HSHS St. Mary's Hospital

Health Needs Assessment
2025-2027 Implementation Plan

HSHS St. Mary's Hospital is an affiliate of Hospital Sisters Health System, a multi-institutional health care system comprised of 13 hospitals and an integrated physician network serving communities throughout Illinois and Wisconsin.

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Introduction

HSHS St. Mary's Hospital is a not-for-profit hospital located in Macon County, Illinois, its primary service area (PSA). Parts of the adjacent four counties (DeWitt, Moultrie, Christian and Shelby) constitute its secondary service area (SSA). For more than 140 years, the hospital has been the leader in health and wellness in Macon County. St. Mary's Hospital provides a wide range of specialties, including cardiology, neurosurgery and sleep center.

St. Mary's Hospital partners with other area organizations to address the health needs of the community, living its Mission to reveal and embody Christ's healing love for all people through its high-quality Franciscan health care ministry, with a preference for the poor and vulnerable. The hospital is part of Hospital Sisters Health System (HSHS), a highly integrated health care delivery system serving more than 2.6 million people in rural and midsized communities in Illinois and Wisconsin. HSHS generates approximately $2 billion in operating revenue with 13 hospitals and has more than 200 physician practice sites. Its mission is carried out by more 11,000 colleagues and 1,000 providers in both states who care for patients and their families.

In 2024, St. Mary's Hospital conducted a Community Health Needs Assessment (CHNA) in collaboration with Decatur Memorial Hospital and the Macon County Health Department. This process involved gathering data from multiple sources to assess the needs of Macon County. Data was presented to an external community advisory council (CAC), an internal advisory council and through a community survey. Together, these groups recommended the health priorities to be addressed in FY2025-FY2027. The full CHNA report may be found at https://www.hshs.org/st-marys-decatur/about-us/community-health-needs-assessment.

The implementation plan builds off the CHNA report by detailing the strategies St. Mary's Hospital will employ to improve community health in the identified priority areas. This plan shall be reviewed annually and updated as needed to address ever-changing needs and factors within the community landscape. Nonetheless, HSHS shall strive to maintain the same overarching goals in each community it serves, namely to:

1. Fulfill the ministry's Mission to provide high-quality health care to all patients, regardless of ability to pay.
2. Improve outcomes by working to address social determinants of health, including access to medical care.
3. Maximize community impact through collaborative relationships with partner organizations.
4. Evaluate the local and systemic impact of the implementation strategies and actions described in this document to ensure meaningful benefits for the populations served.

For purposes of this CHNA implementation plan, the population served shall be defined as Macon County residents of all ages, although the hospital's reach and impact extend to other central and southern Illinois counties as well.

Prioritized Significant Health Needs

As detailed in the CHNA, St. Mary's Hospital in collaboration with community partners identified the following health priorities in Macon County:

1. **Access to mental health and substance use disorder services**
2. **Access to care: focus on chronic conditions**
3. **Disparities in economy**

These priorities emerged from several data sources, including community focus groups, individual and stakeholder interviews, local and national health data comparisons and input from the CAC and internal advisory council.

Community Health Needs That Will Not Be Addressed

As part of the identification and prioritization of health needs, the hospital considered the estimated feasibility and effectiveness of possible interventions to impact these health priorities; the burden, scope, severity or urgency of the health need; the health disparities associated with the health need; the importance the community places on addressing the health need; and other community assets and resources that could be leveraged through strategic collaboration in the hospital's service area.

Based on the CHNA planning and development process the following community health needs were identified but will not be addressed directly by the hospital for the reasons indicated:

