Endeavor Health

Edward-Elmhurst Health

2025-2027 Implementation Strategy

Based on 2024 Community Health Needs Assessment

About Endeavor Health and Edward-Elmhurst Health

Mission

Help everyone in our communities be their best.

Vision

Safe, seamless and personal. Every person, every time.

Values

Act with Kindness
Earn Trust
Respect Everyone
Build Relationships
Pursue Excellence

This Implementation Strategy (IS) pertains to Edward-Elmhurst Health, which is part of Endeavor Health.

Please note that all Endeavor Health hospitals develop and release their own separate IS. This IS pertains to Edward-Elmhurst Health's 2024 Community Health Needs Assessment (CHNA) and is active for 2025-2027.

Endeavor Health's Mission

The core mission is to "help everyone in our communities be their best."

About Endeavor Health

Endeavor Health℠ is a Chicagoland-based integrated health system driven by our mission to help everyone in our communities be their best. As Illinois' third-largest health system and third-largest medical group, we proudly serve an area of more than 4.2 million residents across seven northeast Illinois counties. Our more than 27,600 team members, including more than 1,700 employed physicians, are the heart of our organization, delivering seamless access to personalized, pioneering, world-class patient care across more than 300 ambulatory locations and nine hospitals, including eight Magnet-recognized acute care hospitals – Edward (Naperville), Elmhurst, Evanston, Glenbrook (Glenview), Highland Park, Northwest Community (Arlington Heights), Skokie and Swedish (Chicago) and Linden Oaks Behavioral Health Hospital (Naperville).

About Edward-Elmhurst Health

Edward-Elmhurst Health (EEH) represents Endeavor Health Edward Hospital and Linden Oaks Behavioral Health Hospital in Naperville and Endeavor Health Elmhurst Hospital. EEH is an extensive ambulatory care network that provides comprehensive healthcare to residents of the west and southwest suburbs of Chicago. The system also includes the Edward Foundation and the Elmhurst Memorial Hospital Foundations, part of Endeavor Health, which exist to help the hospitals provide the highest quality healthcare to the communities we serve. Edward and Elmhurst Hospitals have both achieved Magnet recognition for excellence in nursing and have a strong history of earning A's in the Leapfrog Hospital Safety Grades. Elmhurst is one of only 15 hospitals in the U.S. to achieve straight A's since the Grades began in 2012. In addition, EEH has been named one of the nation's 15 Top Health Systems by Fortune and PINC AI for 5 years in a row.

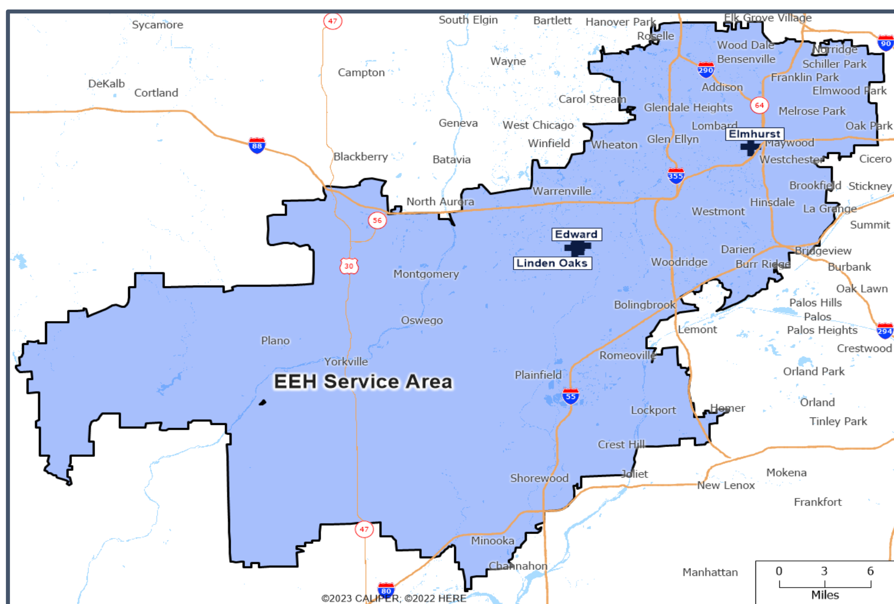
Implementation Strategy Purpose and Development

