Executive Summary

In accordance with the requirements of the Affordable Care Act (ACA) and Internal Revenue Service (IRS) guidelines, Edward Hospital (EH), Elmhurst Memorial Healthcare (EMH), and Linden Oaks Hospital (LOH) have adopted the enclosed joint Community Health Needs Assessment (CHNA) report and Implementation Strategy to identify, prioritize and address significant health needs within their primary service areas of DuPage and Will Counties. Edward Elmhurst Health (EEH) collaborated with DuPage and Will Counties in the development of the counties' most recent CHNAs and implementation strategies and ultimately incorporated these CHNAs into this joint CHNA report.

During March and April 2022, EEH hosted a series of internal and community stakeholder forums to review essential county level CHNA information and to establish recommendations for the joint CHNA and Implementation Strategy for EH, EMH, and LOH. Throughout this process, forum participants, which included representation from county health departments and medically underserved, low-income, and minority populations, prioritized issues and opportunities based on an assessment of:

- **Overlap between DuPage and Will Counties**: The fact that a health need was identified in both the DuPage and Will County CHNAs as an area of opportunity
- **Magnitude**: the size of the population affected and the degree of variance from benchmarks and trends
- **Impact/Seriousness**: the degree to which the issue affects or exacerbates other quality of life and health-related issues
- **Feasibility**: the ability for EEH to reasonably impact the issue given available resources
- **Consequences of inaction**: the risk of not addressing the problem at the earliest opportunity

The result of this process was the identification of the following significant health needs for the FY2023 – FY 2025 CHNA:

- Access to Healthcare
- Chronic Disease (Obesity, Diabetes, Heart Disease (including hypertension), and Cancer)
- Behavioral Health (Mental Health and Substance Use)
- Addressing social determinants and connections to community resources

The following report provides a summary of EEH and characteristics of its community, the CHNA planning process and key findings, and the initiatives EEH has established in its FY2023-2025 Implementation Strategy. Additional detail, including performance against the FY2020 – FY 2022 implementation plan, may be found in the appendix (Appendix E).

Introduction

This document is the joint CHNA and joint Implementation Strategy for EH, EMH, and LOH, which was adopted for each of EH, EMH, and LOH on May 24, 2022.

Health System Information

Edward-Elmhurst Healthcare (EEH)

The Edward-Elmhurst Health System (EEH) is comprised of three hospital facilities: Edward Hospital (EH), Elmhurst Memorial Hospital (EMH) and Linden Oaks Hospital (LOH). The primary service area (PSA) of EH, EMH, and LOH together - defined as the area from which these three hospital facilities draw roughly seventy-five percent (75%) of inpatient (IP) admissions – has a population of nearly one million residents and stretches approximately 42 contiguous miles from Yorkville (southwest corner of EH PSA) to Bensenville (northeast corner of EMH PSA). EH, EMH, and LOH also serve a secondary service area (SSA)—representing approximately 15% of IP discharges—of approximately 1 million additional residents.

Collectively, EH (in Naperville) and EMH (in Elmhurst) operate 617 licensed acute care beds and LOH (Naperville) operates 108 behavioral health beds. In addition, EEH has more than 50 outpatient locations, a large and growing employed and affiliated physician base, two medically based fitness centers, and numerous joint ventures designed to ensure access to cost-effective and high-quality healthcare. A summary of each hospital facility is provided below.

Edward Hospital

EH has 359 acute care beds and a medical staff of over 1,100 physicians across a full scope of medical and surgical specialties and subspecialties. EH serves the residents of Chicago's west and southwest suburbs with a PSA inclusive of the following cities: Naperville, Lisle, Warrenville, Woodridge, Plainfield, Oswego, Yorkville, Bolingbrook and Romeoville.

Elmhurst Memorial Hospital

EMH has 258 acute care beds and a medical staff consisting of over 900 physicians representing nearly every medical specialty and subspecialty. EMH serves the residents of Chicago's west suburbs with a PSA including the cities of Addison, Bellwood, Bensenville, Berkeley, Elmhurst, Franklin Park, Glen Ellyn, Hillside, Lombard, Melrose Park, Northlake, Stone Park, Villa Park, Westchester, Wood Dale and Oak Brook.

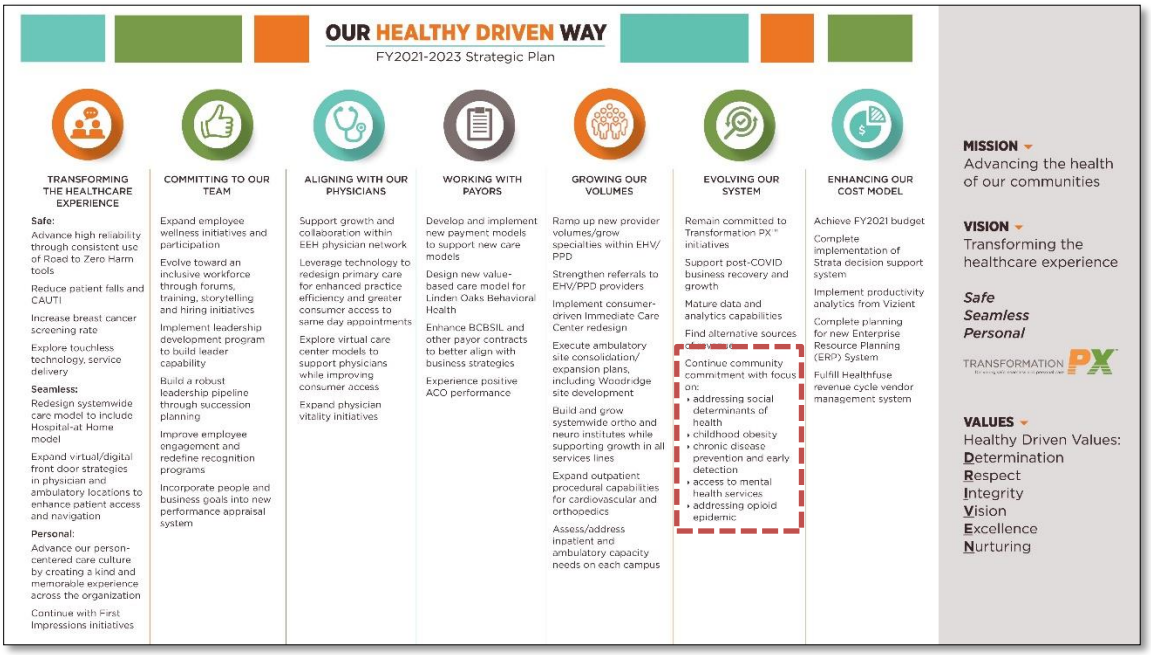
Linden Oaks

LOH is a 108-bed behavioral health hospital on Edward Hospital's Naperville campus with offices in Naperville, Plainfield, St. Charles, Woodridge, Mokena, Hinsdale, Addison and Orland Park. With more than 50 providers on its medical staff, LOH serves the residents of Chicago's west and southwest suburbs. LOH has programs for depression, substance abuse, attention deficit disorders, obsessive compulsive disorders, eating disorders, medication management and disorders resulting from medical conditions. Linden Oaks Medical Group (LOMG) also has doctors with expertise in mood disorders, anxiety, personality disorders, schizophrenia and other psychotic disorders.

As the parent of EH, EMH, and LOH, EEH is a supporting organization of each of EH, EMH, and LOH and is both organized and operated to benefit and perform the functions of these hospitals. In its capacity as their supporting organization, EEH coordinated the CHNA process on behalf of EH, EMH, and LOH that resulted in this report. Accordingly, any reference to the activities of EEH in this report should be understood to be activities conducted on behalf of EH, EMH, and LOH.

The mission of EEH is *"Advancing the health of our communities"* Toward this end, EEH is committed to meeting the needs of the local community while ensuring the scale and geographic spread to provide access, efficiency and high quality healthcare.

EEH's commitment to the health of its community is fully integrated into its strategic plan, identified within one of the seven priorities ("Evolving the System"). The graphic below illustrates the EEH Roadmap, which is used to communicate the System's highest priority initiatives to all stakeholders.

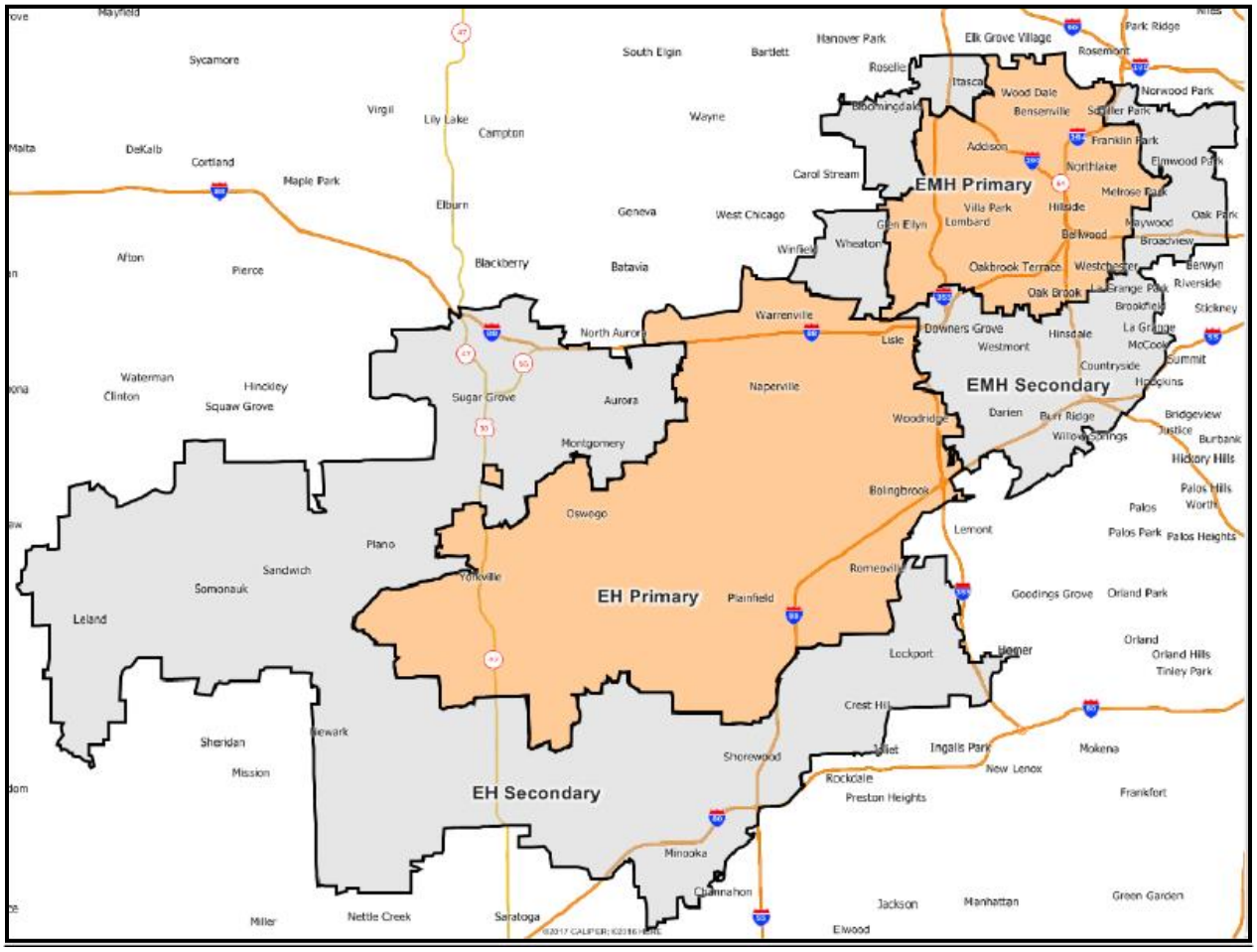


EEH community benefit planning, implementation and reporting is supported by the EEH System Community Benefit Steering Committee. The Committee is tasked to assess community need, establish priorities and supporting initiatives, and monitor outcomes to ensure initiatives are consistent with its mission to advance the health of the community served. In addition, as Community Benefit is integrated into the strategic plan and outcomes are periodically reported to the System Board of Directors.

