HSHS
St. Francis
Hospital

Health Needs Assessment

2018 Implementation Plan

HSHS St. Francis Hospital is an affiliate of Hospital Sisters Health System, a multi-institutional health care system comprised of 14 hospitals and an integrated physician network serving communities throughout Illinois and Wisconsin.

Table of Contents

Introduction 4
Prioritized Significant Health Needs 4
Health Needs That Will Not Be Addressed 4
Implementation Plan. 5
Substance Abuse and Mental Health. 5
Diabetes/Obesity. 7
Next Steps. 10
Approval 10

Introduction

HSHS St. Francis Hospital is a critical-access hospital located in Montgomery County, Illinois. For more than 143 years, the hospital has been the leader in health and wellness in Macoupin and Montgomery counties. St. Francis Hospital (SFL) provides a wide range of specialties, including cancer care center, cardiopulmonary, emergency care, orthopedics, AthletiCare, rehabilitation services, woman and infant centers, surgery center, sleep studies, radiology, laboratory, heart care and mind-body health services.

SFL 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 our 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 15 hospitals and more than 200 physician practice sites. Our mission is carried out by 14,000 colleagues and 2,100 physicians in both states who care for patients and their families.

SFL conducted a community health needs assessment in 2018. Primary and secondary data was gathered from multiple sources to assess the needs of Macoupin and Montgomery Counties. This data was presented to external and internal committees who together recommended the health priorities to be addressed in the FY2019 through FY2021 implementation plan.

Prioritized Significant Health Needs

The following priorities were selected based on the data presented and the prioritization process:

- **Substance Abuse**
- **Mental Health**
- **Diabetes/Obesity**

Health Needs That Will Not Be Addressed

In addition to the three health needs selected as top priorities, community members identified five other significant health needs in Macoupin and Montgomery Counties. These issues will be addressed by other organizations in the community. While the hospital is not taking the lead on the health focus areas below, it will support community efforts whenever possible.

Access to care – The community identified access to care, specifically a lack of mental health professionals. Data showed the number of mental health providers in both counties is significantly lower compared to the state of Illinois. While SFL did not select access to care as a broader topic, mental health was identified as a FY2019 – FY2021 CHNA priority area.

Cancer – The community identified cancer in the FY2015 community health needs assessment as a top need. The hospital will continue to address this need through our new cancer care center that opened in January 2017. The hospital will also continue to support the Montgomery County Cancer Association (MCAA) who has taken a lead role in addressing community needs related to cancer education, prevention and access.

Child Maltreatment – This issue was identified within the community. The hospital believes this is related to both mental health and substance abuse issues and can be addressed through the strategic implementation plan initiatives. United Childhood Advocacy Network, which serves both counties, whom the hospital has worked with and will continue to work with, will address the community needs related to child maltreatment.

Education – The external and internal advisory committee members felt education could be wrapped into each of the final priority areas as a way to raise awareness, educate and see positive change occur. Therefore, education was not selected as a standalone but will be included in strategies developed to meet identified needs.

Nutrition and Exercise – The hospital will address nutrition and exercise under the diabetes and obesity strategic implementation plan initiatives.

Implementation Plan

SFL's implementation plan is part of a broad community effort to address three priority health needs in the community. The hospital works with a broad range of direct service organizations, coalitions and government agencies to address these needs.

The 2018 Implementation Plan outlines the actions the hospital will take to address Macoupin and Montgomery Counties' health needs. However, as noted below, many strategies will be implemented collaboratively. Recognizing that no one organization affects substantial community change alone, the long-term outcomes identified in this implementation plan will be achieved as many community organizations work together for collective impact.

Substance Abuse and Mental Health

Goal: In partnership with health care organizations in Montgomery county SFL will work on developing multi-agency coordination for complex patients with high substance abuse and mental health utilization rates in Montgomery and Macoupin county hospitals. The goal is to identify the appropriate approach to connect super utilizers with the services necessary to break addictive behaviors and/or manage health conditions. SFL will work with area agencies to find safe and reliable transportation for substance abuse patients and provide education around trauma-informed care.