Purpose of a Hospital's Implementation Strategy

An Implementation Strategy (IS) outlines how a hospital plans to address community health needs and is intended to satisfy the requirements set forth by state law and the Internal Revenue Code Section 501(r)(3) regarding Community Health Needs Assessments (CHNA) and Implementation Strategy. The IS process is meant to align EEH's initiatives and programs with goals, objectives and indicators that address significant community health needs described in the CHNA.

Community Definition

The EEH service area is composed of 74 ZIP codes, with a total population of nearly 2 million. This service area crosses three counties - DuPage, Cook and Will Counties geographic footprint is illustrated in the following map along with a chart that lists the ZIP codes.



EEH Service Area						
60101	60104	60106	60108	60126	60130	60131
60137	60139	60141	60143	60148	60153	60154
60155	60157	60160	60162	60163	60164	60165
60171	60176	60181	60187	60189	60191	60301
60302	60304	60305	60403	60404	60431	60435
60440	60441	60446	60447	60490	60502	60503
60504	60505	60506	60507	60512	60513	60514
60515	60516	60517	60519	60521	60523	60525
60526	60527	60531	60532	60538	60540	60541
60543	60544	60545	60548	60552	60554	60555
60558	60559	60560	60561	60563	60564	60565
60566	60567	60585	60586	60598	60634	60707
60706						

Source: Claritas Data from Environics Analytics ENVISION Tool

CHNA Implementation Strategy 2024 Development and Ongoing Review

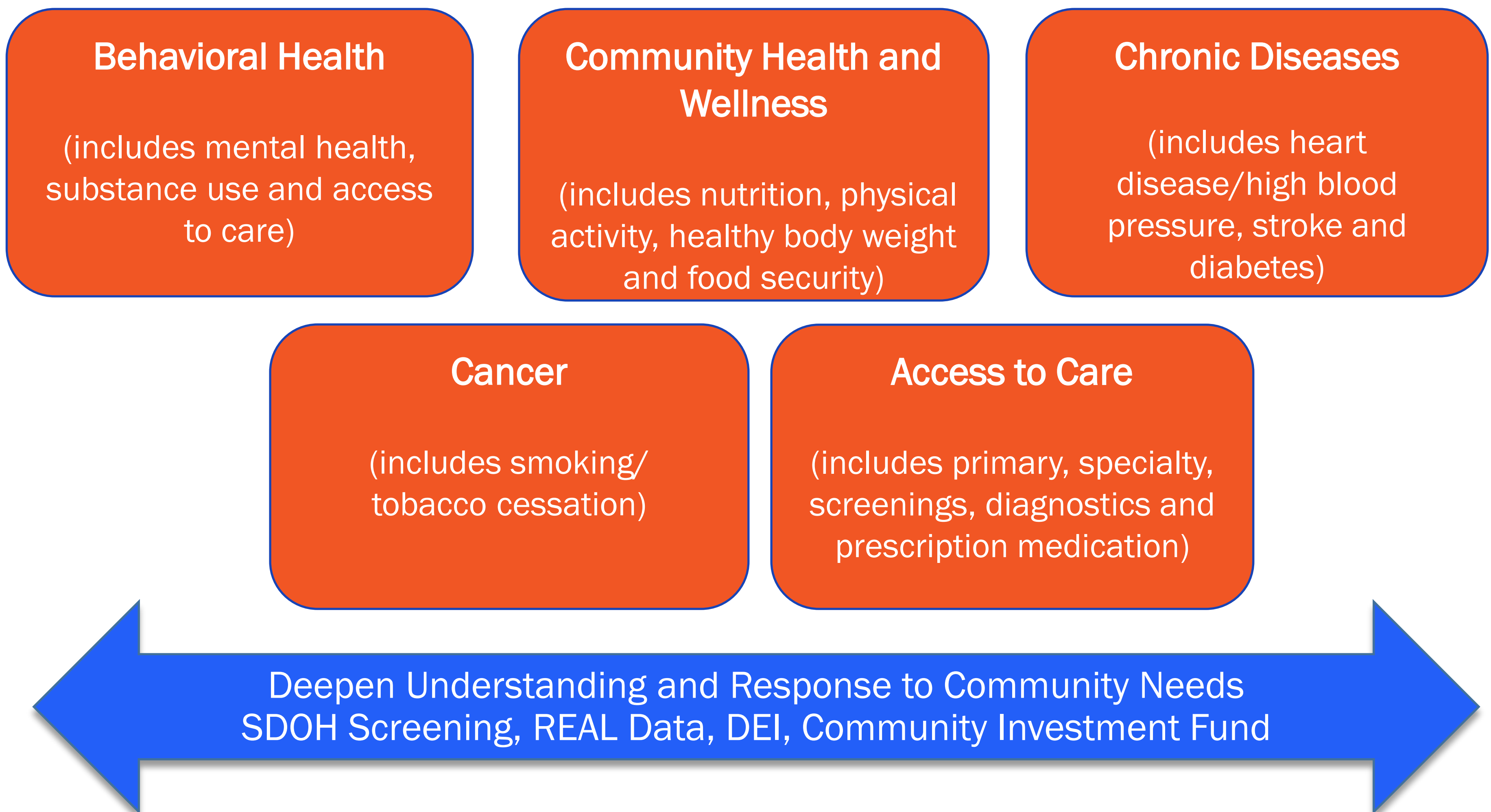
The IS was developed after the comprehensive 2024 CHNA was completed. Please refer to the complete CHNA for the full report. Strategies and action plans were developed based on a consensus among key priority stakeholders for each priority need.

