COMMUNITY BENEFIT REPORT

2022

EQUITY

SERVICE

IMPACT

NorthShore | Edward-Elmhurst HEALTH

NorthShore – Edward-Elmhurst Health
Illinois Annual Non Profit Hospital Community Benefits Plan Report FY22

Table of Contents

AS AMENDED

Annual Non Profit Hospital Community Benefits Plan Report

Name of Hospital Reporting: NorthShore - Edward-Elmhurst Health

Mailing Address: 1301 Central Street, Evanston, IL 60201
(Street Address/P.O. Box) (City, State, Zip)

Physical Address (if different than mailing address):

(Street Address/P.O. Box) (City, State, Zip)

See attached list
Reporting Period: ____/____/____ **through** ____/____/____ **Taxpayer Number:** See attached list
Month Day Year Month Day Year

If part of a health system, list the other Illinois hospitals included in the health system (Note: A separate report must be filed for each Hosp).

Hospital Name	Address	FEIN #
See attached list of reporting		
hospitals		

1. **ATTACH Mission Statement:**
The reporting entity must provide an organizational mission statement that identifies the hospital's commitment to serving the health care needs of the community and the date it was adopted.

2. **ATTACH Community Benefits Plan:**
The reporting entity must provide it's most recent Community Benefits Plan and specify the date it was adopted. The plan should be an operational plan for serving health care needs of the community. The plan must:
   1. Set out goals and objectives for providing community benefits including charity care and government-sponsored indigent health care.
   2. Identify the populations and communities served by the hospital.
   3. Disclose health care needs that were considered in developing the plan.

3. **REPORT Charity Care**:
Charity care is care for which the provider does not expect to receive payment from the patient or a third-party payer. Charity care does not include bad debt. In reporting charity care, the reporting entity must report the actual cost of services provided, based on the total cost to charge ratio derived from the hospital's Medicare cost report (CMS 2552-96 Worksheet C, Part 1, PPS Inpatient Ratios), not the charges for the services.

Charity Care. . . . . $ 53,986,030

ATTACH Charity Care Policy:
Reporting entity must attach a copy of its current charity care policy and specify the date it was adopted.

4. **REPORT Community Benefits** actually provided other than charity care.

See instructions for completing Section 4 of Form AG-CBP-1 (Community Benefits Plan Annual Report Form For Not For Profit Hospital)

Community Benefit Type		
Language Assistant Services		$6,173,842
Financial Assistance		$53,986,030
Government Sponsored		$398,433,051
Donations		$9,883,192
Volunteer Services		
a) Employee Volunteer Services	$38,626	
b) Non-Employee Volunteer Services	$1,933,505	
c) Total (add lines a and b)		$1,972,131
Education		$54,238,817
Government-sponsored program services		$2,000,975
Research		$6,367,547
Subsidized health services		$77,043,798
Bad debts		$40,499,543
Other Community Benefits		$1,201,694

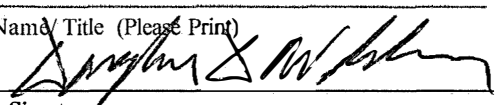
Attach a schedule for any additional community benefits not detailed above.

5. **ATTACH Audited Financial Statements for the reporting period.**

Under penalty of perjury, I the undersigned declare and certify that I have examined this Annual Non Profit Hospital Community Benefits Plan Report and the documents attached thereto. I further declare and certify that the Plan and the Annual Non Profit Hospital Community Benefits Plan Report and the documents attached thereto are true and complete.

Douglas Welday, Chief Financial Officer
Name/ Title (Please Print)

847-570-5050
Phone: Area Code/ Telephone No.


Signature

10/25/2023
Date.

Thomas Bishop
Name of Person Completing Form

847-570-5124
Phone: Area Code/ Telephone No.

tbishop@northshore.org
Electronic / Internet Mail Address

847-570-5240
FAX: AreaCode/FAXNo.

Annual Non Profit Hospital Community Benefits Plan Report

Attachment - List of Illinois hospitals included in the health system

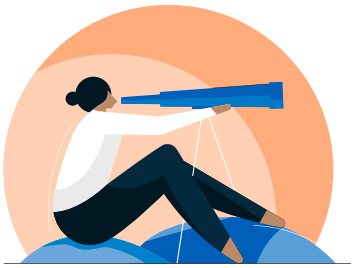
Health System: NorthShore – Edward-Elmhurst Health

Hospital Name	Address	FEIN #	Reporting Period
Evanston Hospital	2650 Ridge Avenue Evanston, IL 60201	36-2167060	10/1/2021 – 12/31/2022
Glenbrook Hospital	2100 Pfingsten Road Glenview, IL 60026	36-2167060	10/1/2021 – 12/31/2022
Highland Park Hospital	777 Park Avenue West Highland Park, IL 60035	36-2167060	10/1/2021 – 12/31/2022
Skokie Hospital	9600 Gross Point Road Skokie, IL 60076	36-2167060	10/1/2021 – 12/31/2022
Swedish Hospital	5145 North California Avenue Chicago, IL 60625	36-2179813	10/1/2021 – 12/31/2022
Northwest Community Hospital	800 West Central Road Arlington Heights, IL 60005	36-2340313	10/1/2021 – 12/31/2022
Edward Hospital	801 South Washington Street Naperville, IL 60540	36-3297173	7/1/2021 – 12/31/2022
Elmhurst Memorial Hospital	155 East Brush Hill Road Elmhurst, IL 60126	36-2167784	7/1/2021 – 12/31/2022
Linden Oaks Hospital	852 South West Street Naperville, IL 60540	36-3965251	7/1/2021 – 12/31/2022

MISSION

The reason we come to work each day; inspires action

Help everyone in our communities be their best.



VISION

What happens when we fulfill our mission

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

VALUES

Beliefs and behaviors that guide us on the journey

Act with Kindness

Meet people where they are and show empathy through listening

Earn Trust

Act with integrity and accountability to earn and maintain trust

Respect Everyone

Champion diversity, equity and inclusion for all through mutual respect

Build Relationships

Develop meaningful connections that have a positive impact on everyone who crosses our path

Pursue Excellence

Seek out ways to keep learning and growing so we can deliver the best care to all, every time

FORWARD TOGETHER

NorthShore | Edward-Elmhurst HEALTH

NorthShore - Edward-Elmhurst Health
Net patient revenue and charity care reported seperately by hospital

Reporting period: 10/1/2021 - 12/31/2022 for Evanston Hospital, Glenbrook Hospital, Highland Park Hospital, Skokie Hospital, Swedish Hospital, and Northwest Community Hospital
7/1/2021 - 12/31/2022 for Edward Hospital, Elmhurst Hospital, and Linden Oaks Hospital

Hospital	Net Patient Revenue	Charity Care at Cost	Charity Care at cost associated with services provided in hospital emergency department
Evanston Hospital	$ 808,096,888	$ 10,294,112	$ 1,217,499
Glenbrook Hospital	373,938,448	4,823,507	1,164,484
Highland Park Hospital	432,340,584	3,844,191	739,945
Skokie Hospital	296,188,779	4,004,353	824,853
Swedish Hospital	342,497,372	12,018,796	2,204,351
Northwest Community Hospital	687,892,185	5,136,387	1,674,500
Edward Hospital	1,136,240,961	5,906,715	2,689,317
Elmhurst Memorial Hospital	812,767,627	7,553,759	3,007,246
Linden Oaks Hospital	79,037,763	404,210	-
Total	**$ 4,969,000,607**	**$ 53,986,030**	**$ 13,522,195**

HOSPITAL FINANCIAL ASSISTANCE REPORT

OFFICE OF THE ATTORNEY GENERAL • STATE OF ILLINOIS

Pursuant to 77 Ill. Adm. Code 4500.60, each Illinois hospital must annually provide, in conjunction with the filing of either its Community Benefits Report as required by the Community Benefits Act or its Worksheet C Part I as required by the Hospital Uninsured Patient Discount Act, a Hospital Financial Assistance Report to the Office of the Attorney General. This form shall be completed and filed with the Office of the Attorney General as described below.

Reporting Hospital: NorthShore - Edward-Elmhurst Health

Mailing Address: 1301 Central Street

City, State, Zip: Evanston, IL 60201

Reporting Period: See attached list of reporting hospitals through _____

Taxpayer Number: See attached list of reporting hospitals

• • •

1. Attach a copy of each Hospital Financial Assistance Application form used during the reporting period. If more than one form was used, identify the date any amended form was adopted.
2. Attach a copy of the Presumptive Eligibility Policy in effect during the reporting period, which shall identify each of the criteria used by the hospital to determine whether a patient is presumptively eligible for Hospital Financial Assistance.
3. Provide the following Hospital Financial Assistance statistics for the hospital during the reporting period:
   - A) The number of Hospital Financial Assistance Applications submitted to the hospital, both complete and incomplete, during the most recent fiscal year: a) 22,687
   - B) The number of Hospital Financial Assistance Applications the hospital approved under its Presumptive Eligibility Policy during the most recent fiscal year: b) 43,983
   - C) The number of Hospital Financial Assistance Applications the hospital approved outside its Presumptive Eligibility Policy during the most recent fiscal year: c) 21,319
   - D) The number of Hospital Financial Assistance Applications denied by the hospital during the most recent fiscal year: d) 1,234
   - E) The total dollar amount of financial assistance provided by the hospital during the most recent fiscal year based on actual cost of care: e) $ 53,986,030
4. If the Reporting Hospital annually files a Community Benefits Plan Report with the Office of the Attorney General pursuant to the Community Benefits Act, the Hospital Financial Assistance Report shall be filed at the same time as the Community Benefits Plan Report is filed each year. All records and certifications required to be filed under this Part in conjunction with the filing of its Community Benefits Report as required by the Community Benefits Act shall be submitted to:

   Charitable Trusts Bureau
   Office of the Illinois Attorney General
   100 West Randolph Street, 11th Floor
   Chicago, Illinois 60601

5. If the Reporting Hospital is not required to annually file a Community Benefits Plan Report with the Office of the Attorney General, the Hospital Financial Assistance Report shall be filed jointly with its Worksheet C Part I from its most recently filed Medicare Cost Report pursuant to the Hospital Uninsured Patient Discount Act. All records and certifications required to be filed under this Part in conjunction with the filing of its Worksheet C as required by the Hospital Uninsured Patient Discount Act shall be submitted to:

   Health Care Bureau
   Office of the Illinois Attorney General
   100 West Randolph Street, 10th Floor
   Chicago, Illinois 60601

6. If the Reporting Hospital utilizes Electronic and Information Technology in the implementation of the Hospital Financial Assistance Application requirements, identify such Electronic and Information Technology so used and the source of such Electronic and Information Technology:

See attached response

7. If the Reporting Hospital utilizes Electronic and Information Technology in the implementation of the Presumptive Eligibility Criteria, identify such Electronic and Information Technology so used and the source of such Electronic and Information Technology:

See attached response

• • •

Under penalty of perjury, I the undersigned declare and certify that I have examined this Hospital Financial Assistance Report and the documents attached thereto. I further declare and certify that this Hospital Financial Assistance Report and the documents attached thereto are true and complete.

Name and Title (CEO or CFO): Douglas D. Welday, Chief Financial Officer

Signature: Douglas D Welday

Date: 6-26-23

• • •

Where the Reporting Hospital utilizes Electronic and Information Technology in the implementation of the Hospital Financial Assistance Application requirements, complete the following additional certification:

I further declare and certify that each of the Hospital Financial Assistance Application requirements set forth in 77 Ill. Adm. Code 4500.30 are included in Hospital Financial Assistance Applications processed by Electronic and Information Technology.

Name and Title (CEO or CFO): Douglas D. Welday, Chief Financial Officer

Signature: Douglas D Welday

Date: 6-26-23

• • •

Where the Reporting Hospital utilizes Electronic and Information Technology in the implementation of the Presumptive Eligibility Criteria, complete the following additional certification:

I further declare and certify that each of the Presumptive Eligibility Criteria requirements set forth in 77 Ill. Adm. Code 4500.40 are included in Hospital Financial Assistance Applications processed by Electronic and Information Technology.

Name and Title (CEO or CFO): Douglas D. Welday, Chief Financial Officer

Signature: Douglas D Welday

Date: 6-26-23

Annual Hospital Financial Assistance Report

Attachment – Responses to Questions 6 and 7

Health System: NorthShore – Edward-Elmhurst Health

Question 6:

If the Reporting Hospital utilizes Electronic and Information Technology in the implementation of the Hospital Financial Assistance Application requirements, identify such Electronic and Information Technology so used and the source of such Electronic and Information Technology:

Evanston Hospital, Glenbrook Hospital, Highland Park Hospital, Skokie Hospital, and Swedish Hospital used Epic's Financial Assistance Module to facilitate application processing.

Northwest Community Hospital used Passport Charity Guide until January 2022 and then used Epic's Financial Assistance Module to facilitate application processing.

Edward Hospital, Elmhurst Memorial Hospital, and Linden Oaks Hospital used a manual process and did not utilize Electronic and Information Technology.

Question 7:

If the Reporting Hospital utilizes Electronic and Information Technology in the implementation of the Presumptive Eligibility Criteria, identify such Electronic and Information Technology so used and the source of such Electronic and Information Technology:

Evanston Hospital, Glenbrook Hospital, Highland Park Hospital, Skokie Hospital, and Swedish Hospital utilized Experian in the implementation of the Presumptive Eligibility criteria.

Northwest Community Hospital utilized PARO in the implementation of the Presumptive Eligibility criteria.

Edward Hospital, Elmhurst Memorial Hospital, and Linden Oaks Hospital had a vendor which utilized a tool named I-Solutions to determine patient presumptive eligibility based on the hospital policy and guidelines.