Long Term Performance Indicators:
- By June 30, 2021 fully deploy a coordinated delivery of care between health care agencies in Montgomery and Macoupin Counties. This includes transitions of care from the emergency department (ED) to appropriate care settings.
  - One measure of success will be a decrease in the number of ED readmissions for patients dealing with behavioral and substance misuse health issues.

Strategy 1: Coordinated Care Delivery

In FY2019 the hospital will develop a shared community worker model for Montgomery County hospitals including SFL and Hillsboro Area Hospital.

Mid-term Performance Indicators:
By June 30, 2019 deploy a collective impact model to identify, intervene and coordinate care around complex mental and behavioral health patients.

Community Resources/Partners:
- Hillsboro Area Hospital
- Montgomery County Health Department
- Macoupin County Health Department
- Maple Street Clinic
- Locust Street Clinic

Hospital Resources:
- Colleague time
- Marketing colleague time, materials and advertising costs

Supporting Information:
- Target population: residents of Macoupin and Montgomery counties.
- Evidence base: The Enos Park Access to Care Collaborative in Springfield, IL has shown a decrease in ED visits among super users living in the community, as well as an increase in community members with health insurance and established primary care physicians through the development of a collective impact model.

Strategy 2: Reliable transportation for substance abuse patients to treatment facilities

Macoupin-Montgomery Addiction and Behavioral Health Coalition is a newly developed regional coalition working with local law enforcement to find safe and reliable transportation for substance abuse patients to treatment facilities.

Mid-term Performance Indicators:
- By June 30, 2020 a contract will be in place between Safe Passage Initiative and the county sheriff offices that will provide transportation for community members in need of detox facilities.

Community Resources/Partners:
- Montgomery County Sheriff's Office
- Macoupin County Sheriff's Office
- Standing Against Addiction and Drugs
- Montgomery County Health Department
- Macoupin County Health Department
- Locust Street Clinic

Hospital Resources:
- Colleague time (coalition meetings, services provided)

Supporting Information:
- Target population: residents in Macoupin and Montgomery counties with substance abuse issues.
- Evidence base: Gloucester Police Department in Massachusetts developed the Angel Program in June 2015. The police-based placement program for direct referral for drug detoxification placed 95.4% of individuals that presented for assistance and were eligible. This program has been adopted by 153 police departments in 28 states.

Strategy 3: Trauma Informed Communities

Provide awareness and education opportunities to develop trauma-informed communities. A trauma-informed approach helps the stakeholder realize the widespread impact of trauma and understand potential paths for recovery. This done by: 1. Recognizing the signs and symptoms of trauma in individuals, 2. Understanding the appropriate steps to engage providers in intervention, 3. Fully integrating knowledge about trauma into policies, procedures and practices, and 4. Actively resisting re-traumatization.

Mid-term Performance Indicators:
By June 30, 2019 offer four cross-sector trauma-informed care education and training in both Macoupin and Montgomery counties.
- Education
- Government
- Health care
- Law enforcement

Community Resources/Partners:
- Montgomery County Health Department
- Macoupin County Health Department
- Department of Children and Family Services
- Litchfield School District
- Macoupin-Montgomery Addiction and Behavioral Health Coalition
- Prevent Child Abuse Illinois
- United Childhood Advocacy Network

Hospital Resources:
- Colleague time
- Hospital space
- Continuing education units
- Printing and distribution costs

Supporting Information:
- Target population: broader community.
- Evidence base: Substance Abuse and Mental Health Service Administration indicates TIC education helps create an awareness of trauma as it relates to health outcomes. A trauma-informed community can better recognize the signs of trauma and understand the appropriate steps for intervention and recovery.
- Evidence base: Early screenings in the emergency department for substance use patients have shown a decrease in substance use following a single brief intervention. It is also effective in individuals with low to moderate screening scores to allow insight into their problem before there are negative consenquences (International Journal of Mental Health and Addiction).

Diabetes and Obesity

Goal: To offer comprehensive, place-based approach to community health improvements through education, nutrition and exercise by focusing on a community garden, diabetes education, summer feeding programs and our current GO217 initiative.

