Community Health Assessment

2020 - 2023

COVENANT HealthCare

FY23 Community Health Implementation Plan

Year-End Report

Planning & Business Development
August 2023

Covenant HealthCare FY23 Community Health Implementation Plan

Executive Summary

Going beyond the traditional Community Benefit reporting, the Affordable Care Act (ACA) of 2010 requires hospitals to conduct extensive community health needs assessments and to then develop board approved implementation plans regarding how the institution will address the needs of the community as identified through the assessment process.

Saginaw County has already been engaged in this kind of effort and has created a process which meets the mandate of the ACA. For several years, Covenant HealthCare has been a partner in the Saginaw County Community Health Improvement Partners network. This network of community partners has completed a comprehensive multi-year community health needs assessment which Covenant may use in meeting the mandate. The two lead agencies, Alignment Saginaw, and the Saginaw County Department of Public Health, developed a structure that includes a Health Strategy Committee of which the Saginaw County hospitals, Covenant and Ascension St. Mary's of Michigan, are members. That committee oversees the work of three Action Groups, each focused on implementing actions to improve the status of three priority health concerns. Over 30 different partners have participated in this work. The latest Saginaw County Needs Assessment covers the period 2020-2023 and is the document being used by both Covenant and St. Mary's as the CHNA meeting the requirements of the Affordable Care Act.

Covenant's proposed Community Health Implementation Plan to address identified community needs is presented below. Covenant will integrate these implementation strategies for community health improvement throughout its strategic plan as it has in the past. Many of the implementation strategies are ongoing although several expanded and/or new programs are proposed to more effectively meet those community health needs identified by the community and Covenant as priorities.

Collaborative Planning Process – The Saginaw County Health Improvement Plan (CHIP)

The health assessment completed by the Community Health Improvement Partners, led by the Saginaw Co. Health Department, meets the requirements of the ACA. This assessment is called the Saginaw County Health Improvement Plan and has also been titled "Saginaw County Community Health Assessment 2020-2023." This document serves as the community health assessment (CHA) that Covenant follows to develop effective community health initiatives included in the Covenant Community Health Implementation Plan.

The community-wide action planning process is led by the Saginaw CHIP Steering Committee, of which Covenant is a member, and three action groups. These action groups are focused on three priority community needs. Covenant supports the identified priorities, and those three arenas will serve as the focus for Covenant's implementation plan.

Relationship to the Community Benefits Report

The new mandated CHA and Implementation Plan go beyond the traditional community health benefit programs and reporting by focusing on programs and services that are in *direct* response to a defined community's identified needs and that have *improved health* as an outcome.

Community Health Assessment & the Covenant HealthCare Community Health Implementation Plan

With more than 65% of Covenant HealthCare's patients coming from Saginaw County, Covenant has identified Saginaw as the primary service area for the CHA. However, Covenant is also working closely with the Michigan Health Improvement Alliance (MiHIA) and supports initiatives identified in the regional CHA.

A. Prioritized Needs Covenant Will Address

The CHIP process identified three priority areas of health improvement needs:

i) Mental Health

ii) Infant Mortality

iii) Obesity

Covenant's implementation plan addresses all three priority areas based on the availability of community resources, the partnerships in place and the resources Covenant can direct to each of these areas. The following implementation plan identifies Covenant's existing and planned actions in each category. In addition, Covenant has elected to include a section for palliative care and for other initiatives that impact community health not included as one of the key areas identified by the CHA.

B. Identified Community Needs Covenant Will Not Address

The ACA requires hospitals to identify which needs, if any, they are not addressing in their current Implementation Plan and why. Covenant is involved in addressing all three action areas to varying degrees however it recognizes that it is not, and should not, be the leader in all areas but that working with appropriate partners it can optimize the use of resources by avoiding duplication and finding the most effective strategies available. In the first action area, Covenant HealthCare plays more of a supportive role to other community partners who are focused on mental health.

Each of the three Action Group areas has goals, objectives, and actions. In many cases Covenant is working collaboratively with other community organizations; in other cases, Covenant is not a direct participant. The implementation plan below includes both areas as well as those activities which Covenant is pursuing internally.