NorthShore - Edward-Elmhurst Health
Hospital Financial Assistance Report
Summary for Health System

Reporting period: 10/1/2021 - 12/31/2022 for Evanston Hospital, Glenbrook Hospital, Highland Park Hospital, Skokie Hospital, Swedish Hospital, and Northwest Community Hospital
7/1/2021 - 12/31/2022 for Edward Hospital, Elmhurst Hospital, and Linden Oaks Hospital

The number of Hospital Financial Assistance Applications:	**Total**	**Evanston Hospital**	**Glenbrook Hospital**	**Highland Park Hospital**	**Skokie Hospital**	**Swedish Hospital**	**Northwest Community Hospital**	**Edward Hospital**	**Elmhurst Memorial Hospital**	**Linden Oaks Hospital**
Submitted to the hospital, both complete and incomplete:	**22,687**	6,292	927	782	909	3,360	2,275	4,006	3,893	243
Approved under its Presumptive Eligibility Policy:	**43,983**	5,484	812	672	800	3,025	134	12,799	19,966	290
Approved outside its Presumptive Eligibility Policy:	**21,319**	6,044	895	741	882	3,334	1,543	3,874	3,777	229
Denied by the hospital:	**1,234**	248	32	41	27	26	598	132	116	14

NorthShore - Edward-Elmhurst Health
Data on financial assistance applications reported by race, ethnicity, sex, and preferred language

Reporting period: 10/1/2021 - 12/31/2022 for Evanston Hospital, Glenbrook Hospital, Highland Park Hospital, Skokie Hospital, Swedish Hospital, and Northwest Community Hospital
7/1/2021 - 12/31/2022 for Edward Hospital, Elmhurst Hospital, and Linden Oaks Hospital

Financial assistance application data separated by patient race:

Applications approved	Total	Evanston Hospital	Glenbrook Hospital	Highland Park Hospital	Skokie Hospital	Swedish Hospital	Northwest Community Hospital	Edward Hospital	Elmhurst Memorial Hospital	Linden Oaks Hospital
Caucasian	**8,060**	1,605	310	288	223	693	587	2,433	1,732	189
Other / Two or More Races	**7,227**	2,356	280	316	291	2,063	327	476	1,109	9
Black or African American	**2,508**	903	57	70	117	106	41	512	684	18
Asian	**2,492**	1,035	232	48	227	214	157	366	204	9
Declined/Unknown	**930**	102	9	17	16	243	425	68	46	4
American Indian or Alaska Native	**84**	41	7	2	8	12	1	12	1	-
Pacific Islander/Hawaiian Native	**18**	2	-	-	-	3	5	7	1	-
Total approved	**21,319**	**6,044**	**895**	**741**	**882**	**3,334**	**1,543**	**3,874**	**3,777**	**229**

Applications denied	Total	Evanston Hospital	Glenbrook Hospital	Highland Park Hospital	Skokie Hospital	Swedish Hospital	Northwest Community Hospital	Edward Hospital	Elmhurst Memorial Hospital	Linden Oaks Hospital
Caucasian	**572**	114	18	20	8	3	307	46	46	10
Other / Two or More Races	**327**	72	5	12	11	17	171	16	23	-
Asian	**147**	25	6	1	4	4	97	1	9	-
Black or African American	**88**	32	3	4	2	2	9	17	19	-
Declined/Unknown	**90**	5	-	3	-	-	8	51	19	4
American Indian or Alaska Native	**5**	-	-	1	2	-	1	1	-	-
Pacific Islander/Hawaiian Native	**5**	-	-	-	-	-	5	-	-	-
Total denied	**1,234**	**248**	**32**	**41**	**27**	**26**	**598**	**132**	**116**	**14**

NorthShore - Edward-Elmhurst Health
Data on financial assistance applications reported by race, ethnicity, sex, and preferred language

Reporting period: 10/1/2021 - 12/31/2022 for Evanston Hospital, Glenbrook Hospital, Highland Park Hospital, Skokie Hospital, Swedish Hospital, and Northwest Community Hospital
7/1/2021 - 12/31/2022 for Edward Hospital, Elmhurst Hospital, and Linden Oaks Hospital

Financial assistance application data separated by patient ethnicity:

Applications approved	Total	Evanston Hospital	Glenbrook Hospital	Highland Park Hospital	Skokie Hospital	Swedish Hospital	Northwest Community Hospital	Edward Hospital	Elmhurst Memorial Hospital	Linden Oaks Hospital
Non-Hispanic	**13,448**	4,202	705	455	727	699	749	3,173	2,542	196
Hispanic/Latino	**7,004**	1,731	185	265	139	2,475	369	609	1,208	23
Declined/Unknown	**867**	111	5	21	16	160	425	92	27	10
Total approved	**21,319**	**6,044**	**895**	**741**	**882**	**3,334**	**1,543**	**3,874**	**3,777**	**229**

Applications denied	Total	Evanston Hospital	Glenbrook Hospital	Highland Park Hospital	Skokie Hospital	Swedish Hospital	Northwest Community Hospital	Edward Hospital	Elmhurst Memorial Hospital	Linden Oaks Hospital
Non-Hispanic	**891**	206	27	29	24	11	402	102	81	9
Hispanic/Latino	**320**	36	5	10	3	13	192	29	27	5
Declined/Unknown	**23**	6	-	2	-	2	4	1	8	-
Total denied	**1,234**	**248**	**32**	**41**	**27**	**26**	**598**	132	116	14

NorthShore - Edward-Elmhurst Health
Data on financial assistance applications reported by race, ethnicity, sex, and preferred language

Reporting period: 10/1/2021 - 12/31/2022 for Evanston Hospital, Glenbrook Hospital, Highland Park Hospital, Skokie Hospital, Swedish Hospital, and Northwest Community Hospital
7/1/2021 - 12/31/2022 for Edward Hospital, Elmhurst Hospital, and Linden Oaks Hospital

Financial assistance application data separated by patient sex:

Applications approved	Total	Evanston Hospital	Glenbrook Hospital	Highland Park Hospital	Skokie Hospital	Swedish Hospital	Northwest Community Hospital	Edward Hospital	Elmhurst Memorial Hospital	Linden Oaks Hospital
Female	**13,942**	3,853	547	492	553	2,489	671	2,680	2,519	138
Male	**6,959**	2,190	348	247	329	845	457	1,194	1,258	91
Declined/Unknown	**418**	1	0	2	0	0	415	-	-	-
Total approved	**21,319**	**6,044**	**895**	**741**	**882**	**3,334**	**1,543**	**3,874**	**3,777**	**229**

Applications denied	Total	Evanston Hospital	Glenbrook Hospital	Highland Park Hospital	Skokie Hospital	Swedish Hospital	Northwest Community Hospital	Edward Hospital	Elmhurst Memorial Hospital	Linden Oaks Hospital
Female	**794**	162	19	27	15	13	369	100	80	9
Male	**440**	86	13	14	12	13	229	32	36	5
Total denied	**1,234**	**248**	**32**	**41**	**27**	**26**	**598**	**132**	**116**	**14**

NorthShore - Edward-Elmhurst Health
Data on financial assistance applications reported by race, ethnicity, sex, and preferred language

Reporting period: 10/1/2021 - 12/31/2022 for Evanston Hospital, Glenbrook Hospital, Highland Park Hospital, Skokie Hospital, Swedish Hospital, and Northwest Community Hospital
7/1/2021 - 12/31/2022 for Edward Hospital, Elmhurst Hospital, and Linden Oaks Hospital

Financial assistance application data separated by patient preferred language:

Applications approved	Total	Evanston Hospital	Glenbrook Hospital	Highland Park Hospital	Skokie Hospital	Swedish Hospital	Northwest Community Hospital	Edward Hospital	Elmhurst Memorial Hospital	Linden Oaks Hospital
English	**14,922**	4,432	625	543	640	1,142	785	3,484	3,044	227
Spanish	**4,377**	1,026	119	161	88	2,012	232	180	559	-
Declined/Unknown	**553**	45	3	4	11	21	421	26	20	2
Urdu	**232**	105	15	4	43	14	1	19	31	-
Mongolian	**160**	103	36	4	5	7	5			
Polish	**139**	12	9	2	3	3	16	44	50	-
Arabic	**106**	34	1	1	15	23	2	10	20	-
Korean	**93**	27	24	2	13	2	15	10	-	-
Russian	**82**	33	11	5	1	9	16	6	1	-
Hindi	**70**	24	7		18	5	5	8	3	-
Other	**62**	10	1	1	4	18	5	2	21	-
Gujarati	**58**	22	12	2	3	9	4	6	-	-
Assyrian	**41**	18	6		14	3				
Farsi (Persian)	**38**	16	6		7	8		1	-	-
Chinese (Mandarin)	**37**	18	4	3	3	4		5	-	-
Albanian	**33**	3	1			4	3	13	9	-
Tagalog	**27**	13	3		1	5		5	-	-
Ukrainian	**27**	3		1	1		5	4	13	-
Vietnamese	**26**	8				5	1	12	-	-
Bulgarian	**21**	9	2	1		2	4	3	-	-
Greek	**21**	5	1		3	2	3	7	-	-
Chinese	**16**	8	3	2	1			2	-	-
Romanian	**15**	6	1		1	6		-	1	-
Bosnian	**15**	4		1		6	3	-	1	-
French	**11**	8		1	1			1	-	-
Filipino	**10**	1						9	-	-

NorthShore - Edward-Elmhurst Health
Data on financial assistance applications reported by race, ethnicity, sex, and preferred language

Reporting period: 10/1/2021 - 12/31/2022 for Evanston Hospital, Glenbrook Hospital, Highland Park Hospital, Skokie Hospital, Swedish Hospital, and Northwest Community Hospital
7/1/2021 - 12/31/2022 for Edward Hospital, Elmhurst Hospital, and Linden Oaks Hospital

Financial assistance application data separated by patient preferred language:

Applications approved	Total	Evanston Hospital	Glenbrook Hospital	Highland Park Hospital	Skokie Hospital	Swedish Hospital	Northwest Community Hospital	Edward Hospital	Elmhurst Memorial Hospital	Linden Oaks Hospital
Malayalam	**9**	3						6	-	-
Serbian	**9**	2	1		1	1		4	-	-
Chinese (Cantonese)	**7**	4			2			1	-	-
Bengali	**7**	3	1			2		1	-	-
Mandarin	**7**	2					5			
Creole	**6**	4		1	1					
Haitian-Creole	**6**	4	1			1				
Portuguese	**6**	1	1				2	1	1	-
Sign Language	**5**	4					1			
Pashto	**5**	3				2				
Thai	**5**	2				3				
Punjabi	**5**	1						3	1	-
Nepali	**5**	1				2	2			
Burmese	**4**	2				2				
Tamil	**3**	1					2			
Turkish	**3**	1				1	1			
Italian	**3**					3				
Japanese	**3**						3			
Croatian	**2**	2								
Hebrew	**2**	2								
Pakistani	**2**	2								
Taiwanese	**2**	1		1						
Telugu	**2**	1					1			
Tibetan	**2**	1			1					
Amharic	**2**					2				
Swahili	**2**					2				
Cambodian	**1**	1								

NorthShore - Edward-Elmhurst Health
Data on financial assistance applications reported by race, ethnicity, sex, and preferred language

Reporting period: 10/1/2021 - 12/31/2022 for Evanston Hospital, Glenbrook Hospital, Highland Park Hospital, Skokie Hospital, Swedish Hospital, and Northwest Community Hospital
7/1/2021 - 12/31/2022 for Edward Hospital, Elmhurst Hospital, and Linden Oaks Hospital

Financial assistance application data separated by patient preferred language:

Applications approved	Total	Evanston Hospital	Glenbrook Hospital	Highland Park Hospital	Skokie Hospital	Swedish Hospital	Northwest Community Hospital	Edward Hospital	Elmhurst Memorial Hospital	Linden Oaks Hospital
Cantonese	**1**	1								
Estonian	**1**	1								
Yoruba	**1**	1								
Hmong	**1**							1	-	-
Marathi	**1**							-	1	-
Norwegian	**1**							-	1	-
Czech	**1**				1					
Lithuanian	**1**			1						
Malaysian	**1**					1				
Rohingya	**1**					1				
Somali	**1**					1				
Yugoslavian	**1**		1							
Total approved	**21,319**	**6,044**	**895**	**741**	**882**	**3,334**	**1,543**	**3,874**	**3,777**	**229**

Applications denied	Total	Evanston Hospital	Glenbrook Hospital	Highland Park Hospital	Skokie Hospital	Swedish Hospital	Northwest Community Hospital	Edward Hospital	Elmhurst Memorial Hospital	Linden Oaks Hospital
English	**1,003**	229	24	37	23	13	456	118	91	12
Spanish	**152**	10	3	4		11	97	9	16	2
Unknown	**16**	1					6	3	6	
Korean	**10**	2			1		7			
Russian	**8**	1					7			
Chinese (Mandarin)	**6**	1	1				4			
Mongolian	**5**				1		4			
Hindi	**5**		1				2	2		

NorthShore - Edward-Elmhurst Health
Data on financial assistance applications reported by race, ethnicity, sex, and preferred language

Reporting period: 10/1/2021 - 12/31/2022 for Evanston Hospital, Glenbrook Hospital, Highland Park Hospital, Skokie Hospital, Swedish Hospital, and Northwest Community Hospital
7/1/2021 - 12/31/2022 for Edward Hospital, Elmhurst Hospital, and Linden Oaks Hospital

Financial assistance application data separated by patient preferred language:

Applications denied	Total	Evanston Hospital	Glenbrook Hospital	Highland Park Hospital	Skokie Hospital	Swedish Hospital	Northwest Community Hospital	Edward Hospital	Elmhurst Memorial Hospital	Linden Oaks Hospital
Other	**4**	1					3			
Tagalog	**4**					1			3	
Gujarati	**3**		1				2			
Polish	**3**		1				2			
Bulgarian	**2**						2			
Telugu	**2**						2			
Ukrainian	**1**						1			
Albanian	**1**						1			
Arabic	**1**	1								
Assyrian	**1**				1					
Bosnian	**1**					1				
Farsi	**1**				1					
Haitian-Creole	**1**		1							
Portuguese	**1**						1			
Turkish	**1**						1			
Urdu	**1**	1								
Vietnamese	**1**	1								
Total denied	**1,234**	**248**	**32**	**41**	**27**	**26**	**598**	**132**	**116**	**14**

NorthShore - Edward-Elmhurst Health
Five most frequent reasons for denial

Reporting period: 10/1/2021 - 12/31/2022 for Evanston Hospital, Glenbrook Hospital, Highland Park Hospital, Skokie Hospital, Swedish Hospital, and Northwest Community Hospital
7/1/2021 - 12/31/2022 for Edward Hospital, Elmhurst Hospital, and Linden Oaks Hospital

Evanston Hospital

1) Incomplete Application or Documentation
2) Balance does not meet Charity guidelines
3) Over Income Threshold
4) Qualified for Other Assistance Programs
5) Date of Service(s) is greater than 240 days

Glenbrook Hospital

1) Incomplete Application or Documentation
2) Balance does not meet Charity guidelines
3) Over Income Threshold
4) Qualified for Other Assistance Programs
5) Automatically Denied

Highland Park Hospital

1) Incomplete Application or Documentation
2) Balance does not meet Charity guidelines
3) Over Income Threshold
4) Qualified for Other Assistance Programs
5) Date of Service(s) is greater than 240 days

Skokie Hospital

1) Incomplete Application or Documentation
2) Balance does not meet Charity guidelines
3) Date of Service(s) is greater than 240 days
4) Over Income Threshold
5) Qualified for Other Assistance Programs

Swedish Hospital

1) Incomplete Application or Documentation
2) Qualified for Other Assistance Programs
3) Balance does not meet Charity guidelines
4) Qualified for Medicaid
5) Over Income Threshold

Northwest Community Hospital

1) Incomplete Application or Documentation
2) Over Income Threshold
3) Does not meet criteria / Not located in service area
4) Qualified for Medicaid
5) Required documentation was not provided

Edward Hospital

1) Over Income Threshold
2) Date of Service(s) is greater than 365 days
3) Over Income Threshold
4) Incomplete Application or Documentation
5) N/A

Elmhurst Memorial Hospital

1) Over Income Threshold
2) Not an Illinois Resident
3) Date of Service(s) is greater than 365 days
4) Incomplete Application or Documentation
5) N/A

Linden Oaks Hospital

1) Over Income Threshold
2) Incomplete Application or Documentation
3) N/A
4) N/A
5) N/A

Financial Assistance Policy

1. POLICY:

- The fundamental purpose of NorthShore University HealthSystem (NorthShore) is to provide quality health care and health-related services that effectively and efficiently meet the needs of individuals and families who reside in the communities served by NorthShore. For purposes of this policy, NorthShore refers to the non-profit hospitals: Evanston Hospital, Glenbrook Hospital, Highland Park Hospital, Skokie Hospital, Swedish Hospital, and Northwest Community Hospital and Northwest Community Day Surgery Center II (collectively, NCH). Where policy differences apply to Swedish Hospital and NCH, those differences are separately identified.