Long-term Performance Indicators:
- By June 30, 2021, have an active community garden producing sustainable crops for the local food pantry and physician use to prescribe fresh produce as an alternative treatment for diabetic and obese patients.
- By June 30, 2021 partner with Litchfield Family Practice providers who will refer all pre-diabetic and diabetic patients to the diabetes-self management class.

Strategy 1: Community Garden

A community garden will create local, sustainable food sources and a safe space for community interaction and fun across all ages, cultures and incomes.

Mid-term Performance Indicators:
By June 20, 2020, the community garden will have a 80% success rate on crops and average around five pounds of produce per square foot (this will vary on a yearly basis due to weather) to be donated to the food pantry.

Community Resources/Partners:
- University of Illinois Extension Office
- St. Clare Food Pantry
- Litchfield Family Practice

Hospital Resources:
- Colleague time
- Volunteer time
- Land
- Monetary support of garden supplies and labor

Supporting Information:
- Target population: Individuals living with diabetes and those utilizing the food pantry.
- Evidence base: Gardens offer physical and mental health benefits by providing opportunities to eat healthy fresh fruits and vegetables, engage in physical activity, skill building, and creating green space, beautify vacant lots, revitalize communities in industrial areas, revive and beautify public parks, create green rooftops and decrease violence in some neighborhoods, and improve social well-being through strengthening social connections (Centers for Disease Control and Prevention, [CDC]).

Strategy 2: Diabetes Self-Management Classes

Provide a free six-week course to community members living with pre-diabetes, diabetes or caring for someone with diabetes to help develop and understand the concept of self-efficacy and strategies to enhance self-efficacy.

Mid-term Performance Indicators:
By June 30, 2020, offer free diabetes self-management classes using material from Stanford University on a quarterly basis through a referral system in place with Litchfield Family Practice and other local health care organizations.

Community Resources/Partners:
- Litchfield Family Practice
- Macoupin County Health Department
- Montgomery County Health Department
- Maple Street Clinic

Hospital Resources:
- Colleague time
- Volunteer time
- Materials for class

Supporting Information:
- Target population: Individuals who are pre-diabetic, recently diagnosed with diabetes and those living with Type II diabetes.
- Evidence base: Stanford University curriculum objectives support informed decision making, self-care behaviors, problem solving and active collaboration in health care to improve clinical outcomes, health status and quality of life (CDC).

Strategy 3: Summer Feeding Program

Provide a free, fresh, warm meal five days a week to local youth in Litchfield over the summer to ensure all children have an opportunity to eat.

Mid Term Performance Indicators:
By June 30, 2020, offer five days of nutritional education or activity along with the free lunch program.

Community Resources/Partners:
- Litchfield School District
- Ministerial Alliance
- First Baptist Church of Litchfield

Hospital Resources:
- Colleague time

Supporting Information:
- Target population: Litchfield youth ages birth-18 years.
- Evidence base: 60% of children in Litchfield qualify for free and reduced lunch in 2018. The summer feeding program fills the gap to ensure all children have access to one hot meal five days a week through the summer.

Strategy 4: GO!217

Provide free exercise classes twice a month to community members.

Mid-term Performance Indicators:
- By June 30, 2020 incorporate a nutritional component to the exercise program where the hospital dietitian provides education and food demonstrations once a month.

Community Resources/Partners:
- Fit-to-Go
- Snap Fitness
- Litchfield Family Practice
- Litchfield Park District

Hospital Resources:
- Marketing material
- Hospital Dietitian
- Colleague time

Supporting Information:
- Target population: broader community.
- Evidence base: Regular physical activity helps improve your overall health and fitness and reduces your risk for many chronic diseases (CDC).

Next Steps

The implementation plan outlines a three-year community health improvement process. Annually, the hospital will:

- Review the implementation plan and update strategies for the following fiscal year.
- Set and track annual performance indicators for each implementation strategy.
- Track progress toward mid-term performance indicators.
- Report progress toward the performance indicators to the hospital board, senior leadership team, HSHS Central Illinois Division and HSHS leaders.
- Share actions taken and outcomes achieved to address priority health needs with the community at large.

Approval

The implementation plan was adopted by the hospital's board on July 10, 2018.


HSHS
St. Francis
Hospital