



Health Needs Assessment 2021 Implementation Plan

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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, woman and infant's center, surgery center, sleep studies, radiology, laboratory, heart care and mind-body health services. It 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 15 hospitals, scores of community-based health centers and clinics, nearly 2,300 physician partners and more than 13,000 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.” St. Francis Hospital has a rich and long tradition of addressing the health needs of the communities it serves. This flows directly from its Catholic identity. In addition to community health improvement services guided by the triennial CHNA process, the hospital contributes to other needs through its broader community benefit program. This includes health professions education, subsidized health services, research and community building activities. In FY2020, the hospital’s community benefit contributions totaled \$6,851,178.

In 2020-2021, St. Francis Hospital conducted a Community Health Needs Assessment (CHNA) in collaboration with SIU Office of Population Science and Policy, Hillsboro Area Hospital and Carlinville Area Hospital & Clinics. 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 a through a community survey. Together, these groups recommended the health priorities to be addressed in 2022—2024. The full CHNA Report may be found at https://www.hshs.org/HSHSFamily/media/St.Francis/About%20us/CHNA-Report-FINAL_SFL.pdf.

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 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. Francis Hospital in collaboration with community partners identified the following health priorities in Montgomery and Macoupin Counties:

- 1. Access to mental and behavioral health services**
- 2. Food insecurity**
- 3. Workforce development**

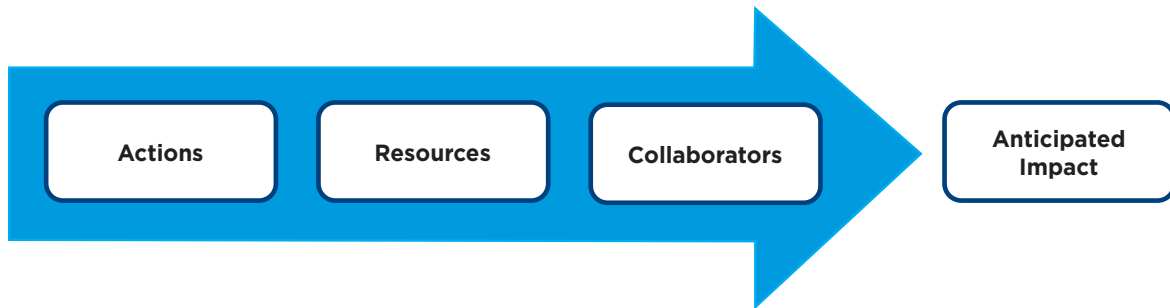
These priorities emerged from several data sources, including community focus groups, individual and stakeholder interviews, local and national health data comparisons and input from the CAC and internal advisory council.

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 described below.

Strategy	Description
Increase access to prevention and early intervention services Increase access to care	This strategy involves taking actions that prevent disease or injury or limit their progression and impact.
Increase access to care	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.
Address other social determinants of health	This strategy involves addressing other conditions and environmental factors that impact health, functioning and quality-of-life outcomes in the community.
Engage in unified planning and policy	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
- Marketing materials
- Advocacy
- Virtual platform

Community Partners

- County health departments
- Behavioral and mental health service providers
- Local providers
- Schools
- Local, regional and state government
- 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.

* From the national health plan: Healthy People 2030

Current Situation

Mental and Behavioral Health consistently arose as the most prominent community health priority in all nine HSHS Illinois Division ministries. Reasons commonly cited for the problem included lack of available services; lack of affordability and/or awareness of services available; lack of understanding of mental health conditions and knowledge of when to seek help; and the frequency with which health systems and providers change which MCO plans they accept, thereby disrupting continuity of care. *Community survey and HRSA data supporting this concern include:*

- Unable to afford treatment (57.4%)
- Lack of mental or behavioral health professionals (50.7%)
- Social stigma (48.4%)
- Montgomery and Macoupin Counties are classified in a Health Professional Shortage Area for mental health providers (<https://data.hrsa.gov/tools/shortage-area/hpsa-find>).

Our Strategies

Improve access to prevention and early intervention services

- Train and partner with the local health department to provide mental and behavioral health first aid and trauma/resiliency training to school staff, students and the general public.
- Partner with the Recovery Oriented Systems of Care teams.