EEH Demographics

Edward-Elmhurst Communities Served

EH, EMH, and LOH serve a total service area (TSA) population of nearly two million residents with the majority residing in DuPage and Will counties (69.6%). The map below illustrates the geographic footprint of EH, EMH, and LOH. The specific communities included in EH and EMH's PSA are directly below the service area map.



Edward Hospital

Service Area	City - Zip Code
Edward North Primary Service Area (NPSA)	Warrenville – 60555 Naperville – 60540 Naperville – 60563 Naperville – 60565 Naperville – 60566 Naperville – 60567 Woodridge – 60517 Lisle – 60532 Aurora – 60502 Aurora – 60503 Aurora – 60504
Edward South Primary Service Area (SPSA)	Naperville – 60564 Plainfield – 60544 Plainfield – 60585 Plainfield – 60586 Bolingbrook – 60440 Romeoville – 60446 Bolingbrook – 60490 Oswego – 60543 Yorkville – 60560

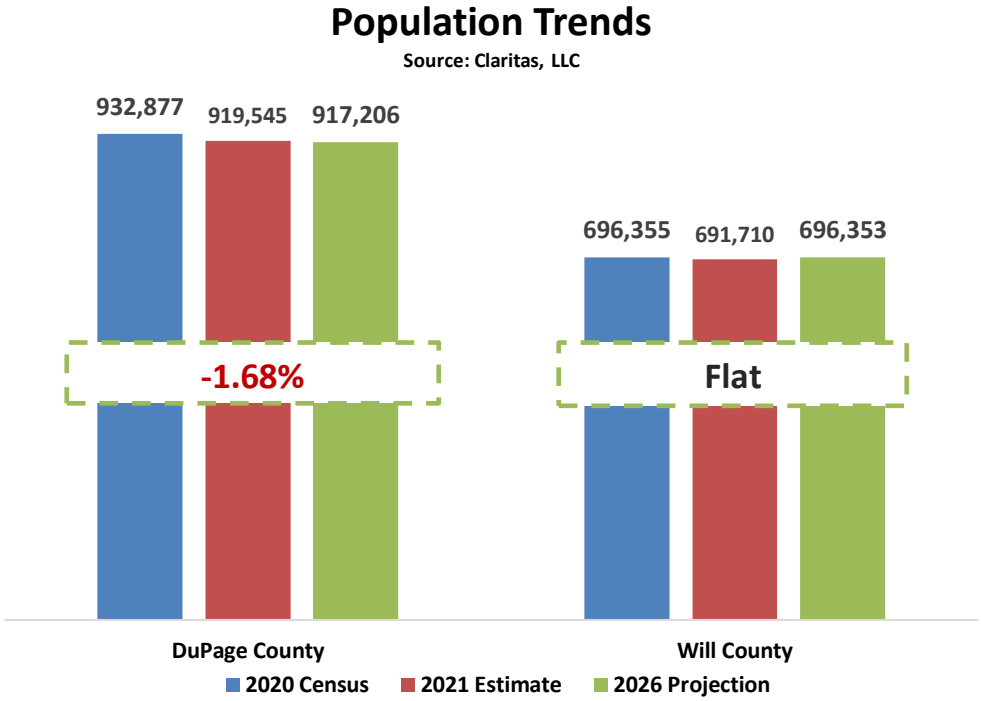
Elmhurst Hospital

Service Area	City - Zip Code
Elmhurst Primary Service Area (PSA)	Elmhurst - 60126 Hillside - 60162 Berkeley - 60163 Villa Park - 60181 Oak Brook - 60523 Bellwood - 60104 Franklin Park - 60131 Westchester - 60154 Melrose Park - 60160 Northlake - 60164 Stone Park - 60165 Addison - 60101 Bensenville - 60106 Wood Dale - 60191 Glen Ellyn - 60137 Lombard - 60148

The table below outlines the System's inpatient population distribution by county. Note the System serves a small segment of Cook County, which has a disproportionately high level of minority population at 31%, compared to Will and DuPage Counties combined at 18%. Cook County also has poverty rate of 10%, which is double that of Will and DuPage Counties combined at 5%.

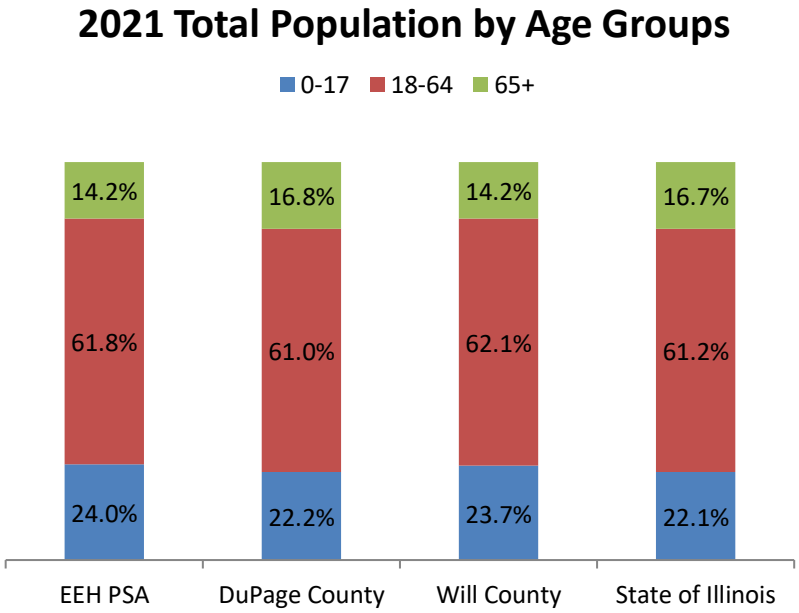
County	FY2021 Inpatient Discharges	Percent of Total	Cumulative Percent
DuPage	19,492	47.1%	47.1%
Will	9,303	22.5%	69.6%
Cook	8,135	19.7%	89.3%
Kane	1,543	3.7%	93.0%
Kendall	1,228	3.0%	96.0%
DeKalb	291	0.7%	96.7%
Grundy	250	0.6%	97.3%
All Others	1,114	2.7%	100.0%

The 2020 census, 2021 population estimates and 2026 projections by county are provided below. While the DuPage County population is projected to decrease slightly, this decrease is projected to be less than the state of Illinois (-2.36%). The growth projection for Will County is flat.

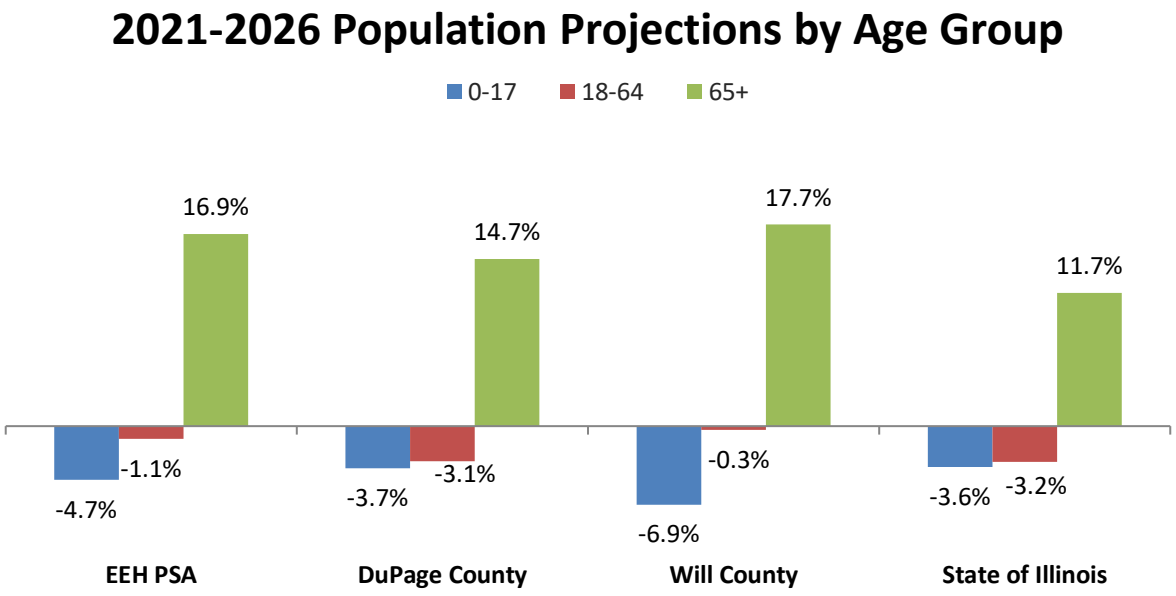


Age Trends

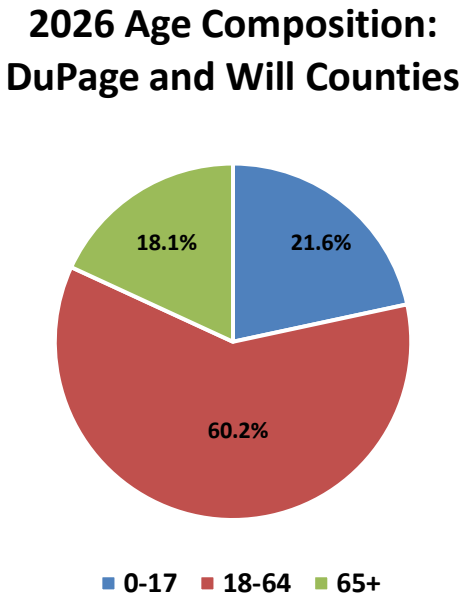
The graph below illustrates the 2021 estimated population by age group for EEH PSA, DuPage and Will counties, and the state of Illinois. When considering median age, EEH PSA and Will County are nearly the same (38.3 and 38.6 years respectively) as the state of Illinois (38.9 years) while DuPage County is slightly older (40.1 years).



Important to note is the disproportionate growth projected for the age group of 65+ years, as demonstrated below.

