services, the pilot required organizations to **create formal systems** for documenting, tracking, managing, measuring, and reimbursing activities that had historically been carried out through more flexible workflows. Interview participants frequently described these operational requirements as one of the most significant implementation challenges introduced through the pilot.

Participants frequently noted that success depended not only on staffing, technology, or financial resources, but also on sites' ability to make decisions, adapt existing workflows, secure approvals, coordinate across departments, and operationalize new processes. Several interviewees described examples in which sites with similar infrastructure and levels of commitment experienced different implementation trajectories because they **differed in their ability to move operational changes through** existing administrative and organizational structures. For example, the Washington site was able to rapidly engage billing and coding leaders, test workflows, and modify operational processes through existing decision-making structures. By contrast, another site's exploration of deciding to deliver the services and potentially formalizing a CBO partnership required multiple rounds of administrative review and approval over a period of months before decisions were made. Interviewees described these experiences as illustrating how organizational decision-making processes could accelerate or slow implementation. In this context, organizational agility could look like site-level authority to change templates, problem solve gaps in documentation workflows, prioritize EHR tickets, and much more.

Implementation barriers reflected the work required to build the systems needed to access reimbursement for services that were already being delivered (Table 4). Documentation requirements, workflow fragmentation, EHR limitations, billing requirements, and operational infrastructure challenges were identified across multiple interview groups. While these barriers differed in their specifics, participants frequently described them as consequences of the work required to align activities with reimbursement requirements when they had previously been delivered outside of reimbursement structures.

Table 4: Implementation Barriers Identified Across Interview Groups

Barriers and Groups	Examples
Referral generation and HRSN screening workflows Project Leads, CHWs, Executive Sponsors	Several sites struggled to generate sufficient referral volume because systematic HRSN screening processes were not consistently integrated into clinic workflows. Sites often needed to establish new referral pathways and provider engagement strategies to support implementation.
Documentation requirements Executive Sponsors, CHWs, Billing, CBOs	CHWs often needed to manually track time spent on eligible activities throughout the month and document services in greater detail to meet CHI/PIN billing requirements.
Workflow fragmentation Billing, CBOs, CHWs	CHWs often documented encounters in the EHR while separately tracking referral status, patient progress, and billable time in other systems, requiring information to be manually maintained across multiple tools.
EHR limitations Project Leads, CHWs, CBOs	Existing EHRs generally supported encounter documentation but often lacked functionality to manage a panel of patients or monthly CHI/PIN documentation requirements.
Billing code requirements Project Leads, CHWs, Billing	Sites often needed new workflows for obtaining patient consent related to Medicare cost sharing responsibilities, securing provider orders, and documenting services in ways that met CMS billing requirements.
Operational coordination and reimbursement workflows Executive Sponsors, CHWs, Billing, CBOs	Implementing CHI and PIN services often required coordination across clinical, operational, compliance, billing, and revenue cycle teams. Several sites described delays because building the operational infrastructure for reimbursement required decisions and approvals from multiple departments, extending implementation timelines even when there was strong support for the pilot.

Implementation Barriers

The barriers described below illustrate the operational challenges sites encountered while adapting existing social care coordination services to a reimbursement model.

Documentation requirements were among the most frequently cited challenges. Interviewees described needing to capture information that was not routinely documented within existing social care coordination workflows, including time spent delivering eligible activities throughout a calendar month and seeking billing provider approval to address additional HRSNs that were not part of the original provider order.

Several CHWs described manually tracking eligible activities throughout the month because existing EHR workflows did not calculate billable time across encounters. In some cases, staff documented patient interactions in the EHR while separately maintaining spreadsheets or tracking tools to monitor time, referral status, and patient progress. As one CHW explained,

> *The 60-minute threshold... it just doesn't match how the work actually happens with patients.*

Interviewees also described **challenges managing patient panels and tracking service delivery** over time. While EHRs generally supported encounter documentation, many interviewees reported that they were not designed to manage CHW patient panels, monitor referral status, or track patient progress. Several sites reported relying on both their EHR and additional tracking tools to monitor referrals, patient status, service delivery, and monthly billing activity. For example, one site described being unable to bill despite enrolling patients because EHR signature functionality did not reliably display provider signatures required for billing review. Other sites reported waiting months for EHR modifications or templates needed to support CHI and PIN documentation.

To address these gaps, the System Office developed an Excel-based Panel Management Tracking Tool that allowed CHWs and Patient Navigators to manage referrals, track patients' identified HRSNs, and monitor case status. Several interview participants described **the tool as a valuable addition** that provided visibility they did not previously have within their broader CHW programs, and some sites expanded its use beyond the pilot. At the same time, maintaining information across multiple systems increased documentation and workflow burden.

