HSHS St. Francis Hospital

Health Needs Assessment
2025-2027 Implementation Plan

HSHS St. Francis 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.

Table of Contents

Introduction

HSHS St. Francis Hospital is a critical access hospital located in Montgomery County, Illinois. For more than 143 years, the hospital has provided health and wellness services to Macoupin and Montgomery counties. St. Francis Hospital provides a wide range of specialties, including a cancer care center, cardiopulmonary, emergency care, orthopedics, rehabilitation services, family maternity center, surgery center, sleep studies, radiology, laboratory, heart care and wound care.

St. Francis Hospital partners with other area organizations to address the health needs of the community, with a focus on 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. With 13 hospitals, scores of community-based health centers and clinics, over 1,000 providers and more than 11,000 colleagues, HSHS is committed to its mission "to reveal and embody Christ's healing love for all people through our high-quality Franciscan health care ministry."

In 2024, St. Francis Hospital conducted a Community Health Needs Assessment (CHNA) in collaboration with Montgomery and Macoupin County Health Departments. This process involved gathering data from multiple sources to assess the needs of Montgomery and Macoupin 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 hshs.org/st-francis/about-us/community-health-needs-assessment.

The implementation plan builds off the CHNA report by detailing the strategies St. Francis 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 Montgomery and Macoupin Counties 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. Francis Hospital in collaboration with community partners identified the following health priorities in Montgomery and Macon counties:

1. **Access to mental health services**
2. **Access to behavioral health services: substance use disorder**
3. **Accessing available care: unmanaged chronic conditions**

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:

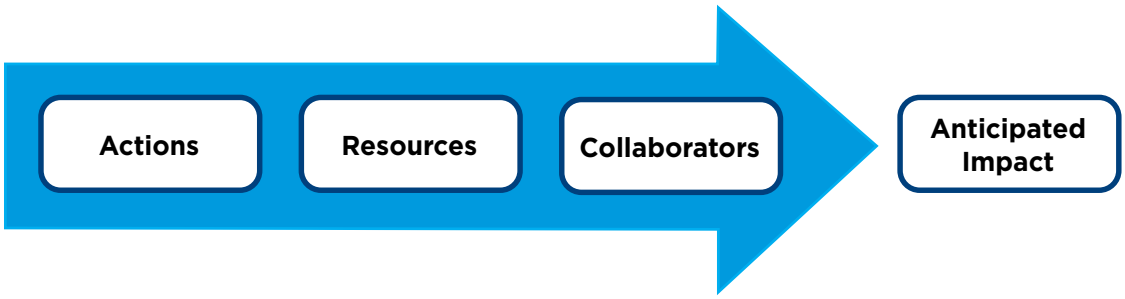
- Affordable housing
- Access to exercise
- Food insecurity
- Poverty
- Transportation
- Homelessness

Primary Implementation Strategies

In each of the priority health areas identified, St. Francis 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
- 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.
- Increase the proportion of children and adolescents who get preventive mental health care in school.

Current Situation

Mental and behavioral health are a challenge for both adults and youth in this service area. Mental health surfaced as a priority for St. Francis Hospital in FY2015, FY2018 and FY2021. It also emerged as a priority for other hospitals in Montgomery and Macoupin counties. Data for adults suggests there are two times as many suicides for Montgomery County and four times as many suicides for Macoupin County than state levels. In addition, there were more opioid overdose deaths among adults in both counties than cocaine and alcohol overdose deaths combined. Part of the reason these issues could have persisted over the years is that there is little access to social workers, psychologists and psychiatrists in this area compared to state averages. Surveys confirmed the challenges of obtaining mental health access in a timely manner and shared the view that when services are available, there is not always a supportive network encouraging treatment.

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 – Access to Mental and Behavioral Health Services, including Substance Use Disorder 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 • Chestnut Health	• 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 • 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

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: Accessing Available Care: Unmanaged Chronic Conditions

Priority No. 2: Accessing Available Care: Unmanaged 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:*

Current Situation

Access barriers are experienced differently across demographics. Issues such as transportation, access to exercise, food insecurity and safe and affordable housing came up throughout the secondary data exploration and the community survey responses. In both counties, 1 in 5 adults report they do not have a regular exercise routine; and only 30% of respondents reported they feel they eat healthy. Montgomery and Macoupin counties have a higher rate of adults who smoke and consume alcohol compared to the state of Illinois. Additionally, both counties have a higher percentage of adults with a body mass index (BMI) that is considered obese. Barriers to accessing preventive and timely care, such as the ones listed above, may exacerbate unhealthy behaviors leading to unmanaged chronic conditions.

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.

Decrease barriers to entry.
- 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 link and double your bucks dollars spent at farmers market
- Number of babies graduating Beyond the NICU program at optimal weight

PLANNED ACTIONS –
Accessing Available 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 healthcare 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

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

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 3, 2024.

HSHS
St. Francis
Hospital