- Consistent with NorthShore's values of compassion and stewardship, it is the policy of NorthShore to provide financial assistance to patients in need. Furthermore, the purpose of this Financial Assistance Policy (FAP) is to provide the framework under which financial assistance will be granted to patients for emergency or medically necessary care provided by NorthShore to those that reside in the commnuities that we serve.

- This policy identifies the specific criteria and application process under which NorthShore will extend financial assistance to individuals whose financial status makes it impossible to pay fully for the services. Note that certain individuals are presumptively eligible to receive services at no cost (see section 4.E).

- This policy applies to all emergency or medically necessary care provided by a NorthShore hospital. This policy is not binding upon providers of medical services outside of the hospital. In **Exhibit 1** of the FAP**,** you can find information on providers delivering emergency or other medically necessary care in the hospital facility whose services are covered as part of this policy and a list of providers whose services are not covered as part of this policy. Note that provider services are covered only if you are found to be eligible for financial assistance in accordance with this policy. Free paper copies of the **Exhibit 1** are available as part of the FAP online at www.northshore.org/about-us/billing/financial-assistance or www.swedishcovenant.org/for-patients-and-visitors/pay-your-bill/financial-assistance or www.nch.org/billing-insurance/financial-assistance/ or upon request in the emergency department and hospital registration areas. Free paper copies are also available by mail by calling (847) 570-5000 or (773) 989-3841 for Swedish Hospital or (847) 618-4542 for NCH.

- NorthShore may exclude services from this policy that are covered by an insurance program at another provider location but are not covered at NorthShore after efforts are made to educate the patient on insurance program coverage limitations and provided that federal Emergency Medical Treatment and Active Labor Act (EMTALA) obligations are satisfied.

- This policy describes the criteria used by NorthShore in calculating the amount of the financial assistance discount, if any, the measures NorthShore will take to widely publicize this FAP within the community served by NorthShore, the process used by NorthShore to determine financial assistance eligibility, and the financial assistance application process. The actions NorthShore may take in the event of nonpayment are described in a separate **Billing and Collections Policy**. That policy can be downloaded on NorthShore's website at www.northshore.org/about-us/billing/financial-assistance or www.swedishcovenant.org/for-patients-and-visitors/pay-your-bill/financial-assistance or www.nch.org/billing-insurance/financial-assistance/ or a free paper copy is available in the emergency department and hospital registration areas or by mail by calling (847) 570-5000 or (773) 989-3841 for Swedish Hospital or (847) 618-4542 for NCH.

- To be eligible for financial assistance, you must complete and submit a financial assistance application (for patients who are not presumptively eligible) along with any required supporting documentation. Financial assistance applications are due no later than 240 days after the date of the first billing statement sent for the services for which you are requesting financial assistance. Exceptions may be granted as described later in this policy. Nothing in this policy takes precedence over federal, state or local laws or regulations currently in effect today or in effect in the future.

- Final authority to determine whether NorthShore has made reasonable efforts to determine FAP eligibility resides with NorthShore's Single Business Office, Swedish Hospital's Financial Services Center, and NCH's Patient Services Center. This policy is intended to benefit NorthShore's community consistent with its values of compassion and stewardship. The existence of this FAP does not constitute an offer of financial assistance to any particular patient and creates no contractual rights or obligations. This FAP may be updated by NorthShore in its sole discretion.

- The policies and procedures stated herein are intended to comply with Illinois state regulations and section 501(r) of the Internal Revenue Code and related guidance.

2. SCOPE:

This policy applies to all emergency or medically necessary care provided by a NorthShore hospital. This policy is not binding upon providers of medical services outside of the hospital. In **Exhibit 1** of the FAP**,** you can find information on providers delivering emergency or other medically necessary care in the hospital facility whose services are covered as part of this policy and a list of providers whose services are not covered as part of this policy. Note that provider services are covered only if you are found to be eligible for financial assistance in accordance with this policy.

3. DEFINITIONS:

Application - Means an application for financial assistance to be completed by a patient.

Application Period - During the application period, NorthShore will accept and process an application for financial assistance. The application period begins on the date the care is provided to the individual and ends on the 240th day after the date of the first billing statement for the care.

Amounts Generally Billed (AGB) - Patients who qualify for financial assistance will not be charged more for emergency or medical necessary care than the amounts generally billed (AGB) to patients who have insurance.

1) The NorthShore AGB percentage is calculated using the "look-back" method, which is the total of Medicare fee-for-service and private health insurer allowed claims divided by the total gross charges for those claims for a 12-month period. Discounts provided to patients who qualify for financial assistance will be reviewed against the AGB percentage limits to ensure patients are not charged more than AGB.

2) AGB percentages can be found in **Exhibit 2** of the FAP.

3) A revised AGB percentage will be calculated annually and applied by the 120th day after the start of the year.

Cost of Services Provided - The usual and customary charges at the time of initial billing, multiplied (reduced) by the hospital's relationship of costs to charges (also referred to as the hospital's "cost to charge ratio") taken from NorthShore's most recently filed Medicare cost report. Costs are updated annually.

Elective Services - Services to treat a condition that does not require immediate attention. Elective services include procedures that are advantageous to the patient, but not urgent and include medically necessary services and non-medically necessary services, such as cosmetic and dental surgery performed solely to improve appearance or other elective procedures not typically covered by health insurance plans. Elective services that are not medically necessary will not be considered for financial assistance.

Emergency Services - Services provided to a patient for a medical condition with acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse), such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or with respect to a pregnant woman, the woman or her unborn child) in serious jeopardy, or cause serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Extraordinary Collection Actions (ECAs) - These are collection actions requiring a legal or judicial process and can also involve other activities such as selling debt to another party or reporting adverse information to credit agencies or bureaus. NorthShore does not engage in ECAs, nor does it permit its collections vendors to engage in ECAs. Further information on NorthShore's collection policies can be found in NorthShore's separate **Billing and Collections Policy**. Free paper copies of this policy are available online at www.northshore.org/about-us/billing/financial-assistance or www.swedishcovenant.org/for-patients-and-visitors/pay-your-bill/financial-assistance or www.nch.org/billing-insurance/financial-assistance/ or free paper copies are available upon request in the emergency department and hospital registration areas or by mail by calling (847) 570-5000 or (773) 989-3841 for Swedish Hospital or (847) 618-4542 for NCH.

Family - The patient, the patient's spouse/civil union partner, the patient's parents or guardians (in the case of a minor patient), and any dependents claimed on the patient's or parent's income tax return, and living in the patient's or his or her parents' or guardians' household.

Family Income - The sum of a family's annual earnings and cash benefits from all sources before taxes, less payments made for child support reportable to the United States Internal Revenue Service. Family income includes, but is not limited to

earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, alimony, child support, and other sources.

Federal Poverty Level (FPL) - Level of income at which an individual is deemed to be at the threshold of poverty. This income level varies by the size of the family unit. The poverty level is updated annually by the United States Department of Health and Human Services and published in the Federal Register. For purposes of this policy, the poverty level indicated in these published guidelines represents gross income. The FPL used for purposes of this policy will be updated annually. FPLs can be found in **Exhibit 3** of the FAP.

Financial Assistance - Financial assistance means assistance offered by NorthShore to patients who meet certain financial and other eligibility criteria as defined in NorthShore's FAP to help them obtain the financial resources necessary to pay for medically necessary or emergent health care services provided by NorthShore in a hospital setting. Eligible patients may include uninsured patients, low income patients, and those patients who have partial coverage but who are unable to pay some or all of the remainder of their medical bills.

Medically Necessary Services - Services or supplies that are provided for the diagnosis, direct care, and treatment of a medical condition, meet the standards of good medical practice in the local area, are covered by and considered medically necessary by the Medicare and Medicaid programs, and are not mainly for the convenience of the patient or physician. Medically necessary services do not include cosmetic surgery or non-medical services, such as social, educational or vocational services.

Plain Language Summary - A plain language summary of NorthShore's FAP includes: 1) a brief description of the eligibility requirements and assistance offered; 2) a listing of the website and physical locations where financial assistance applications may be obtained; 3) instructions on how to obtain a free paper copy of the FAP; 4) contact information for assistance with the application process; 5) availability of language translations of the FAP and related documents; and 6) a statement confirming that patients who are determined to be eligible for financial assistance will be charged no more than AGB for emergency or medically necessary services.

Presumptive Eligibility - A financial assistance eligibility determination made by reference to specific criteria which has been deemed to demonstrate financial need on the part of an uninsured patient without completion of a financial assistance application.

Reasonable Efforts - NorthShore will make reasonable efforts to provide notification to the patient about NorthShore's FAP by offering the plain language summary of the FAP. In addition, NorthShore will take the following steps to inform patients about NorthShore's FAP.

1) Incomplete Applications - If the patient and/or patient's family member submits an incomplete financial assistance application, NorthShore will provide a written notification that describes what additional information or documentation is needed.

2) Completed Applications - If the patient and/or patient's family member submits a complete financial assistance application, NorthShore will provide written notification that documents a determination on whether a patient is eligible for financial assistance in a timely matter and notifies the patient in writing of the determination (including, if applicable, the assistance for which the patient is eligible) and the basis for this determination. This notification will also include the financial assistance percentage amount (for approved applications) or reason(s) for denial, and expected payment from the patient and/or family where applicable. The patient and/or family will continue to receive statements during the evaluation of a completed application.

3) Patient Statements - NorthShore will send a series of statements describing the patient's account and amount due. Patient statements will include a request that the patient is responsible to inform NorthShore of any available health insurance coverage and will include a notice of NorthShore's FAP, a telephone number to request financial assistance, and the website address where financial assistance documents can be obtained.

4) NorthShore Website - NorthShore's website will post a notice in a prominent place that financial assistance is available, with an explanation of the financial assistance application process. NorthShore will post its FAP with a list of providers who are covered and not covered under the FAP, plain language summary, financial assistance application, and billing and collections policy at www.northshore.org/about-us/billing/financial-assistance or www.swedishcovenant.org/for-patients-and-visitors/pay-your-bill/financial-assistance or www.nch.org/billing-insurance/financial-assistance/. NorthShore will have free paper copies of these documents available upon request in the emergency department and registration areas or by mail by calling (847) 570-5000 or (773) 989-3841 for Swedish Hospital or (847) 618-4542 for NCH.

Uninsured Patient - A patient who is not covered in whole or in part under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program (including, without limitation, private insurance, Medicare, or Medicaid, or Crime Victims Assistance) and whose injury is not compensable for purposes of workers' compensation, automobile insurance, or liability or other third party insurance, as determined by NorthShore based on documents and information provided by the patient or obtained from other sources, for the payment of health care services provided by NorthShore.

Urgent Services - Services to treat an unexpected illness or injury that requires immediate medical attention (usually within 48 hours), that is not life threatening, but where a prolonged delay in treatment may threaten the patient's health or well-being.

4. PROCEDURE:

A. *Communication*: To make our patients, families, and the broader community aware of the availability of financial assistance, NorthShore will take a number of steps to notify patients and visitors to its hospitals of the availability of financial assistance and to widely publicize this policy to members of the broader community served by the hospitals. These measures include:

i. *Financial Counseling:* NorthShore patients are encouraged to seek information from their hospital's financial counselor if they anticipate difficulty paying their portion of the hospital bill. Our counselors make every effort to assist patients who are uninsured, underinsured, or face other financial challenges associated with paying for the health care services we provide. Counselors may screen patients for eligibility for a variety of government-funded programs, assist with a worker's compensation or liability claim, set up an extended time payment plan, or help patients apply for financial assistance.

ii. *Plain Language Summary:* A paper copy of the plain language summary of NorthShore's FAP will be offered to all patients. NorthShore will also have free paper copies of financial assistance documents available online at www.northshore.org/about-us/billing/financial-assistance or www.swedishcovenant.org/for-patients-and-visitors/pay-your-bill/financial-assistance or www.nch.org/billing-insurance/financial-assistance/ or upon request in the emergency department and registration areas. Free paper copies are also available by mail by calling (847) 570-5000 or (773) 989-3841 for Swedish Hospital or (847) 618-4542 for NCH.

iii. *Translated Copies Available*: NorthShore will offer its FAP, plain language summary, financial assistance application, and billing and collections policy in English and any other languages spoken by the lesser of 1,000 individuals or 5% of the population likely to be affected or encountered by NorthShore hospitals. NorthShore will have free paper copies of these documents available on the NorthShore website at www.northshore.org/about-us/billing/financial-assistance or www.swedishcovenant.org/for-patients-and-visitors/pay-your-bill/financial-assistance or www.nch.org/billing-insurance/financial-assistance/ or upon request in the emergency department and hospital registration areas. Free paper copies are also available by mail by calling (847) 570-5000 or (773) 989-3841 for Swedish Hospital or (847) 618-4542 for NCH.

iv. *We Can Help Signage*: All financial assistance signage will be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to NorthShore emergency department and patient registration areas. Signage will indicate that financial assistance is available and the phone number to reach a financial counselor for more information.

v. *Brochures*: Brochures will be placed in NorthShore patient access, registration, emergency department, and cashier locations, and will include guidance on how a patient may apply for Medicare, Medicaid, All Kids, Family Care etc., and NorthShore's financial assistance program. A contact and telephone number for help reviewing or applying for financial assistance will be included.

vi. *Website*: NorthShore's website will post a notice in a prominent place that financial assistance is available, with an explanation of the financial assistance application process. NorthShore will post its FAP with a list of providers who are covered and not covered under the FAP, plain language summary, financial assistance application, and billing and collections policy on the NorthShore website at www.northshore.org/about-us/billing/financial-assistance or www.swedishcovenant.org/for-patients-and-visitors/pay-your-bill/financial-assistance or www.nch.org/billing-insurance/financial-assistance/. NorthShore will also have free paper copies of these documents available upon request in the emergency department and registration areas. Free paper copies are also available by mail by calling (847) 570-5000 or (773) 989-3841 for Swedish Hospital or (847) 618-4542 for NCH.

vii. *Patient Bills and Statements:* Patient statements will include a request that the patient is responsible to inform NorthShore of any available health insurance coverage and will include a notice of NorthShore's FAP, a telephone

number to request financial assistance, and the website address where financial assistance documents can be obtained.

