HSHS Good Shepherd Hospital

Health Needs Assessment
2026-2028 Implementation Plan

HSHS Good Shepherd Hospital is part of Hospital Sisters Health System, a Catholic health care system comprised of 13 hospitals and an integrated physician network serving communities throughout Illinois and Wisconsin.

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Introduction

HSHS Good Shepherd Hospital is a critical access hospital located in Shelby County, Illinois. For more than 100 years, the hospital has been a leader in health and wellness in Shelby and surrounding counties as the county's only hospital. Good Shepherd Hospital provides a wide variety of services including emergency care, primary care, imaging (nuclear medicine, CT scans, digital mammography, X-ray, MRI and ultrasound), pulmonary and cardiac rehabilitation, cardiac stress testing, sleep lab and laboratory testing. The hospital also offers physical and occupational therapy in an outpatient setting. Broad scopes of general surgical services, including cataract surgery, are provided in both an inpatient and outpatient setting.

Good Shepherd 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 nearly 2.6 million people in rural and midsized communities in Illinois and Wisconsin. HSHS generates approximately $2 billion in operating revenue with 13 hospitals and has more than 130 care locations.

In 2025, Good Shepherd conducted a Community Health Needs Assessment (CHNA). This process involved gathering data from multiple sources to assess the needs of Shelby 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 FY2026-FY2028. The full CHNA report may be found at https://www.hshs.org/good-shepherd/about-us/community-health-needs-assessment.

The implementation plan builds off the CHNA report by detailing the strategies Good Shepherd 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 Shelby 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, Good Shepherd Hospital in collaboration with community partners identified the following health priorities in Shelby County:

1. Access to care
2. Chronic conditions
3. Access to mental and behavioral health – including 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:

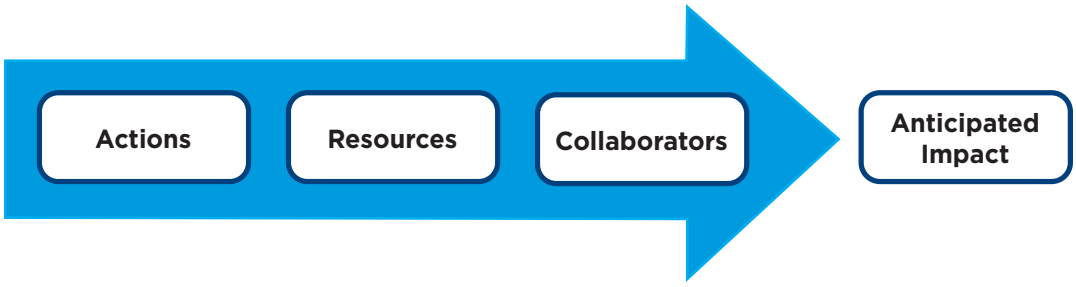
- Maternal and infant health: Good Shepherd Hospital leadership is currently working with providers to address access to maternal and infant health.
- Transportation: While not a direct priority issue, these barriers for health are incorporated in all strategic planning. Additionally, transportation will be assessed during patient social determinants of health (SDOH) screenings. If a patient screens at risk, resources will be provided.
- Food insecurity: While not a direct priority issue, these barriers for health are incorporated in all strategic planning. Additionally, food insecurity will be assessed during patient SDOH screenings. If a patient screens at risk, resources will be provided.

Primary Implementation Strategies

In each of the priority health areas identified, Good Shepherd 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: Access to Care

Target Populations
- Adolescents
- Adults

Hospital Resources
- Colleague time
- Funding
- Marketing materials
- Advocacy
- HSHS Community Connect

Community Partners
- County health departments
- Local businesses
- Community-based organizations
- Local policymakers
- Local hospitals
- Higher education

Anticipated Impact
- Increase in preventive health care visits
- Increase in early screening and intervention
- Reduction in hospital readmissions

Relevant Measures*
- Reduce the proportion of people who cannot get medical care when they need it.
- Increase the portion of people with a usual primary care provider.
- Increase the portion of people who have referrals and resources available at time of hospital discharge.

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

Current Situation

The U.S. Health Resources and Services Administration (HRSA) classifies Shelby County as a health care professional shortage area for primary care, dental and mental health providers. The chart below compares the number of providers per residents for the county and the state. Existing data suggests the county has a higher incidence of preventable hospital stays due to chronic conditions that could be managed through regular visits with a general provider. Access to care efforts since 2019 have led to a measurable improvement in provider- to- resident ratios. Significant work needs to continue to ensure Shelby County residents have timely access to preventive and management care.

Health Care Professional	Shelby County	Illinois	United States
Primary Care	4,360:1	1,260:1	1,330:1
Dentists	4,150:1	1,190:1	1,360:1
Mental Health Provider	2,060:1	300:1	300:1

Additionally, access barriers often arose during discussions around addressing root causes of poor health outcomes. These include lack of basic needs being met and social drivers 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 managed care organization (MCO) contracts with health systems and providers, access to technology and cultural competency with the medical community.

* *Source: U.S. Health Resources and Services Administration (HRSA), https://data.hrsa.gov/tools/shortage-area/hpsa-find Healthy People 2030*

Our Strategies

Improve access to prevention and early intervention services.
- Work with local partners to expand community resource awareness and utilization.
- Work with case management teams to embed HSHS Community Connect in screening and discharge workflows.

Decrease barriers to entry,
- Using a social care referral platform, determine if the patient is experiencing barriers to health care access and identify resources to assist.

Unified policy, planning and advocacy efforts.
- Work with local health care systems to address care disparities in the community.
- Work with state and local leaders to factor health implications into policy.