Implementation **challenges extended beyond the teams** directly delivering services. Participants described the need to engage provider champions, establish consent processes, secure leadership

approvals, coordinate with revenue cycle teams, develop coding and billing workflows, and create reporting systems capable of supporting reimbursement.

Participants also noted that **implementation often advanced faster than measurement systems.** Although participating sites and the System Office established measures intended to track implementation, service utilization, and outcomes, many sites did not reach the enrollment volume or implementation maturity needed to routinely monitor utilization, outcomes, financial performance, or sustainability. Several interviewees also noted that important aspects of CHW and Patient Navigator service delivery, including patient engagement, relationship-building, and care navigation, were not easily reflected in these types of measures.

Translation into Practice

Set up rapid-cycle testing and feedback loops for frontline staff to monitor implementation and outcomes, identify challenges in real time, and enable adjustments to meet unique site needs.

4

Key Finding

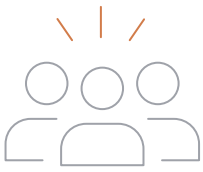
Implementation progressed most effectively when the people needed to solve problems were involved from the beginning.

Interview participants identified a range of factors that supported implementation, but one theme appeared consistently across interview groups: implementation progressed most effectively when the individuals responsible for addressing operational, clinical, and reimbursement challenges were involved early and remained engaged throughout implementation. Figure 4 summarizes the relative prominence of these factors across interview groups. While emphasis varied by participant role, early involvement of key partners, active leadership support, and System Office guidance emerged as the most consistently identified facilitators of implementation.

Figure 4. Relative Prominence of Factors Associated with Successful Implementation Across Interview Participant Groups

Relative Performance: High · Moderate · Low · Not Identified · No

	Executive Sponsors	Project Leads	CHWs/Patient Navigators	Billing/ Coding
People				
Clinical provider and care team engagement	High	High	Not Identified	Not Identified
Active leadership support	High	High	Not Identified	High
Dedicated Implementation Leads	High	Low	Not Identified	Not Identified
Embedded CHWs and Patient Navigators	Not Identified	High	High	Not Identified
Processes				
The right people involved from the beginning	Moderate	High	High	High
Regular cross-functional implementation meetings	Low	High	High	Not Identified
Ability to test and adapt workflows	Not Identified	Low	High	High
Established relationships across teams and partners	Not Identified	High	High	Low
Infrastructure and Supports				
System Office implementation support	High	High	High	High
Existing CHW and social care coordination infrastructure	No	Moderate	High	Moderate
Financial support for implementation	Low	Not Identified	Not Identified	Not Identified



How effectively sites **engaged the people responsible for solving operational challenges** often mattered as much as the assets themselves.

Note: *Symbol color indicates the relative prominence of each theme within each interview group: dark magenta denotes high prominence (theme discussed frequently), purple moderate prominence, and green low prominence (theme discussed less frequently). 'Not identified' indicates the theme was not raised, while 'No' signifies participants explicitly stated the factor was absent. The figure summarizes qualitative patterns and should not be interpreted as quantitative measurements or counts of participants.*

The distribution of themes shown in Figure 4 also highlights an important distinction between organizational readiness and implementation success. Participating sites were selected through a readiness assessment process that considered factors such as existing CHW and Patient Navigator programs, referral infrastructure, leadership support, and prior experience addressing HRSNs. Interview participants generally agreed that these factors provided an important foundation for implementation. However, the pilot demonstrated that the presence of these assets alone did not always predict implementation progress.

By contrast, interviewees frequently described smoother implementation when operational, clinical, and billing partners were involved from the beginning. One commonly cited example involved Billing and Coding staff. In Washington, Billing and Coding representatives participated in monthly technical assistance calls and served as core members of the implementation team. Participants described workflow, documentation, and reimbursement challenges as collaborative problems that could be addressed in real time rather than requiring separate meetings, approvals, or escalation through multiple departments.

Several interviewees contrasted these experiences with situations in which important **operational considerations were identified only after implementation planning was underway.** For example, the North Dakota site ultimately shifted implementation to a different clinical site after determining that its original clinic submitted all claims through Method II billing available to Critical Access Hospitals and therefore could not bill for the non-institutional CHI and PIN services. Participants described this as an example of how reimbursement and operational considerations can significantly affect implementation planning. Several interviewees noted that earlier involvement of operational and billing expertise may help identify these types of constraints before substantial implementation planning occurs. Other sites similarly described engaging billing, operational, or technology partners only after challenges emerged, requiring additional meetings and approvals before changes could be implemented.