Improve access to care

- Work with rural school districts to improve access to school-based tele-mental health services, and other school-based mental health resources.
- Work with Gateway Foundation and the Illinois Telehealth Network to ensure access to screening, treatment plan development and treatment referral for patients presenting with substance use disorder.

Unified planning and policy, and advocacy efforts

- Through collective impact, work with local, regional and state organizations and legislatures to develop an advocacy plan to support telehealth services, reimbursement and equitable access to mental and behavioral health services.

Indicators

- Number of instructors trained, trainings provided, individuals trained.
- County-wide strategic plan identifying gaps in service, barriers to service and a collective impact model to address behavioral health prevention; screening and identification; and prevention, treatment and recovery.
- Number of residents successfully entering and completing treatment.
- Number of school district partnerships.
- Number of patients screened and referred.
- Number of patients successfully completing treatment.

PLANNED ACTIONS – Mental and Behavioral Health

The system of behavioral health care is fundamentally broken. People in crisis have little option other than to access services through hospital emergency room departments, which are the least conducive environments for 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 further investigate best practices and local resources to addressing mental and behavioral health gaps. Through a multi-sector, collective impact model, we will work with local, regional and state organizations and legislatures to develop an advocacy plan to support telehealth services, reimbursement and equitable access to mental and behavioral health services.

While working on long-term planning and solutions, we will deploy the following strategies for prevention, early identification, access and referral in youth and adult populations in years one through three.

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

Action	Resources	Collaboration	Anticipated Impact
Work with schools and other community partners to determine appropriate prevention, education and training for student and adult populations. Including but not limited to: - <i>Question, Persuade, Refer (QPR) suicide prevention training.</i> - <i>Mental Health and Youth Mental Health First Aid</i>	<ul style="list-style-type: none"> • Colleague time • Technology (virtual trainings) • Marketing materials • Community health funding 	<ul style="list-style-type: none"> • County schools • County health departments • County health boards • Community members • Ministerial alliance • SIU Population Science and Policy 	<ul style="list-style-type: none"> • Increase resiliency in student and adult populations. • Reduce suicide and nonfatal intentional self-harm injury rates in the county. • Increase early assessment, detection and intervention.
Work with Prevent Child Abuse Illinois to provide training on Adverse Childhood Experiences and Resiliency (ACE/R) to school staff and other organizations.	<ul style="list-style-type: none"> • Colleague time • Community health funding 	<ul style="list-style-type: none"> • County schools • Prevent Child Abuse Illinois • Other interested community organizations 	<ul style="list-style-type: none"> • Increase resiliency in student populations. • Reduce suicide attempts and nonfatal intentional self-harm by students.
Work with community partners and providers to ensure early identification of pregnant and postpartum moms with behavioral health needs.	<ul style="list-style-type: none"> • Colleague time • Community health funding • Grant funding 	<ul style="list-style-type: none"> • HSHS Med Group • Local providers • Faith-based organizations • County schools • St. Francis Way Clinic 	<ul style="list-style-type: none"> • Increase number of pregnant mothers receiving prenatal care. • Increase early assessment, detection and intervention.
Partner with the County Recovery Oriented Systems of Care team.	<ul style="list-style-type: none"> • Colleague time 	<ul style="list-style-type: none"> • Community stakeholders 	<ul style="list-style-type: none"> • Develop public policy and practice that can support recovery in crucial ways. • Reduction in stigma associated with those struggling with SUDs. • Coordinate a wide spectrum of services to prevent, intervene in and treat substance use problems and disorders.

Strategy II: Improve access to care.

