HSHS
St. Anthony's
Memorial Hospital

Health Needs Assessment

2025-2027 Implementation Plan

HSHS St. Anthony's Memorial 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. Anthony's Memorial Hospital is a fully accredited non-for-profit general acute care health facility. For more than 140 years, the hospital has been the leader in health and wellness in the Effingham community and the south-central region of Illinois. HSHS St. Anthony's has 133 licensed beds and a workforce of over 700 colleagues. The medical staff at St. Anthony's has over 75 active staff members and over 200 consulting physicians representing 39 specialties.

St. Anthony's Memorial 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 mid-sized communities in Illinois and Wisconsin. HSHS generates approximately $2 billion in operating revenue with 13 hospitals and has more than 200 physician practice sites. The Mission is carried out by more than 11,000 colleagues and 1,000 providers in both states who care for patients and their families.

In 2024, St. Anthony's Memorial Hospital conducted a Community Health Needs Assessment (CHNA) in collaboration with the Effingham County Health Department and Jasper County Health Department. This process involved gathering data from multiple sources to assess the needs of Effingham and Jasper counties. 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-anthonys/about-us/community-health-needs-assessment.

The implementation plan builds off the CHNA report by detailing the strategies St. Anthony's Memorial 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 Effingham and Jasper 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. Anthony's Memorial Hospital in collaboration with community partners identified the following health priorities in Effingham and Jasper counties:

1. **Access to mental and behavioral health services**
2. **Chronic conditions including prevention and management, and healthy behavior education**

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:

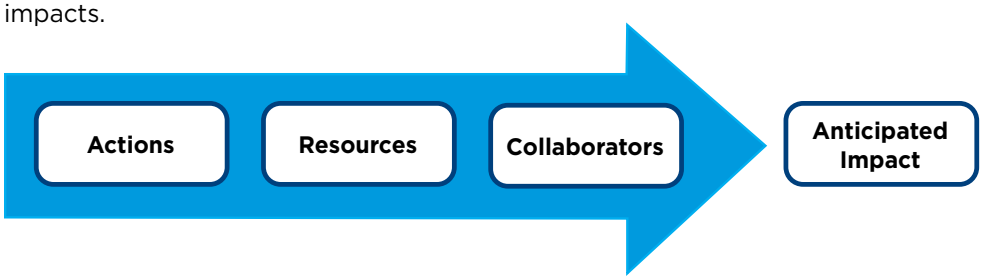
- Access to care: While not a direct priority issue, access to care will be addressed within access to mental and behavioral health services, and chronic disease strategies.
- Affordable housing: While not a direct priority issue, affordable housing challenges and barriers will be explored within the strategic plan of workforce barriers.
- Food insecurity: While not a direct priority issue, food insecurity will be addressed within the strategic plan of chronic conditions.
- Healthy behaviors: While not a direct priority issue, healthy behaviors will be addressed within chronic disease education and prevention strategies.
- Maternal health and infant health: St. Anthony's Memorial Hospital is not focusing on this need as part of the CHNA. However, St. Anthony's has spent years supporting the Crisis Nursery of Effingham County and continues to partner in their efforts for better maternal and infant health.
- Transportation: While not a direct priority issue, transportation challenges and barriers will be explored within the strategic plan of workforce barriers.
- Workforce development: While not a direct priority issue, workforce development challenges and barriers will be explored within the strategic plan of workforce barriers.

Primary Implementation Strategies

In each of the priority health areas identified, St. Anthony's Memorial 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: Mental and Behavioral Health

Priority No. 1: Mental and Behavioral Health

Target Populations
- Adolescents
- Adults

Hospital Resources
- Colleague time
- Grant funding
- Advocacy

Community Partners
- Effingham County Health Department
- Jasper County Health Department
- Behavioral and mental health service providers
- Local providers
- Schools
- Local policymakers
- Local hospitals
- Faith-based organizations
- Trained facilitators

Anticipated Impact
- Increase resiliency.
- Decrease access barriers.
- Increase early assessment and intervention.
- Improve identification and referral to resources.

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.
- Proportion of children and adolescents who get preventive mental health care in school.

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

Current Situation

Individuals living in St. Anthony's Memorial Hospital's service area, which includes Effingham and Jasper counties, face significant barriers to mental and behavioral health care. While it is challenging to fully assess the prevalence of mental illness in this region, some data highlights the extent of the need. In both Effingham and Jasper counties, 14% of adults report experiencing poor mental health for 14 or more days in the last 30 days. Additionally, adults in Effingham County report an average of 3.7 days of poor mental health in the last month, while those in Jasper County report 3.9 days. Binge drinking is also a concern, with 18% of adults in both Effingham and Jasper counties reporting binge drinking, compared to 15% in Illinois overall. Furthermore, in Effingham County, the suicide rate is 17 per 100,000 people, which is notably higher than the state average of 11 per 100,000.