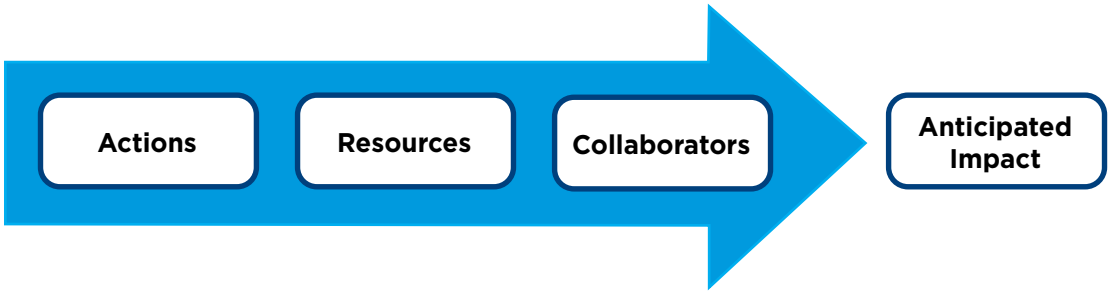
- Safe and affordable housing: While not a direct priority issue, affordable housing challenges and barriers will be explored within the strategic plan of mental and behavioral health services.
- Incarceration rate: St. Mary's did not select this as a top priority; however, all drivers of health and health outcomes will be considered in the development of the hospital's strategic plan.
- Low reading and math scores: Exploration will continue on the impact of educational disparities on disparities in economy.
- Gun violence: While not named in the top three priority areas, gun violence stemming from mental health and poverty will be further investigated and addressed in the CHIP.
- Unemployment: St. Mary's did not select this as a top priority; however, all drivers of health and health outcomes will be considered in the development of the hospital's strategic plan.
- High truancy rates: We will continue to explore the impact of educational disparities on disparities in economy.
- Social vulnerability: St. Mary's did not select this as a top priority; however, all drivers of health and health out comes will be considered in the development of the hospital's strategic plan.

Primary Implementation Strategies

In each of the priority health areas identified, St. Mary's Hospital shall employ strategies that fall into one or more of the categories below.

Strategy	Description
Improve access to prevention and early intervention services.	This strategy involves taking actions that prevent disease or injury or limit their progression and impact.
Decrease barriers to entry.	This strategy involves improving the ability of individuals in the hospital's service area to receive needed treatment and services on a timely basis to achieve optimal health outcomes.
Work with internal and external stakeholders to address drivers of health through unified policy and planning.	This strategy involves working with community partners to factor health considerations into any decision-making that affects the general public or subsets of populations within the general public.

Examples of specific actions that fall under these broad strategies, as well as the anticipated impacts of those actions, are listed on the PLANNED ACTIONS pages for each of the health priorities. This format follows the logic that the stated actions, resources and collaborative partnerships together will produce the anticipated impacts.



Community Health Improvement Plan Overview

These implementation strategies and actions are outlined by health priority, first with a "snapshot" of identified strategies, sample actions and other relevant information, followed by a more comprehensive and specific description of planned actions, resources, collaborative partners and anticipated impacts.

Priority Snapshot: Access to Mental Health and Substance Use Disorder Services

Priority No. 1: Access to Mental Health and Substance Use Disorder Services

Target Populations
- Adolescents
- Adults

Hospital Resources
- Colleague time
- Funding
- Advocacy

Community Partners
- Local health departments
- Local businesses
- Schools
- Local policymakers
- Local hospitals
- Faith-based organizations
- Behavioral and mental health service providers
- Local providers
- Mental Health America

Anticipated Impact
- Prevention and early intervention tools
- Improved mental health literacy
- Inform public policy
- Resilience in youth
- Clinical assessment and referral
- Direct referrals

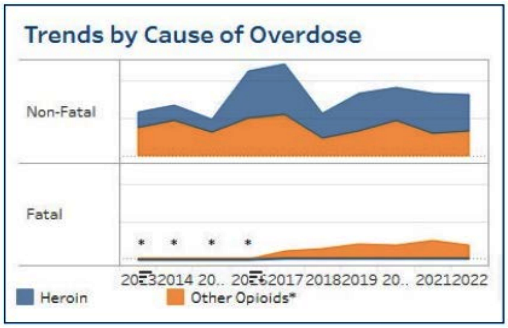
Relevant Measures*
- Proportion of people who get a referral for substance use treatment after an emergency department visit
- Proportion of adolescents and adults with anxiety or depression who get treatment

* *From the national health plan: Healthy People 2030*

Current Situation

Accidental drug overdose deaths have continued to rise in Macon County since the beginning of 2018 and non-fatal overdoses have been climbing once again. According to county coroner reports, substances such as heroin, alprazolam, alcohol and fentanyl have been leading culprits in drug overdose deaths. The county also has higher rates of hospitalization due to opioids and heroin compared to other counties in the state.

