Endeavor Health℠

Swedish Hospital

# 2025-2027 Implementation Strategy

*Based on 2024 Community Health Needs Assessment*



# About Endeavor Health and Swedish Hospital

## 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 Swedish Hospital, which is part of Endeavor Health.** Please note that all Endeavor Health hospitals develop and release their own separate IS. This IS pertains to Swedish Hospital'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 Endeavor Health Swedish Hospital

Endeavor Health Swedish Hospital, which opened in 1886, serves the culturally-diverse residents of Chicago's north and northwest side communities as a safety-net hospital, with a full-service hospital campus located in the Lincoln Square neighborhood. Swedish Hospital offers advanced clinical care in more than 50 medical specialties, which includes the Mayora Rosenberg Women's Health Center, offering 3-D mammography, and their Joint Commission-certified Primary Stroke Center. Swedish provides a full range of comprehensive health and wellness services offering 150+ wellness programs annually, and Chicago's only certified medical fitness center, Galter Life Center, and is one of six regional leads for Healthy Chicago Equity Zones.

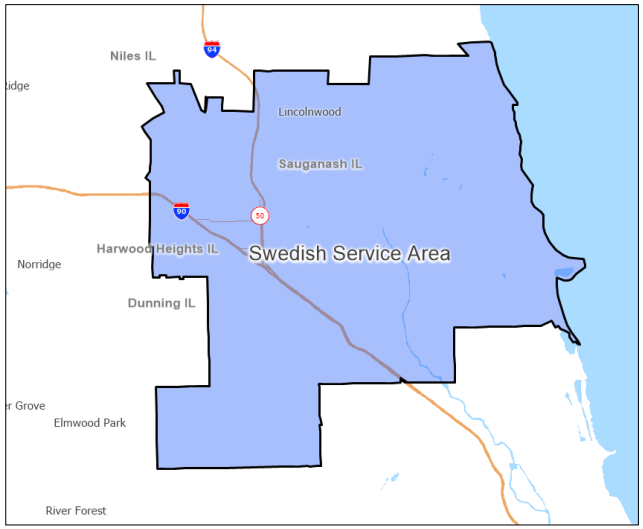
# Implementation Strategy Purpose and Development

## 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 Swedish Hospital's initiatives and programs with goals, objectives and indicators that address significant community health needs described in the CHNA.

## Community Definition

The Swedish Hospital service area is composed of 13 ZIP codes, with a total population of nearly 700,000. These ZIP codes encompass fourteen community areas in Chicago – Albany Park, Avondale, Edgewater, Forest Glen, Irving Park, Jefferson Park, Lake View, Lincoln Square, North Center, North Park, Portage Park, Rogers Park, Uptown, West Ridge – and the village of Lincolnwood. This community definition was determined because most of Swedish's patients originate from these areas.




Source: Claritas Data from Environics Analytics ENVISION Tool

| Swedish Service Area | | |
|---|---|---|
| 60613 | 60639 | 60659 |
| 60618 | 60640 | 60660 |
| 60625 | 60641 | 60712 |
| 60626 | 60645 | |
| 60630 | 60646 | |