This IS will be reviewed annually during the three-year lifespan (2025-2027) of the 2024 CHNA and updated as needed to ensure viability and impact. The impact will be communicated regularly to reporting agencies and our community.

Priority Needs Identified by the CHNA

Priority Needs and Foundational Commitments

The orange boxes below represent the priority needs that were elevated through the CHNA process. The blue arrow represents systemwide initiatives that intersect with all of the priority areas. EEH is committed to addressing these fundamental priorities, as we deepen our understanding and engagement within the communities we are privileged to serve.



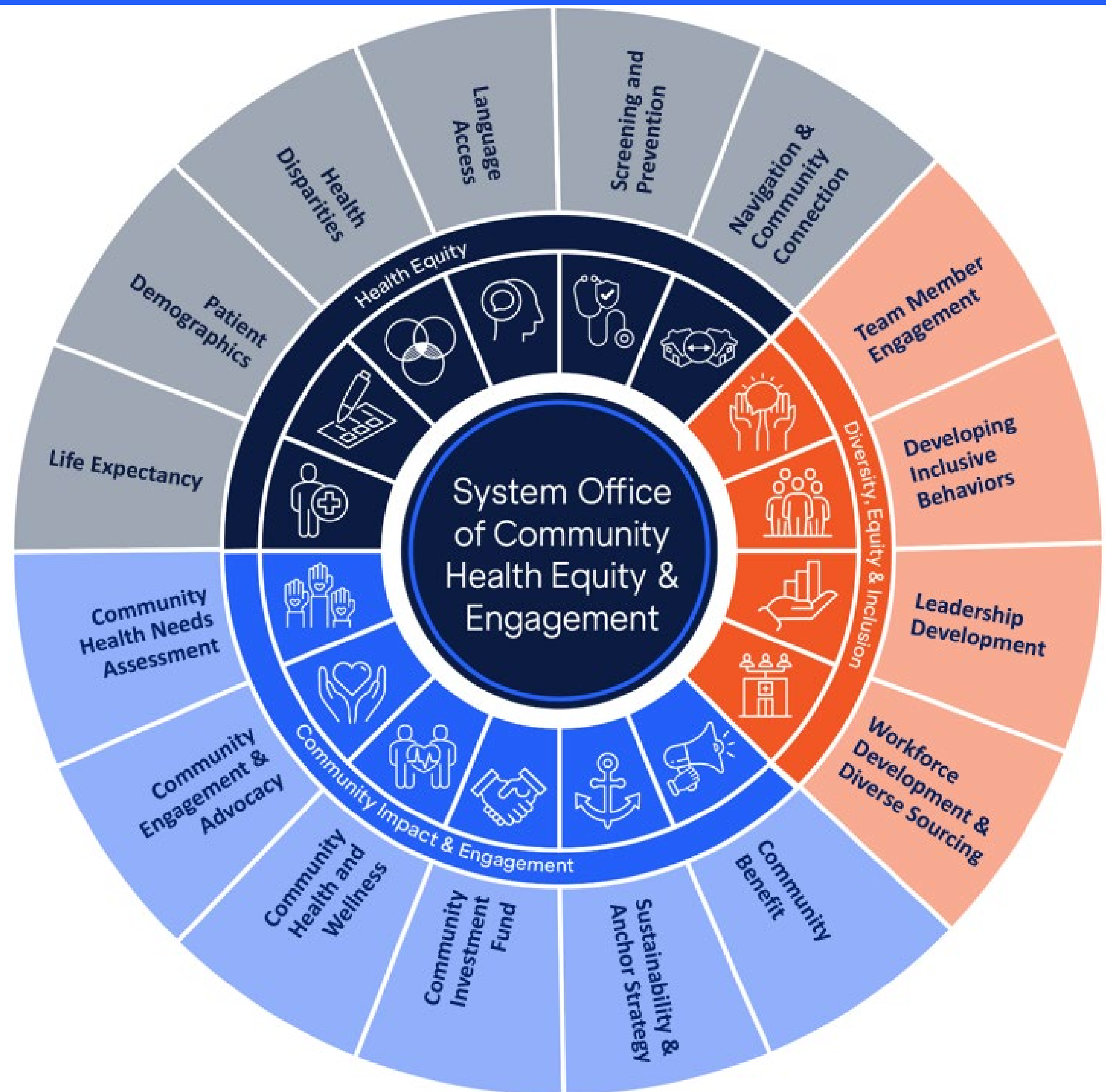
A Multidisciplinary Approach

Through a collaborative multidisciplinary approach, the Implementation Strategy (IS) is developed by working at both a system and entity level with clinical and non-clinical teams. Each priority need includes at least one system initiative in addition to several initiatives specific to EEH.

The System Office of Community Health Equity and Engagement (SOCHEE) is fundamental to this work and serves as a system-wide coordinating body that provides thought leadership and shares best practices to inspire and drive equity and inclusion in our internal and external communities. SOCHEE is led by three core teams dedicated to improving equitable health outcomes for our team members, patients and community. These teams are depicted on the following pages.

Social Determinants of Health (SDOH)

