HSHS
St. John's
Hospital

Health Needs Assessment

2021 Implementation Plan

HSHS St. John's Hospital is an affiliate of Hospital Sisters Health System, a multi-institutional health care system comprised of 15 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 at HSHS St . John's Hospital.

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

In 2020-2021, St. John's Hospital conducted a Community Health Needs Assessment (CHNA) in collaboration with Memorial Medical Center 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 twenty-one focus groups who together recommended the health priorities to be addressed in 2022—2024. The full CHNA Report may be found at https://www.hshs.org/StJohns/About-Us/Community-Health-Needs-Assessment/Files/2021-CHNA.pdf.

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. **Disparities in economy (income and wealth in the community), including disparities in education**
2. **Mental and behavioral health services**
3. **Access to health services, including food access and homeless issues**

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.

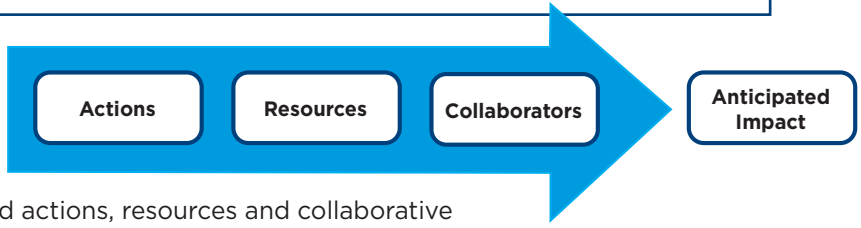
Based on the CHNA planning and development process the following community health needs were identified but will not be addressed directly by the hospital for the reasons indicated:

- Affordable housing: In the past year, a group of community stakeholders came together to address housing issues and disparities in Sangamon County. A representative from St. John's Hospital sits on that committee. St. John's will continue to lend its support to these efforts.
- 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 <32 weeks. This program continues to be provided through St. John's Hospital NICU to address health and development challenges in premature infants.
- Obesity: St. John's participates in community initiatives to address obesity. Additionally, several of our 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.
- Tobacco use: The health department and local school districts currently have curriculum to address tobacco use in youth.
- Unmanaged chronic conditions: Access, early identification, prevention and management of chronic conditions is a major focus of the access to health collaborative developed as a result of the 2015 CHNA. This initiative continues today, and St. John's helps lead the development, implementation and expansion of access initiatives.
- Utility and rental assistance: This issue area has grown as a result of the pandemic. Several community-based organizations are addressing utility and rental assistance programs while preparing for post-pandemic needs. St. John's will participate in community discussions and plans to address these issues as they become more known.
- 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. By expanding the collaborative, we 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.

Primary Implementation Strategies

In each of the priority health areas identified, St. Mary's Hospital shall employ strategies that fall into one or more of the categories below.

Strategy	Description
Increase access to prevention and early intervention services	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 in a timely manner in order 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 of 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 organized by health priority, first with a "snapshot" of identified strategies, sample actions and other relevant information, then with a more comprehensive and specific description of planned actions, resources, collaborative partners and anticipated impacts.

Priority Snapshot: Disparities in Economy

Priority No. 1: Disparities in Economy

Target Populations
- Adolescents
- Adults

Hospital Resources
- Colleague time
- Grant funding
- Marketing materials
- Advocacy
- Virtual platform

Community Partners
- Local health departments
- Local businesses
- Schools
- Local policymakers
- Local hospitals
- Faith-based organizations
- Trades/Union
- Higher education

Anticipated Impact
- lear 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

Disparities in economy often arose during discussions in relation to the disproportionate impact of the following determinants of health on minority populations: cost burdened renters and homeowners, poverty, unemployment, job availability and workforce training opportunities. Reasons commonly cited for key gaps include disparities in education as a key driver to disparities in economy; lack of access to, knowledge of or availability of workforce training opportunities, need for financial counseling and large wealth gap between Black and White individuals.
Data supporting this concern include:

- Unemployment rates in Sangamon County (13.3%) exceed the state unemployment rate (7.1%).
- Minority and low-income students experience higher rates of truancy, chronic absenteeism and lower graduation rates.