## CHNA Implementation Strategy 2024 Development and Ongoing Review

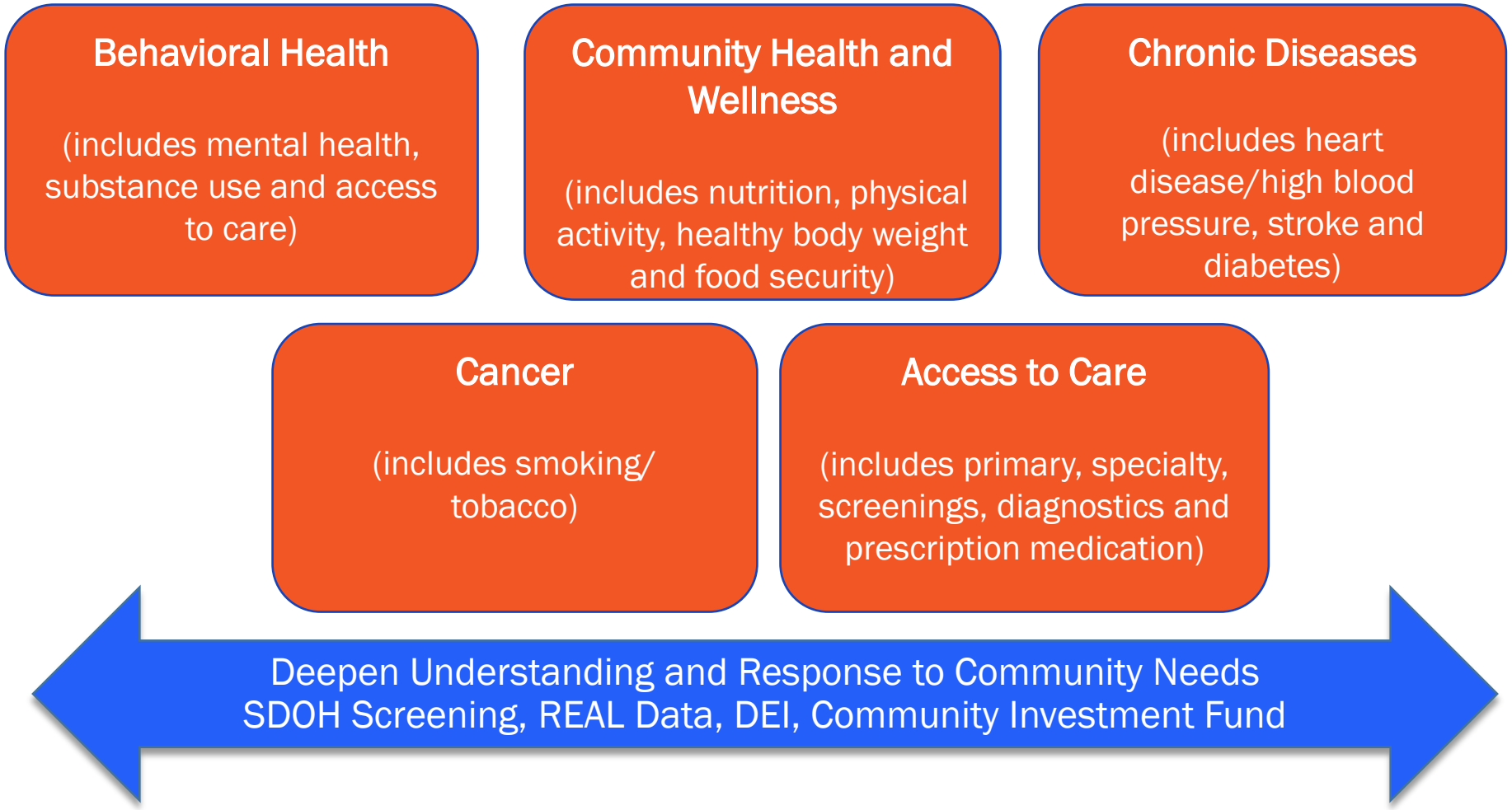
The IS was developed after the comprehensive 2024 CHNA was completed. Please refer to the complete CHNA for the full report. Strategies and action plans were developed based on a consensus among key internal stakeholders for each priority need.

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. Swedish Hospital is committed to addressing these fundamental priorities, as we deepen our understanding and engagement within the communities we are privileged to serve.