The System Office was frequently cited as an important facilitator of implementation. Interview participants described the System Office as providing technical assistance, billing and coding guidance, implementation resources, and opportunities for peer learning throughout the pilot. Support included monthly cohort learning sessions on implementation topics, monthly site-specific technical assistance calls, pre-recorded micro-learning modules, implementation tools and templates, and on-demand consultation as sites encountered operational, documentation, and billing challenges. Several interviewees noted that **access to lessons learned from other sites accelerated problem solving** and reduced the need for individual sites to develop solutions independently. One Project Lead reflected,

> *Without their hand holding [System Office]... I felt like we were their only project. Their regular touchpoints meant that even if an issue came up, we knew a meeting was coming where we could touch base and ask the question. Knowing that support was there regularly, predictably—and that they would step in wherever it was needed—was essential.*

Translation into Practice

To effectively avoid sequential handoffs and reduce time spent in planning phases, ensure:

1. A cross-functional implementation team including Project Leads, CHWs and Patient Navigators, billing and coding, revenue cycle, and IT/EHR is formed from the very beginning; and
2. Technical assistance channels are established to leverage learnings from peers within or outside of the organization who have already solved for similar challenges.

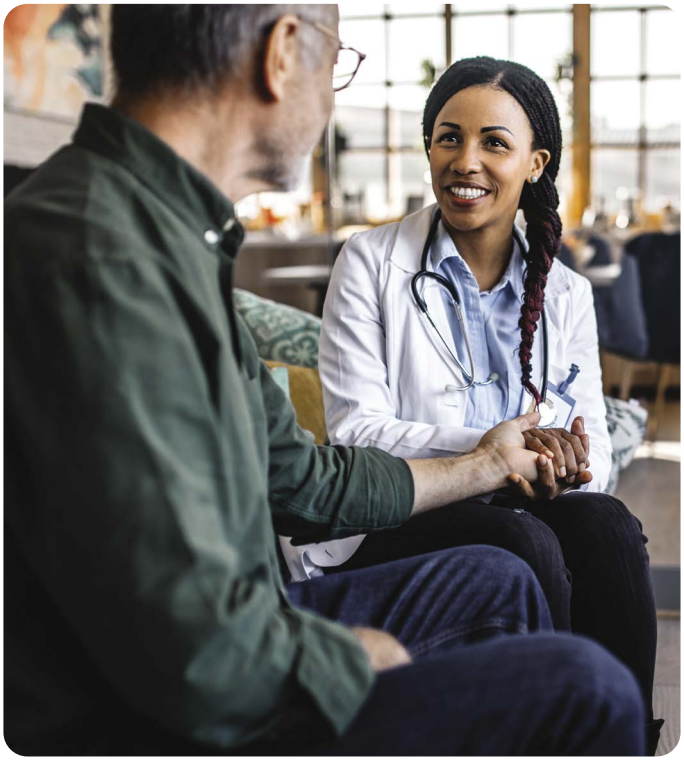
5

Key Finding

Billing for CHI and PIN codes was most viable when CHW and Patient Navigator services involved sufficient frequency, intensity, and longitudinal engagement.

Across interview groups, participants consistently described CHWs and Patient Navigators as central to patient engagement and service delivery. The pilot also revealed an important implementation lesson: **reimbursement feasibility depended in part on how CHW and Patient Navigator services were designed.** In some settings, CHWs provided comprehensive assessments, developed an understanding of patients' broader circumstances, and remained engaged over time through ongoing navigation and follow-up. In other settings, their role focused primarily on identifying needs, triaging patients, and connecting them with community resources. Interview participants consistently observed that the more longitudinal models aligned more naturally with the documentation, engagement, and time requirements associated with CHI and PIN services.

Washington provided one example of a longitudinal service model. Interview participants described **CHW services as extending well beyond resource referral.** Routine HRSN screening served as the starting point for a more comprehensive intake conversation that explored the patient's broader circumstances rather than focusing only on the issue that prompted the referral. Participants explained that these conversations frequently uncovered additional needs that were not apparent during the initial screening. For example, a patient referred for food assistance might also need transportation, help navigating benefits, or support addressing other social needs identified during the intake process. Interview participants described this process as frequently uncovering additional needs that were not initially apparent through screening alone.



This approach often resulted in longer-term engagement. Participants described **CHWs remaining involved until all patients' needs were addressed,** helping them navigate barriers as they arose rather than ending involvement after a single referral. Support frequently included coordinating appointments, addressing transportation challenges, improving access to food resources, navigating insurance concerns, and responding to additional social needs identified. One CHW explained their approach to telling patients,

> *"I'll be with you for however many months it takes to help you get through this.*

Patients often entered the program during periods of significant stress or life transition. As another CHW noted, many patients simply needed

> *a friendly calm voice to help guide them through.*

Interview participants emphasized that this model intentionally prioritized relationship-building, repeated assessment, and ongoing navigation. They believed this deeper level of engagement strengthened care planning by uncovering needs that otherwise would have remained unidentified. At the same time, it naturally generated the level of documented activity needed to support CHI billing.

