HSHS St. John's Hospital

Health Needs Assessment
2025-2027 Implementation Plan

HSHS St. John'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

St. John's Hospital is in Sangamon County, Illinois. For more than 150 years, the hospital has been a leader in health and wellness in Sangamon and surrounding counties. St. John's Hospital provides a wide range of specialties, including a level one trauma center, level two pediatric trauma center, neonatal intensive care unit, St. John's Children's Hospital and the nationally recognized Prairie Heart Institute.

St. John'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. John's Hospital conducted a Community Health Needs Assessment (CHNA) in collaboration with Springfield Memorial Hospital and the Sangamon County Department of Public Health. This process involved gathering data from multiple sources to assess the needs of Sangamon 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-johns/about-us/community-health-needs-assessment.

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

1. **Access to mental health and substance use disorder services**
2. **Homelessness**
3. **Access to care: focus on chronic conditions**

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:

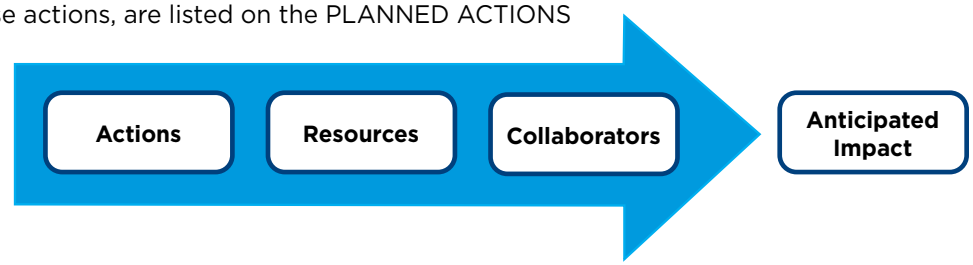
- Affordable housing: While not named, this is being addressed within strategies addressing homelessness.
- Food access: This need is addressed by groups including the Central Illinois Food Bank, Illinois Coalition of Community Services, COMPASS for Kids, local school districts and the county health department. The hospital supports these efforts by donating money and in-kind resources to these programs and organizations.
- Maternal and infant health: As a result of the 2018 CHNA, a program was developed and implemented to address maternal/infant health issues for babies born earlier than 32 weeks. This program continues to be provided through St. John's Hospital NICU to address health and development challenges in premature infants. Additionally, the hospital continues to support local safe sleep initiatives driven by the health department.
- Obesity: St. John's participates in community initiatives to address obesity. Additionally, several of its programs addressing food access, chronic conditions, access to health, etc. are indirectly impacting obesity.
- Senior health: St. John's runs the Caregiver Interfaith Volunteer Services program which provides senior transportation to medical appointments.
- Violent crime: The access to care collaborative developed in response to the 2015 CHNA has led to a decrease in crime in the Enos Park neighborhood. An expansion of the collaborative will continue to impact crime across the city and county. The hospital continues to support these initiatives and others through monetary and in-kind donations.
- Cancer Disparities: St. John's supports the American Cancer Society which partners with patients to provide support and resources. Additionally, the St. John's Cancer Center team is part of the Regional Cancer Partnership focused on screening and early diagnosis.
- Disparities in economy and education: These drivers of health are incorporated into all strategic planning.
- Sexually transmitted infections (STI): The Sangamon County Health Department of Public Health identifies STI as one of its top priorities and is prioritizing resources around this issue area.
- Unemployment: This driver of health is incorporated into all strategic planning.

Primary Implementation Strategies

In each of the priority health areas identified, St. John'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 t ogether 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: Access to Mental Health and Substance Use Disorder Services

Priority No. 1: Access to Mental Health and Substance Use Disorder Services

Target Populations
- Adolescents
- Adults

Hospital Resources
- Colleague time
- Funding
- Advocacy

Community Partners
- Local health departments
- Local businesses
- Schools
- Local policymakers
- Local hospitals
- Faith-based organizations
- Behavioral and mental health service providers
- Local providers
- Mental Health America

Anticipated Impact
- Prevention and early intervention tools
- Improved mental health literacy
- Inform public policy
- Resilience in youth
- Clinical assessment and referral
- Direct referrals

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

Depression, anxiety and suicide ideation have seen a steady upward trend which has been exacerbated by the pandemic. Accidental drug overdose deaths have continued to rise in Sangamon County since the beginning of 2020. According to county coroner reports, substances such as heroin, alprazolam, alcohol and fentanyl have been leading culprits in drug overdose deaths. The county also has higher rates of hospitalization due to opioids and heroin compared to other counties in the state.