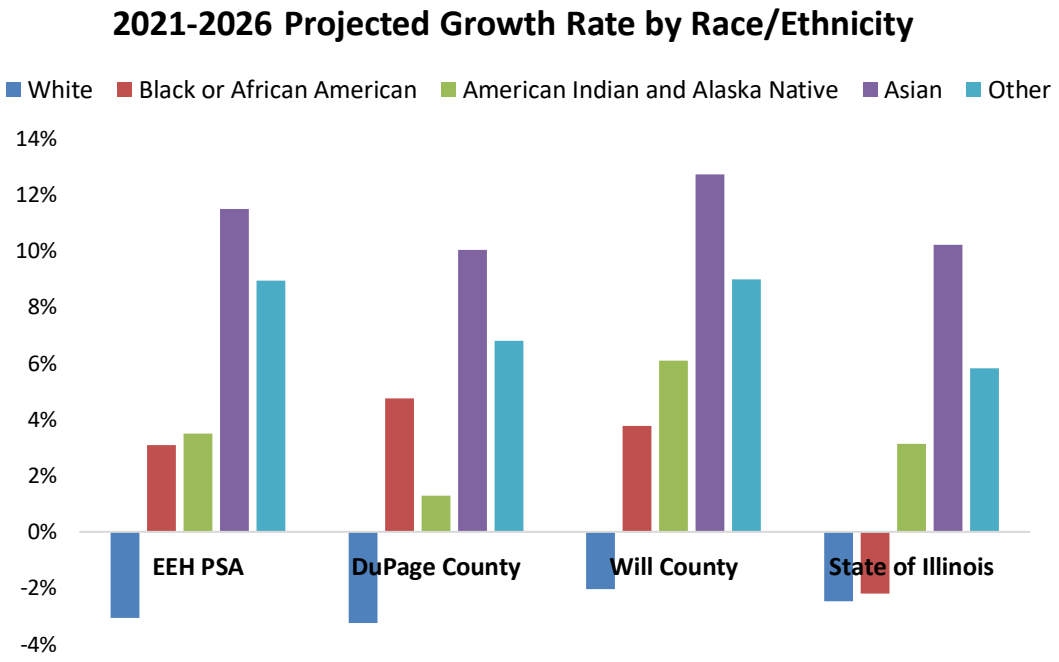


By 2026, it is projected that 18% of DuPage and Will County residents will be 65 years or older, compared to approximately 16% in 2021.

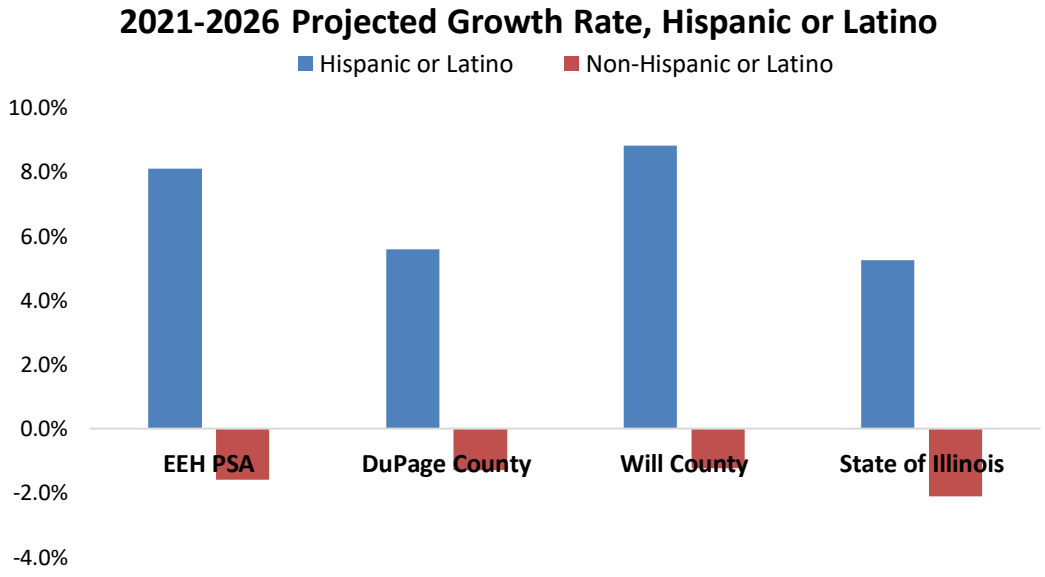


Race and Ethnicity Trends

The graph below illustrates the growth projections across different races/ethnicities. Across the region and consistent with the state of Illinois, the Asian population is expected to grow at the fastest rate, followed by the "Other" population, which includes two or more races or some other race.

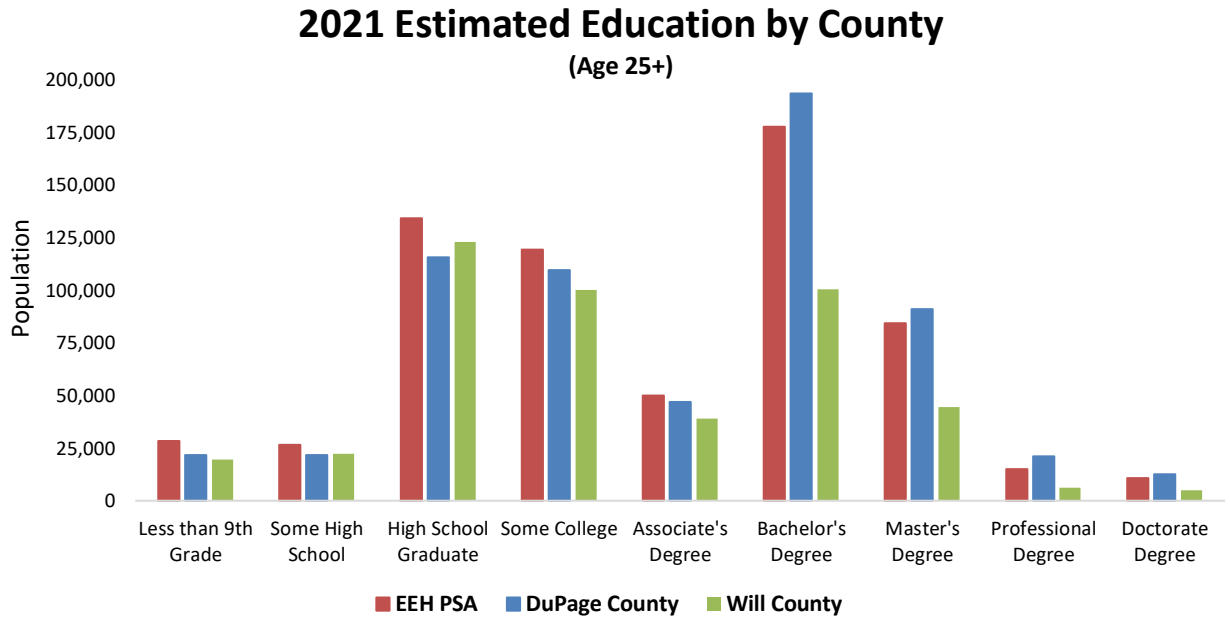


Imbedded within these trends is disproportionate growth in the Hispanic or Latino population. The graphic below indicates that this population will grow over 8% in EEH's region, compared to statewide growth of 5%.

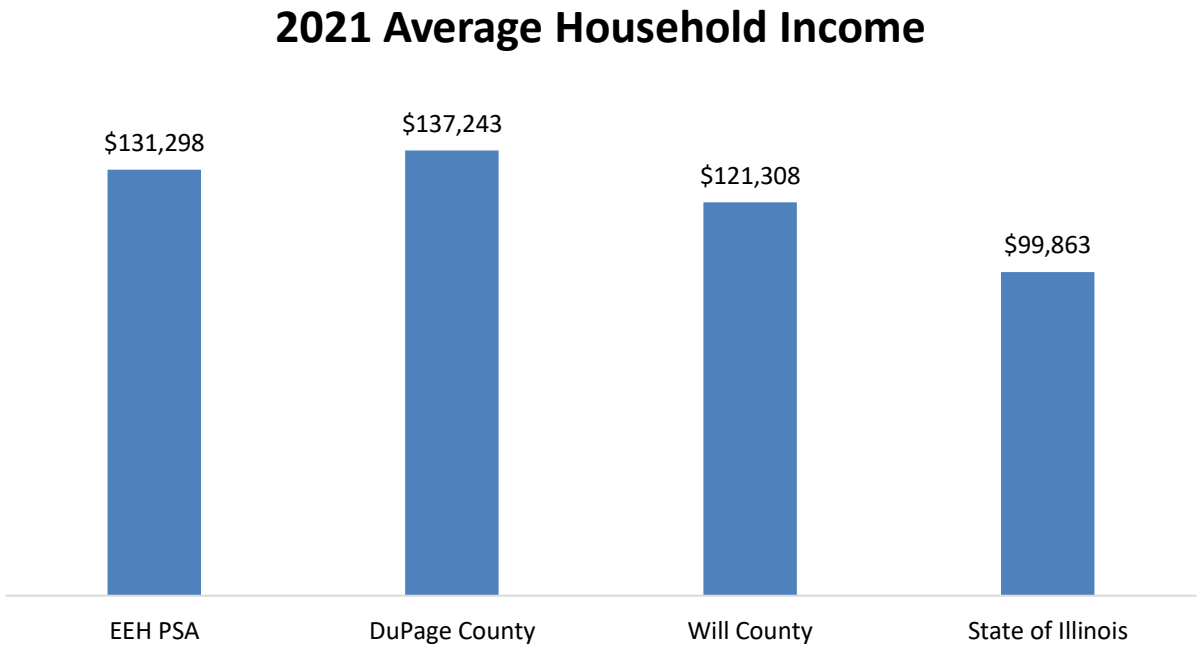


Socioeconomic Status

The graph below illustrates the estimated level of education by county compared to EEH primary service area. Within the EEH region, about 43% of residents have a bachelor's, master's, professional or doctorate degree compared to the Illinois rate of 35%.



The EEH region is relatively affluent compared with the state of Illinois, as depicted below. However, areas of low income residents do exist. Specifically, while reviewing DuPage and Will Counties collectively, nearly 5% or 19,019 families were below the poverty line.



Will and DuPage County Community Health Needs Assessment (CHNA) Process

County-specific CHNAs for Will and DuPage counties were developed through "Mobilizing for Action through Planning and Partnerships" (MAPP) collaborative forums, which allowed for each county, along with community leaders, to identify and prioritize the most pressing health issues within the region. This comprehensive approach considers cross-sector input to ensure creation of outcome-driven county plans that are relevant and responsive to community need. The framework utilizes the following qualitative and quantitative collection methods:

- **Community Themes and Strengths Assessment**: a community survey distributed to residents requesting feedback about the health of the county. The survey is often used by public health systems to evaluate community health by answering questions such as: *What is important to our community? How is quality of life perceived in our community? What assets do we have that can be used to improve community health?*
- **Local Public Health Assessment**: focused on community stakeholder input to assess how well the system works together to provide the 10 Essential Public Health Services[1]. The Assessment is designed to answer two key questions, "What are the components, activities, competencies, and capacities of our local service provider system?" and "How are the 10 Essential Services being provided to our community?"
- **Community Health Status Assessment**: presents quantitative data about each respective county. The information is designed to give a thorough snapshot of the current health status.
- **Forces of Change Assessment**: aims to solicit wide-ranging input from community leaders to identify forces such as trends, factors or events that influence the health of the community. The goal is to better understand the current state to influence the outcomes of the future.

The DuPage County CHNA was conducted from October 2021- February 2022 and finalized in March 2022. The process was led by the DuPage County Department of Community Services, a designated Community Action Agency that works to empower people with needs in DuPage County to become self-sufficient and lead enriched, productive lives, and Impact DuPage, a collective impact partnership, primarily comprised of community leaders from health and human service sectors throughout DuPage County. Across four virtual sessions, EEH partnered throughout the planning phases to develop the DuPage County CHNA, along with the DuPage County Health Department and numerous organizations including representation from public health, healthcare, non-profits, behavioral health, research, education, housing, public safety, and religious/faith-based organizations. Discussion topics focused on review of survey results, discussion of current activities, health equity considerations, strengths, weaknesses, and near and long-term improvement opportunities for each Essential Service. The process and methods used to conduct this CHNA and a description of how input into the CHNA was solicited and considered is contained in the DuPage County CHNA report, provided in Appendix A.