According to Illinois Hospital Association (IHA) COMPdata, Macon County hospitalization rates due to mental health issues has steadily increased since 2008. Considering the rate per population, this is a higher rate of hospitalization than the state. For individuals under the age of 18, Macon County is more than double the state rate for hospitalization. The Centers for Medicare and Medicaid Services reports depression among the elderly population is currently at 19% and has been trending upward since 2009. According to the 2023 County Health Rankings, nearly 17% of the population self-reports experiencing frequent mental distress for 14 or more of the past 30 days. That is up from 11% in 2020.



Our Strategies

Improve access to prevention and early intervention services.
- Provide Mental Health First Aid training for HSHS colleagues.
- Partner with county Recovery Oriented Systems of Care to develop policy and practice to support recovery.
- Implement social-emotional learning curriculum in elementary schools.

Decrease barriers to entry,
- Provide hospital emergency department-based screening, recovery coaching and linkage services.
- Create a social care network within our EMR to connect patients with community-based resources.

Unified policy, planning and advocacy efforts.
- Advocate for pediatric behavioral health patients in emergency departments who lack appropriate care by engaging stakeholders to recommend legislative strategies to the appropriate governing bodies.

Indicators
- Number of instructors trained, trainings provided, individuals trained
- Number of residents successfully entering and completing treatment
- Number of students participating in Resilient Classroom Project
- Number of patients screened and referred
- Number of patients successfully completing treatment

PLANNED ACTIONS – Mental Health and Substance Use Services

The system of mental and behavioral health care is fundamentally broken. People in crisis have little option other than to access services through hospital emergency departments, the least conducive environment for mental and behavioral health patients to become well and receive appropriate services. During a mental health crisis, patients need the right care in the right place at the right time.

In year one of the CHIP, we will work with community partners to evaluate service availability internally and within the community to address current and future service gaps and growth needs. Through a multi-sector, collective impact model, we will work with local, regional and state organizations and policy makers to improve the awareness of and access to mental and behavioral health services and further understand opportunities for prevention, early diagnosis and intervention.

Strategy 1: Improve access to prevention and early intervention services.

Action	Resources	Collaboration	Anticipated Impact
Provide Mental Health First Aid training for HSHS colleagues.	• Colleague time • Event supplies	• Human Resources • Department Leaders • HSHS Ministries	• Provide prevention/early intervention tools for health care providers to support patients and colleagues experiencing mental health challenges • Improved mental health literacy • At least 10% of HSHS Colleagues, including a minimum of 4% representing Leadership positions, will be certified in Mental Health First Aid by end of FY27
Partner with the County Recovery Oriented Systems of Care team.	• Colleague time	• Community stakeholders	• Develop public policy and practice that can support recovery in crucial ways • Reduction in stigma associated with those struggling with substance use disorders (SUDs) • Coordinate a wide spectrum of services to prevent, intervene in and treat substance use problems and disorders
Implement a social – emotional learning curriculum in elementary schools.	• Community health funds • Colleague time	• Local school district • Mental Health America	• Foster resilience in youth • Equip young learners with essential coping skills, promoting mental well-being and empowering them to overcome challenges

Strategy 2: Decrease barriers to entry.

Action	Resources	Collaboration	Anticipated Impact
Hospital emergency department-based screening, recovery coaching and linkage services.	• Colleague time • Engagement specialist • Recovery coach	• Gateway Foundation	• Clinical assessment for patients presenting with SUD • Direct transfer or referral to treatment upon discharge from the hospital
Create a social care network within our Epic platform to connect patients with community-based resources.	• Internal project management team • Care management team • Colleague time • Community health funding	• Community based organizations • FindHelp	• Strategic partnerships with community-based organizations (CBO) to develop referral networks • Connect patients screening at risk for a determinant of health with needed resources through a direct referral

Strategy 3: Work with internal and external stakeholders to address drivers of health through unified policy and planning.