Action	Resources	Collaboration	Anticipated Impact
Work with Illinois division ministries and the Illinois Telehealth Network to secure behavioral telehealth, telepsych and crisis screening in the emergency department.	<ul style="list-style-type: none"> • Colleague time • Technology • System grant writing • Community health and grant funding 	<ul style="list-style-type: none"> • Illinois Telehealth Network • Provider groups • HSHS Illinois division ministries • Non-HSHS hospitals • County health departments • Gateway Foundation • Recovery-Oriented Systems of Care • Locust Street Clinic • St. Francis Way 	<ul style="list-style-type: none"> • Reduce unnecessary transfers. • Ensure high-quality and timely care is provided for patients in crisis. • Decrease length of stay and eliminate psychiatric boarding in ED. • Implement preferred treatment plan for the patient in distress that offers services focused on resolving mental health and substance use crisis.
Continue pilot program with HSHS Good Shepherd Hospital to provide school-based mental health services. Explore opportunities to expand services to other markets.	<ul style="list-style-type: none"> • Colleague time • Health Resources and Services Administration (HRSA) and other funding • Marketing materials • Illinois Telehealth Network resources • Substance abuse and mental health services 	<ul style="list-style-type: none"> • County schools • Local ministries • HSHS Medical Group • Illinois Telehealth Network • County health departments- 	<ul style="list-style-type: none"> • Promote youth resilience and recovery, thereby reducing incidents of harm to self and others and increasing academic success and social cohesion. • Increase early assessment and intervention. • Improve identification and referral to resources.
Streamline behavioral health service access for pregnant and postpartum moms.	<ul style="list-style-type: none"> • Colleague time • Community health funding • Grant funding 	<ul style="list-style-type: none"> • Illinois Telehealth Network • Provider groups • HSHS Illinois division ministries • Non-HSHS Hospitals • County health departments • Gateway Foundation • Recovery-Oriented Systems of Care • St. Francis Way 	<ul style="list-style-type: none"> • Ensure prompt access to care to promote mom's resilience and recovery and prevent mental health impact on baby.

Strategy III: Work with community partners to address other social determinants of health.

Action	Resources	Collaboration	Anticipated Impact
Through a partnership with Safe Families Illinois, provide support for children and families in crisis including financial crisis, unemployment, homelessness, health crisis and/or illness, incarceration, parental drug and/or alcohol use, social isolation, chronic stress, etc.	<ul style="list-style-type: none"> • Colleague time • Community health funding • Community volunteers • Faith-based organizations 	<ul style="list-style-type: none"> • Safe Families Illinois • Department of Children and Family Services • Local churches • Community members • County schools 	<ul style="list-style-type: none"> • Make timely connection between families and support services during times of crisis. • Keep ongoing connection between families and coaches to prevent crises and provide continuing support.

Priority Snapshot: Food Insecurity

Priority No. 2: Food Insecurity

Target Populations

- Adolescents
- Adults
- Focus on low-income individuals and families

Hospital Resources

- Colleague time
- Funding
- Marketing materials
- Advocacy

Community Partners

- County health departments
- Food banks and pantries
- Local providers
- Schools
- Local policymakers
- Faith-based organizations
- Trained facilitators

Anticipated Impact

- Increase number of students receiving summer lunches.
- Increase access to food sources including hours of operation, transportation, cost.

Relevant Measures*

- Proportion of eligible students participating in summer feeding programs.
- Rate of very low food insecurity in children.
- Rate of household food insecurity and hunger.

* From the national health plan: Healthy People 2030

Current Situation

Food insecurity often arose during discussions in relation to obesity, disease management, academic success, healthy nutrition, physical activity and mental health. Reasons commonly cited for the problem included access barriers to transportation, food pantries during operating hours, lack of livable wage to purchase foods, access to in-season produce. *Data supporting this concern include:*

Food Insecurity	Montgomery County	Macoupin County
Children	20.2%	17.1%
Overall	12.1%	10.9%

* Sources include Feeding America, community survey and focus groups

Our Strategies

Improve access to prevention and early intervention services

- Work with providers to determine patient barriers to living a healthy life; i.e. – social determinants of health.
- Work with community partners to provide community education including healthy cooking on a budget, meal planning, etc.
- Work with schools to supplement health and nutrition education curriculum.
- Work with individuals to improve understanding of resources and access.

Improve access to care

- Evaluate access barriers and work to identify solutions to achieve equitable access to care.
- Work with local farmers markets, food pantries and feeding programs to support access to fresh produce and nutrient dense foods.