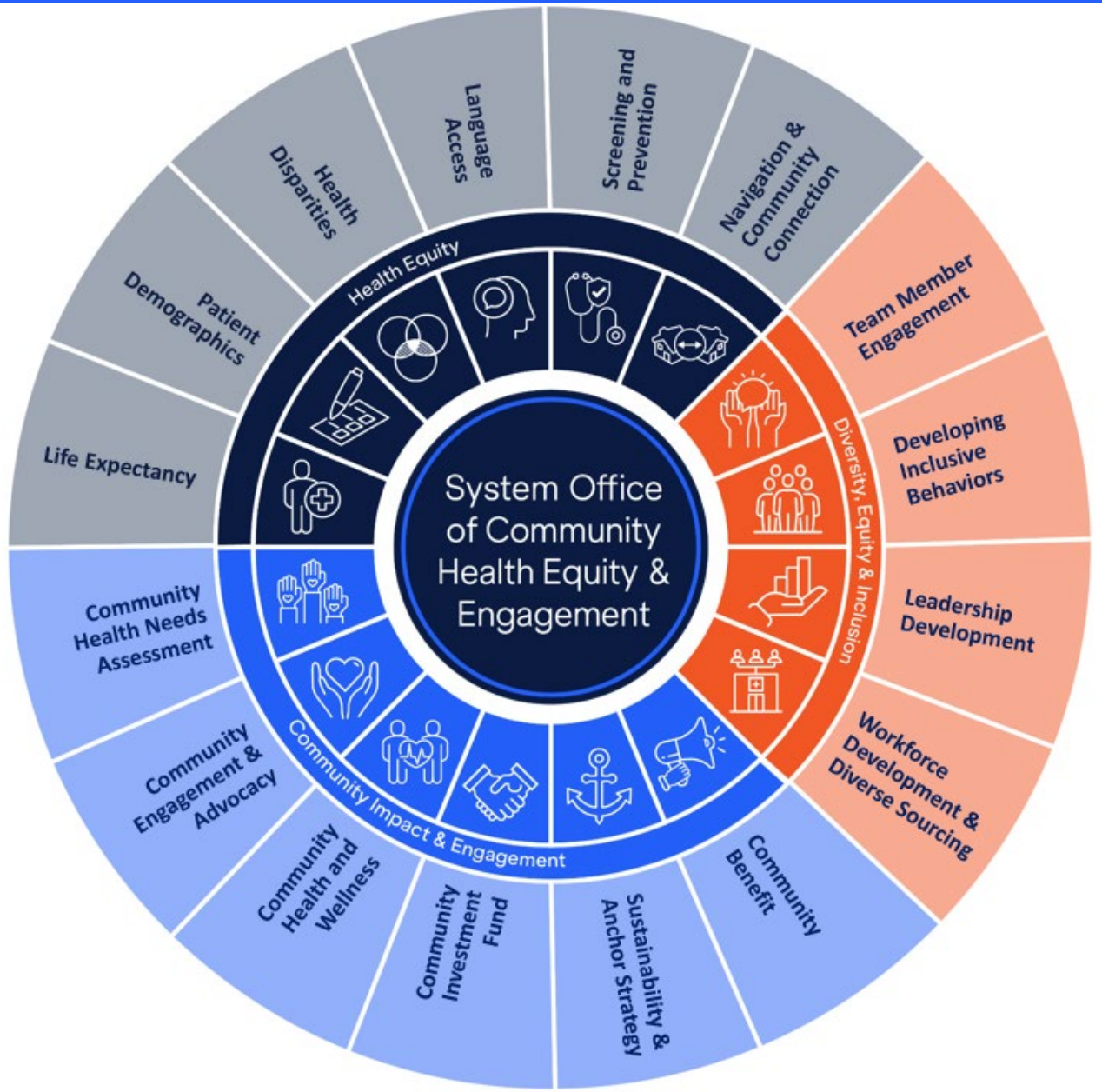
# A Multidisciplinary Approach

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 Swedish Hospital.

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

**Community Health Needs Assessment**
We identify and address community health needs.

**Community Engagement**
We convene and connect people for collective impact.


**Community Benefit**
We demonstrate community impact.

**Anchor Strategy**
We leverage organizational resources to support community health and economic growth.

**Community Health and Wellness**
We promote health and wellness through education and outreach.

**Community Investment Fund**
We invest in local organizations committed to our community's health and wellbeing.

# 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<br>2025 Goal: Successful launch<br>% of inpatients screened<br>2025 Goal: Establish baseline | | | |
| | Launch Findhelp program to provide resources for patients in need. | # of patients supported<br>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"<br>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<br>2025 Goal: Establish baseline | | | |
| | Offer "DEI Academy" trainings to Endeavor Health employees. | # of trainings completed<br>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<br>2025 Goal: 10<br>$ invested<br>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<br>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<br>2025 Goal: 60,000 | | | |
| | Expand co-location of behavioral health within primary care setting to enhance access. | # new patients served<br>2025 Goal: Establish baseline<br># new behavioral health providers co-located within primary care setting<br>2025 Goal: 3 | | | |
| | Offer substance use treatment via Suboxone Clinic in Emergency Department. | # patients<br>2025 Goal: Establish baseline | | | |
| Education and Support | Provide free community education and support via Community Behavioral Health Program. | # of people supported via workshops, support groups and 1:1 counseling<br>2025 Goal: 800 | | | |