Action	Resources	Collaboration	Anticipated Impact
Advocate for pediatric behavioral health patients in emergency departments who lack appropriate care by engaging HSHS and other Illinois and Wisconsin hospitals to recommended legislative strategies to the appropriate state governing bodies.	• Colleague time	• Community stakeholders • Local and state government	• Identify key recommendations for presentation to Illinois Hospital Association, Wisconsin Hospital Association and other appropriate state governing bodies • Secure a state-elected official to support a recommended strategy as it relates to this topic

Priority Snapshot: Access to Care: Focus on Chronic Conditions

Priority No. 2: Access to Care: Focus on Chronic Conditions

Target Populations
- Adolescents
- Adults
- Focus on un/underinsured individuals

Hospital Resources
- Colleague time
- Funding
- Advocacy
- Virtual platform

Community Partners
- Local health departments
- Food banks and pantries
- Local providers
- Schools
- Local policymakers
- Local hospitals
- Faith-based organizations
- Community leaders
- Community health workers

Anticipated Impact
- Fewer new chronic disease diagnoses
- Fewer deaths from chronic conditions

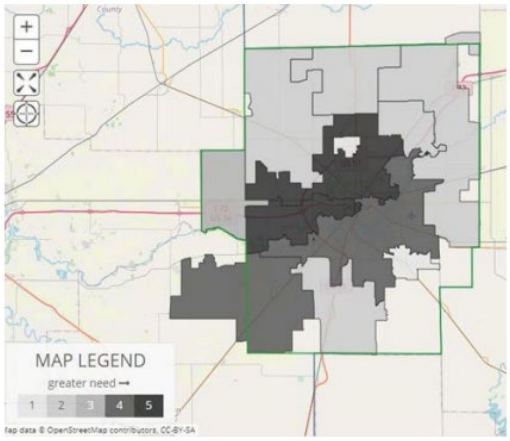
Relevant Measures*
- Proportion of adults with diabetes who receive formal diabetes education.
- Rate of hospital admissions for diabetes among older adults
- Heart failure hospitalizations in adults
- Coronary heart disease deaths
- Stroke deaths

* *From the national health plan: Healthy People 2030*

Current Situation

When addressing access to health needs in Macon County, it is important to note how poverty and safety impact health outcomes overall and in specific areas. For example, the following zip codes represent 46% of Macon County, population 48,305, and have a small footprint in the overall county. These zip codes combined rank highest in the SocioNeeds Index (level 5), all coming in at or above 82 with 100 being the highest need. Zip Code 62523 has a population of 1,382 and scores 100 on the SocioNeeds Index.

ZIP Codes: 62526, 62522 and 62523. Represented by the darkest shade of grey below: The areas representing levels 4 and 5 from the map legend also experience a higher rate of unmanaged chronic conditions such as hypertension, high cholesterol, diabetes, asthma, obesity, unmanaged mental health issues and other conditions that are otherwise manageable with timely access to health care. Current initiatives, such as Health Connect, were established in response to the 2018 CHNA. Health Connect is a partnership with Catholic Charities and places a community health worker and social worker in the ED to connect with frequent utilizers. According to IHA COMPdata, 68% of Macon County patients who presented in the ED had one or more chronic conditions. Repeat visits to the ED for low acuity reasons begs further exploration of access barriers. Since launching Health Connect in 2018, St. Mary's has seen a 33% decrease in ED utilization for low acuity visits among the clients enrolled in the program. Additionally, 85% of clients were established with a primary care physician who they now see for chronic condition management and ongoing care.



Our Strategies

Improve access to prevention and early intervention services.
- Conduct Social Determinants of Health Screenings.
- Coordinate patient navigation with community-based organizations.
- Provide insurance navigation for improved understanding.
- Improve access to fresh, in-season produce.

Decrease barriers to entry.
- Create a social care network within our EMR to connect patients with community-based resources.
- Home health visits for improved physical and socio-emotional development for babies born less than 32-weeks.

Unified policy, planning and advocacy efforts.
- Work with state and local leaders to factor health implications into policy and budget decisions.