B. *Eligibility Determination:* Financial need is determined in accordance with procedures that involve an individual assessment of financial need. Those procedures are described below:

i. A presumptive eligibility determination is completed according to the criteria described in Section 4.E. below. If a patient is presumptively eligible for financial assistance, a financial assistance application is not required. The patient or guarantor is expected to cooperate with the screening process and supply personal or financial information and documentation relevant to making a determination of presumptive eligibility;

ii. A financial assistance application process, in which the patient or guarantor is expected to cooperate and supply personal or financial information and documentation relevant to making a determination of financial need;

iii. Reasonable efforts by NorthShore to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs. Coverage may be pursued by using:

a) Available websites and contact information for worker's compensation or public liability claims
b) Available contact information for patients in police custody
c) The Get Covered Illinois website for patients who are signing up for exchange health coverage during open enrollment
d) The eCareNext tool (as part of Passport OneSource) to search for eligibility for health insurance coverage, public aid coverage, DHS social services, Illinois Healthy Women's program, Renal services only, and Temporary Assistance for Needy Families (TANF)
e) The state's PACIS and/or IES database to search for public aid coverage
f) The SNAP search tool through the Illinois Link EBT card website
g) The Experian eligibility tool to search for public aid coverage
h) Other appropriate third party sources

iv. The use of external publicly available data sources that provide information on a patient or guarantor's ability to pay (including credit scoring) (see section 4.G.);

v. A review of the patient's outstanding accounts receivable for prior services rendered at NorthShore and the patient's payment or bad debt history;

vi. The levels of financial assistance provided by NorthShore are based on income, family size, and FPL. Both uninsured and insured patients can apply for financial assistance; and

vii. The patient's eligibility for financial assistance will be based on the tables below and may vary based on the financial status of the patient, extenuating financial circumstances and the availability of third party health care benefits. Eligibility guidelines will be revised annually after the poverty level guidelines are published by the federal government and will also include NorthShore's most recently filed Medicare cost to charge ratios. Families with incomes exceeding the guidelines stated below can be screened for payment plan consideration.

C. *Uninsured Patient Financial Assistance Eligibility*: Based on the federal poverty levels, the following table shall be used to determine the discounts offered to uninsured patients qualifying for financial assistance. Discounts provided to patients who qualify for financial assistance will be reviewed against the AGB percentage limits to ensure patients are not charged more than AGB.

FPL Tier	0% – 200% FPL	201% - 300% FPL	301% - 400% FPL	401% - 600% FPL
Expected Patient Payment	$0 PMT / 100% write-off	100% of the Cost of Services Provided	100% of the Cost of Services Provided	AGB Percentage (see Exhibit 2)
Annual Maximum Expected Patient Payment	$0 PMT / 100% write-off	20% of Annual Family Income	20% of Annual Family Income	20% of Annual Family Income

i. FPLs can be found in **Exhibit 3** of the FAP and AGB percentages for each hospital can be found in **Exhibit 2**.

ii. Expected payment for NorthShore hospital charges is determined by reducing hospital charges for medically necessary services on the uninsured patient's bill to 100% of the hospital's cost to charge ratio for patients with family income between two and four times the FPL, or amounts generally billed for patients with family income between four and six times the FPL. A revised percentage will be calculated annually and applied by the 120th day after the start of the year. The NorthShore discount percentages by FPL tier can be found in **Exhibit 4**. The Swedish Hospital discount percentages by FPL tier can be found in **Exhibit 5**. The NCH discount percentages by FPL tier can be found in **Exhibit 6**.

iii. In compliance with the Illinois Hospital Uninsured Patient Discount Act (210 ILCS 89/1) effective 1/1/2022, eligibility for financial assistance is restricted to patients with Illinois residency and medically necessary charges exceeding $150. Also in compliance with this law, NorthShore has compared the discounts for 135% of the hospital's cost to charge ratio to the amounts generally billed and have applied the more generous discounts for patients.

iv. NorthShore will offer uninsured patients who received community-based primary care provided by a Federally Qualified Health Center (FQHC)/community health center or a free and charitable clinic, are referred by such an entity to NorthShore, and seek access to nonemergency hospital-based health care services, with an opportunity to be screened for an assistance with applying for public health insurance programs if there is a reasonable basis to believe that the uninsured patient may be eligible for a public health insurance program. An uninsured patient who receives community-based primary care provided by an FQHC/community health center or free and charitable clinic and is referred by such an entity to the hospital for whom there is not a reasonable basis to believe that the uninsured patient may be eligible for a public health insurance program shall be given the opportunity to apply for hospital financial assistance when hospital services are scheduled.

D. *Insured Patient Financial Assistance Eligibility*: Based on the FPLs, the following table shall be used to determine the discounts offered to insured patients qualifying for financial assistance. Patients may request financial assistance consideration for the balance remaining (i.e., self-pay balance) after their health insurance has paid for medically necessary services. Financial assistance for insured patients is restricted to patients with a patient balance remaining of $150 or greater. Discounts provided to patients who qualify for financial assistance will be reviewed against the AGB percentage limits to ensure patients are not charged more than AGB. The NorthShore discount percentages by FPL tier can be found in **Exhibit 4**. The Swedish Hospital discount percentages by FPL tier can be found in **Exhibit 5**. The NCH discount percentages by FPL tier can be found in **Exhibit 6**. Families with family incomes exceeding the guidelines stated below can be screened for payment plan consideration.

FPL Tier	0% – 200% FPL	201% - 400% FPL
Expected Patient Payment	$0 PMT / 100% write-off	AGB Percentage times remaining self-pay balance

FPLs can be found in **Exhibit 3** of the FAP and AGB percentages for each hospital can be found in **Exhibit 2**.

E. *Presumptive Eligibility*: Uninsured patients may be determined eligible for financial assistance based on the presence of one of the criteria listed below. After at least one criterion has been demonstrated, no other proof of income will be requested. The list below is representative of circumstances in which a patient's family income is less than two times the FPL and the patient is eligible for a 100% reduction of medically necessary charges. Presumptive eligibility screening for an uninsured patient should be completed as soon as possible after receipt of medically necessary services and prior to the issuance of any bill for those services. When notified of a possible presumptive eligibility status, NorthShore will hold any patient statement during the completion of the presumptive eligibility review process. Also, NorthShore can work with external charitable and non-profit agencies to pre-approve individuals for presumptive eligibility in extenuating circumstances. Examples of these agencies include federally qualified health clinics or religious non-profit organizations.

i. Presumptive Eligibility Criteria is demonstrated by enrollment in one of the following programs:

a) Women, Infants and Children Nutrition Program (WIC)
b) Supplemental Nutrition Assistance Program (SNAP)
c) Illinois Free Lunch and Breakfast Program
d) Low Income Home Energy Assistance Program (LIHEAP)
e) Temporary Assistance for Needy Families (TANF)
f) Illinois Housing Development Authority's Rental Housing Support Program

g) Organized community-based program or charitable health program providing medical care that assesses and documents low income financial status as criteria
h) Medicaid eligibility, but not eligible on date of service or for non-covered service

ii. Presumptive Eligibility Criteria can also be demonstrated by the following life circumstances:

a) Receipt of grant assistance for medical services
b) Homelessness
c) Deceased with no estate
d) Mental incapacitation with no one to act on patient's behalf
e) Recent personal bankruptcy
f) Incarceration in a penal institution
g) Affiliation with a religious order and vow of poverty
h) Evidence from an independent third-party reporting agency indicating family income is less than two times FPL

iii. Ways to demonstrate Presumptive Eligibility include:

a) Electronic confirmation of program enrollment or other presumptive eligibility criteria.
b) Where independent electronic confirmation is not possible, proof of enrollment or other eligibility criteria will be requested. Any one of the following will be satisfactory proof:

1. WIC voucher
2. SNAP card, proof of enrollment screen print, or copy of SNAP approval letter
3. Letter from the school or Free/Reduced Priced Meals & Fee Waiver Notification with Signature
4. LIHEAP Award or Approval letter
5. TANF Approval Letter from Red Cross, DHS, or HFS
6. Rent receipt in the case of state or federally subsidized housing program
7. Rent adjustment letter from Lessor or HUD card or letter
8. Card or Award statement showing current eligibility for State of Illinois program
9. Statement from Grant Agency or Grant letter
10. Personal attestation or letter from church or shelter confirming homelessness
11. Letter from attorney, group home, shelter, religious order, or church
12. Notice of Discharge of Debtor that identifies NorthShore as a creditor included in bankruptcy filing

F. *Eligibility Timeline*:

i. For uninsured patients, financial assistance determinations will be effective retrospectively for all self-pay balances dated during the application period and prospectively for a period of at least six months without further action by the patient. The patient shall communicate to NorthShore any material change in the patient's financial situation that occurs during the six month period that may affect the financial assistance determination within thirty (30) days of the change. A patient's failure to disclose a material improvement in family income may void any provision of financial assistance by NorthShore after the material improvement occurs. Presumptive eligibility determinations for uninsured patients may be effective retrospectively for all open self-pay balances.

~~ii.~~ For insured patients, financial assistance determinations will be effective retrospectively for all self-pay balances dated during the application period and prospectively for a period of at least six months without further action by the patient.

G. *Final Screening for Financial Assistance Eligibility Determinations*: There are instances when a patient may appear eligible for financial assistance, but there is no application on file or there is a lack of supporting documentation. In this event, external agencies' data and/or NorthShore's accounts receivable payment/charity/bad debt history or membership with the NorthShore Community Health Center at Evanston Hospital or Erie Family Health Center may be used to determine insurance and employment status and to estimate income for financial assistance determinations. NorthShore will approve financial assistance for patients whose financial status has been verified by a third party (e.g., credit scoring). In these situations, a financial assistance adjustment may be posted to the patient account and will not require the patient to submit a financial assistance application. Financial status confirmation through a third party may be done using the Experian Payment Navigator or other third party sources.

H. *Urgent or Medically Necessary Services*: Financial assistance is limited to urgent or medically necessary services rendered in a hospital setting. Nothing in this section is intended to change NorthShore's obligations or practices pursuant to federal or state law respecting the treatment of emergency medical conditions without regard to the patient's ability to pay.

I. *Application Process*

i. *How to Apply*: A financial assistance application should be completed and submitted, along with supporting documentation. Free paper copies of the application are available for download on NorthShore's website at www.northshore.org/about-us/billing/financial-assistance or www.swedishcovenant.org/for-patients-and-visitors/pay-your-bill/financial-assistance or www.nch.org/billing-insurance/financial-assistance/. Free paper copies are also available in the emergency department and in hospital registration areas. Free paper copies are also available by mail by calling (847) 570-5000 or (773) 989-3841 for Swedish Hospital or (847) 618-4542 for NCH.

ii. Applicants may send the completed application and supporting documents to the NorthShore address listed below or bring them to a hospital financial counselor. Patients can locate a hospital financial counselor by visiting the central registration desk and requesting to speak with a financial counselor. For questions about the application process, assistance filling out the application, or to check the status of an application submitted, the hospitals' financial counselors are available to assist in person at the hospital or you can call (847) 570-5000 or (773) 989-3841 for Swedish Hospital or (847) 618-4542 for NCH.

iii. *Where to Send Completed Applications*:

NorthShore University HealthSystem
Patient Financial Services
P.O. Box 1006, Suite 330
Skokie, IL 60076-9877
Fax: (847) 982-6957
or
Bring to a hospital financial counselor

Swedish Hospital
Financial Service Center
5145 N. California Ave.
Chicago, IL 60625
Fax: (773) 878-6838
or
Bring to a hospital financial counselor

Northwest Community Hospital
Patient Services Center
Attn: Financial Counseling
800 W. Central Rd.
Arlington Heights, IL 60005
Fax: 847-618-4549
or
Bring to a hospital financial counselor

iv. Requests for consideration for financial assistance or presumptive eligibility may be initiated by any of the following individuals within the application period: a) the patient or guarantor, b) a representative of the patient or guarantor, c) a NorthShore representative on behalf of the patient/applicant.

v. Notwithstanding considerations outlined elsewhere in this policy, it is the responsibility of the patient to cooperate with and fully participate in the financial assistance application process. This includes providing information about any available third party health coverage; providing in a timely and forthright manner all documentation and certifications needed to apply for funding through government or other programs (e.g., Medicare, Medicaid, All Kids, FamilyCare, Affordable Care Act Health Insurance Exchange, third party liability, Crime Victims funding, etc.) or to determine the patient's eligibility for other financial assistance. Failure to do so may adversely affect consideration of the patient's financial assistance application. Patients are asked to provide the information, certification and documents within thirty (30) days of NorthShore's request unless compelling circumstances are brought to NorthShore's attention. Except in cases of presumptive eligibility, the application for financial assistance must be signed by the patient (or guarantor/ representative).

vi. A financial counselor can assist the applicant in the process of applying for financial assistance. If the patient is deceased and a responsible party is not identified, a NorthShore representative may generate the request and complete the application using available information and documents (e.g., Medicaid spend down form, estate document, etc.)