It is important to note that SDOH greatly impact the health and wellness of individuals in our community. Research shows that income, housing, education, diet and employment have a direct correlation to a person's health status. Endeavor Health recognizes the importance of addressing SDOH and has incorporated it throughout the priority needs' strategies.



Community Impact & Engagement

Health Equity

Health Disparities
We identify gaps and causes of disparities in patient access, outcomes and experience.

Language Access
We support patients who are Limited English Proficient and Deaf/Hard-of-Hearing by reducing barriers to services and promoting health literacy.

Patient Demographics
We standardize how we collect and stratify patient data by race, ethnicity and language (REAL) and sexual orientation and gender identity (SOGI).

Screening and Prevention
We promote access to screening and preventative care.

Life Expectancy
We improve life expectancy by focusing on six key clinical drivers: hypertension, diabetes, violence, mental health, cancer and infant mortality.

Navigation and Community Connection
We utilize Community Health Workers to close disparity gaps and address SDOH barriers through navigation and community connection.

Diversity, Equity & Inclusion

Engagement

Opening doors for dialogue, learning, and celebrating the richness of our diversity expanding our culture of inclusion and belonging.

Education

Building self-reflection, inclusive behaviors and leadership skills advancing our value of respect everyone and continuing to create our inclusive culture.

Development

Enhancing hiring and leadership programs to establish a robust internal pipeline, fostering the professional growth of diverse clinical staff and leadership teams.

