HSHS St. Joseph's Hospital | Highland

Health Needs Assessment
2025-2027 Implementation Plan

HSHS St. Joseph's Hospital Highland 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. Joseph's Hospital Highland is a critical access hospital located in Madison County, Illinois. For more than 140 years, the hospital has been the leader in health and wellness in Madison County. St. Joseph's Hospital provides a wide range of specialties, including inpatient, surgical services, rehabilitation, emergency care and outpatient services such as medical imaging and laboratory.

St. Joseph'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. Joseph's Hospital conducted a Community Health Needs Assessment (CHNA) in collaboration with HSHS St. Joseph's Hospital in Breese, HSHS Holy Family Hospital in Greenville and the Bond County Health Department. This process involved gathering data from multiple sources to assess the needs of Madison 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 https://www.hshs.org/st-josephs-highland/about-us/community-health-needs-assessment.

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

1. Access to mental and behavioral health services
2. Chronic conditions – including food access and disease prevention and education
3. Substance use disorder

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:

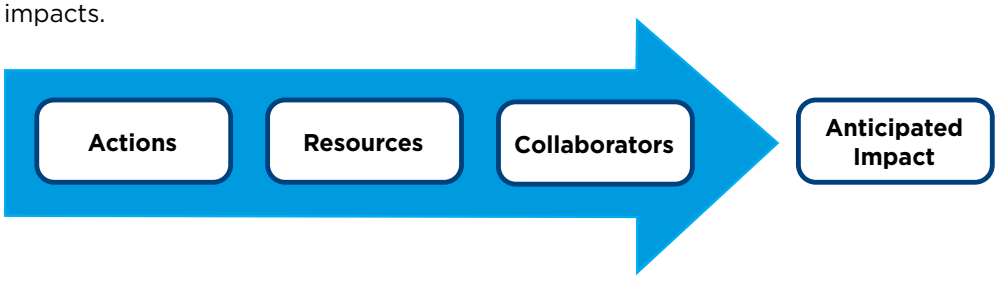
- Affordable housing: While not a direct priority issue, affordable housing challenges and barriers will be explored within the strategic plan of workforce barriers.
- Diabetes and obesity: While not a direct priority issue, diabetes and obesity eating will be addressed within chronic disease education and prevention strategies.
- Food insecurity: While not a direct priority issue, these barriers for health are incorporated in all strategic planning.
- Maternal health and child health: St. Joseph's is not focusing on this need as part of the CHNA. St. Joseph's Hospital Highland offers prenatal support in partnership with its sister hospital St. Joseph's Hospital Breese, in addition to providing comprehensive women's services. With a comprehensive line of women's imaging, surgical services and cardiovascular care programs, among other services, St. Joseph's Hospital Highland has spent years helping women manage and maintain their health in a variety of crucial ways.
- Nutrition and healthy eating (access and knowledge): While not a direct priority issue, nutrition and healthy eating will be addressed within chronic disease education and prevention strategies.
- Oral health: St. Joseph's Hospital will work closely with the surrounding county health departments to raise awareness and provide patient referrals for dental services.
- Transportation: While not a top priority, the transportation strategies developed will assist in further preparing individuals for employment.

Primary Implementation Strategies

In each of the priority health areas identified, HSHS St. Joseph'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 and Substance Use Disorder

Priority No. 1: Mental and Behavioral Health and Substance Use Disorder

Target Populations
- Adolescents
- Adults

Hospital Resources
- Colleague time
- Funding
- Advocacy

Community Partners
- County health departments
- 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