J. *Family Income*:

i. The patient should provide one or more of the following documents to establish family income, if such documents are available. If there is more than one employed person in the patient's family, each person must submit one or more of the documents below:

a) All applicants must provide proof of Illinois residency, which includes any one of the following: valid state-issued identification card, recent residential utility bill, lease agreement, vehicle registration card, voter registration card, other mail addressed to applicant from a government or other credible source, a statement from a family member who resides at the same address and presents verification of residency, or a letter from a homeless shelter, transitional house or other similar facility.
b) If Employed:
1. Most recently filed federal income tax return
2. Two most recent pay stubs
3. Two most recent statements for all checking, savings, and credit union accounts
c) If Self-Employed:
1. Most recently filed federal income tax return
2. Two most recent statements for all checking, savings, and credit union accounts
d) If Unemployed:
1. Most recently filed federal income tax return
2. Unemployment award letter that lists your benefit amount
3. Letter from previous employer with the termination date
4. Confirmation of support letter
e) If a Full-Time Student:
1. Proof of college entrollment (including letter from college or university showing your full-time status, or tuition/financial documentation)
f) If Retired of Disabled:
1. Most recently filed federal income tax return (if applicable)
2. Award letter from the Social Security Administration stating the monthly benefit amount
3. Two most recent statements for all checking, savings, and credit union accounts
g) Proof of Other Non-Wage Income (where applicable)
1. Spousal and/or child support letter
2. Rental property income
3. Investment property income
4. Any other income sources not listed above

ii. Except in cases of presumptive eligibility, the applicant must sign the application certification. NorthShore may rescind or modify a determination if later evidence demonstrates the applicant provided materially false information.

K. *Additional Documentation*: Applicants may elect to provide additional documentation regarding expenses, outstanding debts or other circumstances which would show financial hardship to support a request for financial assistance equal to or greater than the amounts to which they are otherwise eligible pursuant to this FAP. Applicants are required to provide documentation of the value of certain assets, including checking, savings, and non-retirement investment accounts. NorthShore may request applicants to submit additional documentation if the applicant's financial position is not adequately reflected by such income documents.

L. *Eligibility Notification*: NorthShore will use its best efforts to notify applicants in writing of financial assistance determinations within forty-five (45) days after NorthShore has received a fully completed financial assistance application. This notification will also include the financial assistance percentage amount (for approved applications) and expected payment from the patient and/or family where applicable. The patient and/or family will continue to receive statements during the evaluation of a completed application. If a financial assistance application is denied, in whole or in part, NorthShore shall inform the applicant of the reason(s) for the determination and provide contact information if the applicant has any questions.

M. *Incomplete Applications*: If the patient and/or family submit an incomplete application, NorthShore will provide a written notification that describes what additional information or documentation is needed.

N. *False or Misleading Information*: If it is determined that an applicant has intentionally provided materially false or misleading information regarding their ability to pay medical expenses, NorthShore may deny the applicant's current or future applications. In the case of false information provided in the absence of bad faith, NorthShore will base its determination upon the corrected information. If financial assistance has already been granted based on the patient's

intentional provision of materially false information, NorthShore may void the prior grant of financial assistance, in which case NorthShore retains all legal rights to seek payment from the patient of any amounts which may be due. If the provision of materially false information was unintentional, NorthShore will revise the determination based upon the corrected information.

5. ATTACHMENT:

Exhibit 1 - FAP Provider/Physician List
Exhibit 2 - Amounts Generally Billed (AGB) Percentages by Facility
Exhibit 3 - Federal Poverty Level (FPL) Guidelines
Exhibit 4 - NorthShore Financial Assistance Discount Tables
Exhibit 5 - Swedish Hospital Financial Assistance Discount Tables
Exhibit 6 – NCH Financial Assistance Discount Tables

6. DISTRIBUTION:

Administrative Directives Manual

7. POLICY RESPONSIBILITY:

Senior Vice President, Patient Financial Services

8. REFERENCES:

Internal	External
Administrative Directives Manual: Billing and Collections Policy	Health and Human Services (HHS)
Administrative Directives Manual: HIPAA Polices (Management of Information)	Federal Poverty Guideline, most current year
Administrative Directives Manual: HIPAA Policies	Hospital Uninsured Patient Discount Act (210 ILCS 89/1)
EMTALA Compliance Manual: EMTALA Medical Screening Exam Policy	Internal Revenue Code Section 501(r)

9. REVISION:

The organization reserves the right to unilaterally revise, modify, review, or alter the terms and conditions of the policy within the constraints of the law, with or without reasonable notice.

10. APPROVAL:

John Skeans	SVP, Patient Financial Services	
Signature	**Title**	**Date**
Douglas D. Welday	Chief Financial Officer	
Signature	**Title**	**Date**

11. DATES:

Origination: 6/04 **Review:** _____ **Effective:**_____ **Next Review**: ___

Exhibit 1
FAP Provider/Physician List

All NorthShore, Swedish, and NCH Medical Group physicians/providers are covered under this policy. A list of the independent/non-employed providers that deliver emergency or other medically necessary care in NorthShore hospital facilities that are not covered under this policy are made available online in a separate document at www.northshore.org/about-us/billing/financial-assistance. A list of the independent/non-employed providers that deliver emergency or other medically necessary care at Swedish Hospital that are not covered under this policy are made available online in a separate document at www.swedishcovenant.org/for-patients-and-visitors/pay-your-bill/financial-assistance. A list of the independent/non-employed providers that deliver emergency or other medically necessary care at NCH that are not covered under this policy are made available online in a separate document at www.nch.org/billing-insurance/financial-assistance/. Free paper copies of Exhibit 1 are also available upon request in the emergency department and hospital registration areas and by mail by calling (847) 570-5000 for NorthShore or (773) 989-3841 for Swedish Hospital or (847) 618-4542 for NCH. Updates for changes to the provider list will be made on a quarterly basis.

Exhibit 2
Amounts Generally Billed (AGB) Percentages

Patients who qualify for financial assistance will not be charged more for emergency or medical necessary care than the amounts generally billed (AGB) to patients who have insurance. The hospital AGB percentages are calculated using the "look-back" method, which is the total of Medicare fee-for-service and private health insurer allowed claims divided by the total gross charges for those claims for a 12-month period. Discounts provided to patients who qualify for financial assistance will be reviewed against the AGB percentage limits to ensure patients are not charged more than AGB.

Provider	AGB %	Discount %
Evanston Hospital	30%	70%
Glenbrook Hospital	30%	70%
Highland Park Hospital	30%	70%
Skokie Hospital	30%	70%
Swedish Hospital	19%	81%
Northwest Community Hospital	29%	71%
NorthShore Medical Group	30%	70%
Swedish Medical Group	19%	81%
NCH Medical Group	29%	71%

For use in this policy, the AGB percentages for each facility are to be calculated annually and applied by the 120th day after the start of the year.

Exhibit 3
Federal Poverty Level (FPL) Guidelines

The poverty guidelines referenced in this policy are those issued each year by the U.S. Department of Health and Human Services as published in the Federal Register. The income thresholds in the current poverty guidelines were published on January 12, 2022.

Family Size	FPL
1	$13,590
2	$18,310
3	$23,030
4	$27,750
5	$32,470
6	$37,190
7	$41,910
8	$46,630

For family units of more than 8 persons, add $4,720 for each additional person to determine FPL.

For purposes of this policy, the income levels specified above are understood to be at gross income, although certain provisions allow for adjustments to income for extraordinary medical expenses. For use in this policy, the federal poverty income levels are to be updated annually after their revision and publication by the federal government in the Federal Register.

Exhibit 4
NorthShore Financial Assistance Discount Tables

UNINSURED PATIENT DISCOUNT TABLE

Below are the discount percentages by FPL tier for uninsured patients. The discount percentage will be applied to charges for emergency or medically necessary care.

Family Size	0%-200% FPL	201%-300% FPL	301%-400% FPL	401%-600% FPL
	Maximum Income for a 100% Discount	Maximum Income for a 75% Discount	Maximum Income for a 75% Discount	Maximum Income for a 70% Discount
1	$27,180	$40,770	$54,360	$81,540
2	$36,620	$54,930	$73,240	$109,860
3	$46,060	$69,090	$92,120	$138,180
4	$55,500	$83,250	$111,000	$166,500
5	$64,940	$97,410	$129,880	$194,820
6	$74,380	$111,570	$148,760	$223,140
7	$83,820	$125,730	$167,640	$251,460
8	$93,260	$139,890	$186,520	$279,780
Annual Maximum Payment	$0 Payment/ 100% Discount	20% of Annual Family Income	20% of Annual Family Income	20% of Annual Family Income

INSURED PATIENT DISCOUNT TABLE

Below are the discount percentages by FPL tier for insured patients. The discount percentage will be applied to the remaining self-pay balance for emergency or medically necessary care.

Family Size	0%-200% FPL	201%-400% FPL
	Maximum Income for a 100% Discount	Maximum Income for a 70% Discount
1	$27,180	$54,360
2	$36,620	$73,240
3	$46,060	$92,120
4	$55,500	$111,000
5	$64,940	$129,880
6	$74,380	$148,760
7	$83,820	$167,640
8	$93,260	$186,520

Exhibit 5
Swedish Hospital Financial Assistance Discount Tables

UNINSURED PATIENT DISCOUNT TABLE

Below are the discount percentages by FPL tier for uninsured patients. The discount percentage will be applied to charges for emergency or medically necessary care.

Family Size	0%-200% FPL	201%-300% FPL	301%-400% FPL	401%-600% FPL
	Maximum Income for a 100% Discount	Maximum Income for a 83% Discount	Maximum Income for a 83% Discount	Maximum Income for a 81% Discount
1	$27,180	$40,770	$54,360	$81,540
2	$36,620	$54,930	$73,240	$109,860
3	$46,060	$69,090	$92,120	$138,180
4	$55,500	$83,250	$111,000	$166,500
5	$64,940	$97,410	$129,880	$194,820
6	$74,380	$111,570	$148,760	$223,140
7	$83,820	$125,730	$167,640	$251,460
8	$93,260	$139,890	$186,520	$279,780
Annual Maximum Payment	$0 Payment/ 100% Discount	20% of Annual Family Income	20% of Annual Family Income	20% of Annual Family Income

INSURED PATIENT DISCOUNT TABLE

Below are the discount percentages by FPL tier for insured patients. The discount percentage will be applied to the remaining self-pay balance for emergency or medically necessary care.

Family Size	0%-200% FPL	201%-400% FPL
	Maximum Income for a 100% Discount	Maximum Income for a 81% Discount
1	$27,180	$54,360
2	$36,620	$73,240
3	$46,060	$92,120
4	$55,500	$111,000
5	$64,940	$129,880
6	$74,380	$148,760
7	$83,820	$167,640
8	$93,260	$186,520

Exhibit 6
NCH Financial Assistance Discount Tables

UNINSURED PATIENT DISCOUNT TABLE

Below are the discount percentages by FPL tier for uninsured patients. The discount percentage will be applied to charges for emergency or medically necessary care.

Family Size	0%-200% FPL	201%-300% FPL	301%-400% FPL	401%-600% FPL
	Maximum Income for a 100% Discount	Maximum Income for a 72% Discount	Maximum Income for a 72% Discount	Maximum Income for a 71% Discount
1	$27,180	$40,770	$54,360	$81,540
2	$36,620	$54,930	$73,240	$109,860
3	$46,060	$69,090	$92,120	$138,180
4	$55,500	$83,250	$111,000	$166,500
5	$64,940	$97,410	$129,880	$194,820
6	$74,380	$111,570	$148,760	$223,140
7	$83,820	$125,730	$167,640	$251,460
8	$93,260	$139,890	$186,520	$279,780
Annual Maximum Payment	$0 Payment/ 100% Discount	20% of Annual Family Income	20% of Annual Family Income	20% of Annual Family Income

INSURED PATIENT DISCOUNT TABLE

Below are the discount percentages by FPL tier for insured patients. The discount percentage will be applied to the remaining self-pay balance for emergency or medically necessary care.

Family Size	0%-200% FPL	201%-400% FPL
	Maximum Income for a 100% Discount	Maximum Income for a 71% Discount
1	$27,180	$54,360
2	$36,620	$73,240
3	$46,060	$92,120
4	$55,500	$111,000
5	$64,940	$129,880
6	$74,380	$148,760
7	$83,820	$167,640
8	$93,260	$186,520

Healthy Driven
Edward-Elmhurst HEALTH

Origination:	*Feb 02, 2016*
Effective:	*Jan 05, 2022*
Last Approved:	*Jan 05, 2022*
Last Revised:	*Jan 05, 2022*
Next Review:	*Jan 04, 2025*
Owner:	*Gregory Arnold: VP, Revenue Cycle*
Area:	*Finance - Revenue Cycle*
References:	*Policy/Procedure*
Applicability:	*Edward Elmhurst Health System (All Locations)*

Financial Assistance, FIN_011

Policies and procedures are guidelines and are not a substitute for the exercise of individual judgment.

Purpose / Policy Statement:

It is the mission of Edward-Elmhurst Health (EEH) to provide quality healthcare services with efficiency, sensitivity, and a commitment to human dignity and wellness of the individual. It's both a philosophy and practice of EEH that all emergency and medically necessary healthcare services should be available to all individuals, regardless of their ability to pay. EEH make no differentiation between an individual's ability to meet the costs of healthcare and the quality of services it provides regardless of race, creed, color, sex, national origin, sexual orientation, handicap, or age. EEH recognizes as a part of its mission the caring for the sick who are medically or financially indigent, and will assist patients who cannot pay for part of all of the care they receive. However, the need for financial assistance for these patients is always balanced with a broader financial responsibility to keep EEH's doors open for all who live in its community and may need care, now and in the future.

This Policy sets forth guidelines and criteria for EEH's Financial Assistance programs. Any financial assistance awarded will be applied to the patient's responsibility for emergency or other medically necessary services only. This Policy is intended to comply with Section 501(r) of the Internal Revenue Code, the Illinois Hospital Uninsured Patient Discount Act, and the Illinois Fair Patient Billing Act, and the regulations promulgated thereunder.

Definitions:

Affiliated Physician Practices: A practice subject to a Professional Services Agreement whereby EEH is billing for all of the professional services provided by the Providers of the practice.

Amounts Generally Billed: Patients who qualify for Financial Assistance will not be charged more for emergency or medical necessary care than the amounts generally billed (AGB) to patients who have insurance. See Exhibit C for current levels.

Federal Poverty Level: Poverty guidelines stated in the Federal Register by the United States Department of Health and Human Services under Title 42 USC Section 9902.

Financial Assistance / Charity Care: Is defined as care given at reduced or no cost due to the inability of the recipient to pay for such care due to being uninsured/underinsured, and having minimal income and assets.

This is a financial determination and in no way will affect the quality or level of care provided.

Financial Indigence: Patients who have reasonable measures of financial hardship.

Illinois Resident: An Illinois Resident is a patient who lives in Illinois and who intends to remain living in Illinois indefinitely. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement under the Illinois Hospital Uninsured Patient Discount Act ("HUPDA").