Washington was not the only site where interview participants described this level of engagement. The site in Redding, CA provided a different example of how an intensive CHW model supported both patient care and CHI implementation. Following the initial assessment, the CHW and/or Social Work Supervisor often conducted joint home visits to better understand patients' living circumstances. Redding interviewers explained that these visits frequently revealed barriers that could not be identified through the initial assessment alone, such as limitations within the home environment, transportation challenges, caregiver needs, or other factors affecting patients' ability to manage their health. These visits expanded the understanding of patient needs beyond what had initially prompted the referral. Interviewers noted that this level of engagement reflected the site's longstanding patient engagement model. Because they routinely conducted home visits, providing intensive, longitudinal support was already an established part of their approach rather than a new workflow introduced through the pilot.

Interview participants also described how observing approaches used by other pilot sites prompted **some markets to reconsider their own intake and assessment processes.** North Dakota was cited as one example. The project implementation team has finalized a standardized CHW intake assessment modeled after a System Office assessment tool, the assessment is intended to support more consistent documentation, strengthen identification of patient needs, and encourage more sustained engagement over time. Interview participants viewed this effort as part of a broader shift toward developing a more complete understanding of patients' circumstances. They believed that a more structured assessment and follow-up would strengthen care planning while also improving alignment with CHI and PIN billing requirements.

Case Example: Kentucky's Experience Operationalizing CHI Services

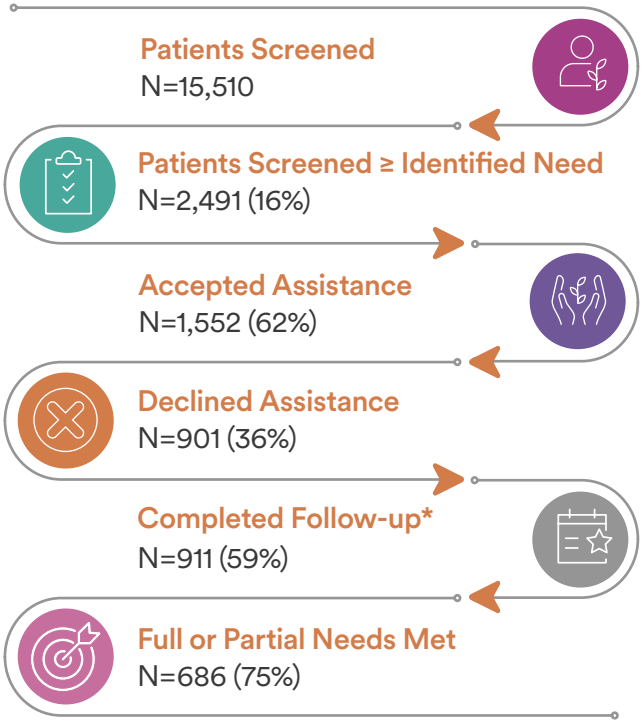
While not part of the pilot, CommonSpirit clinics in Kentucky have experience implementing CHI services. Their experience provides additional context regarding how reimbursable CHW services can be operationalized within a healthcare setting. Kentucky has been conducting universal social needs screening since 2017, began billing Medicaid for CHW services in 2023, and expanded to Medicare CHI billing in 2024. At the time of reporting, CHI services were being delivered across nine clinics by nine certified CHWs supported by universal screening, referral, and follow-up processes.

Kentucky data (Figure 5) illustrate that CHI service delivery involved multiple stages of patient engagement beyond initial social needs screening, including acceptance of CHW assistance, follow-up, and efforts to address identified needs. Among 15,510 screened patients, 2,491 were identified as having one or more needs. Of those, 1,552 requested assistance from a CHW, 911 completed follow-up, and 686 ultimately reported that needs were fully or partially addressed. These data demonstrate the multi-stage engagement essential to move from initial screening to documented resolution of identified needs, indicating that CHI service delivery frequently involves CHW outreach, navigation, persistent follow-up, and ongoing support.

The data also demonstrate that identifying needs did not automatically result in service utilization. More than one-third of patients identified as having one or more needs (901 of 2,491) declined assistance. This observation is consistent with challenges described by pilot sites and highlights the distinction between screening, enrollment, and ongoing participation.