Many people in need of mental health or substance use treatment are unable to access it in a timely manner due to provider shortages, particularly in rural areas. Additionally, the following barriers were listed by community members as leading challenges to accessing mental and behavioral health services:

- Barriers such as cost of care, transportation, long wait times and low number of providers prevent patients from accessing mental health treatment in a timely manner.
- Mental health providers are not experienced in addressing traumas related to immigration systems and racism.
- Easy availability of drugs and alcohol in the community, especially near community gathering places like schools and churches. This encourages self-medicating.
- A greater awareness of when, why and how to access mental health services is needed overall.
- There is a stigma associated with seeking mental health assistance.

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.
- Reduce barriers to health care for individuals experiencing homelessness.

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, individuals trained
- Number of residents successfully entering and completing treatment
- Number of students participating in Resilient Classroom Project
- Number of patients screened and referred
- Number of patients successfully completing treatment

PLANNED ACTIONS – Access to Mental Health and Substance Use Disorder Services

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	• 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 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
Work with Heartland Continuum of Care and Helping Hands to continue offering the Hands and Feet Clinic for individuals experiencing homelessness.	• Community health funding • Colleague time	• Heartland Continuum of Care • Helping Hands • Central Counties Health Centers • Heartland HOUSED	• Improve trust in health care and health care providers • Increase assessment and intervention for unattached clients

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
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.	• Colleague time • Community health funding • Community volunteers • Strategic development	• Safe Families Illinois • Illinois Department of Children and Family Services • Local churches • Community members • County schools	• Timely connection between families and support services during times of crisis • Ongoing connection between families and coaches to prevent crisis and provide continuing support

Priority Snapshot: Access to Care: Focus on Chronic Conditions

Priority No. 2: Access to Care: Focus on Chronic Conditions

Target Populations
- Adolescents
- Adults
- Focus on un/underinsured individuals

Hospital Resources
- Colleague time
- Funding
- Advocacy
- Virtual platform

Community Partners
- Local health departments
- Food banks and pantries
- Local providers
- Schools
- Local policymakers
- Local hospitals
- Faith-based organizations
- Community leaders
- Community health workers

Anticipated Impact
- Fewer new chronic disease diagnoses
- Fewer deaths from chronic conditions

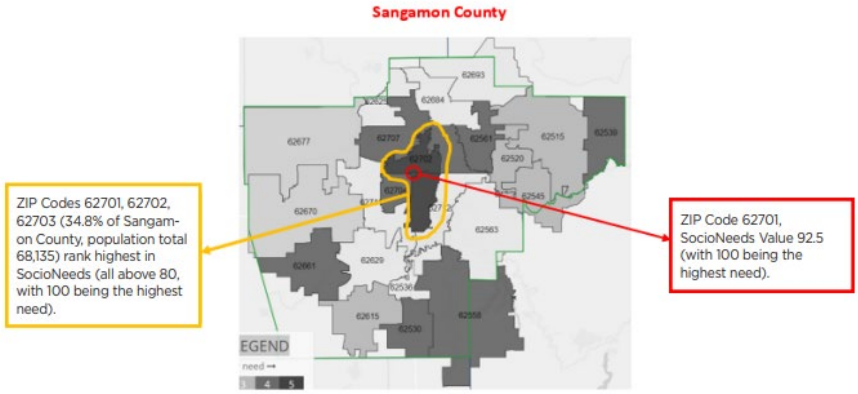
Relevant Measures*
- Proportion of adults with diabetes who receive formal diabetes education.
- Rate of hospital admissions for diabetes among older adults
- Heart failure hospitalizations in adults
- Coronary heart disease deaths
- Stroke deaths

* *From the national health plan:*

Current Situation

Access to care has many dimensions. In Sangamon County, there is a direct correlation between access barriers and ZIP code on the socio-needs index (see Diagram Four). Existing data shows these areas have a higher incidence of emergency department visits and hospitalization due to chronic conditions that could be managed through regular visits with a general provider. Access to care efforts since the 2015 CHNA have led to a measurable improvement in health. Using the effective and nationally recognized model in place, individual and population health improvement should continue while current access to care strategies are expanded.

