HSHS St. Vincent Hospital

Health Needs Assessment
2025-2027 Implementation Plan

HSHS St. Vincent 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. Vincent Hospital is located in Green Bay, Wis., in Brown County. For more than 130 years (including 64 at its current location), the hospital has served as a leader in health and wellness in Northeast Wisconsin. HSHS St. Vincent Hospital provides a wide range of specialties, including 24-hour Emergency Medicine, Cancer Care, Children's Health, Heart Care, Stroke Center and Women's Health.

HSHS St. Vincent 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, HSHS St. Vincent Hospital conducted a Community Health Needs Assessment (CHNA) in collaboration with sister hospital, HSHS St. Mary's and Beyond Health, a steering committee comprised of leaders from both the public and private sectors in Brown County. Upon completion, the hospital developed a set of implementation strategies and adopted an implementation plan to address priority community health needs. 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-vincent/about-us/community-health-needs-assessment).

The implementation plan builds off the CHNA report by detailing the strategies HSHS St. Vincent 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 Brown 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, HSHS St. Vincent Hospital in collaboration with community partners, identified the following health priorities in Brown County:

- **Health Care Access and Quality**
  - **Specific focus on Chronic Disease and Preventative Care**
- **Social and Community Context**
  - **With specific focus on Mental Health/Youth Mental Health and**
  - **Risk Behaviors; specifically, Substance Use and Overdose Deaths**

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:

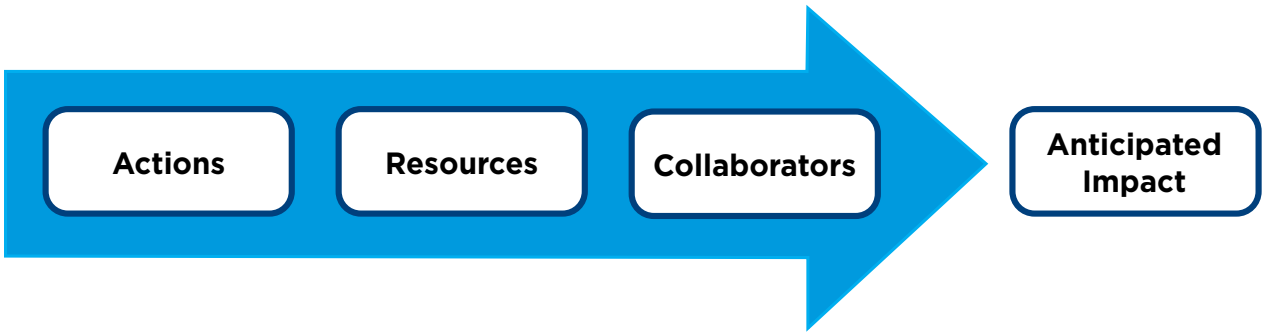
- Education Access and Quality
- Neighborhood and Built Environment

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: Health Care Access and Quality

Priority No. 1: Access to Health Care Services, Prevention and Chronic Disease Management

Target Populations
- Adolescents
- Adults

Hospital Resources
- Colleague time
- Funding
- Advocacy

Community Partners
- Local health departments
- Community partners
- Local hospitals
- Local school districts

Anticipated Impact
- Lower rate of obesity
- Lower percentage of adults with chronic disease diagnosis

Relevant Measures*
- Lower percentage of children and adolescents with obesity
- Lower percentage of adults with obesity

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

Current Situation

In Quarter 4 of 2023, cardiovascular disease, diabetes and obesity were the most commonly diagnosed conditions upon discharge at Aurora Bay Care Medical Center, Bellin Hospital, HSHS St. Mary's Hospital Medical Center and HSHS St. Vincent Hospital, according to hospital claims data.

Chronic Disease	Percentage of adults in Brown County
High cholesterol	36%
High blood pressure	39%
Diabetic	9%
Heart disease	6%

Risk factors are influenced by our environment, not just personal choices.

Risk Factor	Percentage of adults in Brown County
Obesity	36%
Excessive drinking	25%
Physical inactivity	19%
Smoking	17%
Uniinsured	8%

Our Strategies

Improve access to prevention and early intervention services.
- Work with local partners to expand community resource awareness and utilization.
- Work with local community programs to provide prevention services infants and children and their families.
- Implement a social – emotional learning curriculum (Resilient Classroom) in elementary schools.

Decrease barriers to entry,
- Provide affordable access to fresh food.

Work with internal and external stakeholders to address drivers of health through unified policy and planning.
- Work with local health care systems to address care disparities in the community.
- Work with state and local leaders to factor health implications into policy.

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 Health Care Services, Preventative Services and Chronic Disease Management

In Quarter 4 of 2023, cardiovascular disease, diabetes and obesity were the most diagnosed conditions upon discharge at Aurora Bay Care Medical Center, Bellin Hospital, HSHS St. Mary's Hospital Medical Center and HSHS St. Vincent Hospital. The ability to access high-quality health care can be affected by several things, including insurance coverage, physician availability, reliable transportation, health literacy, and cultural and linguistic barriers.

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 policymakers to improve the quality of and access to health care services and further understand the causes of unmet drivers of health.