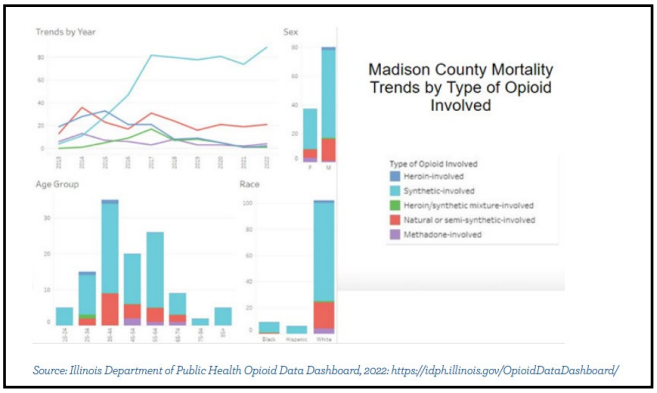
Relevant Measures*
- Proportion of people who get a referral for substance use treatment after an emergency department visit
- Proportion of adolescents and adults with anxiety or depression who get treatment
- Proportion of children and adolescents who get preventive mental health care in school

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

Current Situation

Individuals living in St. Joseph'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 the BRFSS question which asks the number of days that mental health is not good for respondents, the rate for Madison County of those who report frequent mental distress is an average of 13%.

According to the Opioid Dashboard, the majority of Madison County opioid deaths were related to synthetic-involved (fentanyl, carfentanil) and natural or semi-synthetic-involved (morphine, codeine, oxycodone, hydrocodone – i.e., pain relievers).



Source: Illinois Department of Public Health Opioid Data Dashboard, 2022: https://idph.illinois.gov/OpioidDataDashboard/

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 and 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 students participating in Resilient Classroom Project
- Number of patients screened and referred
- Number of patients successfully completing treatment

PLANNED ACTIONS – Mental and Behavioral Health and Substance Use Disorder

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 addition to the challenges faced in mental health care, those struggling with Substance Use Disorder (SUD) encounter similar obstacles within the health care system. Emergency departments are often ill-equipped to handle the complexities of SUD, where patients require specialized care and long-term support rather than short-term stabilization. Without dedicated treatment pathways, individuals are frequently left without the appropriate resources or follow-up care to address the root causes of their addiction.

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
Have at least 10% of HSHS colleagues, including a minimum of 4% representing leadership positions, certified in Mental Health First Aid by end of FY27.	• 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.
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. • Reduce the stigma associated with those struggling with 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 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.
Support safe medication disposal.	• Ministry space	• Local and state government	• Allow for a safe space for community members to dispose of unused or expired prescriptions and over-the-counter medications.

Strategy 2: Decrease barriers to entry.

Action	Resources	Collaboration	Anticipated Impact
Provide hospital emergency department-based screening, recovery coaching, and linkage services.	• Colleague time • Engagement Specialist • Recovery Coach	• Gateway Foundation • Chestnut Health	• Conduct clinical assessment for patients presenting with SUD. • Provide 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 funding	• Community-based organizations • FindHelp	• Form 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 recommend legislative strat egies 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: Access to Care: Unmanaged Chronic Conditions

Priority No. 2: Access to Care: Unmanaged Chronic Conditions

Target Populations
- Adolescents
- Adults

Hospital Resources
- Colleague time
- Funding
- Advocacy

Community Partners
- County health departments
- 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, Madison County is ranked in the lower middle range of counties in Illinois (lower 25% - 50%). Unhealthy lifestyle choices and lack of disease awareness, prevention and management lead to poor health outcomes in a community. Among the leading causes of death for residents of Madison County are heart disease, stroke and cancer. These may be preventable with timely access to health care and lifestyle modification. There is a higher incidence of adult smoking, adult obesity, physical inactivity, limited access to exercise and excessive drinking in Madison County as compared to the state.

Health Behavior	Madison County	Illinois
Smoking	18%	13%
Obesity	40%	33%
Physical inactivity	23%	24%
Access to exercise	87%	90%
Excessive drinking	18%	15%
Alcohol-impaired driving deaths	33%	29%
Sexually transmitted infections	452.9	542.3

Source: County Health Rankings

Our Strategies

Improve access to prevention and early intervention services.
- Conduct Social Determinants of Health screenings.
- Provide patient navigation to 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 meetings with local leaders and policy impacts

PLANNED ACTIONS – Access to 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 health care 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 • 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 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 25, 2024.

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