C. Next Steps

The community-wide CHA was updated during 2019 and 2020 and rolled-out in the spring of 2020. Covenant will continue to be involved in this process and will participate in updating the CHA every three years as specified in the Affordable Care Act. Each year, Covenant will review and revise its Community Health Implementation Plan.

The FY21 Covenant CHIP is divided into the following five sections:

1. Mental Health
2. Obesity Related Chronic Disease
3. Infant Mortality
4. Palliative Care
5. Additional Community Health Initiatives

1. Mental Health		FY23 End of Year Update
Initiative	*Lead*	*Accomplishments*
Re-establish collaborative efforts to help facilitate getting medication assisted treatment in the ED for MAT.	Jill Toporski/Matt Deibel	Working with MIOPEN for resources within the ECC that is a collaborative effort of physicians, pharmacists, and nursing.
Continue Covenant's opioid task force "Covenant's path to recovery".	Jill Toporski	This task force has dissolved.
Conduct community outreach on substance abuse.	Jill Toporski/Matt Deibel	Continued efforts with Narcan distribution in the ECC. No specific community outreach at this time.
Covenant provides ethanol screening and intervention. Our distracted driving programs entitled "Avoid Trauma, Don't Drive Distracted" also reviews how substance abuse can lead to accidents and adds to distractions.	Deb Falkenberg	We have collaborated with high schools, MI career quest and Saginaw Career complex discussing the risk of distracted driving reaching over 1000 students throughout the fiscal year.
We do alcohol screening and intervention for all patients utilizing the CAGE questionnaire and the Quantity and frequency questions. For Pediatrics we use CRAFFT (Center for Adolescent Substance Abuse Research).	Deb Falkenberg	We monitor every trauma patient that is admitted to our program to ensure they are screened for substance abuse and consult social work to offer counseling services.
Provide CIPP (the Covenant Injury Prevention Program) initiatives to all our customers in a variety of settings including schools, community, health events, churches etc.	Deb Falkenberg	Programs include water safety, bike safety, Stop the Bleed, Fall Prevention, Gun Safe Storage. We have collaborated with police and fire to help promote these programs. We have written grants to provide Stop the Bleed kits and lifejackets in the communities. We offer education via media, health fairs and in house education. We have completed over 120 outreach events throughout the fiscal year effecting thousands of people.
Increase awareness of suicide including prevention and postvention.	Deb Falkenberg	We collaborate with our pediatric department to do follow up phone calls on our patients that are discharged with suicide attempts to ensure that access to lethal means has been eliminated in households and see if they need any additional resources. We collaborate with Barb Smith Suicide Network teaching Safe Talk and participating in prevention/postvention events.

Expand current nurse coach program to focus on chronic disease management and mental health.	Erik Fielbrandt	Partnered with CUP Health a vendor that focuses on mental wellbeing for all employees. In FY22, an average of 116 visits assisting 91 employees utilized the service each month.
Collaborate with Hope Not Handcuffs to provide service upon discharge to assist patients in getting placed to outpatient treatment centers.	Jill Toporski	Work collaboratively Saginaw County mental health on placement for patients. No specific work at this time with Hope Not Handcuffs.
Offer Autism Diagnostic & Treatment with Applied Behavioral Analysis Approach returning to CY 2019 volumes – recovering from Covid19 influence.	Sally Wagner	At FY end, we were able to provide a total of 77 Non-AAEC/Bridge Authorization and a total of 51 AAEC evaluations for patients. Our treatment center was able to provide ABA Treatment to a total of 34 patients during FY 23. Fully recovering from the Covid19 influence.
Continue Bereavement Support for pregnancy losses beyond discharge from the hospital.	Kathy Bonn	At the July 14 Covenant burial service at St. Andrew Cemetery, there were 9 babies buried and approximately 60 people in attendance. At the September 8 service, there were 8 babies buried and 35 people in attendance. At the November 3 service, there were 13 babies buried and 50 people in attendance. At the March 2 service, there were 14 babies buried and 25 people in attendance. At the May 4 service, 15 babies were honored (10 of these were buried at the cemetery) and there were 31 people in attendance.