The Will County CHNA was conducted from May 2018 - July 2019 and completed in December 2019. Planning partners supporting development of the plan are listed in Appendix B (Will County CHNA). EEH partnered throughout the planning phases to develop the Will County CHNA, along with the Will County Health Department and numerous organizations serving and representing the interests of medically

[1] Monitor health status to identify and solve community health problems; Diagnose and investigate health problems and health hazards in the community; Inform, educate, and empower people about health issues; Mobilize community partnerships and action to identify and solve health problems; Develop policies and plans that support individual and community health efforts; Enforce laws and regulations that protect health and ensure safety; Link people to needed personal health services and assure the provision of health care when otherwise unavailable; Assure competent public and personal health care workforce; Evaluate effectiveness, accessibility, and quality of personal and population-based health services; Research for new insights and innovative solutions to health problems.

underserved, low-income and minority populations. The process and methods used to conduct this CHNA, and a description of the participants and input provided is contained in the Will County CHNA report, provided in Appendix B.

The DuPage County and Will County CHNA are incorporated by reference into this joint CHNA report for EH, EMH, and LOH.

Will and DuPage County Community Health Needs Assessment (CHNA) Findings

Key priorities from the Will and DuPage County CHNAs for each county are summarized below:

Factors Impacting Health Status
Health systems traditionally focus most of their resources on providing clinical care, but evidence has shown that underlying social determinants of health (SDOH), individual health behaviors, and the physical environment all play a role in the overall health status of communities. County level CHNA findings associated with these underlying influencers are outlined below.

Social Determinants: Primary Drivers - Neighborhood, Built Environment, and Economic Stability
Social determinants impacting residents throughout DuPage and Will Counties are summarized below:

	DuPage	Will
Food Accessibility	• Estimated 72,580 persons with food insecurity • High fast-food density [.94 per 1,000 restaurants] • Below average for WIC and SNAP certified stores	• 10% of population is affected by food insecurity • 15 per every 100,000 people have access to WIC authorized stores • 81 neighborhoods are within food deserts [Affecting 437,000 residents] • 31.83% of pop has low food access [Compared to IL (17.69%) and US (19.04%)]
Housing Access and Affordability	• 425 individuals identified as homeless with an average of 156 homeless nights • 16% return to homelessness	• 341 individuals identified as homeless (32% children) • 4% of homes are overcrowded and 30% are substandard conditions
Access to Transportation	• High mean travel time to work (29.8 minutes compared to 26.9 US value) • 7.3% of residents utilize public transportation for commute to work, compared to 8.3% for Illinois.	• 3.5% of residents utilize public transportation for commute to work, compared to 8.3% for Illinois.

Behavioral Factors and Quality of Life

The behavioral factors identified as most significant across DuPage and/or Will County are summarized below:

	DuPage County	Will County
Obesity	24.7% of adults are obese ***(+~2%)[d]*** ***15% of children are obese (+.5%)[d]***	31.1% of adults are obese ***(+~3%)[d]*** [Men are more likely to be obese]
Substance Abuse	• 21.3% of adults drink excessively ***(+~1%)[d]*** • Of 12th graders who reported drinking alcohol in the past year, 44% usually obtained alcohol from their parents with their permission [Impact DuPage target (2018) 30%][e]	• 24% of adults drink excessively ***(flat)[d]*** • 23% of 12th graders have engaged in binge drinking in the past two weeks ***(-7%)[d]***
Tobacco Use	14.2% of adults smoke tobacco ***(+~2%)[d]***	13.4% of adults smoke tobacco • Higher than HP 2020 goal of 12%[c] 1.9% of 12th graders smoke tobacco and 2/3 use e-cigarettes[d]
Marijuana	20% of teens use marijuana ***(+~2%)[d]***	26% of 12th graders used marijuana in past 30 days ***(-13%)[d]***
Opioids and Drug-Induced Deaths	• 90% of 12th graders think there is moderate or great risk in using prescription drugs not prescribed to them [93% impact DuPage 2018 target][e] • 112 opioid deaths 2020 ***(+~16%)*** **[**Up from 96 in 2019][e]	*Drug-Induced deaths: 19.1 /100,000* ***(+~8)*** [e] • Well over HP 2020 target of 11.3[c]
Social Associations	• 9.5 membership associations per 10,000 ***(+.2%)***	19.2% of adults report having inadequate social and emotional support ***(no new value)***
Bullying	38% of 8th graders bullied over past 12 months ***(no new value)***	41% of 8th graders bullied over past 12 months ***(-9%)[e]***

Outcome comparison legend: a: IL; b: US; c: HP2020; d: prior CHNA; e: County target; f: prior value reported

Physical Environment

The physical environment directly impacts health and quality of life. Essential to physical health are clean air and water as well as safely prepared food. Further, exposure to toxic substances increases the risk of preventable diseases. County Health Rankings has several indicators that measure facts about a community's physical environment. This includes the built environment and quality of the environment. Measures specified under the Physical Environment category include daily density of fine particulate matter, drinking water violations, severe housing issues, driving alone to work, and having a long commute. During the current CHNA planning process timeframe, Will County was ranked 102 out of 102 (Illinois counties) in this category. Will County has significantly dropped in rank since 2011.

DuPage County and Will County Identified Areas of Opportunity

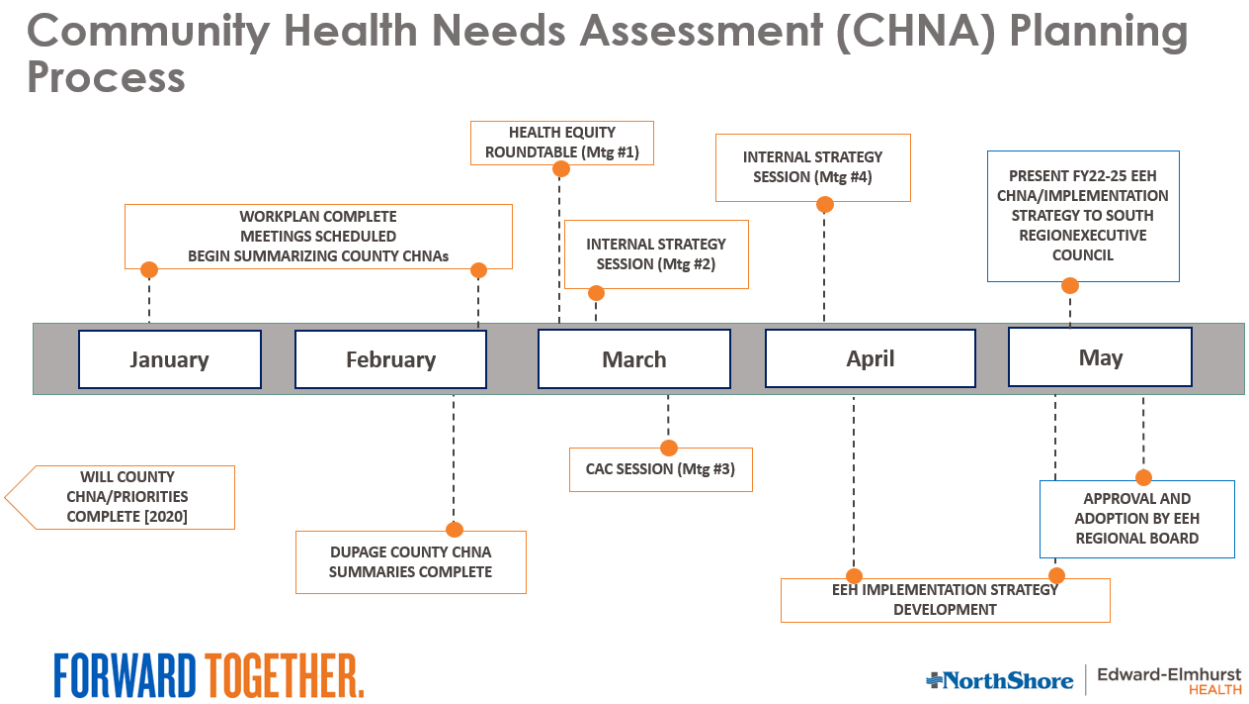
The MAPP process framework involves examining qualitative and quantitative analysis and performance against industry benchmarks and health outcome trends. From this process, areas of opportunity to improve health status were identified by each county, as summarized below. The areas of overlap between the two may be summarized as: economic stability including built environment, access to healthcare, chronic disease, and mental health/substance abuse.

Area of Opportunity	DuPage County CHNA 2022	Will County CHNA 2019
Access to Health Care	X	X
Economic Stability (food access/ transportation)	X	X
Neighborhood and Built Environment (physical environment, public transportation to work, household w/ no vehicle)	X	X
Social and Community Context (social associations/social-emotional support)	X	X
Chronic Disease (Cancer/Heart Disease)	X	X
Language/Literary Access	X	X
Mental Health (adults and adolescents)	X	X
Substance Use Disorder Prevention/Treatment (adults and adolescents)	X	X
Obesity	X	X
Workforce Development		X
Diabetes	X*	X
Education	X	X
Maternal/Child Health		X
Nutrition/Physical Activity		X
Oral Health		X
Tobacco Use		X

*Racial/ethnic disparity focus

EEH CHNA and Implementation Strategy Development

After collaborating with DuPage and Will Counties in the development of the counties' three-year CHNAs and Implementation Plans (with involvement ranging from participation on executive steering committees to local public health assessments), EEH engaged in the process summarized in the graphic below to develop its FY2023 – FY2025 Plan:



This collaborative process involved participation across many internal and community stakeholders (identified in Appendix C) throughout a series of forums**.** These forums were designed to review EEH service area demographics, Will and DuPage County CHNA findings and areas of focus, finalize the selection of significant health needs for this 2022 joint CHNA report, prioritize these health needs, and identify resources potentially available to impact and prioritize. Discussions generated from these forums also laid the groundwork for the establishment of community benefit initiatives to support the FY2023-2025 Implementation Strategy.

The following criteria were used to identify and prioritize the most significant health needs:

- **Overlap between DuPage and Will Counties**: The fact that a health need was identified in both the DuPage and Will County CHNAs as an area of opportunity through the MAPP process
- **Magnitude**: the size of the population affected and the degree of variance from benchmarks and trend
- **Impact/Seriousness**: the degree to which the issue affects or exacerbates other quality of life and health-related issues
- **Feasibility**: the ability for EEH to reasonably impact the issue given available resources
- **Consequences of inaction**: the risk of not addressing the problem at the earliest opportunity

Further, participants were asked to consider the following questions:

- What current EEH initiatives are effective and should continue or be enhanced/expanded?
- What new initiatives should EEH consider to advance the health of the community within the identified priorities?
- Are there specific population segments that require focused initiatives not already established by EEH?
- As a health care provider, where can EEH have the greatest impact when addressing health equity
- What are key community partnerships we should explore, continue and/or enhance?
- If EEH were to commit to ONE meaningful new initiative to support the health of our community, what do you suggest?

Two additional meetings with external community stakeholders were held:

- EEH hosted a Health Equity Roundtable event with DuPage and Will County representatives on March 2, 2022. At this event, cross sector leadership came together to discuss the most pressing issues, learn from one another, and ultimately discuss ways to strengthen strategies for engagement between EEH/CBOs to effectively serve DuPage and Will County residents.
- On March 22, 2022, members of the Edward-Elmhurst Community Advisory Council, which includes representatives of organizations serving and representing the interests of medically underserved, low-income, and minority populations provided input to guide the EEH FY2023 – 2025 Plan. The attendees and populations represented are listed in Appendix C. This group provided their perspective of the most pressing needs of the community, confirmed and refined EEH's preliminary priorities, and provided valuable input around opportunities and initiatives to address these priorities.