Indebtedness: is defined as legal financial obligations both secured and unsecured including such items as mortgages, student loans, auto loans, other commercial loans, credit card debt and other medical debt.

Medically Indigent: Patients whose income level would not quality them for financial assistance based on the federal poverty levels, but have incurred catastrophic charges for medically necessary services. Medical expenses, in relationship to their income, would make them indigent if they were to pay full charges for their medical expenses.

Medically Necessary Services: Any inpatient or outpatient service (s) that is covered by and considered to be medically necessary under Title XXVIII of the Federal Social Security Act. Medically necessary services do not include non-medical services such as social, educational, vocational services and elective cosmetic surgery.

Net Worth: is defined as liquid assets in excess of indebtedness

Payment Plan: Plan which sets a series of equal payments over an extended period of time to satisfy the patient-owed amounts of bills

Presumptive Eligibility: In lieu of patient financial assistance application, the criteria used to deem a patient eligible for financial assistance

Qualifying Assets: Monetary assets which are counted toward the patient's income in determining if the patient will meet the income eligibility for the program. For purposes of this Policy, "Qualifying Assets" will mean 50% of the patient's monetary assets in excess of $10,000, including cash, stocks, bonds, savings accounts, or other bank accounts, but excluding IRS qualified retirement plans and deferred-compensation plans. Certain real property or tangible assets (primary residences, automobiles, etc.) will not be included in "Qualifying Assets;" however, additional residences in excess of a single primary residence will be included, as will recreational vehicles. "Qualifying Assets" will not include the principal amounts of funds contained within an IRS recognized retirement account, such as an IRA, 401K, 403B retirement accounts.

Underinsured Patient: A Patient with health insurance or coverage, but facing high deductibles, coinsurance and/or large out-of-pocket expenses.

Uninsured Discount: With respect to the medical necessary services rendered to an uninsured patient, a discount is applied after charges are incurred. The uninsured discount applies to the eligible patients whose income is less than 600% of the Federal Poverty Level (FPL).EEH may also provide discounts to individuals who have been verified as eligible through contracted local health access programs. These discounts will be identified as charity care.

Uninsured Patient: A patient who does not have third party coverage from a health insurer, a health care service plan, Medicare, or Medicaid or not eligible for state funded programs, or whose injury is not compensable for purposes of workers compensation, automobile insurance, or other insurance as determined and documented.

Procedure:

UNINSURED DISCOUNT:

1. Uninsured patients not applying for financial assistance may be granted a discount. Determination for an uninsured discount applies to both inpatient and outpatient services.
2. See system policy, Self-Pay Discount, FIN_023.

FINANCIAL ASSISTANCE:

1. Eligibility for financial assistance will be considered for those individuals who are uninsured or underinsured, and who are unable to pay for their care, based on a determination of financial need in accordance with this Policy.
2. For purposes of this Policy, the following healthcare services are eligible for financial assistance:
    a. Emergency medical services provided in an emergency room setting.
    b. Medically necessary services.
    c. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting.
3. If a patient seeking care other than Emergency Services is covered by an HMO or PPO and Edward-Elmhurst Health is not an in-network provider, then the patient should be directed to seek care from his participating providers and shall not be eligible for Financial Assistance. Financial Assistance is not available for out-of-network costs.
4. The determination of eligibility for financial assistance is based on either a presumptive review using a sophisticated software program or a completed application with required documentation; a review of the patient's gross annual income, expenses and assets to determine if a patient has adequate means to pay their hospital bill. All applicants for financial assistance will be Illinois Residents.
5. The financial assistance discount criterion for uninsured patients is based on 200% to 600% of the Federal Poverty Level (FPL). Uninsured patients whose income is less than 200% will qualify for 100% discount. Uninsured patients whose income exceed 200% but are less than 600% of FPL will qualify for a discount based on Amounts Generally Billed (AGB) Exhibit C. For underinsured patients the discount criterion is based on 200% to 300% of the Federal Poverty Limit (FPL). Underinsured patients whose income is less than 200% of FPL will qualify for a 100% discount on amounts owed after insurance pays its portion. Underinsured patients whose income exceeds 200% but is less than 300% will receive a percentage discount based on Amounts Generally Billed (AGB) Exhibit C, for amounts owed after insurance pays its portion. Underinsured patients whose income exceeds 300% are eligible for other forms of assistance such as payment plans or full payment discounts. For both the uninsured and underinsured discounts the Qualifying Assets test will be added to annual income.
6. Approved applications are active for six (6) months from the date of approval notice. Patients who are granted less than a 100% discount based on a prior approved application during this six month period will be notified that their discount was based on a prior approved application and about how to apply for more generous assistance and given a reasonable period of time to apply for such assistance. Patients will have 240 days from the first post-discharge bill for an episode of care to apply for assistance for that care. A determination that a patient is eligible for financial assistance based on a completed application will apply to (and only to) all initial post-discharge bills issued during the 240-day period preceding the receipt

of that application. At no point will expected payments for that care from the patient exceed the Amounts Generally Billed (AGB) Exhibit C.

7. Patients will be notified in writing of the decision of the completed application.
8. If the amount a patient is personally responsible for paying (i.e. in the form of deductibles, co-insurance amounts, co-pays, or other self-pay amounts) exceeds AGB after the discount percentages are applied, the patient's bill will be further reduced to AGB.

PRESUMPTIVE FINANCIAL ASSISTANCE ELIGIBILITY

EEH may use a flexible evaluation platform for missed applications that utilizes multiple demographic, behavioral and financial variables to perform a comprehensive financial review and determine financial assistance and discount eligibility in lieu of patient-provided data. Several data sources are used including historical data, census data and credit report data. Results are delivered in a timely, efficient manner, enabling the hospital to extend appropriate discounts and maintain documentation for auditing. There is no credit report impact. Using such technology allows EEH to review as many patients as possible for financial assistance, in keeping with the Affordable Care Act. In the event EEH presumptively determines a patient qualifies for less than financial assistance for the full amount, it will give the patient an opportunity to demonstrate that he or she qualifies for more assistance by notifying the patient that he or she has been presumptively determined to be eligible for financial assistance based on the methodology described above and about how he or she may apply for more assistance under this Policy.
Presumptive eligibility may be determined on the basis of individual life circumstances that may include the following:

- Homelessness
- Deceased with no estate
- Mental incapacitation with no one to act on the patient's behalf
- Medicaid eligibility, but not on a date of service or for non-covered service
- Enrollment in the following assistance programs for low-income individuals having eligibility criteria at or below 200% of the Federal Poverty Guidelines.
  - Women, Infants and Children Nutritional Program (WIC)
  - Supplemental Nutritional Assistance Program (SNAP)
  - Illinois Free Lunch and Breakfast Program
  - Low-Income Home Energy Assistance Program (LIHEAP)
  - Organized community-based program providing access to medical care that assesses and documents limited low-income financial status as criteria
  - Receipt of grant assistance for medical services
  - Temporary Assistance for Needy Families (TANF)
  - Illinois Housing Development Authority's Rental Housing Support Program
- Recent personal bankruptcy
- Incarceration in a penal institution
- Affiliation of a religious order and vow of poverty

APPLYING FOR ASSISTANCE AND PATIENT RESPONSIBILITIES:

1. Complete the "Request for Determination of Eligibility for Financial Assistance".
2. Cooperate with EEH to provide the information and documentation necessary to apply for Public Aid or

other financial programs that may be available to pay for the healthcare services. If an application for other public aid or other coverage is subsequently denied for no cooperation from the patient EEH may also deny a request for Financial Assistance.

3. Provide financial and other documents needed to determine financial assistance eligibility within thirty (30) days of request for such information.
4. If approved for a partial discount, cooperate with EEH to establish a reasonable payment plan that takes into account available income and assets, the amount of the discounted bill and any prior payments.
5. If payment plan is established, promptly inform EEH of any changes of circumstances that will impair patient's ability to comply with the payment plan.

CALCULATING AMOUNTS CHARGED TO PATIENTS

1. Individuals eligible for financial assistance will not be charged more for emergency or other medically necessary care than the amounts generally billed for individuals who have insurance coverage (AGB). The lookback method will be used to determine AGB. AGB percentages are calculated as follows:
    a. Numerator: the sum of all claims during the prior 12-month period by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility; and
    b. Denominator: the sum of the associated gross charges for those claims
2. AGB percentages will be calculated annually and will be used within 120 days after the end of the 12-month period used in calculating the amounts generally billed.
3. The AGB percentages calculated and in effect for each hospital facility are presented in Exhibit C.
4. EEH will not charge an individual eligible for assistance under this policy an amount equal to or exceeding gross charges for any medical care covered under this policy.

EEH COLLECTION PRACTICES IN THE EVENT OF NON-PAYMENT:

1. EEH has the right to pursue collections directly or working with a third party collection agency. No outside collection activity against uninsured patients will begin for at least one hundred and twenty (120) days after an EEH facility provides it first post-discharge billing statement.
    a. Prior to pursuing outside collection activity, patients will be notified of this Policy with a plain language summary of the Policy; referencing the Policy on billing statements; and at least one written notice explaining the "extraordinary collection actions" (described below) that EEH or its third party collection agency intends to take at least thirty (30) days prior to such actions. This written notice will also indicate that financial assistance is available, include the plain language summary as an attachment, and state the date after which extraordinary collection actions may occur.
    b. EEH or its third party collection agent will also make reasonable efforts to orally notify patients about this Policy and how the individual may obtain assistance with the application process under this Policy at least thirty (30) days prior to any extraordinary collection action being initiated.
    c. Patients may submit financial assistance applications up to two hundred and forty (240) days after the first post-discharge billing statement is mailed. If received within this time frame, EEH will suspend collection actions and assess patient eligibility for assistance. If a patient submits a financial assistance application during the permitted 240-day period that is incomplete, EEH will provide a

written notice describing the additional information and/or documentation required to complete the application and including contact information for the office or department that can provide information about this Policy and assist with the application process.

2. The fair debt collection practices act will be followed when seeking to collect payment from all patients, including patients receiving financial assistance discounts and will require outside collection agencies to do the same.
3. No legal action will be taken for non-payment of bills by patients or responsible parties who have demonstrated that they do not have sufficient income or assets to pay these bills.
4. EEH or its third party collection agency may take the following collection actions that are described as "extraordinary collection actions" in Treas. Reg. § 1.501(r) -6(b):
    a. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus; and
    b. Legal action, including commencing a collection lawsuit and pursuing remedies such as wage garnishments and liens and attachments on property if there is evidence that the patient or responsible party has sufficient income and assets to meet his or her financial obligation.
5. Regarding real property, no lien or legal action will be taken to force the sale of the patient's primary residence to pay an outstanding medical bill.
6. All collection agents, both internal and external, hired to obtain payment of outstanding bills will follow up guidelines outlined above and are required to obtain authorization from the Director of Patient Accounts before taking any legal action against any patient or responsible party.
7. If EEH determines that a patient is eligible for assistance under this Policy for any care, it will do the following:
    a. If a discount is less than a total discount, provide the patient with an updated billing statement that indicates the amount the patient owes for the care after applying the discount and how that amount was determined and that states the AGB for the care.
    b. Refund to the patient any amount he or she has paid for the care (whether to EEH or its third party collection agent) that exceeds the amount he or she is determined to be personally responsible for paying after applying the assistance, unless the excess amount is less than $5.
    c. Takes all reasonable available measures to reverse any extraordinary collection actions taken against the patient to obtain payment for the care, including measures to vacate any judgement against the patient, lift any levy or lien applied to the patient's property, and remove from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.

OTHER PROVIDER BILLS

This Financial Assistance Policy applies to services provided by Edward-Elmhurst Health. As a patient within our facilities other providers may also be giving you care. These other providers are not bound by our policy therefore you may need to work directly with their offices to address any billing issues. These other providers are listed in Exhibit A.

PUBLIC NOTICE

1. Notice of Financial Assistance Policy is posted in the emergency departments and at all registration areas

within the hospitals and off-site clinics. Information regarding the Financial Assistance Policy will also be on the hospital website.

a. A copy of the Financial Assistance Policy will be provided to any person in the public upon request.

b. Questions about financial assistance, how to apply for assistance, uninsured discounts or how to receive paper copies of our policy and or application can be directed to 630-527-5307 at Edward Hospital or at 331-221-6740 at Elmhurst Memorial Hospital. For all other billing-related questions, please contact our Patient Accounts Department at 630-527-3100 at Edward or at 331-221-6600 at Elmhurst Hospital. For in person assistance, please visit the financial counselor at Edward or Elmhurst.

c. The Policy is in English and Spanish, the two primary languages that cover the Edward-Elmhurst Health service area. Annually we will conduct a review of the primary language provided by patients at registration to ensure that our policy is translated into any language that covers the lesser of 1,000 or more individuals or at least 5% of the population located within the hospitals service area or likely to be affected or encountered by the hospital.

2. A monthly report listing total dollar amounts of uninsured and financial assistance discounts should be prepared and submitted for information to EEH Services Corporation Financial Committee.

EXHIBITS:

EXHIBIT A - EEH Provider Exceptions- Automated Review of Presumptive Eligibility

For services provided by the following eligibility determinations will be made through completion of the "uninsured questionnaire".

1. Edward Health Ventures, d/b/a Edward Medical Group, Edward Hematology Oncology Group, Edward-Elmhurst Surgical Oncology Group, Edward Neuroscience Institute, Elmhurst Neuroscience Institute, Elmhurst Memorial Medical Group, and Linden Oaks Medical Group
2. Elmhurst Memorial Healthcare, d/b/a Elmhurst Clinic and Elmhurst Medical Associates,

The Patient or Responsible party for payment is responsible for making the discount request. A review of the patient's gross annual income and number of exemptions as identified on the most recently filed 1040 tax return may also be needed. Asset information may be reviewed on a case-by-case basis to determine if the patient is eligible for an uninsured discount.

