HSHS St. Elizabeth's Hospital

Health Needs Assessment
2025-2027 Implementation Plan

HSHS St. Elizabeth's 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. Elizabeth's Hospital in O'Fallon is a regional referral hospital located in St. Clair County, Illinois. For more than 140 years, the hospital has been the leader in health and wellness in St. Clair County.

St. Elizabeth's 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. Elizabeth's Hospital conducted a Community Health Needs Assessment (CHNA) in collaboration with Memorial Medical Center and the St. Clair County Department of Public Health. This process involved gathering data from multiple sources to assess the needs of St. Clair County. 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 CHNA_report_SEO_DY_2024_FINAL.pdf (hshs.org).

The implementation plan builds off the CHNA report by detailing the strategies St. Elizabeth's 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 St. Clair 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. Elizabeth's Hospital in collaboration with community partners identified the following health priorities in St. Clair County:

1. **Mental and behavioral health**
2. **Access to care: unmanaged chronic conditions**
3. **Healthy lifestyles**

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:

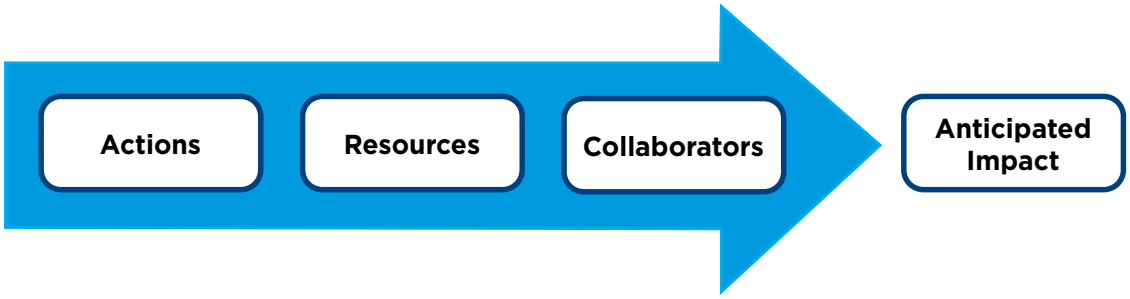
- Food insecurity: While not a direct priority issue, food insecurity will be addressed within the strategic plan for chronic conditions.
- Maternal and infant health: St. Elizabeth's Hospital continues to serve as the hospital of choice for families seeking a family-centered, high-quality, maternity experience. The hospital offers a wide range of resources, services and special touches to help mothers during pregnancy and delivery.

Primary Implementation Strategies

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

Priority No. 1: Mental and Behavioral Health

Target Populations
- Adolescents
- Adults

Hospital Resources
- Colleague time
- Grant funding
- Advocacy

Community Partners
- St. Clair County Health Department
- East Side Health District
- 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
- Increase the 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. Elizabeth's service area have less access to mental health care providers. While it's difficult to measure the rate of individuals in the service area suffering from mental illness, there is some data available that can aid in assessing the need. When looking at St. Clair County, 17% of adults report binge or heavy drinking. As of 2020, St. Clair County experienced a death-by-homicide rate of 16 per 100,000 population and a suicide rate of 11 per 100,000 population. According to the CDC, St. Clair County has a higher rate of suicide than the state but lower than the U.S. rate. The male death rate due to suicide is significantly higher and the suicide rate trend has continued to increase over the years.

Data available through the Illinois Department of Public Health Opioid Data Dashboard provides an overview of mortality trends by type of opioid. In 2022, more than 80 deaths were reported due to overdose. According to the dashboard, St. Clair County opioid deaths were largely related to synthetic-involved (fentanyl, carfentanil) and natural or semi-synthetic-involved (morphine, codeine, oxycodone, hydrocodone – i.e. pain relievers) opioids. When compared to the state of Illinois, St. Clair County has a younger population impacted by drug use leading to hospitalization. The majority of cases in Illinois are ages 45 and above. Source: Illinois Department of Public Health Opioid Data Dashboard, 2022: https://idph.illinois.gov/OpioidData-Dashboard/

Our Strategies

Improve access to prevention and early intervention services.
- 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.
- 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 planning and policy, 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 • 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 • Community health funds	• 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
Work with local health departments to improve county workgroups.	• Colleague time • Community health funding	• Local health departments • Community stakeholders	• Improve county stakeholder cooperation on major public health issues • Unify county health strategies
Partner with County Behavioral Health Stakeholders Group	• Colleague time	• Community stakeholders • Local health departments	• Unify voices of local stakeholders addressing behavioral health issues • Develop collaborative strategies to address county-wide behavioral health issues

Priority Snapshot: Access to Care: Unmanaged Chronic Conditions & Healthy Lifestyles

Priority No. 2: Access to Care: Unmanaged Chronic Conditions & Healthy Lifestyles

Target Populations
- Adolescents
- Adults

Hospital Resources
- Colleague time
- Advocacy
- Virtual platform

Community Partners
- St. Clair County Health Department
- East Side Health District
- 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, St. Clair County is ranked among the least healthy counties in Illinois (lowest: 0%-25%). Unhealthy lifestyle choices and reduced access to disease awareness, prevention and management lead to poor health outcomes in a community. According to IHA COMPdata, approximately 60% of St. Clair County patients who presented in the ED had one or more chronic conditions such as obesity, depression, hypertension or diabetes. There is a higher incidence of adult smoking, physical inactivity, mental health disorders and premature mortality in St. Clair County as compared to the state.

According to the Behavioral Risk Factor Surveillance System, St. Clair County adults are surpassing other counties in the state of Illinois in risk factors leading to chronic conditions and in chronic conditions such as diabetes, high blood pressure and more, as shown in the chart below. Additionally, the leading causes of premature death in St. Clair County are heart disease and cancer, both of which may be preventable and/or manageable with healthy behaviors and early detection and intervention.

Condition	St. Clair County	Illinois
Adult obesity	37%	30%
Physical inactivity	31%	22%
Arthritis	31.3%	24.7%
Asthma	10.3%	8.2%
High blood pressure	37.1%	32.2%
Cancer	7.3%	6.4%
High cholesterol	35.1%	31.5%
Diabetes	12%	10%

Our Strategies

Improve access to prevention and early intervention services.
- Conduct Social Determinants of Health Screenings.
- Provide insurance navigation and 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 planning and policy, 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 providers participating in food as medicine
- Number of individuals receiving food boxes and/or vouchers

PLANNED ACTIONS –
Access to Care: Unmanaged Chronic Conditions & Health Lifestyles

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).

Promoting healthy lifestyles is a critical component in improving both individual and population health. Encouraging regular physical activity, balanced nutrition and mental well-being is essential to reducing the prevalence of chronic diseases such as heart disease, diabetes and obesity. Health systems must collaborate with community organizations, schools and local governments to create environments that support healthy choices, from access to nutritious food to safe spaces for exercise.

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 healthcare 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 • 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 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
Partner with St. Clair County Chronic Disease Workgroup to address food insecurities as they relate to chronic conditions.	• Colleague time • HSHS Advocacy • Community health funding	• Community stakeholder • County health departments • Local and state government	• Reduce the risks and impacts of chronic disease

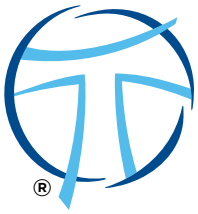
Next Steps

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 26, 2024.



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