A final meeting was held on April 13, 2022, where key EEH internal stakeholders joined together to confirm the prioritized strategic areas of focus and further brainstorm relevant initiatives to develop the implementation strategy.

EEH maintains its commitment to responsiveness to the community; to that end, EEH solicits written comments from the community on the most recent CHNA reports and Implementation Strategy of EH, EMH, and LOH. This solicitation can be found on the EEH Community Benefit webpage where the EEH CHNA reports and Implementation Strategy are made widely available, the following solicitation is posted: "Please provide any comments you may have on our most recent Community Health Needs Assessment (CHNA) or Implementation Strategy. Should you have questions, comments or require additional information, email Edward-Elmhurst Health". No written comments have been received to date.

The FY2023 – 2025 implementation strategy, which is the culmination of collective input and agreement on the significant health needs for EH, EMH, and LOH's 2022 joint CHNA, can be found on pages 18-20. These strategies were identified based upon areas of overlap between the Will and DuPage County CHNAs and consensus on where EEH can play a unique and significant role and therefore drive greatest impact.

Based on the above detailed process and input, the following health needs were identified as the significant health needs of the EH, EMH, and LOH community for this 2022 CHNA report:

Access to Healthcare

People who lack a regular source of health care may not receive the proper medical services when they need them, which can lead to untreated and missed diagnosis along with adverse health outcomes. In DuPage and Will Counties, approximately 15-17% (+250,000 residents) of adults do not have a usual provider or source of health care.

Chronic Disease (Obesity/Diabetes/Heart disease (including hypertension))

For both children and adults, obesity is a significant problem within DuPage and Will counties. It can be indicative of underlying SDOH and an unhealthy lifestyle, which increases the risk of chronic disease. Across both counties, nearly 450,000 individuals above the age of 20 years were categorized as obese (BMI > 30). In addition, as previously reported, 14.8% (137,496) of children/adolescents in DuPage County and 13% (90,046) of 6th graders in Will County are obese.

Diabetes has been identified as top concerns based upon high rates of uncontrolled diabetes, lack of education and awareness, and cultural barriers to receive appropriate care. Further, racial and ethnic disparities have been identified within the EEH community, thus resulting in higher emergency department utilization and potentially avoidable inpatient hospital stays.

Within DuPage and Will Counties, heart disease continues to remain as one of the most pressing healthcare issues. The most recently published age-adjusted death rate due to coronary heart disease was 68.3/100,000 in DuPage County. Will County's coronary heart disease mortality rate (95.6 per 100,000 population) is higher than the Illinois' mortality rate (94.44 per 100,000 population). Further, uncontrolled blood pressure has surfaced as a prioritized concern with varying degrees of implication across difference races and ethnicities.

In both DuPage and Will Counties, cancer continues as a top 2 cause of death. Further, breast cancer incidence is higher in DuPage County (143.5/100k) than the US (126.8/100k). In particular the age adjusted death rate due to breast cancer is approximately 38/100k for Black/African American which is nearly double that realized for White. Finally, in Will County the incidence rate of prostate cancer is higher among the Black population (222/100k), which is nearly double the rate of the White population.

Mental Health/Substance Abuse

Recent estimates indicate that one in four adults and one in five youth have had a mental health issue in the past year. Mental health disorders are strongly associated with the risk, occurrence, management, progression, and outcome of serious chronic diseases and health conditions. During the Will and DuPage County Community Health Needs Assessment survey period, nearly 200,000 community members reported frequent mental distress.

Further alarming is the increasing prevalence of adolescent depression and suicide. In Will County, when asked, “During the past 12 months did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?” 35% of 12th graders responded yes in 2018, which is an increase from 30% reported in 2016. When asked, “During the past 12 months did you ever seriously consider attempting suicide?” 13% of 12th graders and 15% of 10th graders responded yes, which has decreased from 2014.

Addressing Social Determinants and Connections to Community Resources

Health systems traditionally focus most of their resources on providing clinical care, but evidence has shown that underlying social determinants of health (SDOH), individual health behaviors, and the physical environment all play a role in the overall health status of communities. Studies indicate that social determinants and other non-medical factors can account for up to 80% of health outcomes. The primary drivers within DuPage and Will County are detailed on page 11.

During the most recent planning cycle, and guided by the Health Equity Task Force, EEH teams gathered to explore, identify and prioritize efforts around addressing health disparities within the community. To that end, and in consideration moving forward, efforts to develop and enhance programs and partnerships will incorporate recommendations guided by health equity findings.

FY2023-FY2025 Joint Implementation Strategy for EH, EMH, and LOH

As an integral part of the communities it serves, EEH already provides substantial resources to advance its mission (see Appendix E [FY2020-FY2022 EEH Implementation Strategy: Outcomes Update]). EEH will continue to support local, regional and national efforts addressing the priorities identified in its FY 2023-2025 CHNA through coalition building, advocacy, community education and financial support. Active partnership with DuPage and Will County, local municipalities, and other organizations, including but not limited to area school systems, social service agencies, advocacy groups and research organizations will be essential in addressing these priorities.

In addition to these ongoing efforts, the EEH Board of Trustees approved the establishment of a $100 Million Community Investment Program in August 2021. The Program will provide annual grant funding to community organizations aligned with the following goals:

- Advancing Health (health equity and social determinants of health)
- Local economic growth (supply chain diversity and job creating prioritizing DEI principles).

The Program will be guided by input from the EEH Regional Board and the EEH Community Advisory Council, which will support ongoing engagement around community need.

Synergistic with broader and ongoing initiatives around community education and advocacy, EEH will be focused over the next three years on the following initiatives (set forth in the chart directly below) to address the significant health needs identified in this 2022 CHNA report. Unless otherwise noted in the chart below, the entity in the Edward-Elmhurst Health system that will be devoting resources to these initiatives will be EEH. As the parent of the system, EEH is in the best position to tackle and lead these initiatives on a coordinated basis. EEH will be carrying on these activities on behalf of its supported organizations, EH, EMH, and LOH. When EH, EMH, or LOH are expected to devote their own resources to an initiative, this fact will be specifically noted in the chart. As an example, as a behavioral health hospital, LOH is especially well-positioned to address the Behavioral Health significant health need and is thus specifically identified as provided resources to this need throughout the initiatives listed under ‘Behavioral Health’.

PRIORITY #1: ACCESS TO HEALTHCARE			
TACTIC	**MEASUREMENT**	**EEH RESOURCES**	**ANTICIPATED IMPACT**
STRATEGY 1: Increase access to healthcare			
Expand public education about the availability of cost effective ambulatory access points	Proportionate growth in IC/WIC/Retail versus Levels 1-3 outpatient ED	EEH System marketing/digital communications	Reduce avoidable ED utilization Increase right site of care delivery
Optimize virtual triage program to enhance connection and include live chat access and	Number of virtual triage users	EEH System digital marketing and IT resources; outside virtual triage vendor	
Expand EEMG integrated primary care provider and urgent care network, including identification of specialty care gaps	Increased number of EEMG PCP visits/new visits Number of Medicaid/Medicare visits Urgent care visit volume	EEH System recruitment team to support physician recruitment and practice support needs, planning support	Reduce avoidable ED utilization; increase access and linkages with primary care and reduce percentage of population without 'usual source of care'
Develop expanded virtual care options and 24/7 virtual access to key services	Visit volume by time of day Visit volume	EEMG ops leadership, digital team support	Improve access to needed to key services;
STRATEGY 2: Develop robust community partnerships to identify access deficits and connect patients to services			
Explore partnerships with Community partners to expand outreach, reduce transportation barriers, reach vulnerable and underserved populations	Number of physician visits (0-17, 18+ yrs) Number of low acuity OP ED visits (0-17 yrs, 18+)	EEH community/wellness resource and community outreach resource, planning support	Reduce avoidable ED utilization; increase access and linkages with primary care and reduce percentage of population without 'usual source of care' Improve access to needed specialty care; reduce incidence and improve management of chronic diseases
Connect with Hispanic organizations to understand deficits in healthcare literacy/ navigation and support program development assessments	Number of Hispanic physician visits	EEH community/wellness resource and community outreach resource	
STRATEGY 3: Reduce financial and transportation barriers to care			
Promote and offer financial assistance to eligible patients	Number of individuals receiving financial assistance	Financial assistance policy; EEH financial counselors	Ensure that community un- and under-insured patients have access to high quality health care
Identify and assist uninsured patients in ED in obtaining coverage through counseling and related assistance	Growth in uninsured patients connected to Medicaid/other insurance	EEH financial counselors	
Partner with DuPage Health Coalition, Will County MAPP collaborative, Impact DuPage to ensure access for low income residents	Financial/volunteer support provided to DuPage Health Coalition, Will County MAPP Collaborative.	EEH System Community /Government Relations and leadership support of County initiatives; Funding for DuPage Health Coalition and related programming	
PRIORITY #2: CHRONIC DISEASE (OBESITY, DIABETES, HEART DISEASE (+HTN) andandCANCER)			
TACTIC	**MEASUREMENT**	**EEH RESOURCES**	**ANTICIPATED IMPACT**
STRATEGY 1: Encourage early detection and elevate awareness/education to prevent and manage risk factors			
Continue to grow EEH System AWARE programs and connect 'at risk' patients (weight, diabetes, stroke, heart, breast, colon)	Number of (+growth) completed assessments Number of 'at risk' identified and accepting offer for f/u	EEH System Marketing support, including online/digital campaign around online assessment and associated resources	Increased screening rates Reduce county-wide obesity and diabetes rates Reduce county-wide heart and cancer mortality
Expand UltraFast Heartscan (UFHS) programs and connect 'at risk' patients to appropriate resources	Number of heart scans	EEH System UFHS program resources; Marketing support	Reduced cardiovascular risk factors; reduce incidence and mortality
Conduct community Peripheral	Number of vascular	EEH System vascular	

vascular screenings and connect 'at risk' patients to appropriate resources	screenings	screening program resources; Marketing support	
Support "Young Hearts for Life" to provide EKG testing in high schools	Adolescents screened; at risk students identified	EEH System funding to YHFL program in selected school districts	Reduced cardiovascular mortality
Increase cancer screening rates through EEMG primary care providers; Increase colon and breast cancer screenings for underserved populations	Increase in number of patients screened	Physician division operational and analytical support	Increased screening rates Reduced breast and colorectal cancer mortality
Increase EEMG provider education on culturally appropriate pre-diabetic care planning (community resources, lifestyle modification training)	Number of referrals to resources	Community and wellness support; operational support; marketing and operations resources	
Expand Hispanic diabetic pilot program	Number of patients	Operations resources	Reduction in conversion from pre-diabetes to diabetes
STRATEGY 2: Expand treatment options for weight management			
Expand EEH adult and pediatric weight management programming	Growth in participants in EEH Weight Management programs, bariatric surgical procedures	EEH System Program management and resources; marketing support	Reduce county-wide obesity rates
Enhance and further develop school relationships to specifically address childhood obesity; consider potential for regional initiative	Number of students reached	EEH System operations, marketing and planning support; EEH community outreach resource	
Explore expansion options for Jump Start Your health through funding	Number of participants	EEH System operations, marketing and planning support	
STRATEGY 3: Develop approach to align resources across sectors, patient populations and disease states			
Expand and streamline EEH transitional care clinic/specialty care clinic concepts; evaluate chronic care management model	Number visits Number readmissions	Hospital/ambulatory operations resources, planning support	Reduction in avoidable readmissions
Explore opportunities to expand diseases specific navigation and integration programs	Number visits	EEH leadership support and program resources	Reduction in care gaps Increase in favorable health outcomes
PRIORITY #3: BEHAVIORAL HEALTH (MENTAL HEALTH/SUBSTANCE USE)			
TACTIC	**MEASUREMENT**	**EEH RESOURCES**	**ANTICIPATED IMPACT**
STRATEGY 1: Increase access to behavioral health programs and providers			
Expand the local supply of LOMG psychiatrists and APPs	Number of new psychiatrists and APC's. Volume of new patients	EEH System recruitment team support for LOH physicians and APCs	Increase supply of behavioral health providers and enhanced access to treatment, resulting in reduced rates of reported behavioral health issues
Engage academic organizations to partner with recruitment (nursing, therapists, BHAs)	Number of new providers	EEH System recruitment team, LOH operations support	Lower adverse outcomes due to depression, anxiety Lower substance abuse rates
Continue to grow and expand integration and navigation programs (ambulatory/hospital settings)	Number of behavioral health integration/navigation referrals	Linden Oaks behavior health navigators and coordination with Edward Health Ventures and Physician Practice Division	Early detection of behavioral health concerns and access to timely and appropriate mental health care
STRATEGY 2: Reduce behavioral health stigma, increase awareness and enhance education			
Adopt new Mental Health First Aid	Number of people trained	Linden Oaks leadership for	Reduce stigma and promote