| Key |
|---|
| Systemwide Entity |
| Local Metric Entity |

# 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<br>% of survey respondents who learned something new<br>2025 Goal: Establish baselines | | | |
| | Provide free community nutrition and health education at Community Wellness Center aligned with CHNA priority needs. | # of attendees<br>2025 Goal: 1,000 | | | |
| | Launch Sapphire Circle, focused on free health and wellness offerings for older adults in community. | # of Sapphire Circle members<br>2025 Goal: Establish baseline | | | |
| Access to Physical Activity | Increase referrals to Galter Life Center wellness programs via EPIC referral process and other referral sources. | # EPIC referrals<br># referrals from other sources<br>2025 Goal: Establish baselines | | | |
| | Provide Galter Life Center membership scholarships to individuals with medical and financial need. | # scholarships<br>2025 Goal: 200 | | | |
| Access to Healthy Food | Connect patients who screen as food insecure with immediate and/or longer-term support. | # patients referred to LINK/SNAP/WIC benefits enrollment services<br>2025 Goal: 350<br>% of food insecure inpatients offered immediate or long term support (ex. discharge food bag, food pantry connections)<br>2025 Goal: 80% | | | |

| Key |
|---|
| Systemwide Metric |
| Local Entity Metric |

# Priority Need: Chronic Disease
## (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)<br>2025 Goals: System: 78%<br>SW: 76% | | | |
| | 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)<br>2025 Goals: System: 76%<br>SW: 74% | | | |
| | 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.<br>2025 Goals: System: 3.9%<br>SW: 5.7% | | | |
| | Support controlled diabetes/A1C levels among uninsured and underinsured Healthcare Transformation (HCT) patients who have uncontrolled diabetes. | % of HCT patients with uncontrolled diabetes upon referral who have seen HCT endocrinologist or registered dietitian in past year and now have a controlled A1C level (Controlled = A1C <8)<br>2025 Goal: 25% | | | |
| | Offer 1:1 and group education via outpatient registered dietitians (Nutrition & Diabetes Center (NDC) and other MG or outpatient sites. | # of 1:1 encounters<br>2025 Goal: 600<br># programs for group education (Diabetes Prevention Program, Veggies for Health, Back to Basics)<br>2025 Goal: 18 | | | |
| Education and Outreach | Offer free blood pressure screenings and hypertension education for community members. | # of individuals screened<br>2025 Goal: Establish baseline | | | |

| Key |
|---|
| Systemwide Metric |
| Local Entity Metric |

# Priority Need: Cancer
## (includes smoking/tobacco cessation)

| Strategy | Initiatives/Programs | Metrics and Goals | 2025 Progress | 2026 Progress | 2027 Progress |
|---|---|---|---|---|---|
| Screening 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<br>2025 Goals: System and SW: Establish baselines | | | |
| | Use Lens of Equity Tool to identify populations and develop targeted interventions around cancer screenings. | % cancer screening rate among MG target population<br>2025 Goals: Focus on breast cancer screenings for patients who live in lowest quartile for median family income.<br>System: 81%<br>SW: 81.5% | | | |
| | Connect patients with free breast health services via Community Breast Health Program. | # breast health services<br>2025 Goal: 1,000 | | | |
| Education and Support | Provide 8-week smoking cessation program, including discounted fees for under-resourced individuals. | # of smoking cessation programs<br>2025 Goal: 4<br># of attendees<br>2025 Goal: 30 | | | |
| Survivorship and Support | Provide wraparound support and free wellness services at Galter Life Center for patients undergoing cancer treatment via the Integrated Cancer Care Program (ICCP). | # services (acu, massage, pers. training, meditation)<br>2025 Goal: 1,020<br># ICCP patients<br>2025 Goal: 90 patients | | | |