Commonly cited barriers to receiving mental and behavioral health care include a lack of available services, affordability and awareness, along with frequent changes in managed care organization (MCO) plans accepted by health providers, which disrupts continuity of care. These challenges contribute to the prominence of mental and behavioral health as a top community health priority.

* *Sources include National Comorbidity Survey Replication (NCS-R) and the National Survey on Drug Use and Health (NSDUH)*

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.

Improve access to care.
- 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 and Behavioral Health

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 • Reduce the 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
Continue partnership with Crisis Nursery of Effingham County.	• Community health funding	• Community stakeholders	Ensure immediate care for families and children in crisis, directly preventing adverse health outcomes by providing essential support services.
Continue partnership with El Shaddai Maternity Homes	• Community health funding	• Community stakeholders	Provide support and assist in housing for pregnant women to ensure healthy outcomes for both mother and child.

Strategy 2: Decrease barriers to entry.

Action	Resources	Collaboration	Anticipated Impact
Provide hospital emergency department-based screening, recovery coaching, and linkage services.	• Colleague time • Engagement specialist • Recovery coach	• Gateway Foundation • Chestnut Health	• Conduct clinical assessment for patients presenting with SUD.
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 funds	• Community based organizations • FindHelp	• Form 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 recommend 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: Unmanaged Chronic Conditions

Priority No. 2: Access to Care: Unmanaged Chronic Conditions

Target Populations
- Adolescents
- Adults

Hospital Resources
- Colleague time
- Grant funding
- Marketing materials
- Advocacy

Community Partners
- Effingham County Health Department
- Jasper County Health Department
- Local providers
- Schools
- Local policymakers
- Local hospitals
- Faith-based organizations
- Trained facilitators

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

According to the County Health Rankings, both Effingham and Jasper counties face significant health challenges. Unhealthy lifestyle choices, such as obesity and physical inactivity, coupled with limited access to disease awareness, prevention, and management, contribute to poor health outcomes. In both counties, 35% of adults have a body mass index (BMI) of 30 or greater, both slightly higher than the state average of 33% for Illinois. Furthermore, approximately 70% of patients who presented to the Emergency Department in this region had one or more chronic conditions, such as obesity, depression, hypertension or diabetes.

In Effingham County, 34.1% of adults report high blood pressure, 34.2% have high cholesterol, and 10.3% live with diabetes. Similarly, in Jasper County, 36.2% of adults have high blood pressure, 35.8% have high cholesterol, and 10.2% have diabetes. Addressing these chronic conditions through prevention and early intervention remains a key priority for improving health outcomes in St. Anthony's Memorial Hospital's service area.

Condition	Effingham County	Jasper County
Arthritis	28%	30.4%
Asthma	9.6%	9.6%
High blood pressure	34.1%	36.2%
Cancer	7.6%	8.2%
High cholesterol	34.2%	35.8%
Kidney disease	3.1%	3.3%
COPD	7.4%	7.7%
Heart disease	7.1%	7.2%
Diabetes	10.3%	10.2%
Stroke	3.2%	3.9%

* *Sources include Illinois Department of Public Health Community Map, County Health Rankings, and United States Diabetes Surveillance System.*

Our Strategies

Improve access to prevention and early intervention services.
- Conduct Social Determinants of Health screenings.
- Provide insurance navigation for improved understanding.
- Improve access to nutrient dense foods and fresh produce.

Improve access to care.
- Create a social care network within our EMR to connect patients with community-based resources.

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 meetings with local leaders and policy impacts.

PLANNED ACTIONS – Access to Care: Unmanaged 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.
Partner with The Master's Hands Inc. food pantry	• Community health funding	• Community stakeholders	• Provide food and healthy alternatives to those unable to afford groceries.

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 • Community health funding	• Community based organizations • FindHelp	• Form 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.
Continue funding the dental voucher program in partnership with Catholic Charities.	• Community health funding • Colleague time	• Catholic Charities • Community Stakeholders • Local dental providers	• Connect patients to local dental offices to combat chronic or ongoing dental issues. • Decrease the barrier of cost for low-income patients to dental services.

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

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 24, 2024.

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