Unified planning and policy, and advocacy efforts

- Work with state and local leaders to factor health implications into policy and budget decisions.

Indicators

- Number of community-based education sessions and referrals.
- Number of families receiving nutrient dense foods through hospital-supported food pantries, farmers markets and other food access initiatives.
- Number of individuals receiving SDOH screenings and appropriate referral resources.
- Number of meetings with local leaders, policy impacts.

PLANNED ACTIONS – Food Insecurity

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 CHIP, we will investigate the use of screening tools to improve health care through a better understanding of SDOH in communities and the social needs of patients. A better understanding of barriers will lead to organizational and community-based solutions to 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 partnerships and relationships among clinical, community and public health organizations 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.	<ul style="list-style-type: none"> • Colleague time • Provider education • Financial assistance policy updates 	<ul style="list-style-type: none"> • County health department • County providers • Community members • Physicians, medical staff 	<ul style="list-style-type: none"> • Screening tool integrated into the practice’s care management workflow. • Connect patients to essential community resources.
Work with community partners to provide health education, screenings and referrals to care.	<ul style="list-style-type: none"> • Colleague time • Marketing materials 	<ul style="list-style-type: none"> • County health department • County providers • Community members • Physicians, medical staff 	<ul style="list-style-type: none"> • Reduce the prevalence and impacts of poor nutrition due to food insecurity. • Increase early assessment and intervention.
<p>Work with individuals to improve understanding of resources and access opportunities.</p> <p>Work with service organizations to increase understanding of key barriers clients experience when accessing food.</p>	<ul style="list-style-type: none"> • Colleague time • Marketing materials 	<ul style="list-style-type: none"> • County health department • County providers • Community members • Physicians, medical staff 	<ul style="list-style-type: none"> • Improve identification and referral to resources. • Increase hours of operation in local food pantries. • Improved understanding of resources, access barriers and access improvements.

Strategy II: Improve access to care.

Action	Resources	Collaboration	Anticipated Impact
Evaluate access barriers and work to identify solutions to achieve equitable access to care.	<ul style="list-style-type: none"> • Colleague time • Marketing materials • SDOH screening tool 	<ul style="list-style-type: none"> • County health department • County providers • Community members • Physicians, medical staff 	<ul style="list-style-type: none"> • Enhanced understanding of patient's health barriers. • Improved compliance of treatment plans. • Coordinate health care delivery, public health and community-based activities to promote healthy behavior
Work with local farmers markets, food pantries and feeding programs to support access to fresh produce and nutrient dense foods.	<ul style="list-style-type: none"> • Colleague time • Community health funding 	<ul style="list-style-type: none"> • County health department • Community organizations • Central Illinois Food Bank • Local food pantries • County schools 	<ul style="list-style-type: none"> • Improve access to sustainable nutrition. • Decrease impact of poor nutrition on chronic disease.
Work with community partners to expand opportunities for nutrition education including health cooking, menu and meal planning and eating on a budget.	<ul style="list-style-type: none"> • Colleague time • Technology • System grant writing • Community health and grant funding 	<ul style="list-style-type: none"> • County schools • Provider groups • County health departments • Food pantries • Local farmers • Other community partners 	<ul style="list-style-type: none"> • Improve knowledge and application of menu planning. • Frequently reinforce and promote positive lifestyle changes through education. • Improve accessibility to nutrient-dense food by overcoming access barriers such as time, transportation, cost, etc.

Strategy III: Work with internal and external stakeholders to engage in unified planning and policy.

Action	Resources	Collaboration	Anticipated Impact
Work with state and local leaders to factor health implications into policy and budget decisions.	<ul style="list-style-type: none"> • Colleague time 	<ul style="list-style-type: none"> • Local, state leaders • Other community partners 	<ul style="list-style-type: none"> • Reduce the risks and impacts food insecurity.