| Key |
|---|
| Systemwide Metric |
| Local Entity Metric |

# Priority Need: Access to Care

## (includes primary, specialty, screenings, diagnostic, 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) 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<br>2025 Goal: System and SW: Establish baselines | | | |
| | Connect patients to medical homes and other healthcare services via CHW of Community CARE Program. | # patients connected to a PCP (at FQHC or EHMG)<br># patients connected to healthcare services (behavioral, specialty or ancillary)<br>2025 Goals: Establish baselines | | | |
| Access to Specialty Care | Enhance access to specialty care for uninsured or underinsured patients via Healthcare Transformation (HCT). | Average # of days from referral to appointment<br>2025 Goal: 30<br># completed new and follow-up visits<br>2025 Goal: 1,768 visits | | | |
| Access to Prescription Medication | Provide inpatient and emergency dept prescription support for under-resourced patients from Foundation. | $ provided<br>2025 Goal: $3,000 | | | |

| Key |
|---|
| Systemwide Metric |
| Local Entity Metric |

# Key Collaborative Partnerships

## Active Partnerships

Swedish Hospital is committed to active and ongoing collaboration with local organizations addressing a variety of health and social needs. The hospital offers a robust array of community health and outreach programs designed to serve the needs of its diverse community, addressing health equity and various social determinants of health. These programs are collectively called Community CARE – *Creating Access to Resources for Equity* – working both within the health system as well as externally throughout the community in deep partnership with area organizations. More details are available at SwedishCovenant.org/communitywellness.

**Pathways –** Developed to strengthen the hospital's ability to identify and assist patients who are survivors of interpersonal violence. Local partners include Apna Ghar, Between Friends, The Network, STOP-IT, Ascend Justice, KAN-WIN, Resilience and others.

**Food Connections –** Designed to strengthen the hospital's ability to address food insecurity and remove food access as a barrier to health. The program includes distributing food packages upon patient discharge, operating food pantries, managing a community garden for staff and referring patients for benefits enrollment assistance. Local partners include The Friendship Center, ICNA Relief, Common Pantry, Nourishing Hope, Green City Market and others.

**Nutrition and Diabetes Center –** Offers comprehensive education, resources and support to patients diagnosed with type 1 or type 2 diabetes, prediabetes and gestational diabetes. It also provides individual nutrition education to patients with various dietary needs.

**Community Outreach Registered Dietitian (CORD) –** This community-facing dietitian engages in educational activities, outreach and public benefit education. CORD classes include onsite nutrition and cooking classes taught in Swedish Hospital's Community Wellness Center such as the eight-week Veggies for Health nutrition education program.

**Healthy Chicago Equity Zones (HCEZ) –** Contracted by the Chicago Department of Public Health, Swedish Hospital serves as Regional Lead for the North/Central area of the HCEZ initiative. This program collaborates with trusted local community organizations and leaders to address social and environmental issues contributing to health and racial inequity. Local partners include Thresholds, Tapestry 360, Apna Ghar, C4, Family Matters, Rohingya Culture Center, ICNA Relief, Girl Forward, All Starts, Streetwise, Lutheran Social Services of Illinois, Common Pantry and others.

**Family Connects Chicago** – Provides essential at-home support for new parents in Chicago, at no cost to families who deliver at Swedish Hospital. This program, in collaboration with the Chicago Department of Public Health and Family Connects International, offers comprehensive care including baby and mother health checks, breastfeeding support, guidance on infant care and navigation of community resources and services.