Community

Increasing young adult career opportunities, diverse sourcing partnerships building robust local talent pipelines, and enhancing supplier diversity, elevating local economic growth.

Systemwide Foundational Goals Embedded In All Priority Areas

Deepen Understanding and Response to Community Needs
SDOH Screening, REAL Data, DEI, Community Investment Fund

Strategy	Initiatives/Programs	Metrics and Goals	2025 Progress	2026 Progress	2027 Progress
Screen all patients for SDOH needs.	Launch new North Carolina screening tool among Endeavor Health inpatients.	Launch tool at all entities 2025 Goal: Successful launch			
		% of inpatients screened 2025 Goal: Establish baseline			
	Launch Findhelp program to provide resources for patients in need.	# of patients supported 2025 Goal: Establish baseline			
Understand patient demographics.	Collect race, ethnicity and preferred language data from all inpatients and outpatients at time of registration (REAL data).	% of patients answering "other" or "unknown" 2025 Goal: 5% or less			
Develop inclusive skills and behaviors among team members.	Provide annual "Introduction to DEI" training for all Endeavor Health employees.	% of employees who completed training 2025 Goal: Establish baseline			
	Offer "DEI Academy" trainings to Endeavor Health employees.	# of trainings completed 2025 Goal: Establish baseline			
Build community capacity via the Community Investment Fund (CIF).	Partner and provide financial support to local nonprofit organizations addressing behavioral health, food insecurity, housing, workforce development and other needs identified in recent Community Health Needs Assessments.	# of community partners 2025 Goal: 10 $ invested 2025 Goal: $10 million			

Key
Systemwide Metric
Local Entity Metric

Priority Need: Behavioral Health

(includes mental health, substance use and access to care)

Strategy	Initiatives/Programs	Metrics and Goals	2025 Progress	2026 Progress	2027 Progress
Screenings and Access to Care	Provide standardized behavioral health inpatient placement for individuals in crisis via the ED Crisis Teams and Care Management Center.	# of individuals successfully placed for inpatient stay within Endeavor Health or other Illinois behavioral health treatment facilities 2025 Goal: 8,000			
	Offer free, confidential 24/7 telephone support to individuals needing behavioral health support and referrals (1-847-HEALING).	# of individuals who receive support and referrals via 24/7 telephone support lines 2025 Goal: 60,000			
	Expand colocation of behavioral health within primary care setting to enhance access.	# new patients served 2025 Goal: Establish baseline # of new therapists 2025 Goal: 2			
	Collaborate and refer patients to Community Substance Use Treatment Providers to enhance access and ongoing care.	# of patients referred 2025 Goal: Establish baseline			
Patient Safety	Increase compliance with safe prescribing practices of opioids and other controlled substances via Patient Provider Pain Agreement through medical group outpatient practices.	% compliance 2025 Goal: 35%			

Key
Systemwide Metric
Local Entity Metric

Priority Need: Community Health and Wellness
(includes nutrition, physical activity, healthy body weight and food security)

Strategy	Initiatives/Programs	Metrics and Goals	2025 Progress	2026 Progress	2027 Progress
Education and Outreach	Offer free wellness webinars focused on health education and living a healthy lifestyle.	# of participants % of survey respondents who learned something new 2025 Goal: Establish baselines			
	Offer free community events focused on health education and living a healthy lifestyle.	# of participants 2025 Goal: Establish baseline			
Access to Physical Activity	Provide fitness opportunities for community members and patients.	# of Access Fit memberships (free or reduced cost for Access DuPage patients) 2025 Goal: Establish baseline # of new partners introduced to Take a Hike challenge from Endeavor Health 2025 Goal: 4 new partners			
Access to Treatment	Offer physician-supervised medical weight loss program for adults and explore opportunities to expand access via alternate providers.	# of patients supported/seen 2025 Goal: Establish baseline Launch PCP education 2025 Goal: Launch pilot			
Access to Healthy Food	Conduct events to address food insecurity (food drives, hot meals for local partners, health education at food pantries, mobile food pantry, etc.).	# of events supporting food insecurity 2025 Goal: One per quarter			