2. Obesity Related Chronic Disease		**FY23 End of Year Update**
Initiative	*Lead*	*Accomplishments*
Provide Covenant Oncology Rehabilitation Education (CORE) which includes ongoing Health & Fitness Exercise classes & yoga post treatment to improve outcomes and quality of life for those diagnosed with cancer.	Sandy Johnson	In FY23: We had 36 registrations for our Oncology Exercise class with September being our last class (program eliminated due to budget constraints) 31 registrations for our Oncology Yoga class, and 59 patients have participated in the breast pre op instruction class. PM&R is currently unable to provide any updates at this time on stats for PT, OT, and SLP due to reporting issues due to merging data systems.
Continue to provide lung screening/awareness.	Sandy Johnson	Program continues; approximately 2000 screenings per year
Continue to provide free smoking cessation classes/resources.	Sandy Johnson	Program continues; low utilization approximately 2 patients per quarter

Provide numerous support group offerings for Saginaw and surrounding communities for Oncology patients.	Sandy Johnson	In FY23: 43 support groups were held with a total of 362 attendees. (Approx: Four support groups per month: Oral Head & Neck, Coping with Cancer, Young Women's, Women's Cancer Support)
Work with Outpatient Pharmacy on the Wellness program that will waive co-pays for diabetic medications and diabetic supplies.	Erik Fielbrandt	Continue to work with pharmacy on exploring the option on waiving co-pays in the upcoming year while maintaining compliance with the health plan. Currently are providing the Continuous Glucose Monitors for employees engaged with the DayTwo program.
Partner with a vendor to help improve the overall health of those employees who are prediabetic and diabetic.	Erik Fielbrandt	Have partnered with DayTwo since 2021 - in FY23 we had 16 participants and an additional 7 go through the screening process. Total participation over the 2-3 years has been 49 total participants (7 prediabetic, 42 diabetic) and 21 going through the screening process. Average weight loss by participants was 7.3 lbs. and a drop of 0.4 in A1C. Looking to increase participation in FY24
Covenant hosts three monthly information seminars for bariatric surgery and our average attendance rate is 515 people each year. We work to increase seminar attendance rates in order to educate the community about the health benefits of weight loss and when bariatric surgery is an appropriate option. Each year more than 180 bariatric surgical procedures are performed at Covenant. Benefits for these patients related to chronic illnesses include 83% resolution in Type II Diabetes, 82% resolution of Asthma, an 80% risk reduction of developing cardiovascular disease and a decrease in 5-year mortality rates by 89%. Covenant also provides nutritional and lifestyle change education to every person that works with Covenant to prepare for bariatric surgery.	Libby Palmer	Covenant has transitioned the information seminars to be completely online. By doing this we have increased access to the program by removing any date and time constraints and allowing people to get program information from the convenience of their home. Our attendance rate has increased to 560 for this past fiscal year with over 200 surgical procedures performed.
Covenant HealthCare provides Diabetes Prevention Program, a free one-year program for pre-diabetics.	Rebecca Srebinski	Three separate cohorts of the yearlong Diabetes Prevention Program took place FY2023. Cohort 1, at CMU, started in January 2022 with completion January 2023. Cohort 1 started with nine participants and ended with five. Cohort 2, held at Victorious Believers Ministries, started May 2022 with a completion date May of 2023. Sixteen participants started and completed this session. Cohort 3, held at the

		Eleanor Frank Senior Center (Commission on Aging), was initiated in June 2023 with a completion date earmarked June 2024. The current cohort has nine participants.
Provide six virtual educational offerings to the community focusing on education & exercise to promote continued healing and maintenance of wellness.	Sally Wagner	1 continuing education offering completed, program on indefinite hold due to budgetary constraints.