Supplemental billing data provide additional context regarding the intensity of services delivered. Between May 2024 and March 2026, Kentucky submitted 1,175 CHI claim lines, including 791 initial CHI service codes (G0019) and 384 additional 30-minute CHI add-on codes (G0022). The substantial use of additional time-based billing suggests that many patients required services extending beyond the initial 60-minute billing threshold. Diagnoses associated with billed services reflected a range of social, functional, and navigation-related needs, including financial insecurity, housing instability, transportation barriers, food insecurity, insurance coverage challenges, health literacy concerns, and age-related functional support needs.

Figure 5: Kentucky CHW Service Pathway



*Metric definition based on Kentucky operational reporting.

Kentucky's CHI services operated within an established infrastructure that included universal social needs screening, dedicated CHW staffing, Medicaid and Medicare billing experience, referral workflows, and longitudinal follow-up processes. Although Kentucky had a different implementation context than the pilot sites, their experience provides an example of operational practices that may warrant further examination as organizations consider implementation of CHI services.

Translation into Practice

Avoid mistaking low volume of enrolled patients in this pilot as a universal indictment against the feasibility of the services. Instead, use the findings to guide a heightened level of precision around which clinical sites might be successful with these codes.

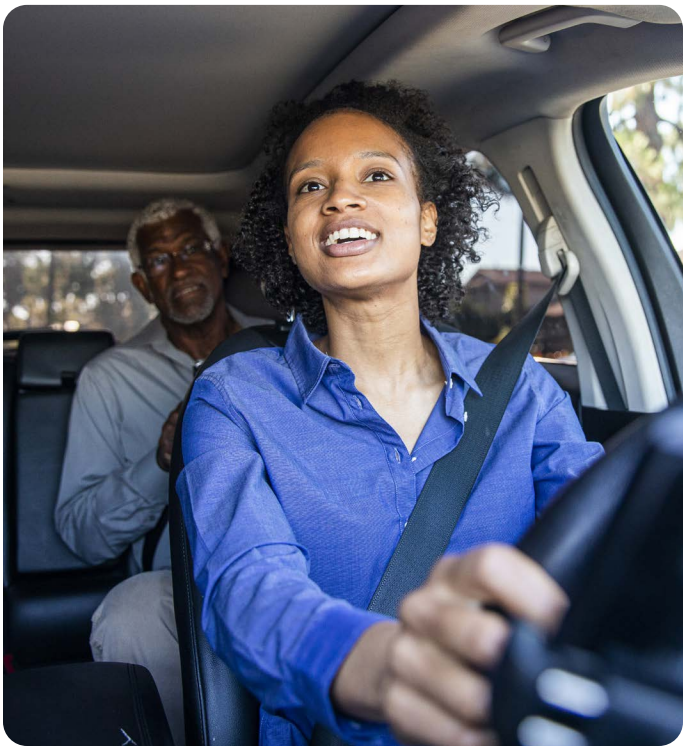
6

Key Finding

Sites generally rely on community organizations to address social needs, but these services require an even greater level of formal integration across healthcare-community organizations that is difficult to achieve.

Participants across interview groups consistently emphasized that addressing HRSNs depended on resources and services that existed outside the healthcare system. While healthcare teams identified needs and connected patients to support, community organizations often provided the social care services to address those needs. As one CBO partner explained,

> *"They're [healthcare system] never going to help somebody fill out an application for meals, transportation and housing... we're going to do all three and then we're going to ask what are the other needs and figure out how to get those services going and follow up with the person.*



Community organizations were consistently described as essential implementation partners. However, the pilot revealed **an important distinction between referral relationships and formal partnership models.** Most participating sites successfully connected patients to community resources through referrals and care coordination. Far fewer examples existed of healthcare organizations and CBOs operating through shared workflows, jointly managed services, formal information-sharing processes, integrated staffing models, or coordinated operational and reimbursement structures designed specifically to support CHI and PIN services.

This distinction was particularly notable because **the pilot intentionally created opportunities to test multiple implementation approaches,** including internal CommonSpirit-employed CHWs, CBO-employed CHWs, and hybrid models. Additional start-up grant funding was made available to encourage pilot sites to explore formally integrated partnerships with CBOs. Despite these intentional efforts, **most participating sites ultimately relied on internally operated CHWs and Patient Navigators,** rather than formal service delivery partnerships with community organizations. Interview participants noted that while referral relationships could often be established relatively quickly, **formal partnerships required substantially greater operational coordination and planning.** Several participants observed that these models often **required organizations to work across structures that healthcare systems are not designed to support easily,** including information sharing across organizations, documentation in separate systems, differing operational requirements, and reimbursement models that do not naturally incentivize cross-sector service delivery.

This pattern suggested that organizations found it considerably easier to build upon existing internal staffing models than to establish the infrastructure needed to support cross-organizational service delivery.