The uninsured discount will be a percentage of billed charges based on the EEH Hospital Uninsured Patient Discount for services provided by the aforementioned entities within Exhibit B

EXHIBIT B - Other Providers Providing Services in EEH Facilities Not Bound by EEH Financial Assistance Policy

1. Cardiac Surgery Associates, S.C.
2. DuPage Medical Group, Ltd.
3. DuPage Neonatology Associates, S.C.

4. Fox Valley Radiation Oncology, LLC.
5. Laboratory and Pathology Associates
6. Laboratory and Pathology Diagnostics
7. DuPage Valley Anesthesiology Ltd.
8. Naperville Radiologists, S.C.
9. Pediatric Critical Care Specialists, P.C.
10. Breg Inc.
11. Elmhurst Anesthesiology (Anesthesia Business Consultants)
12. Suburban Surgical Associates, Ltd.
13. Elmhurst Emergency Medical Services (Change Healthcare)
14. Elmhurst Radiology (Change Healthcare)
15. Associated Pathology Consultants (Change Healthcare)

Exhibit C - Amounts Generally Billed (AGB)

7/1/2018 Edward Hospital 77% Elmhurst Memorial Hospital 78% Linden Oaks Hospital 56%

9/28/2019 Edward Hospital 79.45% Elmhurst Hospital 80.81% Linden Oaks Hospital 59.07%

10/1/2020 Edward Hospital 79.36% Elmhurst Hospital 80.27% Linden Oaks Hospital 57.33%

9/1/2021 Edward Hospital 77.69% Elmhurst Hospital 78.71% Linden Oaks Hospital 49.08%

Cross Reference(s)

Self-Pay Discount, FIN_023

Current Policy Replaces:

Edward Hospital FINL_011 Financial Assistance Determination

All revision dates: Jan 05, 2022, Oct 06, 2021, Nov 05, 2020, Nov 04, 2020, Dec 03, 2019, Jun 04, 2019, Jun 10, 2016

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Content Activated By	Margaret Cross: Clinical Education Mgr	Jan 05, 2022
Content Owner	Gregory Arnold: VP, Revenue Cycle	Dec 10, 2021

Applicability

Ambulatory, Edward Elmhurst Health System, Edward Hospital, Elmhurst Hospital, Linden Oaks Behavioral Health, Plainfield Lab

NorthShore
University HealthSystem

Financial Assistance Application Patient Account Number(s): _____

Important: ***You may be able to receive free or discounted care.***

Completing this application will help NorthShore University HealthSystem (NorthShore) determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. If you are uninsured, a Social Security Number is not required to qualify for free or discounted care. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help NorthShore determine whether you qualify for any public programs.

Please complete this form as soon as possible after the date of service in order for NorthShore to determine your eligibility for financial assistance. NorthShore will accept your application for up to 240 days following the first billing statement for the care.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist NorthShore in determining whether the patient is eligible for financial assistance.

INSTRUCTIONS: COMPLETE THE APPLICATION IN FULL AND SIGN THE AUTHORIZATION TO VERIFY INFORMATION.					
APPLICANT INFORMATION					
Email Address					Family Size (Incl. Pt.)
Last Name	First Name	M.I.	Date of Birth		Social Security Number
Street Address	Apt. #	City	State	Zip	Home Phone
Employer Name		Employer Street Address			Cell Phone
Employer City		State	Zip	Gross Monthly Income	Work Phone
Race (Optional)	Ethnicity (Optional)		Gender (Optional)		Preferred Language (Optional)
SPOUSE/GUARANTOR OR PARENT(S) OF MINOR (WHEN APPLICABLE)					
Email Address				Relationship to Patient	Date of Birth
Last Name	First Name			M.I.	Social Security Number
Street Address	Apt. #	City	State	Zip	Home Phone
Employer Name		Employer Street Address			Cell Phone
Employer City		State	Zip	Gross Monthly Income	Work Phone

Presumptive Eligibility:

Uninsured patients who demonstrate one of the Presumptive Eligibility Criteria listed below individually or through the benefits provided to their Family are automatically eligible to receive ***free care*** and ***no proof of income will be requested***. We verify eligibility electronically when possible, but may need you to assist us to demonstrate your eligibility.

Check as many as apply:

- ☐ WIC
- ☐ SNAP
- ☐ ILLINOIS FREE LUNCH/BREAKFAST
- ☐ INCARCERATED
- ☐ HOMELESSNESS
- ☐ DECEASED WITH NO ESTATE
- ☐ LIHEAP: LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
- ☐ COMMUNITY-BASED MEDICAL ASSISTANCE PROGRAM
- ☐ GRANT ASSISTANCE FOR MEDICAL SERVICES
- ☐ TANF: TEMPORARY ASSISTANCE FOR NEEDY FAMILIES
- ☐ PERSONAL BANKRUPTCY (CASE #_____ DISCHARGED DATE_____)
- ☐ AFFILIATION WITH A RELIGIOUS ORDER AND VOW OF POVERTY
- ☐ MEDICAID ELIGIBILITY, BUT NOT ON THE DATE OF SERVICE OR FOR NON-COVERED SERVICE
- ☐ ILLINOIS HOUSING DEVELOPMENT AUTHORITY'S RENTAL HOUSING SUPPORT PROGRAM
- ☐ MENTAL INCAPACITATION WITH NO ONE TO ACT ON PATIENT'S BEHALF

**** If you demonstrate Presumptive Eligibility, you do not need to supply any income information. You still need to sign the Applicant Certification on the following page.**

NorthShore
University HealthSystem

Financial Assistance Application **Patient Account Number(s): _____**

Income Information:

Please provide the documents requested below (where applicable). Your application may be delayed or denied in the event that any of the required documents are not included.

The following documentation should be provided for the applicant, spouse/partner of the applicant, or if the applicant/patient is a minor, the parent or guardian. If you cannot provide any documentation relating to your income, please complete the letter of support on the last page of this application.

All applicants must provide proof of Illinois residency, which includes any one of the following: valid state-issued identification card, recent residential utility bill, lease agreement, vehicle registration card, voter registration card, other mail addressed to applicant from a government or other credible source, a statement from a family member who resides at the same address and presents verification of residency, or a letter from a homeless shelter, transitional house or other similar facility.
If Employed: • Copy of your prior year tax return • Copies of the two most recent pay stubs • Copies of the two most recent statements for all checking, savings, and credit union accounts
If Self-Employed: • Copy of your prior year tax return • Copies of the two most recent statements for all checking, savings, and credit union accounts
If Unemployed: • Copy of your prior year tax return • Copy of your unemployment award letter that lists your benefit amount • A letter from your previous employer with the termination date • A confirmation of support letter (complete letter on the last page of this application)
If a Full-Time Student: • Proof of college enrollment (including letter from college or university showing your full-time status, or tuition/financial documentation)
If Retired or Disabled: • Copy of your prior year tax return (if applicable) • Copy of your most recent award letter from the Social Security Administration stating the monthly benefit amount • Copies of the two most recent statements for all checking, savings, and credit union accounts
Proof of Other Non-Wage Income: Provide the following information if applicable to your financial situation: • Spousal and/or child support letter • Rental property income • Investment property income • Any other income sources not listed above

Family/Household Information:

Number of persons in family/household	
Number of persons who are dependents of the applicant	
Ages of applicant's dependents	

Other Information:

If you have additional documents that may help NorthShore make a determination regarding your application, such as large outstanding bills which would show financial hardship, please provide those documents (example: phone bills, electricity bills, medical bills, bank or checking statements, etc.)

NorthShore
University HealthSystem

Financial Assistance Application **Patient Account Number(s): _____**

Application Certification:

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal, or local assistance for which I may be eligible to help pay for this NorthShore bill. I understand that the information provided may be verified by NorthShore, and I authorize NorthShore to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the NorthShore bill.

Applicant Signature: _____ Date: _____

Submit completed applications by:	**Need Assistance? We can help.**
Mail: NorthShore University HealthSystem Patient Financial Services P.O. Box 1006, Suite 330 Skokie, IL 60076-9877 **Fax:** (847) 982-6957 **In Person:** Bring to the hospital financial counselor by visiting a hospital central registration desk	**Call (847) 570-5000** **or meet with a hospital financial counselor by visiting a hospital central registration desk**
For Swedish Hospital: **Mail:** Swedish Hospital Financial Service Center 5145 N. California Ave. Chicago, IL 60625 **Fax:** (773) 878-6838 **In Person:** Bring to the hospital financial counselor by visiting the Financial Service Center	**For Swedish Hospital:** **Call (773) 989-3841** **or meet with a hospital financial counselor by visiting the Financial Service Center**
For Northwest Community Hospital: **Mail:** Northwest Community Hospital Patient Services Center Attn: Financial Counseling 800 W. Central Rd. Arlington Heights, IL 60005 **Fax:** (847) 618-4549 **In Person:** Bring to the hospital financial counselor by visiting the Patient Services Center	**For Northwest Community Hospital:** **Call (847) 618-4542** **or meet with a hospital financial counselor by visiting the Patient Services Center**
Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General at 1-877-305-5145 or illinoisattorneygeneral.gov	

NorthShore University HealthSystem

Financial Assistance Application **Patient Account Number(s): _____**

Room and Board Statement/Confirmation of Support Letter

This form is to be completed by the person that is providing room and board and is only to be completed for the applicant if he/she is living with someone other than his/her legal spouse

I currently provide room and board for _____
(Please print applicant's name)

The address where the room and board is provided
_____
_____

I provide a monetary allowance of $_____ per week/month (circle one)

Other support (please explain) _____

Name and address of person providing support (please print)

Name: _____

Address: _____

_____

Phone Number: _____

Signature of Applicant: _____ Date: _____

Signature of Person Providing Support: _____ Date: _____

Healthy Driven
Edward-Elmhurst
HEALTH

The financial assistance program of the Hospital is a program designed to provide medical care for free or at a reduced cost if the recipient of the care is not able to pay for the services received. This program does not cover services that are provided by medical personnel not considered part of the hospital's medical staff; for example, radiologists or anesthesiologists not employed by the hospital.

Eligibility for this program is based upon your family income and resources, taking family size into account. Additionally, you must apply for and use any private health care coverage or government health care coverage (such as Medicaid and Medicare) available to you.

You must submit any the following documents. If you have other documents that will support your eligibility, you may submit those as well. ***Please do not send originals, as the documents are securely shredded after a decision has been reached. In addition, please do not staple documents.***

- Any one of the following documents verifying income:
  A. Copy of most recent Tax return
  B. Copy of most recent W2 or 1099 form
  C. Copies of 2 most recent pay stubs
  D. Written income verification from and employer if paid in cash
- Any one of the following documents verifying Illinois residency:
  A. A Valid Illinois-issued identification card
  B. A recent residential utility bill
  C. A lease agreement
  D. A vehicle registration card
  E. Mail addressed to the patient at an Illinois address from a Government or other credible source.
  F. A statement from a family member of the patient who resides at the same address and presents verification of residency, or
  G. A letter from a homeless shelter, transitional house or other similar facility where the patient resides

Once the hospital has received the requested documentation from you, we will make every reasonable effort to make a determination and notify you of our decision within **30 calendar days**.

You may return the completed application via email to Financialassistance@eehealth.org or U.S. mail. If returning the application via mail, please use the following address:

Edward/Elmhurst Health
Attn: Financial Counseling Department
4201 Winfield Rd
Warrenville IL. 60555

Healthy Driven
Edward-Elmhurst
HEALTH

APPLICATION FOR FINANCIAL ASSISTANCE

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help the Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help the hospital determine whether you qualify for any public programs.

Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

PATIENT INFORMATION

Patient Name	Date of Birth	Social Security Number

Address	City	State	Zip code

E-mail address	Telephone number	Was patient an Illinois Resident at time services were rendered?
	( )	YES NO

HOUSEHOLD INFORMATION

Number of persons in the family household	Number of persons who are dependents of the patient.	List all Ages of dependents

EMPLOYMENT INFORMATION

Patient's Employer	Address	Telephone number
		( )
Spouse's Employer	Address	Telephone number
		( )

INCOME

Wages (including Social Security)	$
Self Employment	$
Workers' Compensation	$
Alimony/Child Support	$
Retirement Income	$
Disability	$
Temporary Assistance for Needy Families	$
Other Income:	$

ASSETS

Checking	$
Savings	$
Stocks	$
Certificates of Deposit	$
Mutual funds	$
Automobiles or other vehicles	$
Property	$
Health Savings/Flexible Spending	$

Note: If the patient meets one of the following criteria, the Monthly Expenses table does not need to be completed. Please check all that apply.

☐ Homeless
☐ Deceased with no estate
☐ Mentally incapacitated with no one to act on patient's behalf
☐ Recent personal bankruptcy
☐ Incarceration in a penal institution
☐ Medicaid Eligible, but not on date of service or for non-covered service.

Enrolled in one of the following programs:
☐ Women, Infants and Children Nutrition Program (WIC)
☐ Supplemental Nutrition Assistance Program (SNAP)
☐ Illinois Free Lunch and Breakfast Program
☐ Low Income Home Energy Assistance Program (LIHEAP)
☐ Receipt of grant assistance for medical workers
☐ Enrollment in an organized community-based-program proving access to medical care that assesses and documents limited low-income financial status as a criterion for membership.

Monthly Expenses	Monthly Amount Due
Housing	$
Utilities	$
Food	$
Transportation	$
Child Care	$
Loans	$
Medical Expenses	$
Other expenses	$

Certification

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Signature of Patient or Applicant

Date:

PATIENT RIGHTS AND RESPONSIBILITIES

While you are a patient at NorthShore – Edward-Elmhurst Health, on behalf of its hospitals, physician offices, outpatient clinical and day surgery centers, urgent care clinics and any other affiliated entities (collectively known as "NS-EEH", "we", "us", or "our"), we will respect your patient rights without regard to your age, race, ethnicity, national origin, religion, culture, language, physical or behavioral health disability, socioeconomic status, sex, sexual orientation, gender identity or expression, or any other status, protected by and consistent with applicable laws.

While you are a patient at NS-EEH, you are responsible for treating our doctors, nurses, other clinical and non-clinical staff, and other patients, their families and visitors with respect and dignity.

While you are a patient at NS-EEH, you have the following rights:

- You have the right to receive patient care, treatment, and services in a safe setting free of abuse, such as emotional, mental, physical, sexual abuse, verbal abuse, neglect, exploitation, intimidation, harassment, or any other form of discrimination protected by applicable law.
- You have the right of access to care, treatment and services that is ethical, medically necessary appropriate to your condition, illness, or injury that is consistent with applicable standards of care guidelines approved by major professional organizations or as required by law.
- You have the right to know the identity and type of professionals providing you with care, treatment, and services, including the name of the doctor who is primarily responsible for your care.
- You have the right to have a family member, or other designated representative, and your doctor notified as soon as possible if you are admitted to the hospital.
- You have the right to concise explanations and to ask questions about the type, nature, and extent of your condition, illness or injury, any proposed treatments and procedures, about any unanticipated outcomes, potential risks and benefits, and approximately how long it may take you to recover, if known.
- You have the right to have informed consent explained to you by your doctor, or other clinical person such as a nurse or clinical professional and ask questions, about any care, treatment, or services being provided to you or any procedure performed on you. The informed consent will explain the type of care, treatment, and services being given or procedure being performed, the reason why, the potential benefits, and risks, if known.
- You have the right to know if a vendor will be present during your treatment, services, or procedure, and/or if any images, photographs or films of your treatment, services, or procedure will be shared with a vendor, for any reason not related to your treatment, services, or procedure such as education and development. You may be asked to sign another consent to allow NS-EEH to share any images, photographs or films while receiving treatment, services or having a procedure.