Key
Systemwide Metric
Local Entity Metric

Priority Need: Chronic Diseases

(includes heart disease/high blood pressure/stroke and diabetes)

Strategy	Initiatives/Programs	Metrics and Goals	2025 Progress	2026 Progress	2027 Progress
Support and Intervention	Support controlled hypertension (HTN) levels among Endeavor Health Medical Group (MG) patients.	% of adult MG patients with a HTN diagnosis with controlled HTN level (Controlled = BP<140/90) 2025 Goals: System: 78% EEH: 81%			
	Support controlled levels of diabetes/A1C among MG patients.	% of adult MG patients with Type I or Type II diabetes with controlled diabetes/A1C levels (Controlled = A1C <8) 2025 Goals: System: 76% EEH: 76%			
	Use the Lens of Equity Tool to identify populations and develop targeted interventions around chronic disease management.	% reduction in the disparity gap for MG target population. 2025: Target Population-African American HTN -Disparity Gap for Hypertension. 2025 Goals: System: 3.9% EEH: 4.4%			
Education and Outreach	Develop blood pressure screening toolkits for community screenings.	# of individuals screened # of screening events 2025 Goal: Establish baselines			
	Collaborate with Access DuPage to develop an abbreviated diabetes curriculum.	Create curriculum and launch program pilot 2025 Goal: Successful launch			
Screening and Early Detection	Partner with Young Hearts for Life to support cardiac screening for high school students to identify heart conditions and prevent sudden cardiac death.	# of schools supported 2025 Goal: 11 # of students screened 2025 Goal: 12,000			

Key
Systemwide Metric
Local Entity Metric

Endeavor Health.

Priority Need: Cancer
(includes smoking/tobacco cessation)

Strategy	Initiatives/Programs	Metrics and Goals	2025 Progress	2026 Progress	2027 Progress
Screenings and Early Detection	Utilize FIT Tests (fecal immunochemical test) for Endeavor Health Medical Group (MG) patients who have been recommended a colonoscopy screening and declined.	% of positive FIT Tests that have a colonoscopy scheduled within 90 days of receiving results 2025 Goals: System and EEH: Establish baselines			
	Use Lens of Equity Tool to identify populations and develop targeted interventions around cancer screenings.	% cancer screening rate among MG target population 2025 Goals: Focus on breast cancer screenings for patients who live in lowest quartile for median family income. System: 81% EEH: 81%			
	Screen mammogram patients for genetic risk factors to identify those in need of genetic screening referral.	% of patients screened positive for genetic risk factors 2025 Goal: Establish baseline			
Education and Outreach	Provide EPIC centered outreach to educate patients on new age guidelines for colon cancer screening.	Launch program to patients of appropriate age 2025 Goal: Successful program launch			
	Utilize awareness campaigns and outreach to promote screening for breast, prostate, colon and lung cancer.	% incremental volume post awareness campaigns 2025 Goals: Establish baseline # of community outreach events 2025 Goal: 4			
Survivorship and Support	Hire Lung and GI navigators to support newly diagnosed cancer patients.	# of patients supported 2025 Goal: Establish baseline			

Key
Systemwide Strategy
Local Entity Strategy

Priority Need: Access to Care

(includes primary, specialty, screenings, diagnostics and prescription medication)

Strategy	Initiatives/Programs	Metrics and Goals	2025 Progress	2026 Progress	2027 Progress
Access to Healthcare and Community Resources	Deploy a team of Community Health Workers (CHW's) to provide patient support which may include finding medical homes, scheduling appointments and screenings, addressing social determinants of health and referrals to other community resources.	# of patients supported 2025 Goals: System and EEH: Establish baselines			
	Increase the number of specialty care appointments to care for population at or below 250% of current FPL as referred by our FQHC partners and/or Access DuPage.	% increase of specialty appointments for patients referred 2025 Goal: 25% increase in Access DuPage referrals seen			
Addressing Financial Barriers and Burden	Partner with UNDUE to relieve medical debt and with Pay Zen to defer medical payments.	# of patients receiving medical debt relief # of patients accepting payment plan to defer payments 2025 Goals: Establish partnerships and baseline			
Addressing Language Barriers	Bridge language access gaps via proficiency testing of multilingual team members.	# of employees who successfully completed proficiency testing 2025 Goal: Establish baseline			

Key
Systemwide Metric
Local Entity Metric

Endeavor Health

Key Collaborative Partnerships

Active Partnerships

EEH is committed to active and ongoing collaboration with community organizations to close the gap in various social determinants of health and health equity disparities. These partnerships have allowed our community members increased access to resources and programming that have impact on their health outcomes and well being.