Indicators
- Number of patients screened and referred
- Number of patients successfully completing treatment
- Number of link and double your bucks dollars spent at farmers market
- Number of babies graduating Beyond the NICU program at optimal weight

PLANNED ACTIONS – Access to Care: Focus on Chronic Conditions

Leading studies indicate social and environmental factors account for nearly 70% of all health outcomes. The connection between essential needs, such as food, housing and transportation, must be considered when exploring solutions to sustainable health improvement. Improving population and individual health requires health systems, hospitals and providers to adopt comprehensive health equity solutions that address health care holistically – including social determinants of health (SDOH).

In year one of the Community Health Improvement Plan, we will implement a screening and referral tool to better understand the social needs of our patients and improve closed loop referrals. A better understanding of barriers will lead to organizational and community-based solutions to addressing those SDOH. The overall goals of the following investigative and programmatic strategies are to:

- Promote patient, family and community involvement in strategic planning and improvement activities using SDOH screening tools.
- Coordinate health care delivery, public health and community-based activities to promote healthy behavior.
- Form clinical – community linkages to fill gaps in needed services.

Strategy 1: Improve access to prevention and early intervention services.

Action	Resources	Collaboration	Anticipated Impact
Work with providers to determine patient barriers to living a healthy life; i.e. – social determinants of health.	• Colleague time • Provider education	• County health department • County providers • Community members • Physicians, medical staff	• Integrate screening tool into the practice's care management workflow • Connect patients to essential community resources
Work with individuals to improve understanding of insurance benefits, health care resources and accessing timely care.	• Colleague time • Marketing materials • Financial assistance program	• County health department • County providers • Community members • Physicians, medical staff	• Increase the number of insured individuals and families • Improve understanding of benefits and how to access preventive and specialty care for timely health care visits
Work with local farmers markets, food pantries and feeding programs to support access to fresh produce and nutrient dense foods.	• Colleague time • Community health funding	• County health department • Community organizations • Good Samaritan Inn • Crossings Health • Local food pantries • Downtown Farmers Market	• Improve the management of chronic disease/reduce impact severity
Continue funding the Health Connect initiative between HSHS St. Mary's Hospital and Catholic Charities.	• Colleague time • Community health funding • Foundation funding • Grant funding	• HSHS Med Group • Crossings • SIU Community and Family Medicine • Heritage Behavioral Health • Other community organizations	• Increase number of individuals and families with primary care provider • Increase show-rate for Health Connect clients • Decrease number of barriers to health experienced by clients • Increase number of insured clients

Strategy 2: Decrease barriers to entry.

Action	Resources	Collaboration	Anticipated Impact
Create a social care network within our Epic platform to connect patients with community-based resources.	• Internal project management team • Care management team • Colleague time • Monetary	• Community based organizations • FindHelp	• Strategic partnerships with community-based organizations (CBO) to develop referral networks • Connect patients screening at risk for a determinant of health with needed resources through a direct referral
Work with highly skilled NICU nurses from HSHS St. John's Children's Hospital to improve physical and socio/emotional development for babies born less than 32 weeks in the NICU.	• Colleague time • Community health funding • Foundation funding	• SIU Department of Neonatology • HSHS Illinois Home Care • St. John's NICU and Children's Hospital • Social service agencies • St. John's Foundation	• Optimal growth and development at 18 months • Decrease incidence of poor brain development by providing education and opportunity for at-home baby brain development and infant engagement • Increase number of check-up and provider visits post discharge

Strategy 3: Work with internal and external stakeholders to address drivers of health through unified policy and planning.

Action	Resources	Collaboration	Anticipated Impact
Work with state and local leaders to factor health implications into policy and budget decisions.	• Colleague time • HSHS Advocacy	• Community stakeholders • Local and state government	• Reduce the risks and impacts of chronic disease

Priority Snapshot: Disparities in Economy

Priority No. 2: Disparities in Economy

Target Populations
- Adolescents
- Adults

Hospital Resources
- Colleague time
- Funding
- Advocacy

Community Partners
- Local health departments
- Local businesses
- Schools
- Local policymakers
- Local hospitals
- Faith-based organizations
- Trades/Unions
- Higher education

Anticipated Impact
- Clear post HS graduation path for trades, job, higher education or career
- Increase in employable workforce and fewer open positions

Relevant Measures*
- Proportion of adolescents and young adults who are neither enrolled in school or working
- Increase employment in working-age people
- Proportion of people living in poverty

* *From the national health plan: Healthy People 2030*

Current Situation

In Macon County, poverty disproportionately impacts minority populations, children and persons living with a disability. Decatur ranks in the top 10% nationally for severe disparities between white and Black household incomes. According to the 2017-2021 American Community Survey, on average, Black households earn 45 .6% of what white households earn. Forty-one percent of persons living with a disability are living in poverty, and 27% of children live in poverty. The table below shows the disparity between Black, white and Hispanic poverty rates overall and in children.