The Sacramento site illustrated these challenges. The site explored a partnership model involving a local CBO but encountered barriers related to legal and administrative review processes that prevented the project team from securing approval from operational leadership. Interviewees described spending substantial time addressing these requirements before service delivery could even begin. The experience illustrated that **establishing a formal partnership required more than shared goals or referral relationships; it required the creation of new operational structures** capable of supporting coordinated service delivery across organizations.

Interviewees frequently connected these experiences to broader implementation challenges observed throughout the pilot. The pilot sites spent considerable effort developing documentation processes, billing workflows, reporting systems, consent procedures, technology solutions, and operational supports needed to implement CHI and PIN services within their own organizations. Several interviewees noted that **normal healthcare-community partnerships would require many of these same capabilities to be developed jointly across organizational boundaries.** Several interviewees described this as one of the pilot's most important lessons: building formal healthcare-community partnerships required solving many of the same operational challenges that sites were already working to address internally, but doing so with a set of complex questions that would be new to many leaders across departments.

Importantly, interview participants did not describe a lack of interest in collaboration. **Both healthcare organizations and community partners expressed strong interest in deeper partnership models.** Many participants noted that successful implementation often depended on relationships that existed before the pilot. Established referral networks, longstanding organizational relationships, and familiarity with available community resources frequently allowed sites to connect patients to services more effectively. One community partner noted that partnership success depended on trust and authenticity, explaining,

> *"I think that level of authenticity really reflects in the results of partnership.*

Several interview participants also described examples where **closer collaboration improved implementation.** The Redding site, a CBO itself, described the importance of having staff physically present within the healthcare setting, explaining that,

> *actually having somebody from Connected Living over there to be able to connect with them and say, 'Hey, we're still here,' increased visibility and strengthened communication with clinic staff. The same participant noted, We started to see a lot more momentum when we started doing that.*

Interview participants viewed co-location as one example of a more integrated partnership model because it created opportunities for routine communication, relationship-building, shared problem-solving, and ongoing coordination that were difficult to achieve through referral processes alone. Several interviewees suggested that these types of operational connections represented a step toward the deeper partnership models many participants hoped to achieve.

Interviewees also noted that **successful partnership models required both healthcare organizations and community organizations to participate** in planning, workflow design, and operational decision-making from the outset. Interview participants frequently emphasized that neither sector could realistically build these structures independently. Several interviewees observed that **current healthcare and community service environments provide limited incentives** to support the substantial upfront work required to build and sustain integrated partnership models. As a result, organizations were often expected to invest significant time and effort in partnership development without dedicated operational or financial support for doing so.

Translation into Practice

Intentionally define CHI/PIN partnership models with CBOs that move beyond transactional referrals. Prioritize mutual benefit and CBO capacity to strengthen the entire ecosystem of clinical and community support for patient social needs, not just health system reimbursement.

7

Key Finding

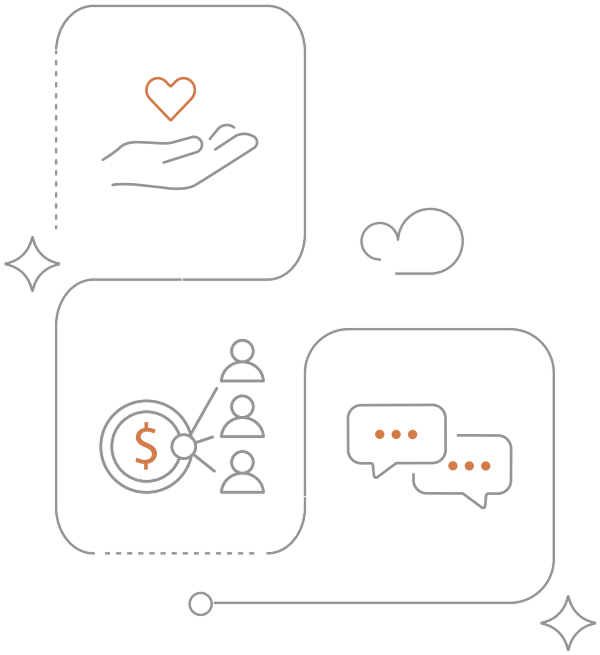
Several requirements to access reimbursement for CHI and PIN services created challenges for organizations trying to scale and sustain services.

While interview participants consistently described CHI and PIN services as valuable and well aligned with patient needs, they also identified several reimbursement requirements that complicated implementation. The most frequently discussed example was the **difficulty reaching the 60-minute monthly billing threshold for CHI services.** This challenge was discussed primarily in relation to CHI, where participants described many patient interactions as shorter encounters that did not consistently accumulate to the required billing threshold within a calendar month. Interview participants consistently distinguished between implementation challenges that organizations could address through workflow redesign or operational improvements and reimbursement requirements that were largely outside their control. The examples below illustrate several policy and billing requirements that participants believed affected implementation regardless of organizational readiness.