(MHFA) curricula focused on teens and seniors (incorporate substance use disorder)		coordination, training and program expansion	awareness
Expand MH school liaison support to provide navigation + early intervention		Linden Oaks leadership for coordination, training and program expansion	Reduce stigma; Enhance education Reduce adolescent depression and suicide; Increase awareness
Partner to produce a Healthy Driven podcast focused on mental health and substance use disorders	Number of attendees	Linden Oaks leadership for coordination	Reduce stigma Enhance education Increase awareness
Grow local community partnerships as a vehicle for continued education/awareness	Count of programs/events	Linden Oaks business development team	Reduce stigma and promote awareness and literacy around mental health issues
STRATEGY 3: Reduce community-wide opioid abuse			
Expand Haymarket/Gateway partnership to the ambulatory environment to reach vulnerable populations	Number of referrals from Gateway/Haymarket Number of referrals to CBOs	EEH System project Leads EEH System program management and resources EEH System public safety monitoring; coordination with pharmacy and mail rooms	Reduced community-wide opioid prescribing Reduced opioid use; reduce opioid mortality rate
Develop tools to monitor improvement efforts: • ED protocols • Provider prescribing patterns	Number of visits Number of frequent fliers Number of outlier providers		
PRIORITY #4: SOCIAL DETERMINANTS OF HEALTH and COMMUNITY RESOURCES			
TACTIC	**MEASUREMENT**	**EEH RESOURCES**	**ANTICIPATED IMPACT**
STRATEGY 1: Streamline referrals and EEH-CBO communication			
Enhance provider awareness/education on Epic SDOH platform and referral resources	Number of assessments Number of referrals	EEH population health/quality/social work hospital/ambulatory leadership support, IT resources, communication liaison resource	Reduced food insecurity Reduced transportation and housing barriers Reduced drug/alcohol use Increased health/wellness outcomes Social context improvements
Expand EPIC SDOH module to all patient care areas at acute care hospitals (ambulatory/inpatient)	Number of assessments		
STRATEGY 2: Develop and elevate partnerships between EEH and Community Based Organizations (CBOs)			
Utilize FIndhelp.org and other community based relationships to enhance partnerships to reduce housing and transportation deficits; reduce food insecurity	Number of 'close loop' correspondence Number of referrals	EEH population health/quality/social work hospital/ambulatory leadership support, IT resources, communication liaison resource	Reduced food insecurity Reduced transportation and housing barriers Reduced drug/alcohol use Social context improvements
STRATEGY 3: Increase data collection and data literacy including stratification to understand health influencers and develop action plans			
Improve data collection and utilize dashboards to analyze areas of health disparities	# of patients assessed as percentage of total patients # of patients identified with disparities of total patients assessed	EEH South Region BI and Planning support and resources Hospital/ambulatory operational leadership support	Identification of patients in need of resources
Develop scorecard to measure progress against goals and improvement benchmarks	Reduction in number of patients with care gaps Reduction in number of patients in need of SDOH resources	BI and Planning support and resources Hospital/ambulatory operational leadership support	Reduction in care plan gaps Increase in patents connected to essential next steps

Summarized below is a list of health priorities by Will and DuPage County that will ***not*** be directly addressed by the FY2023-2025 EEH Implementation Strategy. Note that, while not directly driving initiatives around these priorities, EEH will support many of them by participating in task forces, community collaborative forums, coalition building activities, and distributions through the EEH Community Investment Program.

DuPage and Will County Priority Health Issue That Will Not be Addressed and Supporting Rationale:

Health Priorities Identified	Rationale
Education	This was identified as a priority area within both Counties as higher education has been linked to positive health outcomes. Specifically, disparities are noted among certain races/ethnicities. As EEH's core competency is health care delivery and not education, support will be provided through community partnerships and collaboration around job training and other initiatives as appropriate. Funding for educational programs related to workforce development focused on disadvantaged populations is within the scope of the EEH Community Investment Fund and may be supported through that vehicle.
Transportation	Within the Counties there is consensus around lack of a true transportation system, limited public transit routes and long commutes to work. Support from EEH will be provided through collaborative partnerships and involvement with community coalitions. Further, as EEH aims to address transportation barriers for patients, the System already provides transportation vouchers to low-income individuals on an as-needed basis, as well as a discounted ride services in the Elmhurst region.
Food Access	Food access, both insecurity and uncertainty, was identified in the most recent CHNAs of both Will and DuPage Counties. As EEH's core competency is healthcare delivery, support will continue to be provided through community partnerships and collaboration.
Workforce Development	This was identified within Will County and the County Investment Board has targeted seven key industry sectors: Healthcare and Social Assistance, Wholesale Trade, Professional and Technical Services, Finance and Insurance, Information Technology, Manufacturing, and Transportation and Warehouse. As one of the largest employers in the region, EEH is a major provider of jobs and attracts a diverse workforce. Continued growth of the organization and active involvement in regional economic development coalitions will ensure an ongoing positive contribution. Funding for educational programs related to workforce development focused on disadvantaged populations is within the scope of the EEH Community Investment Fund and may be supported through that vehicle.
Oral Health	This was identified within Will County, which they aim to address through expansion of telehealth/mobile response (mobile dental van). As EEH does not provide dental care services, this is out of scope and will be addressed at the county level.
Maternal/Child Health	This was identified within Will County during the CHNA assessment process. While not directly prioritized in the FY2023-2025 EEH implementation strategy, the Hospital is a major contributor to Maternal and Child Health through its obstetrics and pediatric service lines, which provide a full range of preventive and treatment services for women and children in the region.

Appendix A and B: Will and DuPage County Community Health Needs Assessments; these may be found on their respective websites or will be made available upon request.

Appendix C: KEY STAKEHOLDER MEETINGS and PARTICIPANTS

HEALTH EQUITY ROUNDTABLE: PARTICIPANTS (3/2/22)

Name	Organization	Title
Colin Dalough	EEH	Community and Government Relations
Dr. Kim Darey	EEH	VP, Chief Medical Officer
Joe Dant	EEH	President and CEO, Edward Hospital
Dr. Joseph Kaliski	EEH	Physician
Dr. Mark Gomez	EEH	Physician
Katie Polz	EEH	Ambulatory Strategy System Director
Rachel Nichols	EEH	Counsel
Kara Murphy	DuPage Health Coalition	President
Kathie Watts	EYFP	Executive Director
Teri Miller	Beyond Hunger	Director of Development
Michele Zurakowski	Beyond Hunger	CEO
Jose Vera	SSIP	Executive Director
Laura Bohorquez	SSIP	Health Justice Organizer
Elizabeth Cervantes	SSIP	Director of Organizing
Brandon Pettigrew	Hamdard Health	Director of Development and Strategy

INTERNAL PLANNING SESSION, MEETING #1: PARTICIPANTS (3/15/22)

Name	Title
Dawn Sander	Director, Physician Practice QI
Nicole Garret	PM, MAPP Collaborative
Jennifer Enright	Director, EMG Practice Ops.
Yvette Saba	System VP,Ops
Keith Hartenberger	System Director, Public Relations
Hiral Patel	Innovation Program Manager
Adam Schriedel	Chief Medical Officer - Edward Medical Group
Doug Johnson	Patient Experience Officer
Maureen Kunz	AVP, CNO LOH
Jim Economou	System Director, Pat Access and Pre Svs Ctr.
Cheryl Eck	AVP, Strategy and Planning
Beth Menges	Manager, Addiction Services
Jessi Cole	Mgr, Business Development LOH
Katherine Crandell	Planning Analyst
Nicholas Love	Physician, EHV
Bridget McLemore	System Director, Specialty Services
Teri Kaneski	System Director, Clinical Integration and Population Management

Trish Fairbanks	System VP, Ops and CNO
Becky McFarland	PM, Impact DuPage
Marcie LaFido	AVP, CNO
Marianne Spencer	System VP Ops
Gina Sharp	President and CEO, Linden Oaks
Pat Bradley	Sys Dir, Women's Svs
June Makowski	Manager, Population Health and Care Management -EHV/PPD
Cathy Smith	Services Line Director, Cardio/Neuro IP and CVS
Dr. Kim Darey	VP, Chief Medical Officer
Kirsten Mullinax	Coord Community Wellness
Ellen Turnbull	System Director, Emergency Services
Tracy Collander	Dir, Practice Ops LOMG
Colin Dalough	Community and Government Relations
Robert Payton	VP, Chief Medical Officer
Pamela Dunley	President and CEO, Elmhurst Hospital
Annette Kenney	Exec . VP, Chief Strategy Officer
Katie Polz	Ambulatory Strategy System Director
Katy Catura	System Director, Case Management/Social Work

COMMUNITY ADVISORY COUNCIL: PARTICIPANTS (3/22/22)

Name	Organization	Title
Amar Kapadia	KPMG	Managing Director
Christine Jeffries	Naperville Development Partnership	Board Member
Dan Bridges	Superintendent	Superintendent
Dawn Melchiorree	360 Youth	CEO
Desiree Chen-Menichini	Elmhurst University	Senior Dir, Communications and External Relations
Dr. Adrian Talley	District 204 (Naperville)	Superintendent
Dr. Mimi Cowan	Will County	Chairman, Will County Board
Hugh McLean	Rock Island Capital	Partner
Jason Arres	Naperville Police	Chief of Police
Jason Richardson	VP Finance Global Business Units	VP Finance Global Business Units
Jenelle Mallios	Midwestern University Multispecialty Clinic Eye Clinic	Associate Dean of Clinic Affairs
Kara Murphy	DuPage Health Coalition	President
Katy LeClair	YMCA	President and CEO
Kim White	Career and Networking Center	Executive Director
Linnea Windel	VNA Healthcare	President and Chief Executive Officer
Lisa Schvach	DuPage County / workNet Dupage	Executive Director
Mike Havala	Loaves and Fishes	President and CEO
Rich Pehlke	Naperville Resident	Naperville Resident
Richard Inskeep	Private Practice Attorney	Private Practice Attorney
Shafeek Abubaker	Zumitin, Inc	President