Young Hearts for Life (YH4L) – YH4L is the largest cardiac detection program in the United States for preventing sudden cardiac death for youths. Over recent years, EEH has provided ongoing financial support to YH4L, allowing for screenings at over 50 schools throughout the community.

DuPage Health Coalition – The DuPage Health Coalition is a nonprofit organization with a mission to manage the health of low-income and medically vulnerable residents of DuPage County. It operates through a partnership of health providers including hospitals, physicians and leaders of community-based organizations. EEH supports the coalition with funding and active participation on the Board of Directors. We also have worked on collaborative efforts in their Access Fit program, medical debt relief program and ongoing sharing of resources to better service our community members.

Loaves & Fishes – Loaves & Fishes provides food and support to over 9,000 people a week. EEH has supported Loaves & Fishes to enable increased community access through extended hours and a mobile food distribution truck.

DuPage PADS – DuPage PADS provides interim housing to over 1,200+ individuals with one-third of them being children. They have transitioned their model to an Interim Housing Center (IHC) and have provided meals and wrap around services in addition to a stable place to stay. EEH has partnered with PADs to bring their IHC to fruition and has helped to build out services and programming to support the families during their stay.

Kids Matter – Kids Matter empowers youth in the community to build healthy relationships and increase self esteem. EEH partners with Kids Matter on their Springboard series, which introduces teens to career opportunities and provides training for teens on Mental Health First Aid.

Indian Prairie School District 204 and Naperville Education Foundation – Partnerships with these two school districts have enabled us to provide counseling to students on-site at their schools and has removed barriers for education by providing transportation, access to food, childcare, clothing and behavioral health.

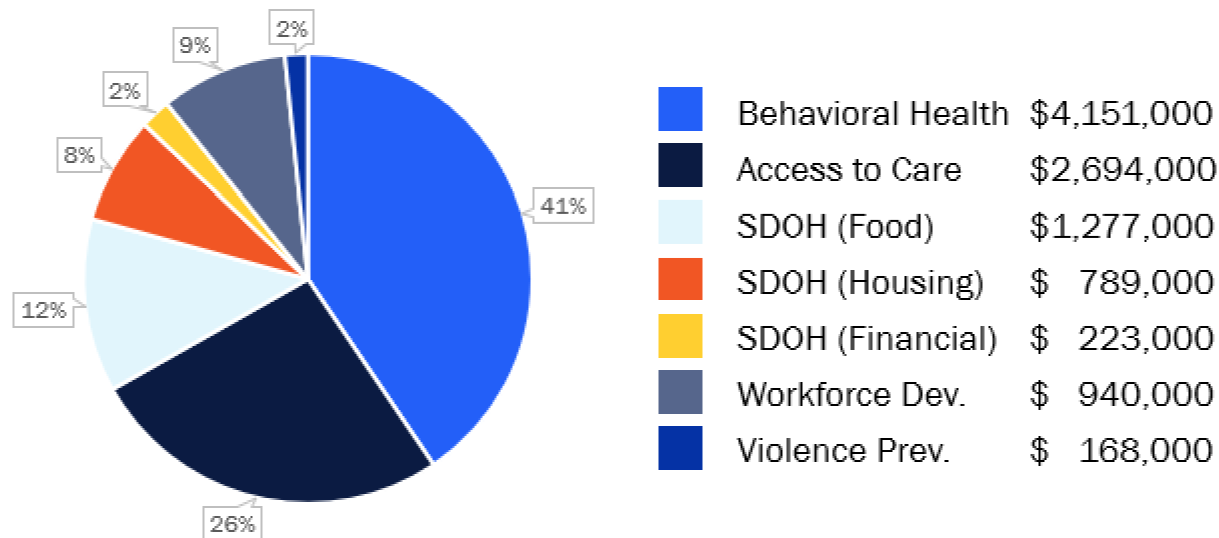
Greater Family Health – Greater Family Health opened its Franklin Park location in 2022 with support from the Endeavor Health Community Investment Fund. This location serves a vulnerable and diverse population. EEH has built strong partnerships with the team that will continue to serve the community through financial and collaborative efforts.