Several sites reported that some patients benefited from meaningful but relatively brief periods of support. Their needs were sometimes addressed through intermittent contacts or resolved before the required billing threshold was reached. As one Project Lead explained,

> *We're trying to sustain our program, but we really can't if we're not able to meet a 60-minute threshold with our interventions with patients.*

Interview participants emphasized that meaningful services were often delivered even when reimbursement was not possible because the total time fell below the required threshold. While these codes were viewed as well suited for patients with more complex needs requiring ongoing navigation, they did not align as naturally with patients whose needs could be addressed more quickly.



Some interviewees believed improved documentation and workflow design would help capture all eligible billable time. However, they also emphasized that many patients simply did not require 60 minutes of services, suggesting that the reimbursement threshold itself, not implementation alone, limited billing opportunities. In effect, sites changed workflows to implement services that ultimately only applied to a segment of the patients they serve, which limited their scaling potential. These experiences highlighted **a tension between service delivery and reimbursement requirements.**

Interview participants also identified **Medicare cost-sharing requirements** as an important implementation consideration. Several sites reported that discussing potential patient financial responsibility introduced conversations that had not previously been part of CHW and Patient Navigator workflows. CHWs explained that these discussions sometimes created confusion, raised concerns about unexpected costs, and led some patients to decline services despite initially expressing interest. At least one site also questioned the ethical fairness of charging Medicare patients, many of whom are presumably already experiencing financial distress, for services to address the challenges they encountered. During the pilot, participating sites and the System Office explored whether existing financial assistance policies could be used to reduce or eliminate these cost-sharing obligations. However, interview participants explained that modifying organizational financial assistance policies for a relatively small pilot was not feasible. Interview participants viewed this less as a technical implementation issue. Instead, they saw it as a broader organizational policy decision that extended beyond the authority of local implementation teams. As a result, Medicare cost-sharing remained a barrier to enrollment at some sites throughout the pilot. As one Project Lead reflected,

> *When I realized that the billing is a bigger lift than what we were receiving... it is a lot of effort for what's received.*

Project Leads, CHWs and Patient Navigators, and Billing and Coding leaders also identified **provider ordering and supervision requirements** as important implementation considerations. Participants described the operational work required to incorporate these requirements into existing clinical workflows. This included establishing processes for obtaining provider orders, coordinating supervision, securing provider review when necessary, and ensuring that these activities aligned with existing documentation and billing procedures. Interview participants noted that these requirements introduced new coordination between clinical, operational, and billing teams that had not previously been necessary for CHW and Patient Navigator services. While these services allow for billing providers to provide general supervision, and not direct supervision, of the CHWs rendering the service, participants still viewed the general supervision requirements as being onerous to implement. Many viewed these additional workflow requirements as influencing implementation feasibility independent of patient need or the perceived value of the services themselves.

A third lesson involved **the relationship between reimbursement and administrative effort.** Executive Sponsors, Project Leads, and Billing and Coding leaders frequently questioned whether reimbursement levels would ultimately offset the operational work required to support billing. Many sites conducted early financial planning that projected referral volume, staffing needs, reimbursement, and anticipated revenue. However, participants explained that several of those assumptions had not materialized during the pilot. Referral volumes were often lower than expected. Additionally, attrition occurred as patients progressed from referral to outreach, enrollment, consent, and ultimately billable service delivery. For many participants, this uncertainty made it difficult to judge long-term financial sustainability. Several Executive Sponsors and Project Leads emphasized that it was too early to determine whether reimbursement would ultimately offset implementation costs because they were continuing to refine workflows, increase referrals, and build operational capacity.

At the same time, they questioned whether reimbursement would ever justify the administrative effort required if patient volumes remained lower than anticipated. A Billing and Coding leader similarly noted that

> *If we could get the health plans to follow all the same policies... and maybe instead of a monthly code, be a per visit code, I think that would probably have been a little bit less burden from a billing perspective.*

These observations suggest that implementation feasibility depended not only on whether services could be reimbursed, but also on whether reimbursement ultimately justified the administrative effort required to support them. These lessons may also inform policymakers, payers, and health systems considering future implementation or expansion of reimbursement for social care services.

Translation into Practice

Identify which implementation barriers can be addressed internally and which require external policy changes. To overcome common challenges and foster the delivery of CHI and PIN services, engage with peer organizations and share solutions across the field.