Sherman Neal	Aspire Ventures, LLC	Principal Owner
Tom Lee	Blazio LLC	Board Member
Troy Phillips	BPOC	Partner
Valerie Cahill	EEH Regional Board Member	Board Member
Annette Kenney	EEH	EVP/Chief Strategy and Marketing Officer
Colin Dalough	EEH	Community/Govt Relations Manager
Gina Sharp	EEH	President and CEO Linden Oaks
Joe Dant	EEH	President and CEO Edward
Katherine Crandell	EEH	Planning Analyst
Katie Polz	EEH	Ambulatory Strategy Sys Director
Kim Darey	EEH	VP, Chief Medical Officer
Lou Mastro	EEH	System CEO, South Region
Lus Vargas	EEH	Elmhurst Clinic Hospitalist Group RN / DEI Committee
Pam Dunley	EEH	President and CEO EMH
Rachel Nichols	EEH	Legal Counsel
Sheri Scott	EEH	VP, Marketing and Communications
Rachel Nichols	EEH	Legal Counsel

INTERNAL PLANNING SESSION, MEETING #2: PARTICIPANTS (4/13/22)

Name	Title
Dawn Sander	Director, Physician Practice QI
Jennifer Enright	Director, EMG Practice Ops.
Yvette Saba	System VP,Ops
Hiral Patel	Innovation Program Manager
Jim Economou	System Director, Pat Access and Pre Svs Ctr.
Cheryl Eck	AVP, Strategy and Planning
Beth Menges	Manager, Addiction Services
Jessi Cole	Mgr, Business Development LOH
Katherine Crandell	Planning Analyst
Bridget McLemore	System Director, Specialty Services
Teri Kaneski	System Director, Clinical Integration and Population Management
Marianne Spencer	System VP Ops
Gina Sharp	President and CEO, Linden Oaks
Cathy Smith	Services Line Director, Cardio/Neuro IP and CVS
Dr. Kim Darey	VP, Chief Medical Officer
Kirsten Mullinax	Coord Community Wellness
Ellen Turnbull	System Director, Emergency Services
Tracy Collander	Dir, Practice Ops LOMG
Robert Payton	VP, Chief Medical Officer
Pamela Dunely	President and CEO, Elmhurst Hospital
Katie Polz	Ambulatory Strategy System Director
Julie Jones	Physician

Danielle laBure	Director Patient Care, Women's Services
Jim Lengemann	President, Illinois Health Partners
Diane Long	System Director, Children's Services
Arvind Ramanathan	Svc Line Dir, Medical Group Ops
Katie McGovern	AVP, Physician Practice Management
Katy Catura	System Director, Case Management/Social Work
Mike McKenna	System Service Line Director, Cancer Services and Palliative Care

Appendix D: EEH System Community Benefit Steering Committee

Name	Title
Annette Kenney	Exec VP, Chief Strategy Officer
Katie Polz	System Director, Ambulatory Strategy
Jessica Wolf	Associate General Council
Gina Sharp	President and CEO, Linden Oaks
John Klosowski	Director, Physician Practice Operations
Bridget McLemore	Service Line Dir, Specialty Clinics and Rehab
Kirsten Mullinax	Community Wellness Coordinator
Sheri Scott	VP, Marketing and Communications
Colin Dalough	Community and Gov Relations Manager
Keith Hartenberger	System Director, Public Relations
Alicia Holloway	System Director, Reimbursement
Marcie Lafido	AVP, Chief Nursing Officer
Katie McGovern	AVP, Physician Practice Management
Yvonne Maltese	Planning Analyst
Katy Catura	Sys Dir, Care Coordination
Jason Ogden	AVP, Corporate Controller and Treasury Management
Dr Marie Wadas	System Medical Director, Continuum of Care and Wellness to System
Cheryl Eck	VP, Strategy and Planning
Christina Kotlarz	Supervisor, Navigation Services Linden Oaks
Dawn Sandner	Director, Phy Practice Quality and Pop Health

Appendix E: Evaluation of the Impact of Actions Taken to Address the Significant Health Needs Identified in the FY2019 CHNAs for EH, EMH, and LOH

EH, EMH, and LOH's FY 2020-2022 implementation strategy included activities to address the priority issues of access to health services and community resources, chronic disease (obesity/diabetes, cancer, heart disease/stroke) and behavioral health (mental health/substance use/adolescent depression and suicide). Governance and oversight is provided by the EEH Community Benefit Steering Committee (Appendix D), a system-wide committee with representation from nursing and other clinical areas, case management and social work, population health management, legal, finance, planning, marketing, and community/government relations.

Highlights of accomplishments are summarized below.

Access to Healthcare

- Provider Recruitment: The System's Physician Services Department recruited over 100 providers (physicians and advanced practice providers) which allowed for growth in the local employed/affiliated provider network from 631 to 665 (+5%), thus increasing access throughout the community. Further, the primary care provider network conducted more than 400,000 Medicaid and Medicare visits which represented nearly one third of total primary care visit volume. EEH continues to recruit into specialties where access and service gaps have been prioritized within the community including psychiatry, primary care, endocrinology, and rheumatology.
- Financial Assistance: Informing under- and uninsured patients that financial assistance is available is an important part of EEH's plan to increase patient access to essential health care services. EEH proactively screens patients, identifies those in need of assistance, and guides them to next steps based on their unique financial circumstances. During FY2020 and FY 2021, EEH provided over $20MI in financial assistance to qualified patients. Information on the financial assistance program, thresholds and the application process can be found on the System's website2.
- DuPage Health Coalition: The DuPage Health Coalition is a nonprofit organization with a mission to develop and sustain a system for managing 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 provides support to the coalition through both funding and active participation on the Board of Directors. During the first two years of the three year plan, EEH donated over $1.5M to assist with the operation of the Coalition's three key programs – Access DuPage, Silver Access DuPage and DuPage Dispensary of Hope. These programs are designed to keep residents healthy regardless of their financial situation, including inability to pay.
    - The **Access DuPage** program coordinates health services for low income and medically uninsured residents of DuPage County. The program operates through a network of volunteer physicians, hospitals and other community-based organizations. During FY2021 alone, 5,329 DuPage County residents were served.
    - **Silver Access DuPage** provides assistance to families eligible for the Affordable Care Act Marketplace by contributing to premium payments in order to reduce financial barriers to insurability.

[2] https://www.eehealth.org/patients-visitors/manage-my-costs-and-billing/billing/financial-assistance/

- **DuPage Dispensary of Hope** provides medications to low income and uninsured DuPage County residents. Worth an estimated $318,927 (+12% from prior year), 2,630 prescriptions were filled at no cost to the patient.

Social Determinants of Health (SDOH)

During the most recent CHNA and Implementation Strategy planning process, EEH identified an opportunity to improve the systematic identification of patients with underlying SDOH aimed to enhance the referral process to community-based organizations (CBO). An Epic module was implemented to identify patients in need of community resources such as food banks and other social support. Further, during FY2021 EEH partnered with findhelp.org (formerly known as Aunt Bertha), a social care network that connects people with social services in their communities to ensure they receive the care they need to improve their overall health status. Data collected through this program, which was fully implemented in Q4 FY2021, will be utilized to guide program development and community relationship opportunities in CY2022 and beyond.

Early Detection, Prevention and Wellness

Obesity

EEH continues to prioritize its response to the obesity epidemic by expanding the breadth and depth of program offerings. Program highlights include:

- Endeavor Health Medical Weight Loss Clinics: The Endeavor Program is a comprehensive and multidisciplinary approach to weight loss including surgical, medical and lifestyle modifications for individuals aged 16 and older. During FY2021, EEH expanded access to two new locations, Plainfield and Lombard, expanding beyond the existing clinics in Naperville, Elmhurst and Hinsdale. In addition, EEH established a new pediatric weight loss clinic for children 15 and younger. During the last few years, over 30,000 patient weight loss visits were completed and over 250 bariatric surgical procedures were performed.
- Jump Start Your Health with Group Lifestyle Balance: Jump Start your Health is a year-long lifestyle change program accredited by the Centers for Disease Control and Prevention (CDC) to help people lose weight, increase activity, and prevent disease. Led by a registered dietitian and trained lifestyle coach this group focuses on nutrition, physical activity, and behavioral modification. The research-based curriculum helps individuals make lasting lifestyle changes and adopt healthy lifestyle habits aimed to prevent diabetes and cardiovascular disease. Over the course of the FY20-22 planning cycle, the program was expanded to include participants by adding a virtual component to improve access for community members.
- Healthy Driven Families: A community facing electronic platform [1] was created to educate, guide and support parents and families in a prevention lifestyle, with a goal of effecting change in childhood obesity rates. Key areas of focus include healthy eating, exercise, and sleep habits. In addition, families are linked to a variety of resources including nutrition consults, mental health, primary care, fitness programs, food pantries and mental health organizations. This resource is automatically included in the patients After Visit Summary (AVS) for all at-risk pediatric patients, which provides families with important guidance on available resources.
- Healthy Driven Take a Hike Challenge: In collaboration with community partners, EEH sponsored a community Take a Hike [2] challenge for the second consecutive year to encourage the community to rediscover the health benefits of being active and spending time outdoors. During the past few years, over 2,000 community residents participated in the Challenge.

[1] https://www.eehealth.org/healthy-driven/healthy-driven-families/
[2] https://www.eehealth.org/healthy-driven/take-a-hike/

- Weight Aware: This online risk assessment tool continues to be an important resource for our community that not only identifies at-risk patients but navigates them to treatment if indicated by their outcomes. During FY20 and FY21, there were over 1,350Weight Aware completions, with over 50% of respondents identified as "at risk," and 60% (400) accepting the challenge to address their weight loss goals through EEH resources.

Diabetes

- Diabetes Centers: The EEH Diabetes Centers are one component of a comprehensive strategy to address diabetes care for community members by providing education on required skills deemed essential for appropriate diabetic management. Given the positive patient outcomes and demand for services, EEH expanded access points over the past year – collectively services are now offered in Elmhurst, Naperville, Bolingbrook, Plainfield and Yorkville. With the goal to empower residents to take accountability of their disease, during FY2021 EEH treated over 7,500 patient visits.
- Diabetes and Health Equity: While not originally identified in the 2019 CHNA, internal EEH data revealed racial and ethnic disparities (Hispanic and African American) associated with prevalence of diabetes across certain geographies. To that end, a pilot program was launched in Addison which embeds a diabetic educator and utilizes a diabetes equity navigator aimed to identify patients and further improve diabetic-related health outcomes.

Cardiovascular Care

Program highlights and accomplishments include:

- Young Hearts for Life (YH4L): EEH continued to support and participate in the Young Hearts for Life program. This is the largest cardiac detection program in the United States for the prevention of sudden cardiac death for youths. The organization's mission is to:
    - Offer free electrocardiograms to all students to detect conditions which may cause sudden cardiac death
    - Educate the community about sudden cardiac death and how it can be prevented
    - Help schools/trainers prepare an Emergency Action Plan to effectively manage cardiac emergencies
    - Provide families who have lost a child or sibling with support through interaction with other families who have faced the same unimaginable loss

  Over recent years, EEH provided over $100,000 in financial support to YH4L. This donation allowed for screenings at many schools throughout the community.
- EEH continues to offer free online screening tools (HeartAware and StrokeAware) with the goal to identify 'at risk' individuals and connect them to appropriate, potentially life-saving resources. To serve as an example of the magnitude of these efforts, FY2021 highlights are below:
    - Total HeartAware submissions increased 33%, while more than 4,500 heart scans were provided to the community (+21%)
    - StrokeAware health risk assessment submissions increased 33% (250 total submissions) and peripheral vascular screenings increased 53% (1,661 total screenings).
- EEH continues to provide many community education programs focused on hearth health and stroke prevention. During FY2021 alone, a series of webinars reached nearly 900 community members, providing education on awareness, prevention, and symptom identification. Topics included coping with stress, healthy eating, atrial fibrillation, stroke, and sleep apnea.
- Regular news, email, blog, and newsletter content is provided to the community by EEH on variety of topics associated with heart disease and stroke prevention. During FY2021 alone: :
    - A monthly Healthy Hearts Newsletter provided education to a subscriber list of 3,850

  - A monthly Healthy Driven Newsletter, with a distribution of over 300,000 covered heart healthy lifestyle topics such as "Exercising with an online group", "Don't delay care. It's safe here.", "Don't Ignore these Chronic Conditions", 'hypertension, heart disease, obesity", and "Stroke."
- Through "Healthy Driven Chicago," a collaboration between EEH and local ABC news affiliate ABC7, EEH provided Heart and Stroke education to the greater Chicago area. Video content is shared during news broadcasts and shorter educational commercials throughout a given month. February 2021 featured "Don't ignore these heart attack warning signs," while March 2021 featured "Is it a stroke? Learn how to recognize the warning signs."