	Sangamon County	Illinois
Poverty	12.2%	13.5%
White	10.21%	8.9%
Black/Brown	39.23%	28.6%
Hispanic	17.09%	18.3%
Children	20%	16%
Persons with disabilities	32%	26.7%

* *Sources include U.S. Census Bureau, 2021; Illinois Public Community Map, 2020; Illinois School Report Card, 2020.*

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.
- Internally, work with diversity, equity and inclusion team to implement best practices for workforce equity.

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 quality education implications into policy and budget decisions impacting equitable education.

Indicators
- Number of students graduating.
- 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, policy impacts.

PLANNED ACTIONS – Disparities in Economy

Leading economic journals indicate the most important factor in strengthening the region's economy is 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 and further understand the causes of inequities in wealth distribution.

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.	• Colleague time • Marketing materials	• County schools, including higher education and vocational • Chamber of Commerce • Community members • Other community organizations • Workforce Equity Initiative at Richland Community College • Big Brothers Big Sisters of Central Illinois	• 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 hospital.	• Colleague time • Marketing materials	• County schools, including higher education and vocational • Chamber of Commerce • Community members • Other community organizations • Workforce Equity Initiative at Richland Community College • Big Brothers Big Sisters of Central Illinois	• Increase job shadow and learning opportunities for working-age individuals. • Increase employment in working-age individuals.

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.	• Colleague time • Marketing materials	• County schools, including higher education and vocational • Chamber of Commerce • Community members • Other community organizations	• Asset and gap analysis with identified workforce resources and needs. • Enhanced 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	• Local, state leaders • Other community partners • Regional Office of Education	• Increase knowledge of disparities in education and economy driving workforce barriers. • Use knowledge gained to develop an advocacy plan to address workforce barriers on a regional and state level.
Work with community leaders and local policymakers to better understand inequities in wealth distribution and solutions for resolution.	• Colleague time • Community health funding	• Local, state leaders • Other community partners	• Increase knowledge of disparities in household and individual income amongst minority populations. • Use knowledge gained to develop an advocacy plan to address wealth gaps on a regional and state level.

Priority Snapshot: Mental and Behavioral Health

Priority No. 2: Mental and Behavioral Health

Target Populations
- Adolescents
- Adults

Hospital Resources
- Colleague time
- Grant funding
- Marketing materials
- Advocacy
- Virtual platform

Community Partners
- Local 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.

* *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 include 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. Data supporting this concern include:

- Depression among Medicare population has steadily increased to 19% since 2009. (Centers for Medicare and Medicaid Services).
- 12.2% of Sangamon County adults reported their mental health was not good for 14 or more days each month. (Illinois County Behavioral Risk Factor Surveys, 2019 reporting period).

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.
- Work with Gateway Foundation and local behavioral health services (Crossings in Decatur and Memorial Behavioral Health in Springfield) to ensure access to screening, treatment plan development and treatment referral for patients presenting with substance use disorder.
- Work with homeless shelters and CoC on the development of housing and health models for improved access to preventive and management health care.

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 address 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 I: 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. • *Question, Persuade, Refer (QPR) suicide prevention training.* • *Mental Health and Youth Mental Health First Aid*	• Colleague time • Technology (virtual trainings) • Marketing materials • Community health funding	• County schools • County health departments • County health boards • Community members • Ministerial alliance • County health providers	• 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.	• Colleague time • Community health funding	• County schools • Prevent Child Abuse Illinois • Other interested community organizations	• 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.	• Colleague time • Community health funding • Grant funding	• HSHS Medical Group • Local providers • Faith-based organizations • County schools	• Increase number of pregnant mothers receiving prenatal care. • Increase early assessment, detection and intervention.
Partner with the Sangamon 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 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 division ministries and the Illinois Telehealth Network to secure behavioral telehealth, tele-psych and crisis screening in the emergency department.	• Colleague time • Technology • System grant writing • Community health and grant funding	• Illinois Telehealth Network • Provider groups • HSHS Illinois Division ministries • Non-HSHS hospitals • Local county health departments • Gateway Foundation • Recovery oriented systems of care	• 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. • 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 to provide school-based mental health services. Explore opportunities to expand services to other markets.	• Colleague time • HRSA and other funding • Marketing materials • Illinois Telehealth Network resources • Substance abuse and mental health services	• Local county schools • Local ministries • HSHS Med Group • Illinois Telehealth Network • Local county health departments	• 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.
Work with Heartland Continuum of Care and Helping Hands to continue offering the Hands and Feet Clinic for our homeless residents.	• Community health funding • Colleague time	• Heartland Continuum of Care • Helping Hands • St. John's College of Nursing • Central Counties Health Centers	• Improve trust in health care and health care providers. • Increase early assessment and intervention. • Increase primary care provider visits.