Conclusion

The MHES Pilot represented one of the nation's first and largest efforts to implement and evaluate CHI and PIN services across diverse care settings and geographies. Although the pilot did not establish long-term financial sustainability, it uncovered valuable insights about how to transition CHW and Patient Navigator services that historically operated outside of reimbursement structures into more traditional healthcare payment and delivery operations. Sustaining these services depended not just on identifying the technical components needed to integrate them into routine healthcare operations, but also enabling shared decision making with cross-functional colleagues to continually improve implementation. These findings provide practical implementation guidance for future CHI and PIN efforts within CommonSpirit and for other health systems seeking to integrate social care services into routine healthcare delivery.

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Appendix A: Evaluation Questions and Logic Model

Evaluation Questions

 Implementation	**How is the new program being implemented?** • What systems/processes/capacities are being built? • What are the facilitators and barriers to implementation? • What partnerships are being established? • Is the program sustainable as implemented?
 Reach, Access, Utilization	**Who is participating and how?** • Which populations of patients are being reached (and not?) • Do patients have increased access to social and healthcare services? • Are utilization and referral patterns changing?
 Staff Experience	**What is the experience of staff who are implementing services?** • Do they understand the processes and feel comfortable with delivery? • Is there sufficient buy-in, perception of value-add, satisfaction etc.?
 Patient Experience	**What is the experience of patients who are receiving services?** • Do they have increased knowledge, self-efficacy? • Do they feel the support from CHWs was helpful/value add? • Do they feel their social service access is e asier/more consistent/broader?
 Health Outcomes	**Are health outcomes for patients in these clinics improving?** • Are clinical quality measures improving? Closing care gaps? • Do they experience improved quality of life? • Do patients have fewer unmet social health needs?
 Cost	**Are the services cost effective?** • Is overall cost of care decreasing? • Is there a change in costs associated with hospitalizations/ED visits?
 Disparities	**Are there differences in implementation, reach, experience, outcomes?** • Do we have the necessary data to measure disparities in our system? • Is there variation across sites and by presence of CBO/other partnerships? • Are there demographic differences for patients? • Are disparities decreasing because of the initiative? How can we do better?

Medicare Health Equity Services Pilot — Program Logic Model

Inputs	Outputs		Outcomes		
	Activities	Participation	Short-term	Intermediate	Long-term
Funding CSH Medical Group start-up funds; CBO start-up funds; technology builds; third party consultant; third party evaluators; site visits; comms materials; **Talent** CSH and participant market staff; cross-functional SMEs in areas like rev cycle, legal/compliance, operations, pop health; partner CBO program leadership, program oversight, and delivery staff. **Information** Technical assistance materials to address key questions around legal/compliance, billing, service delivery, documentation, and other areas. **Technology** Support from technology SMEs to determine documentation and reporting practices	**A1:** Achieve alignment from project stakeholders **A2:** Develop internal operations to support delivery of CHI and/or PIN services **A3:** Educate and train appropriate staff **A4:** Deliver high-quality CHI/PIN services **A5:** Monitor and report on the services delivered **A6:** Establish evaluation systems **A7:** Monitor Compliance with Regulatory and Billing Requirements **A8:** Implement long-term technology solutions **A9:** Put systems in place to track participant demographic	**P1:** 6 Pilot CSH sites participate; three of which are engaged in a partnership with a CBO **P2:** Each site has engagement from key stakeholders and teams	**By the end of the pilot:** *Measured, change expected* **Sites** **S1:** Processes for the program are established **S2:** Sites can bill for services **S3:** Participating teams have a positive perception of services and buy-in to provide them **S4:** Clinical-community partners establish key partnership parameters **Patients** **S5:** Clinical CHW workflows result in successfully engaging patients in services (Engagement) **S6:** Patients increase their knowledge, and positive attitudes and beliefs about services **S7:** Patients have improved utilization of health and social care services for healthcare services (Outcomes)	**Within 2 years:** *Measured, may not change by end of pilot* **Sites** **I1:** Sites have a sustainable process to bill for services **I2:** Participating clinics have billable revenue capture to support CHW service delivery **I3:** Overall costs of care are decreasing **I4:** Sustainable clinic-to-community partnerships are established **Patients** **I5:** Patients have increased access to social care services (Access) **I6:** Patients have improved health outcomes and quality of life	**Within 3-5 years:** *Not measured* **L1:** The program is sustained with dedicated non-grant resources **L2:** Patients who need social care services have needs met equitably, and fewer overall needs **Impact** **CSH patients:** Are healthier, have greater economic stability, stronger social connections, and overall higher quality of life **CSH organization:** Has improved quality, cost, satisfaction, and utilization of care related to these services; stronger CBO connections **CSH replication:** **1.** Create sustainable infrastructures (including contracting and CBO reimbursement) **2.** Embrace an extended care continuum across clinical/community settings to address social and care navigation needs