Priority Snapshot: Workforce Development

Priority No. 3: Workforce Development

Target Populations

- Adolescents
- Adults
- Businesses

Hospital Resources

- Colleague time
- Funding
- Marketing materials
- Advocacy
- Virtual platform

Community Partners

- County health departments
- Local businesses
- Local chambers
- Schools
- Local policymakers
- Faith-based organizations
- Trades/union
- 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

Workforce development often arose during discussions in relation to disparities in economy, poverty, unemployment and job availability vs skilled employee availability. Reasons commonly cited for key gaps in the current workforce include lack of training opportunities, lack of knowledge of training opportunities, lack of or affordability of childcare, lack of affordable and safe housing. *Data supporting this concern include:*

	Montgomery Co.	Macoupin Co.	Illinois
Poverty	16%	1.5%	11.5%
- Children	28.4%	21.4%	17.1
Unemployment	5.8%		7.1%
Did not graduate high school	12.3%	8.7%	12.58%
Burdened renters	33.5%	35.4	47.7%

* Sources include U.S. Census Bureau, 2021; Illinois Public Community Map, 2020; Town Charts, 2019.

Our Strategies

Integrated programs, long-term goals with workers at the center.

- Work with schools, community colleges and colleges to develop or scale-up pipeline programs.
- Work with existing career organizations to provide supervised internship and workforce training opportunities at the local ministry.
- Explore partnerships and opportunities to support local childcare development groups.

Develop workforce plan and training programs.

- Evaluate current initiatives and resources to better understand gaps.
- Engage community partners and resident participants.
- Focus on specialized training modules based on local workforce needs.
- Provide hands-on learning experiences and soft-skill development.

Unified planning and policy, and advocacy efforts

- Work with state and local leaders to factor health implications into policy and budget decisions impacting barriers to employment.

Indicators

- Number of students graduating post-high school planning strategies.
- Number of businesses participating in workforce strategies.
- Number of individuals (high school, higher education and unemployed adults) participating in workforce development strategies.
- Number of meetings with local leaders and policy impacts.

PLANNED ACTIONS – Workforce Development

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 by working toward the following strategies.

Strategy I: Integrated programs, long-term goals with workers at the center.

Action	Resources	Collaboration	Anticipated Impact
Work with schools, community colleges and colleges to develop or scale-up pipeline programs.	<ul style="list-style-type: none"> • Colleague time • Marketing materials 	<ul style="list-style-type: none"> • County schools, including higher education and vocational • Chamber of Commerce • Community members • Other community organizations 	<ul style="list-style-type: none"> • Increase number of students graduating with a career plan. • Increase employment in working-age individuals.
Work with existing career organizations to provide supervised internship and workforce training opportunities at the local ministry.	<ul style="list-style-type: none"> • Colleague time • Marketing materials 	<ul style="list-style-type: none"> • County schools, including higher education and vocational • Chamber of Commerce • Community members • Other community organizations 	<ul style="list-style-type: none"> • Increase job shadowing and learning opportunities for working-age individuals. • Increase employment in working-age individuals.
Explore partnerships and opportunities to support local childcare development groups.	<ul style="list-style-type: none"> • Colleague time 	<ul style="list-style-type: none"> • Childcare workgroup • Community organizations 	<ul style="list-style-type: none"> • Safe, accessible and affordable childcare for working families.

Strategy II: Develop workforce plan and training programs.

Action	Resources	Collaboration	Anticipated Impact
Evaluate services available internally and within the community, and work to address service gaps.	<ul style="list-style-type: none"> • Colleague time • Marketing materials 	<ul style="list-style-type: none"> • County schools, including higher education and vocational • Chamber of Commerce • Community members • Other community organizations 	<ul style="list-style-type: none"> • Conduct an asset and gap analysis with identified workforce resources and needs. • Enhance access to workforce development and essential life skills training opportunities.

Strategy III: Work with internal and external stakeholders to engage in unified planning and policy.

Action	Resources	Collaboration	Anticipated Impact
Work with state and local leaders to factor health implications into policy and budget decisions.	Colleague time	<ul style="list-style-type: none"> • Local, state leaders • Other community partners • Regional Office of Education 	Increase knowledge of disparities in education and economy driving workforce barriers.

Next Steps

This implementation plan outlines intended actions over the next three years. Annually, HSHS Illinois 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 board of directors on November 2, 2021.



HSHS
St. Francis
Hospital