Strategy III: Work with community partners to address other social determinants of health through unified planning and policy.

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.	• Colleague time • Community health funding • Community volunteers • Faith-based organizations • Community health funding • 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.
Work with Heartland Continuum of Care to develop a strategic plan for housing and homelessness.	• Colleague time • Community health funding	• Heartland Continuum of Care • City of Springfield • Sangamon County • United Way of Central Illinois • Community Foundation • Springfield Memorial Health • Other community organizations	• Identify short- and long-term steps and investments necessary to eliminate homeless ness by 2025. • Implement racial equity assessment and plan based on data and needs identified.
Work with Heartland Continuum of Care and Helping Hands to support housing models such as health and housing, shelter housing, permanent supportive housing, rapid rehousing, transitional housing, etc.	• Colleague time • Strategic development	• Heartland Continuum of Care • City of Springfield • Sangamon County • Helping Hands • Other community organizations	• Increase appropriate housing units in Springfield and Sangamon County. • Address access barriers to housing for those experiencing homelessness.

Priority Snapshot: Access to Health

Priority No. 3: Access to Health

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

Hospital Resources
- Colleague time
- Funding
- Marketing materials
- 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 health disease deaths
- Stroke deaths

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

Current Situation

Access to health often arose during discussions around addressing root causes of poor health outcomes. These include lack of basic needs being met and social determinants of health. Reasons commonly cited for the problem included lack of understanding of available resources and how to access them, difficulty navigating complex health systems, frequent changes in MCO contracts with health systems and providers, access to technology and cultural competency with the medical community. *Data supporting this concern include:*

	Sangamon County	Illinois
Two or more cronic conditions	60%	N/A
Cost burdened renters	48.5%	48.8%
Food insecurity Total	11.4%	10.1%
- Children	13.7%	6.8%

* *Sources include Illinois Department of Public Health Community Map, County Health Rankings and United States Diabetes Surveillance System.*

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, health screenings and referrals to care.
- Work with individuals to improve understanding of insurance benefits, health care resources and accessing timely care.

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.
- Work with CoC to develop a strategic plan to eradicate homelessness by 2025.

Indicators
- Number of community-based screenings, 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.
- Number of sheltered and chronic homeless persons.

PLANNED ACTIONS – Access to Health

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 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 partnerships and relationships among clinical, community and public health organizations to fill gaps in needed services.

Strategy I: 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 • Financial assistance policy updates	• County health department • County providers • Community members • Physicians, medical staff	• 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.	• Colleague time • Marketing materials	• County health department • County providers • Community members • Physicians, medical staff • Healthier Together	• Reduce the prevalence and impacts of chronic diseases. • Increase early assessment and intervention. • Improve identification and referral to resources.
Work with individuals to improve understanding of insurance benefits, health care resources and accessing timely care.	• Colleague time • Marketing materials	• County health department • County providers • Community members • Physicians, medical staff	• Increase the number of insured individuals and families. • Improved understanding of benefits and how to access preventive and specialty care for timely health care visits.
Continue funding for Caregiver Interfaith Volunteer Services 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 • St. John's Caregiver Interfaith Volunteer Services (CIVS)	• 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.

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.	• Colleague time • Marketing materials • SDOH screening tool	• County health department • County providers • Community members • Physicians, medical staff	• 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.	• 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.
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.
Work with high 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 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	• Local, state leaders • Other community partners	Reduce the risks and impacts of chronic disease.

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 3, 2021.

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