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

Action	Resources	Collaboration	Anticipated Impact
Work with local partners to expand community resource awareness and utilization.	• Community health funding • Colleague time • Board representation	• NEW Community Clinic • Oral Health Partnership	• Increase access to care for our most vulnerable populations and reduce emergency department usage.
Work with local community programs to provide prevention services infants and children and their families.	• Community health funding • Colleague time	• Welcome Baby Program • Center for Childhood Safety • Prevea Pediatrics	• To provide basic needs to families expecting a baby or after a recent birth. • To reach parents and children before an injury can cause deformity, disability (temporary or permanent), or death and keeping them out of the hospital.
Implement a social – emotional learning curriculum (Resilient Classroom) in elementary schools.	• Community health funding • 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
Provide affordable access to fresh food.	• Community health funding • Colleague time	• Wello • Double your Bucks and Farm to School programs	• Increase access to fresh foods in schools and the underserved community.
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
Work with local health care systems to address care disparities in the community.	• Colleague time	• Beyond Health • Emplify Health • Aurora Health • NEW Community Clinic	• Identify care gaps and work to provide system/county/state level approach to solutions.
Work with state and local leaders to factor health implications into policy.	• Colleague time • HSHS Advocacy	• Community stakeholders • Local and state government	• Reduce the risks and impacts of chronic disease.

Priority Snapshot: Social and Community Context

Priority No. 2: Mental Health/Youth Mental Health and Substance Use and Overdose Deaths

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
- AODA service providers
- Local recovery resources

Anticipated Impact
- Expanded treatment services
- Expanded care coordination
- Reduced substance use and misuse

Relevant Measures*
- Proportion of adolescents who used drugs in the past month
- Proportion of people who get a referral for substance use treatment after an emergency department visit
- Percentage of people with a substance use disorder who get treatment
- Drug overdose deaths per 100,000 population

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

Current Situation

Substance Use Disorder
Alcohol and drug use in Brown County has consistently risen above national levels. Access to care has been limited due to legislative changes to qualified providers and limited reimbursement for care. As the need continues to rise in our community, Brown County is considered a high-risk county for substance use in our state, specifically illicit drug use. Data supporting this concern include:

Percent of adults that report excessive drinking:
- Brown County – 25%, United States – 18%

Percentage of motor vehicle crash deaths that involved alcohol:
- Brown County – 36%, United States – 26%

Overdose Deaths
The rise of overdose deaths in recent years is largely a result of synthetic opioids.

Brown County Overdose Deaths:
- (2018-2020) 124 deaths/ 55 involved fentanyl
- (2021- 2023) 194 deaths/ 138 involved fentanyl

Youth Risk Behaviors:
Risk behaviors in grades 9-12 reported in the 30 days prior to survey:
- 11% report vaping
- 21% report using alcohol
- 9% report using pain killers
- 19% report using marijuana

Our Strategies

Improve access to prevention and early intervention services.
- Work with schools, community colleges and colleges to develop or scale-up pipeline programs.
- Work with HSHS Libertas to expand treatment services and provide referral pathway to system providers.
- Coordinate bi-annual Medication Take Back Days in the community.

Decrease barriers to entry.
- Implement Health Navigator Training.
- Coordinate a social care network within Epic.

Work with internal and external stakeholders to address drivers of health through unified policy and planning.
- Work with Community partners to develop a “No Wrong Door” approach to recovery.

Indicators
- Increased number of pounds of medication collected annually
- Increase i number of referrals for assessment and treatment
- Decreased reported substance use in YRBS survey
- Decrease in number of OD deaths
- Decrease in number of automobile accidents involving alcohol

PLANNED ACTIONS – Mental Health/Youth Mental Health and Substance Use and Overdose Deaths

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 policymakers to improve access to prevention, treatment, and recovery strategies.

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

Action	Resources	Collaboration	Anticipated Impact
Work with HSHS and Libertas Treatment Centers to provide substance use disorder treatment, with a special emphasis on adolescent services.	• Colleague time • Engaged leaders • Grant funding • Marketing materials	• Beyond Health • Brown County Public Health • Prevea Health • Emplify Health • NEW Community Clinic	• Reduce the number of alcohol related deaths. • Reduce the number of overdose deaths. • Improve access to adolescent treatment.
Coordinate regular Medication Take Back days to remove unused prescriptions from the community.	• Colleague time • Local law enforcement • Marketing materials	• Brown County Law Enforcement • Emplify Health • Aurora Hospital • NEW Community Clinic	• Remove unused prescription drugs from the community.
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

Strategy 2: Decrease barriers to entry.

Action	Resources	Collaboration	Anticipated Impact
Implement Health Navigator Training Program for addiction prevention and treatment services.	• Colleague time • Marketing • Community health funding	• Mental Health America • University of Wisconsin-Green Bay • Beyond Health • Public Health • Other health systems	• Increase access to addiction prevention and treatment services for all people including for underserved populations due to language, economic or cultural barriers.
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 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 community partners to identify barriers to care and implement "No Wrong Door" approach to treatment.	• Colleague time	• Beyond Health • Emplify Health • NEW Community Clinic • Recovery Community Organizations • Department of Justice (jail, prison)	• Build a recovery friendly region where people are encouraged and supported to seek recovery and services. • Establish a pathway for justice involved patients to receive treatment upon release.
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 substance use disorder.

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 18, 2024.


HSHS
St. Vincent
Hospital