The following diagram represents socioeconomic need that correlates with poor health outcomes.



Our Strategies

Improve access to prevention and early intervention services.
- Conduct Social Determinants of Health Screenings.
- Provide Insurance navigation for improved understanding.
- Connect seniors with transportation service for basic needs.
- Partner for improved prescription medicine assistance.
- Improve access to fresh, in-season produce.

Decrease barriers to entry.
- Create a social care network within our EMR to connect patients with community-based resources.
- Access to health collaborative focused on neighborhood-based community health workers.
- Home health visits for improved physical and socio-emotional development for babies born less than 32-weeks.

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 link and double your bucks dollars spent at farmers market
- Number of babies graduating Beyond the NICU program at optimal weight

PLANNED ACTIONS – Accessing Available Care: Focus on 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
Continue funding and implementing Caregiver Interfaith Volunteer Services (CIVS) to provide rides to seniors to increase access to medical appointments, medication and grocery stores.	• Colleague time • Volunteer time • Community health funding • Foundation funding	• Local churches and faith-based organizations • Local community volunteers	• Increase access to basic needs, specifically health, medication and nutrition • Decrease risks caused from senior isolation through weekly companion calls
Continue funding to Kumler Outreach to provide needed management medications and prescriptions for disease management and prevention.	• Colleague time • Community health funding	• Kumler Outreach Ministries • Springfield Memorial Health	• Increase medication compliance for chronic conditions • Decrease barriers to accessing medications by at-risk residents
Work with local farmers markets, food pantries and feeding programs to support access to fresh produce and nutrient dense foods.	• Colleague time • Community health funding	• County health department • Community organizations • Central Illinois Food Bank • Local food pantries • County schools • Downtown Springfield, Inc. • Downtown Farmers Market	• Improve the management of chronic disease/reduce impact severity

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 • Monetary	• 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
Continue funding the access to health (A2H) collaborative between HSHS St. John's Hospital, SIU School of Medicine's Office of Community Care and Springfield Memorial Health.	• Colleague time • Community health funding • Foundation funding • Grant funding	• HSHS Med Group • Central Counties Health Centers • SIU Community and Family Medicine • SIU Office of Community Care • Springfield Memorial Health • Enos Park Neighborhood Improvement Association • Pillsbury Mills Neighborhood Association • Springfield Neighborhood Police • Other community organizations	• Increase number of individuals and families with primary care provider • Increase show-rate for A2H clients • Decrease number of barriers to health experienced by clients • Increase number of insured clients • Overcome unique barriers to health and social services experienced by the immigrant community and for individuals experiencing homelessness
Work with highly skilled NICU nurses from HSHS St. John's Children's Hospital to improve physical and socio/emotional development for babies born less than 32 weeks in the NICU	• Colleague time • Community health funding • Foundation funding	• SIU Department of Neonatology • HSHS Illinois Home Care • St. John's NICU and Children's Hospital • Social service agencies • St. John's Foundation	• Optimal growth and development at 18 months • Decrease incidence of poor brain development by providing education and opportunity for at-home baby brain development and infant engagement • Increase number of check-up and provider visits post discharge

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

Priority Snapshot: Homelessness

Priority No. 3: Homelessness

Target Populations
- Individuals at risk for homelessness
- Individuals experiencing homelessness

Hospital Resources
- Colleague time
- Funding
- Advocacy

Community Partners
- Local health departments
- Food businesses
- Schools
- Local policymakers
- Local hospitals
- Faith-based organizations
- Behavioral and mental health providers
- Local providers
- Continuum of Care
- Heartland HOUSED