Community Investment Fund

Endeavor Health Community Investment Fund

The Community Investment Fund (CIF) is a dedicated resource aimed at fostering health and wellness, addressing social determinants of health (SDOH) and creating equitable access to quality healthcare within our community. By strategically allocating these funds, we support local initiatives, partnerships and non-profit organizations that respond to priority community health needs.

Whether it's funding for preventive health programs, grants for community health education or resources for mental health initiatives, our goal is to provide the supportive framework that helps community members thrive.



Current CIF Partners within EEH Community

Information Gaps and Other Needs

Information Gaps

While this CHNA is quite comprehensive, EEH recognizes that it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

Other Significant Health Needs

In acknowledging the wide range of priority health issues that emerged from the CHNA process, EEH determined that it could only effectively focus on those which it deemed most pressing, most under-addressed and most within its ability to influence. EEH worked with key stakeholders to develop strategies, tactics and metrics for the majority of the top 50% prioritized needs identified in the CHNA. The remaining needs in the top 50% are addressed as noted below.

Issue or Concern	Reason
HIV/AIDS/STDs	Our internal employee resource group (True North) is also working on educational resources for the LGBTQI+ population. EEH continues to partner with organizations including the ALIVE Center, 360 Youth, Outreach Communities, FQHCs and school districts to raise awareness about these issues, however due to resource constraints and lower priority, this need was not selected for further prioritized attention.
Older Adults Aging In Place	This need is addressed and integrated into the SDOH screening assessment. EEH social workers have referral links and work to navigate older adults to necessary resources based on identified needs. We continue to work with our community partners to provide transport (Ride Assist), home improvement (Habitat for Humanity) and adult day care (Riverwalk). We will continue to uncover potential collaborations with park districts and coalitions.
Housing	Other local community organizations with who EEH partners including PADS, Bridge Communities, 360 Youth and Outreach Communities are addressing this need, and we will continue to partner where appropriate. At this time, EEH lacks the expertise to effectively address this need.
Audiology	We have an audiology department to refer community members to and are working with our Language Line services to better serve patients who are deaf or hard of hearing. We will continue to partner with our educational partners such as Elmhurst University, Midwestern University and North Central. EEH sponsors the Lions Club to assist in their ability to provide screenings for our underserved population.
Financial Instability	We work with our finance team to help our patients apply for insurance coverage. In addition, Access DuPage is working to align insurance coverage and alleviate medical debt and SSIP is working on the Medicaid redeterminations. We also partner and fund our local FQHCs to provide care for patients that are uninsured including Greater Family Health, VNA, MAPP and Access DuPage.

Implementation Strategy Approval and Publication

This Implementation Strategy was reviewed and approved by the Edward-Elmhurst Health Board of Directors on October 22, 2024.
EEH has taken an in-depth look at the needs and assets in the communities we serve, and we are committed to addressing those needs through implementation strategies in partnership with communities most impacted by health inequities. These strategies are in addition to millions of dollars of Charity Care and Medicaid/Medicare unreimbursed costs that EEH provides. We recognize that as a health system we cannot improve our community's health and wellbeing without the support of valued partners and community support.

The approved IS was posted on the hospital's website in December, 2024 and is available along with the CHNA at endeavorhealth.org/community#reports. It was also shared broadly with internal and external stakeholders, including employees, volunteers, physicians, elected officials and members of our community.

To provide feedback on this Implementation Strategy or the corresponding Community Health Needs Assessment please complete the online feedback form.