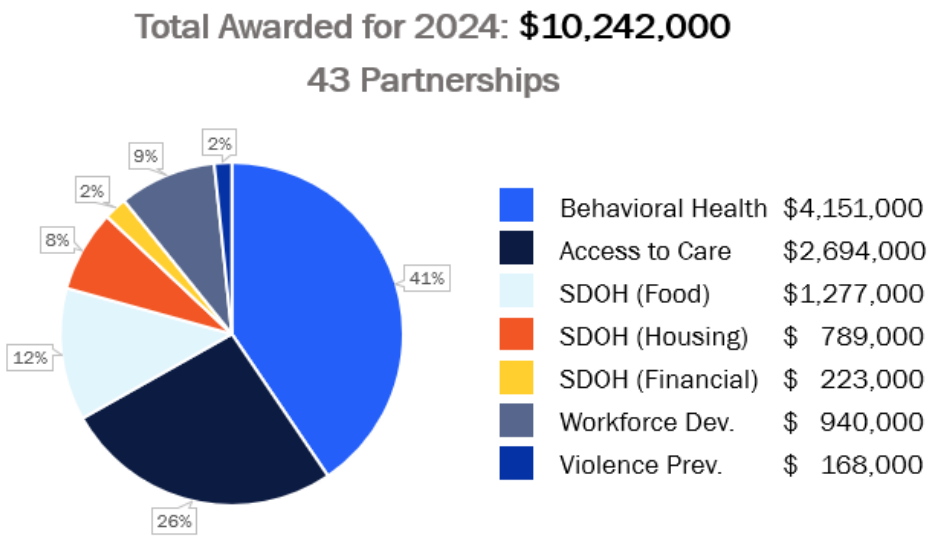
**Chicago North Side Collaborative –** This Healthcare Transformation Program, funded by the Illinois Department of Healthcare and Family Services (HFS) Transformation Funding, helps reduce barriers to care and other disparities by embedding specialty care and other supportive services into local Federally Qualified Health Centers (FQHCs). Local partners include Erie Family Health, Tapestry 360 (formerly Heartland Health), Hamdard Health Alliance, Asian Human Services Family Health Center, Howard Brown Health and American Indian Health Service of Chicago.

# 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 Serving Swedish Hospital Community

Between Friends

MARJORIE KOVLER CENTER
HEARTLAND ALLIANCE INTERNATIONAL

THE FRIENDSHIP CENTER

Midwest Refuah Health Center

ONE Northside
ORGANIZING NEIGHBORHOODS FOR EQUALITY

Lutheran Social Services of Illinois

Howard Brown Health

# Information Gaps and Other Needs

## Information Gaps

While this CHNA is quite comprehensive, Swedish 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 Needs

In acknowledging the wide range of priority health issues that emerged from the CHNA process, Swedish determined that it could only effectively focus on those which it deemed most pressing, most under-addressed and most within its ability to influence. Swedish 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 |
|---|---|
| Homelessness and Housing (adequate, affordable, safe) | This need is addressed and integrated into the SDOH screening assessment. Swedish social workers have direct linkages with organizations addressing affordable housing. Swedish collaborates with numerous local not-for-profit organizations that support homelessness including Lutheran Social Services of Illinois. The Swedish Hospital Foundation also engages with Emergency Department staff to support housing needs. The hospital is committed to working with other organizations where possible to support these efforts and elevate awareness of these issues. |
| Older Adults Aging In Place | This need is addressed and integrated into the SDOH screening assessment. Swedish social workers have direct linkages and work to navigate older adults to necessary resources based on identified needs. Additionally, Swedish is launching a Sapphire Circle senior affinity program to provide ongoing education and support for local senior community members. |
| Domestic Violence and Community Violence | The Pathways Program at Swedish Hospital provides crucial support for patients experiencing domestic violence, human trafficking, and sexual assault, leveraging healthcare providers' roles to identify abuse and offer immediate support with safety planning, crisis intervention and advocacy at bedside. The program also links survivors to free trauma counseling and case management services on campus. Swedish partners and provides financial support to a number of not-for-profit organizations that address domestic and community violence including: Apna Ghar, Between Friends, The Network, Salvation Army's STOP-IT Program and others. In addition, Endeavor Health is a member of the Northwell Collaborative Gun Violence Prevention Learning Collaborative for Health Systems and Hospitals. |
| Adequate Employment Opportunities | Swedish Hospital is committed to raising awareness about employment opportunities at all levels within the health system, as well as creating opportunities for youth to learn about careers within health care. Due to resource constraints, Swedish is focused on other initiatives which we are able to most effectively impact. However, the hospital is committed to working with other organizations where possible to support these efforts, as well as supporting local community organizations via our Community Investment Fund. |
| Access to Oral Health Care | Swedish Hospital's Dental Clinic helps community members, including uninsured and low-income patients to access dental services. Additional support is provided by the Swedish Hospital Foundation. Swedish also partners with local FQHCs who provide various dental services to community members. |

# Implementation Strategy Approval and Publication

**This Implementation Strategy has been reviewed and approved by Swedish Hospital's Board of Directors on November 6, 2024.**
Swedish 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 Swedish 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 and swedishcovenant.org/CHNA. 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.