Race	Macon County Population	Overall Living in Poverty	Children Living in Poverty
White/Caucasian	74.8%	10.9%	16%
Black/African American	18%	33.2%	46%
Hispanic/Latino	2.6%	21.9%	37%

U.S. Census 2015-2019; American Community Survey

Our Strategies

Improve access to prevention and early intervention services.
- Work with existing career organizations to provide supervised internship and workforce training opportunities at the local hospital.
- Big Brothers Big Sisters of Central Illinois Mentor2.0 partnership in local high schools.

Decrease barriers to entry.
- Work with existing career organizations to provide supervised internship and workforce training opportunities at the local hospital.
- Big Brothers Big Sisters of Central Illinois Mentor2.0 partnership in local high schools.

Unified policy, planning and advocacy efforts.
- Work with community leaders and local policymakers to better understand inequities in wealth distribution and solutions for resolution.

Indicators
- Number of students graduating
- Number of internships within SMD departments
- Number of individuals (high school, higher education and unemployed adults) participating in workforce development strategies

PLANNED ACTIONS – Disparities in Economy

Leading economic journals indicate the most important factor in strengthening the region's economy is having an educated and skilled workforce. Workforce development refers to a relatively wide range of activities including policies and programs intended to create, sustain and retain a viable workforce that can support current and future business and industry. Workforce development, including soft skill development, is effective when adopted in schools to help students graduate with an awareness of skillsets needed to advance career goals; in the community to help unemployed individuals become employable; and in businesses to focus on internal colleague growth and development.

In year one of the CHIP, we will work with community partners to evaluate services available internally and within the community to address current and future service gaps and growth needs. Through a multi-sector, collective impact model, we will work with local, regional and state organizations and policy makers to improve the quality of the region's workforce and to further understand the causes of inequities in wealth distribution.

Strategy 1: Improve access to prevention and early intervention services.

Strategy 2: Decrease barriers to entry.

Action	Resources	Collaboration	Anticipated Impact
Work with existing career organizations to provide supervised internship and workforce training opportunities at the local hospital.	• Colleague time • Community health funding	• County schools, including higher education and vocational • Chamber of Commerce • Community members • Other community organizations • Workforce Equity Initiative at Richland Community College • Big Brothers Big Sisters of Central Illinois	• Increase job shadow and learning opportunities for working-age individuals • Increase employment in working-age individuals
Mentor2.O	• Colleague time • Community health funding	• Decatur Public School District High Schools • Big Brothers Big Sisters of Central Illinois	• Improved academic success and graduation rate for participating students • Increase number of students graduating with a career plan • Explore opportunities for HSHS Leader Mentors

Strategy 3: Work with internal and external stakeholders to address drivers of health through unified policy and planning.

Action	Resources	Collaboration	Anticipated Impact
Work with community leaders and local policymakers to better understand inequities in wealth distribution and solutions for resolution	• Colleague time • Community health funding	• Local, state leaders • Other community partners	• Increase knowledge of disparities in household and individual income amongst minority populations • Use knowledge gained to develop an advocacy plan to address wealth gaps on a regional and state level.

Next Steps

This implementation plan outlines intended actions over the next three years. Annually, HSHS community benefits/community health staff shall do the following:

- Review progress on the stated strategies, planned actions and anticipated impacts.
- Report this progress at minimum to hospital administration, the hospital board of directors and community health coalitions.
- Work with these and other stakeholders to update the plan as needed to accommodate emerging needs, priorities and resources.
- Notify community partners of changes to the implementation plan.

Approval

This implementation plan was adopted by the hospital's governing board on September 17, 2024.

HSHS
St. Mary's
Hospital