3. Infant Mortality		FY23 End of Year Update
Initiative	*Lead*	*Accomplishments*
Continue Critical Congenital Heart Disease Screening for newborns in the NICU and Birth Center.	Rebecca Schultz	This screening continues for every infant in the RNICU and Birth Center.
Continue to provide post discharge lactation services. This includes providing services to Adult IP Rehab if needed.	Rebecca Schultz	These services continue. Lactation Consultants take appointments for mothers after discharge and will offer assistance to inpatients & Rehab patients if needed.
Continue Development Assessment Clinic for follow up of RNICU babies at no cost to the patient. Includes assessment by neonatologist, NICU nurse, and nutrition and therapies as appropriate.	Rebecca Schultz	The DAC continues to see babies that are discharged from the RNICU. Close to 600 patient visits took place this fiscal year.
Continue to offer RSV prevention for at-risk infants; operating RSV clinic from November 2020 through March 21	Rebecca Schultz	RSV clinic was started early due to the high incidence of RSV in the community. 195 patient visits were completed.

Maintain Regional NICU services. • Maintain the Newborn Transport Program (air and ground ambulance) with Covenant NICU staff accompanying babies during transport. • Continue data sharing and analysis with Pediatrix Medical Group to improve neonatal care and outcomes. • Work with Birth to Five to complete home visiting referrals for infants with Neonatal Opiate Withdrawal Syndrome (NOWS)	Rebecca Schultz	The Neonatal Transport Program continues to transport infants to and from the RNICU. Weekly Continuous Quality Improvement Committee meetings are held to examine quality data and implement process improvement measures to improve quality outcomes.
Continue to support the community through Women's and Children's Outreach Department to • provide community education and health information to other organizations, groups and the community at large • promote Covenant's "Protect Your Baby's Life" program which focuses on don't shake your baby, safe sleep, car seats, postpartum mood disorder screening) • provide childbirth education classes throughout the community including a support/education program for pregnant teens. • Offer CRP training for parents • Provide sibling education for families with new infants • Continue partnership with CAN Council to provide education to nonparent caregivers	Rebecca Schultz	The Women's and Children's Outreach Department continues to provide community education and health information to other organizations and community groups at large. They are also chairing two community based subcommittees for the BWell Maternal Infant Action committee: Safe Sleep and Parent Fair. Childbirth education classes are being held both virtually and in person. CPR training is being provided to parents, grandparents, and various community members. (Bus drivers, teachers, other school workers, etc.) Lactation education classes and protect your baby's life program are being taught. Serve as the school nurse for Carlton School District.

Once the new Community Health Assessment is completed Covenant will work with the BWell collaborative to develop a Community Health Improvement Plan focused on community needs.	Rebecca Schultz	Continue to participate as a member of the BWell collaborative steering committee. Also serve as chair for the BWell Maternal Infant Action committee.

4. Palliative Care		FY23 End of Year Update
Initiative	*Lead*	*Accomplishments*
Home based palliative care provided by Covenant VNA will strive to improve communication and support a seamless transition for patients within the healthcare system. Care will focus on creating an integrated person-centered healthcare support system for patients with serious or life-threatening illnesses by improving the quality of life for both patients and their families. **Metric:** Advance directives discussion will be confirmed or completed on at least 90% of patients Serviced by VNA Palliative care.	Katie Parkhurst	Covenant Inpatient Palliative Care and Covenant VNA Home-Based Palliative Care have successfully merged into one program. Alignment of providers, workflow and documentation has been a large focus. VNA community initiatives and educational efforts have been combined including inpatient, outpatient and ACP services. Metric established for VNA outpatient ACP discussions have been revised/re-evaluated with the merge of the programs and new metrics are being established for FY24 in collaboration with the new care model.
Continue to offer interdisciplinary education on palliative care and ACP.	Tracy Bargeron/ Summer Bates	• Respecting Choices ACP Facilitator Training/Certification provided to employees from Covenant, Hills & Dales, Scheurer Healthcare, St. Francis Home, Diamond HHC & Hospice, and OCS OT & Case Management Services. • 19 educational presentations provided to interdisciplinary team members. • Ongoing informal education to Covenant and non-Covenant interdisciplinary team members. • Palliative Care Rotation provided to, 7 CMU Family Medicine Residents, 13 CMU Medical Student, 1 Nurse Practitioner Student, and 2 Pharmacy Residents
Collaborative ACP initiative with a minimum of ten PCP offices to increase the number of patients with a valid ACP in the EMR.	Katie Parkhurst	Inpatient and Outpatient Palliative Care program merged under one program to promote Palliative care growth and continuity within the organization. Initiated Palliative Care Clinic within the Cancer Care population with the first clinic in June 2023. Hired a part-time Social Worker for Palliative Care program. Hired additional providers and now have 6 APP and our Lead Provider making 7 total providers servicing Covenant Palliative care patients both across the continuum.
Continue to offer ACP group presentation to anyone in the community on ACP, Michigan Advance Directive specific	Tracy Bargeron	• Provided six ACP & CPR Presentations to the community. • ACP Educational booth provided at 15 community events