Cancer Care

EEH offers three comprehensive cancer centers in Naperville, Elmhurst and Plainfield, each with high quality clinical care teams that focus on individual physical and emotional needs. These multidisciplinary clinics provide genetic counseling and comprehensive cancer treatments including chemotherapy, radiation therapy and advanced surgical oncology, along with a wider range of support services.

An example of the programs, magnitude and impact are below:

- EEH enhanced its website allowing for streamlined patient navigation based on individual diagnosis. The dedicated Breast Cancer page was launched, and work began on expanding content to include lung, colorectal, prostate and urology.
- Virtual navigation service – In collaboration with Impact Advisors, EEH established a virtual navigation program to ensure timely follow-up post-diagnosis.
- EEH continues to offer free online screening tools (BreastAware, ColonAware and LungAware) to identify 'at risk' individuals and connect them to appropriate resources for early detection and treatment. During FY2021 alone:
  - LungAware health risk assessments increased 125% (+1,310)
  - System lung CT scans continue to increase with more than 270 provided to the community in FY2021 (+45%).
- Regular news, email, blog, and newsletter content is provided to the community by EEH on variety of topics associated with cancer prevention. As an example of impact, below are FY2021 outcomes:
  - A monthly Cancer Newsletter provided education to a subscriber list of 1,040
  - A monthly Healthy Driven Newsletter, with a distribution of over 300,000 covering prevention lifestyle and informative articles such as "8 risky activities that could affect your health."
- Through "Healthy Driven Chicago," a collaboration between EEH and local ABC news affiliate ABC7, EEH provided informative articles and videos in FY2021 on a range of topics from cancer survivorship to detection and treatment options. Breast cancer and skin cancer were featured in FY2021.

Mental Health

Linden Oaks continues to focus on creating access to mental health treatment that is safe, seamless, and personal. To that end, LOH provides extensive programming to serve the community, including treatment for depression, anxiety, substance abuse, attention deficit disorders, obsessive compulsive disorders, and eating disorders.

The information below highlights the initiatives Linden Oaks have made in access and outreach to provide appropriate and essential behavioral health services to our community members in need.

Access to Behavioral Health Services

During the Will and DuPage County Community Health Needs Assessment survey period, over 185,000 community members indicated that their mental health was 'not good' for at least the prior 8 days. Access to behavioral health services is critical to enhance the health of this population. LOH continues to expand access through provider recruitment, new care delivery models, new services, and expansion of both outpatient locations and virtual care.

Highlights include:

- Provider Recruitment: recruitment continues in a very competitive market with limited supply of providers. Over the FY20-22 Community Benefit planning cycle, Linden Oaks Medical Group (LOMG) successfully added over 10 psychiatry providers and 14 Counselors to expand access to critical counseling and medication management services.
- Virtual Care: Driven initially by the impact of COVID-19, LOMG counselors and psychiatrists continue to offer virtual visits to ensure access to counseling and telepsychiatry/medication management treatment. During FY2021 alone, 74,000 visits were conducted virtually—a dramatic 330% increase over 2020.
- Behavioral Health Integration (BHI): BHI has proven to be successful through the EEH network. This care delivery model embeds behavioral health therapists within the physician office as an immediate resource for community members ensuring appropriate follow-up care. Linden Oaks expanded this care delivery model to additional primary care and specialty clinic locations. During FY2021 nearly 14,000 visits were completed through this clinical model, representing a 38% increase from FY2019.
- Ambulatory Expansion: Many of the Linden Oaks outpatient sites have experienced tremendous growth over the past few years. To support access and reduce treatment delays, Linden Oaks expanded into the Woodridge outpatient site, offering eating disorder outpatient programming and Linden Oaks Medical Group psychiatric services.
- True North Initiative: Upon discovery that LOH patients were triaged into lower levels of care than appropriate, the True North initiative was created to identify issues and define recommended solutions. The Linden Oaks staff were retrained on proper patient education and tactics to motivate patients to enter into the recommended level of care to ensure most optimal outcomes.
- Re-engineered Care Coordination within ED and Medical Floors at Acute Care Hospitals. The number of patients seeking psychiatric care in the emergency departments (EDs) and medical floors has risen both nationally and locally, creating barriers to appropriate patient access. In response, Linden Oaks enhanced processes to ensure optimal throughput across the units. Key modifications included: increased discharge planners, expanded virtual telepsychiatry, and Medical Director rounding.

Community Outreach to Support Behavioral Health

Linden Oaks leadership and staff routinely gather input from the broader community to proactively address key imperatives. Below are examples of community events intended to bring front line leaders together to address mental health services within the community:

- School Virtual Meetups: Linden Oaks leadership facilitated two virtual community forums for local educational partners in FY 2021. In total over 100 local school district employees attended these events to receive education on various program treatment tools and COVID protocols.
- Community Provider Think Tank Events: Linden Oaks continues a collaborative partnership with clinical providers of traditional outpatient counseling and therapy services. To improve engagement and dialogue with community providers, Linden Oaks provided an opportunity to solicit feedback; topics included COVID reactivation plans and the newly formed Centralized Admission Inpatient Unit.
- Patient Family Advisory Council: The Linden Oaks Patient Family Advisory Council (PFAC) seeks to enhance the delivery of health care at Linden Oaks by providing a forum for patients and families to

work in partnership with hospital staff in the development and implementation of programs, policies, and practice standards. The PFAC members are encouraged to bring forward suggestions and recommendations that may influence the patient care experience to ensure all patients receive, Safe, Seamless, and Personal Care.

- Teen MHFA: As a part of the Linden Oaks Mental Health First Aid (MHFA) program, a pilot program was launched to expand the Program focused specifically on adolescents (Teen MHFA); 96 individuals were trained during FY2021.
- Community Presentations: Linden Oaks held 16 educational presentations targeted at community schools/organizations/municipalities requiring additional mental health training. Select topics included: maternal mental wellness, working with resistant patients, pandemic resiliency psychological trauma in healthcare providers, and compassion fatigue.

EEH Opioid Initiative

EEH continues to play a leadership role in fighting the opioid epidemic. Led by a task force launched in 2016, the health system has implemented a series of programs and projects, including standardized treatment plans and best practice guidelines for patients presenting to EEH on selected opioids. Key initiatives and accomplishments are summarized below:

- Medication-Assisted Therapy (MAT) Clinic: This clinic provides support for adults recovering from opioid use disorders through medication management, psychotherapy, and drug testing. The combination of medication management, group therapy, and individual therapy helps patients remain stable on an outpatient basis and avoid re-hospitalization. During FY2021 the clinic expanded the use of once monthly injectable medications for adults recovering from an opioid use disorder to support patient compliance and reduce the risk of medication misuse.
- Midwest Alternative to Opioids Project (ALTO): The ALTO project is a collaboration between the Illinois, Michigan and Wisconsin Hospital Associations and represents a unique opportunity to impact emergency department prescribing across the region. EEH participated in the Illinois Hospital Associate ALTO cohort study and adopted performance metrics considered best practices to measure outcomes associated with opioid reduction efforts.
- Performance Measurement: An opioid dashboard was developed to reflect performance outcomes across its MAT and ALTO programs, and to monitor physician prescribing patterns (PPP), . both across the ED and ambulatory settings.
- Provider Education: System-wide opioid education was provided in the form of continuing medical education and continuing education units. The goal is to create one consistent program, both general and specialty education for both nurses, advanced practice providers and physicians.
- Narcan Distribution: EEH Emergency Department partnered with DuPage County to distribute Narcan (provided to EEH free of charge from the County) for home use as part of an initiative to prevent overdose related deaths.
- Maternal Opioid Reduction: New standardized, evidence-based pain management protocols and order sets were piloted at Edward Hospital to reduce opioid use among mothers experiencing cesarean deliveries. As a result of this project, opioid use during a hospital stay was reduced from 92% to 68% and opioid prescriptions at discharge were reduced from 92% to 60%. Given the success of this pilot project, the protocols will be implemented across the System.
- Community Partnerships: EEH partnered with third party addiction treatment centers to provide services to Emergency Department patients in need of follow-up care associated with chemical dependency or substance abuse. By way of this program, and last year alone, 247 patients were assessed and offered appropriate treatment options to address their chemical dependency or substance abuse issues.

Other Initiatives

Initiatives not explicitly identified in the FY2020-FY2022 Community Benefit Implementation plan but meaningfully contributing to the advancement of health within our community include:

Diversity, Equity and Inclusion Council (DEI)

A DEI committee was established in 2016 to advance diversity, equity and inclusion goals within our organization and across our community. Highlighted accomplishments include:

- EEH's Voices of Diversity blog, where employees share their unique stories and experiences, was nationally recognized by eHealthcare and Ragan Communications. The power of diversity was reinforced by activities promoting Black History Month and Ramadan throughout EEH.
- During FY2021, nine employee listening forums occurred across three campuses to hear from employees about their experiences with Diversity and Inclusion at EEH. These forums revealed stories of personally experienced racism, though primarily not inside of EEH. Leadership Development provided Facilitator training to 15 leaders as part of this effort.
- An annual scorecard on patient race, ethnicity, and language (REAL) was established to better understand patient demographics and drive future initiatives.
- Edward-Elmhurst Health was one of 25 providers to pilot the Racial Equity in Healthcare Progress Report (Progress Report) for the Illinois Hospital Association and the Chicago's Racial Equity Rapid Response Team. The Progress Report serves as a long-term accountability tool to document progress toward achieving racial health equity.
- A Health Equity subcommittee was formalized to address racial and ethnic health disparities across the EEH community. Based on internal utilization data and CHNA findings, 2021 initiatives prioritized disparities in access to diabetic screening and treatment in specific geographies. In addition, the health equity subcommittee collaborated with local NAACP chapters and other community organizations to explore strategies to address vaccine hesitancy, food insecurity, and diabetes screening and management. A final area of focus was the development of a health equity dashboard to monitor current state and guide future program development prioritization.

Community Investment Program

In August 2021, the EEH Board of Trustees approved the establishment of a $100 Million Community Investment Program to provide annual grant funding to community organizations aligned with the following goals:

- Advancing Health (health equity and social determinants of health)
- Local economic growth (supply chain diversity and job creating prioritizing DEI principles).

The Program will be guided by input from the EEH Regional Board and a newly established Community Advisory Council, which will support ongoing engagement around community need. It is expected that $3-$6 million will be distributed annually through this program.