Indicators
- Number of new providers
- Number of patients screened and referred
- Number of partnering community-based organizations
- Number of colleagues trained
- Number of HSHS Community Connect users

PLANNED ACTIONS – Access to Care

Throughout the Community Health Improvement Plan (CHIP) cycle, Good Shepherd Hospital will work with community partners, internal providers and System strategies to evaluate service availability internally and within the community to address current and future service gaps and growth needs.

Through multi-sector, collective impact partnerships, Good Shepherd Hospital will work with local, regional and state organizations and policymakers to improve the quality of and access to health care services and further understand the causes of unmet drivers of health.

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

Action	Resources	Collaboration	Anticipated Impact
Work with providers to determine patient barriers to accessing resources in a timely manner.	• Colleague time • Internal workflows • Screening tool	• Community-based organizations • Case management teams • Provider teams	• Reduce the proportion of people who cannot get medical care when they need it.

Strategy 2: Decrease barriers to entry.

Action	Resources	Collaboration	Anticipated Impact
Evaluate access barriers and work to identify solutions to achieve equitable access to care.	• Colleague time • Data analysists • Heatmaps by SDOH screening outcomes	• Community-based organizations • Case management teams • Data analysts	• Improve linkage and referral partnerships in areas with high need.

Strategy 3: Work with internal and external stakeholders to engage in unified policy and planning.

Action	Resources	Collaboration	Anticipated Impact
Work with state and local leaders to improve the quality of and access to health care services and further understand the causes of unmet drivers of health.	• Colleague time	• Local and state leaders • Other community partners	• Improve timely access of care when needed.

Priority Snapshot: Chronic Conditions

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

Hospital Resources
- Colleague time
- Funding
- Advocacy
- HSHS Community Connect

Community Partners
- County health departments
- Community-based organizations
- Local providers
- Schools
- Policymakers
- Local health care
- Faith-based organizations
- Community leaders

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

Shelby County remains higher than the state rate for obesity and physical inactivity. Additionally, Shelby County residents experience stroke, diabetes and asthma at a higher rate than national average. One factor compounding this issue is the lack of primary care providers in the county. As noted above, Shelby County is in a health care professional shortage area and significant work needs to continue to ensure Shelby County residents have timely access to preventive and management care.

Chronic Conditions Among Adults	Shelby County	Illinois
Coronary heart disease	8.7%	6.8%
Stroke	4.3%	3.6%
Diabetes	13.0%	12.0%
Asthma	10.4%	9.9%
Adult obesity	36.7%	33.3%

Source: Centers for Disease Control and Prevention: https://places.cdc.gov/?view=county&locationIds=17173

Our Strategies

Improve access to prevention and early intervention services.
- Conduct Social Determinants of Health screenings.
- Provide insurance navigation for improved understanding.
- Improve access to nutrient dense foods and fresh produce.

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 impact

PLANNED ACTIONS – 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 (CHIP), Good Shepherd Hospital will implement a screening and referral tool to better understand the social needs of 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.

Strategy 2: Decrease barriers to entry.

Action	Resources	Collaboration	Anticipated Impact
Create a social care network within HSHS' Epic platform to connect patients with community-based resources.	• Internal project management team • Care management team • Colleague time • Monetary	• 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.
Work with high-skilled NICU nurses from HSHS St. John's Children's Hospital to improve physical and socio-emotional development for babies born at 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	• Increase in 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: Access to mental and behavioral health – including substance use disorder

Target Populations
- Adolescents
- Adults

Hospital Resources
- Colleague time
- Funding
- Advocacy
- HSHS Community Connect

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

Anticipated Impact
- Increase in prevention and early intervention tools
- Improved mental health literacy
- Inform public policy
- Increase resiliency in youth
- Increase clinical assessment and referral
- Increase 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

While successful initiatives are underway, individuals living in Good Shepherd Hospital's service area continue to have limited 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 Behavioral Risk Factor Surveillance System (BRFSS) question which asks the number of days that mental health is not good for respondents, the rate for Shelby County of those who report frequent mental distress is an average of 20%, compared to the state average of 14% (County Health Rankings, 2022).

The U.S. Health Resources and Services Administration (HRSA) classifies Shelby County as a health care professional shortage area for mental health providers. The chart below compares the number of providers per residents for the county and the state. According to the 2024 data below, the ratio has improved slightly since the last measurement period — 2,700:1 in 2022 — however, significant work still needs to be done to ensure Shelby County residents have timely access to mental and behavioral health services.

Health Care Professional	Shelby County	Illinois	United States
Mental Health Provider	2,060:1	300:1	300:1

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.
- Continue behavioral telehealth partnership with Shelbyville schools.

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 and behavioral health – including 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 year one of the CHIP, Good Shepherd Hospital 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 multi-sector, collective impact partnerships, Good Shepherd Hospital 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 FY28.
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.

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	• Conduct clinical assessment for patients presenting with substance use disorder (SUD). • Provide direct transfer or referral to treatment upon di scharge 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.
Continue work with Shelbyville School District to provide school-based behavioral tele-health for students in crisis.	• Colleague time • Illinois Telehealth Network	• Schools • Illinois Telehealth Network • Providers	• Improve medication adherence and disease outcomes. • Frequently reinforce and promote positive lifestyle changes through virtual education. • Improve accessibility to providers by overcoming access barriers such as time, transportation, weather, mobility, etc.

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 • Health care organizations • Local and state government	• Identify key recommenda-tions 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.

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 August 18, 2025.

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