requirements, Michigan Out of Hospital DNR orders and Resuscitation.		
Continue to offer individual ACP conversations in-person or via phone conference as a community service.	Tracy Bargeron	• 950 Initial ACP visits completed
Establish partnership with other agencies including Cancer Care Center, Heart Failure Clinic, VNA, SNF's, ALF, Law Offices, Religious Organizations, and CRTN partners	Tracy Bargeron	• Ongoing collaboration with Cancer Care Center for ACP services with added initiatives with Thoracic, GI and Breast populations. • Ongoing collaboration with SNF, ALF, Law Offices, Religious Organizations and CRTN partners."
Continue involvement with state-wide ACP group in promoting ACP services, as well as ACP legislative topics.	Tracy Bargeron	• Continued involvement with Michigan Physician Orders for Scope of Treatment (MI-POST) implementation planning. Active involvement in creating and finalizing MI-POST Education -Clinicians and Hospital Care Teams available on MI DHHS site. • Continued participation with statewide ACP Community of Practice.
Continuation of inpatient palliative care services focused on improving quality of life through symptom management, advance care planning, goals of care conversations and family meetings.	Tracy Bargeron	• Ongoing ACP collaboration with CMG PCP offices • New ACP initiative rolled out with CMU Family Medicine Clinics

5. Additional Community Health Initiatives		FY23 End of Year Update
Initiative	*Lead*	*Accomplishments*
Inpatient Rehabilitation provides a Stroke Support group for stroke survivors. This is a community event.	Sally Wagner	MFB Inpatient Rehab had 15 participants at the October 2022 meeting.
Inpatient Rehabilitation will conduct three community education events on brain injury, fall prevention and stroke risk factor modification, with a goal to reach 100 people through these programs.	Sally Wagner	Brain Injury prevention education was provided at the 2022 National Night Out for over 100 people. We have provided education to patients and community members through Stroke Classes and educated on Stroke Risk factor during those times. MFB has educated community members on fall prevention through our Amputation Support Group that meeting quarterly.
Provide skilled Pre-hab for Total knee patients and Lung Cancer patients in support of positive outcomes & quality life returning to CY 2019 volumes – recovering from Covid19 influence.	Sally Wagner	608 Total Joint Pre-Hab patients were served and 1 Lung Pre-Hab patient was served
Regularly review the financial assistance policy. Review includes updating for the annual Federal Poverty Level and compliance with federal regulations. FY 2017 review incorporated language to be compliant with IRC 501(r) requirements.	Peggy Maine	Regularly review the financial assistance policy. Review includes updating for the annual Federal Poverty Level and compliance with federal C 501(r) requirements.
Continued use of Certified Application Counselors to assist patients in obtaining health insurance through the exchange.	Peggy Maine	Continued use of Certified Application Counselors to assist patients in obtaining health insurance through the exchange.
Continue to participate in the Childhood Healthcare Access Program assisting children in seeking insurance coverage and working with insurers to improve access.	Peggy Maine	Continue to participate in the Childhood Healthcare Access Program assisting children in seeking insurance coverage and working with insurers to improve access.
Continued expansion and support of physician practices as Patient Centered Medical Homes.	Lynne Benkert	Over 90% of primary care practices are designated as Patient Centered Medical Homes, with one nominated practice awaiting designation.
Continued emphasis at primary care offices in monitoring immunizations and well-child visits.	Lynne Benkert	All family medicine offices have processes in place to provide timely well-child visits and immunizations to patients under the age of 18.
Continue to utilize the “Saginaw County Community Resource Guide” in Covenant Medical Group primary care offices.	Lynne Benkert	All primary care offices continue to use the Community Resource Guide.