Anticipated Impact
- Prevention and early intervention tools
- Inform public policy
- Clinical assessment and referral
- Homelessness is rare, brief and nonrecurring

Relevant Measures*
- Number of available, affordable housing units
- Number of respite beds available
- Number of patients screened and referred
- Proportion of adolescents and adults with anxiety or depression who get treatment

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

Current Situation

St. John's Hospital joined many agencies and members of this community to design a strategy to protect some of the most vulnerable members of the community and end their homelessness. As a result of this planning process, a new non-profit, Heartland HOUSED, was formed in 2022 to drive the following goal: By 2028, our community will put everyone who becomes homeless back in suitable and safe housing within 30 days.

According to the National Institutes of Health, people who are homeless have higher rates of illness and die on average 12-years sooner than the general U.S. population. Individuals experiencing homelessness are at a greater risk of living with unmanaged chronic conditions and sexually transmitted infections, have a higher rate of substance use and are more likely to be living with untreated mental illnesses. As people become stabilized in housing, their dependence on emergency services drops and their health outcomes improve significantly.

The following data was gathered and reported during the 2022 Springfield and Sangamon County strategic planning process:
- 264 people are homeless in the community on a given day.
- Each year, the number of people that are homeless grows by 155.4 people.
- 56% of people who are homeless need housing with supports to remain housed.
- 16% of people who live outside or in shelters in Sangamon County get into housing.

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.
- Reduce barriers to health care for individuals experiencing homelessness.

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 patients screened and referred
- Number of patients successfully completing treatment

PLANNED ACTIONS – Homelessness

HSHS St. John's Hospital partnered with local hospital and health organizations, city and county governments, and other community-based organizations to complete the Springfield and Sangamon County's 2022 – 2028 Strategic Plan to Address Homelessness. From that process, Heartland HOUSED was developed. A new non-profit, Heartland HOUSED exists to create housing opportunities for under-served persons through equitable delivery.

St. John's is committed to continue partnering with Heartland HOUSED to achieve the goals outlined in the strategic plan. A HSHS leader chairs the strategy board which focuses on four strategic pillars:

1. Create safe, effective housing opportunities.
2. Improve the effectiveness of the homeless system.
3. Coordinate with other systems to reduce homelessness.
4. Community is working together to address homelessness.

The actions outlined below align with the three HSHS Community Health strategies and the Heartland HOUSED Strategic Plan.

Action	Resources	Collaboration	Anticipated Impact
Continue work with Heartland HOUSED to progress toward the collaborative goal: By 2028, our community will put everyone who becomes homeless back in suitable and safe housing within 30-days.	• Colleague time as strategy board chair • Community health funding • Colleague time	• Heartland Continuum of Care • City of Springfield • Sangamon County • United Way of Central Illinois • Community Foundation • Springfield Memorial Health • Other community organizations	• Create more housing • Improve the homeless system • Coordinate seamless care to help those experiencing homelessness to easily get what they need like health care, housing and jobs
Work with Heartland Continuum of Care and Helping Hands to continue offering the Hands and Feet Clinic for individuals experiencing homelessness.	• Community health funding • Colleague time	• Heartland Continuum of Care • Helping Hands • Central Counties Health Centers • Heartland HOUSED	• Improve trust in health care and health care providers • Increase assessment and intervention for unattached clients
Collaborate with Heartland HOUSED to develop health care system support for Medical Respite Care.	• Colleague time on planning team	• Heartland HOUSED • Helping Hands • Springfield Memorial Health • Central Counties Health Center • SIU Center for Family Medicine	• Provide short-term residential care that allows those experiencing homelessness to rest while receiving medical care for acute illness or injury
Explore strategies for internal streamlined engagement and screening processes through coordinated entry.	• Colleague time	• Heartland HOUSED • Coordinated Entry Manager	• Timely screening, connection and intervention for those experiencing homelessness or those at risk of experiencing homelessness

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 4, 2024.

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Hospital