PATIENT RIGHTS AND RESPONSIBILITIES

- You have the right to participate in and make decisions about your care, treatment and services before starting or while you are receiving care, treatment and services.
- You have the right to receive information about pain and pain relief treatment that may be available to you, participate in discussions, and make decisions about how to effectively control your pain.
- You have the right to select a legal representative to help you make decisions or make decisions on your behalf about your care and treatment, including withdrawal and/or refusal of care. This right may be limited if you have a court appointed legal guardian, conservator, or other power of attorney for decision-making, including healthcare. Additionally, this right may be limited by applicable federal or state law if the person you choose poses a risk of harm to you or has been determined to be legally, mentally, or medically unable to perform this responsibility.
- Subject to hospital policy, applicable law and/or other conditions, you may have the right to have visitor(s) and support person(s) come see you and communicate with you to the extent you are able to without disrupting the delivery of care, treatment and services, infringing upon the rights of other patients being disrespectful to staff, and is safe for you and the visitor.
- Subject to hospital policy, applicable law and/or other conditions related to your care, you have the right to request a medical chaperone and/or support person be present for certain care, treatment or services.
- You have the right to refuse any care, treatment or services after being informed of:
    - Treatment options available to you;
    - The risks and effects upon your condition, illness, or injury if you refuse care, treatment or services; or
    - How your decision to refuse care, treatment, or services may impact your insurance coverage, if known.
- You have the right to be free from any type of medication or physical restraint or seclusion to the extent used as a means of coercion, discipline, convenience, or retaliation. However, medication or physical restraint and seclusion may be used if your doctor determines it is necessary to prevent you from harming yourself or others.
- If you are eligible, you have the right to choose to participate in or not participate in any research study or clinical trial of any medication or medical device after receiving full information, the information explained to you in plain language you can understand, except as permitted or allowed under applicable law.
- You have the right, and/or your legally designated representative, to request a consultation to discuss any ethical concerns you may have about the care, treatment, or services you are receiving.

- You have the right to file a good faith complaint without fear of retaliation or adverse impact on your care, treatment or services. To file a complaint or grievance, you or your legally authorized representative may contact one of the following:
    - Your nurse, a supervisor and department manager or director;
    - By calling:
        - The Edward Hospital Patient Experience Line at (630) 527-7225;
        - The Elmhurst Hospital Patient Experience Line at (331) 221-1115;
        - The Edward-Elmhurst Health Corporate Compliance Hotline at (800) 901-7422;
        - The Evanston Hospital Patient Advocacy Line at (847) 570-1536;
        - The Glenbrook Hospital Patient Advocacy Line at (847) 657-5603;
        - The Highland Park Patient Advocacy Line at (847) 480-2882;
        - The Linden Oakes Behavioral Health Patient Experience Line at (630) 305-5115;
        - The NorthShore Medical Group Patient Advocacy Line at (847) 503-4332;
        - The Northwest Community Healthcare Patient Advocacy Line at (847) 618-4394
        - The Skokie Hospital Patient Advocacy Line at (847) 993-6531; or
        - The Swedish Hospital Patient Advocacy Line at (773) 878-8200 x 8910.
- You have the right to file a good faith complaint or grievance with any of the following:
    - The Illinois Department of Public Health
      Division of Healthcare Facilities and Programs
      525 West Jefferson Street
      Springfield, IL 62761
      Telephone: (800) 252-4344
      Fax: (217) 524-8885
      TTY: (800) 547-0466
      Monday-Friday, 8:00 am to 4:30 pm

    - The Joint Commission
      Office of Quality and Safety
      One Renaissance Blvd.
      Oakbrook Terrace, IL 60181
      Telephone: (630) 792-5800
      Fax: (630) 792-5636

TTY: Call Illinois Relay at 711
Email: patientsafetyreport@jointcommission.org

- Healthcare Facilities Accreditation Program (HFAP) – **For Swedish Hospital Only**
  Attention: Complaint Department
  139 Weston Oaks Ct.
  Cary, North Carolina 27613
  Telephone: (855) 937-2242
  Fax: (919) 785-3011

- If you have Medicare insurance and think you are being discharged too soon, you have the right to request an appeal of your discharge by contacting:

  - Illinois Foundation for Healthcare
    2625 Butterfield Road #102E
    Oakbrook, IL 60523

- You have the right to receive instructions regarding any post-discharge or post-procedure care, treatment or services and provider follow-up appointment(s) you may need including names and contact information.
- You have the right to know how much your care, treatment or services may cost you, how much your insurance may pay, how much you may have to pay if you have a co-payment, deductible, or co-insurance amount before you receive your care, treatment, or services except in an emergency or other life-threatening situations or where otherwise required by applicable law.
- You have the right to receive an itemized copy of your bill, to have the charges explained to you in plain language you can understand, and access to a financial counselor who may be able to help you find financial aid or financial counseling to help you pay your bill.
- You have the right to know the cost of, how much your insurance may pay for, and how much may be your responsibility, including co-payments, co-insurance, and deductibles, for care, treatment, or services before being provided to you except in an emergency or life-threatening situations, or other situations as required by law.
- If you have Medicare insurance, you have the right to receive an "Advanced Beneficiary Notice", or "ABN", telling you in writing why Medicare will not pay for the care, treatment, or services, how much you may be required to pay, and to accept or refuse the care, treatment, or service before it is provided to you.
- You have the right to request and receive information about Advanced Directives, such as a Living Will, Physician Orders for Life Sustaining Treatment ("POLST"), Durable Medical Power of Attorney or Mental Health Care Advance Directives, to tell us how you would like to be treated when you may not be able to. This includes, but is not limited to, Do Not Resuscitate

("DNR") orders, asking us not to do CPR if your heart stops, to use medications to control you blood pressure or keep your heart pumping, not to be placed on a ventilator, or breathing machine, not to have a feeding tube placed or be fed by IV, or any other end-of-life care you may or may not want. You may change your mind at any time about the type of end-of-life care you want or do not want. The provision of care will not be conditioned on whether or not you have an advanced directive.

  - It is your responsibility to tell your doctor, nurse, or any other member of your healthcare team if you have Advanced Directives, such as a Living Will, POLST, Do Not Resuscitate Orders, Durable Healthcare Power of Attorney for Healthcare, or a court appointed legal guardian, conservator, loco parentis, or any other power of attorney for decision-making including healthcare.

  - It is your responsibility to provide a copy of your Advanced Directives or other similar information to your doctor, nurse or a member of your healthcare team so that copies of this information can be scanned into your medical records.

- You have the right to keep your protected health information that relates to your medical and behavioral healthcare diagnoses, treatment and services private and protected from unauthorized access, use and disclosure to the extent allowed under applicable law.

- You have the right to review the information in your medical record within a reasonable time-period, have the information explained to or interpreted for you in plain language you can understand and receive a copy of your medical record in the format you choose to the extent allowed under applicable law. NS-EEH reserves the right to charge a fee for copies of your medical records.

- You have the right to receive information about how to access domestic violence, child or elder protective services and other advocacy services and receive information about the process to have a legal guardian selected for you by a court of law.

In addition to other responsibilities you have set forth here and elsewhere, while you are a patient at NS-EEH, you have the following responsibilities:

- It is your responsibility to tell your provider and care team, to the best of your knowledge, why you are seeing the provider, all of your current and past medical and behavioral health history, conditions, illnesses and injuries, all the medications you are taking currently including those you can buy over-the-counter without a prescription, such as vitamins and herbal supplements, if you've ever been in the hospital before and the reason why, and any other information, such as an unexpected change in your condition, illness or injury. We need to know this information to care and treat you to the best of our ability.

PATIENT RIGHTS AND RESPONSIBILITIES

- It is your responsibility to participate in your plan of care and to ask questions about the care, treatment, or services that will be provided to you. Such questions will be answered in plain language you can understand.
- It is your responsibility to follow the care and treatment plan agreed upon between you and your providers. This includes taking any medications, participating in care, treatment or services, your providers have prescribed or recommended for you.
- It is your responsibility to accept personal accountability for any outcome resulting from your or your legal representative's decision to refuse care, treatment or services or to not follow your provider's treatment plan, including any payment responsibilities that may result from your decision to refuse care
- It is your responsibility to provide complete and accurate information about your health insurance and coverage, if known, a copy of your insurance card and a government issued photo ID, such as a driver's license or state issued identification card at the time the care, treatment or service is being provided to you.
- It is your responsibility to pay, in a timely manner, for the care, treatment, and services you receive, including deductibles, co-payments and co-insurance. If you have concerns about paying your bill or need to arrange a payment plan, you may speak with a financial counselor at any time during or after your stay, treatment, procedure or service by calling:
    - Edward, Elmhurst or Linden Oaks Hospitals at: (866) 756-8348
    - Evanston, Skokie, Glenbrook and Highland Park Hospitals at: (847) 570-5000;
    - Swedish Hospital at (773) 878-8200, extension 3841; or
    - Northwest Community Hospital at: (847) 681-4780, option 2.
- It is your responsibility to follow all applicable hospital rules and safety regulations. It is your responsibility to treat all providers, nurses, all other hospital staff, other patients, their family and visitors with respect and courtesy. NS-EEH has a zero-tolerance policy for verbal abuse or threats of violence toward any provider, staff member, patient, or visitor. Any person who acts in a disruptive, threatening or intimidating manner, is verbally abusive or threatens to commit or commits an act of violence may be removed from the premises in addition to, but not limited to, law enforcement being contacted and/or charges being filed.
- It is your responsibility to not use any type of camera or video or audio recording device, including, but not limited to smart phones and tablets, to not photograph or video or audio record any care, treatment, or service being provided to you, or another patient's care treatment or services, including the providers and staff, facilities, or others on any NS-EEH property without the express written permission of NS-EEH.

- It is your responsibility that your family and visitors comply with all applicable portions contained in this Patient Rights and Responsibilities document.

This Document is written in English. If this Document is translated into any other language, the English version shall control

Community Benefit Plan Report FY22

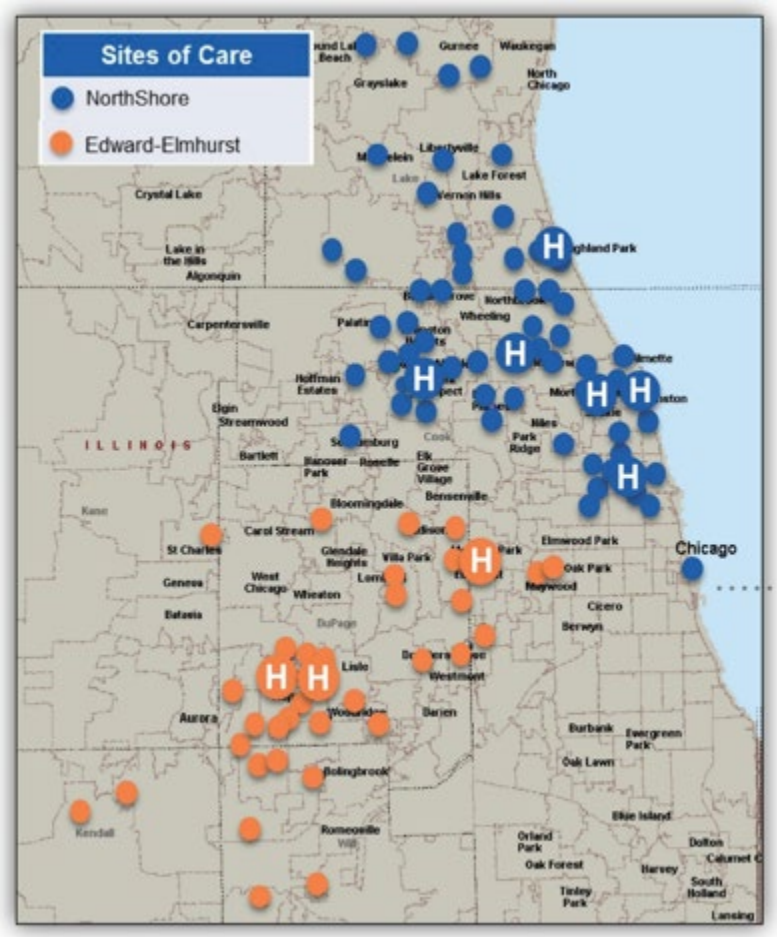
Executive Summary

NorthShore – Edward-Elmhurst Health

NorthShore – Edward-Elmhurst Health (NS-EEH) is a fully integrated healthcare delivery system committed to providing access to quality, vibrant, community-connected care, serving an area of more than 4.2 million residents across six northeast Illinois counties. Our more than 27,000 team members and more than 7,000 physicians aim to deliver safe, seamless and personal experiences and expert care close to home across more than 300 ambulatory locations and eight acute care hospitals – Edward (Naperville), Elmhurst, Evanston, Glenbrook (Glenview), Highland Park, Northwest Community Healthcare (Arlington Heights), Skokie and Swedish (Chicago) – all recognized as Magnet hospitals for nursing excellence. Located in Naperville, Linden Oaks Behavioral Health provides for the mental health needs of area residents.

Additional details for each hospital are included within specific chapters later in this report.

Service Area Map



Understanding and Responding to Community Health Needs

NS-EEH's mission is helping everyone in its communities be their best. Central to this mission is a commitment to providing clinical programs and services that meet community health needs, while also pursuing continuous improvement to identify and understand future needs. As such, hospitals within the NS-EEH system conduct Community Health Needs Assessments (CHNA's) every three years, in accordance with the requirements of the Affordable Care Act (ACA) and the Internal Revenue Service (IRS). This comprehensive CHNA process is a collaboration with community partners, using primary and secondary data, to identify, prioritize and address health issues within the service areas. The process ensures that community benefit programs and resources are focused on significant health needs as perceived by the community at large, as well as alignment with NS-EEH's mission, services and strategic priorities.

Internal and community stakeholders review the data and prioritize issues and opportunities based on an assessment of:

- **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 to reasonably impact the issue given available resources
- **Consequences of inaction:** the risk of not addressing the problem at the earliest opportunity

Below are the links to full CHNAs for each entity within the health system:

- Edward – Elmhurst Health (inclusive of Edward, Elmhurst and Linden Oaks Hospitals) www.eehealth.org/CHNA
- NorthShore (inclusive of Evanston, Glenbrook, Highland Park and Skokie Hospitals) www.northshore.org/CHNA
- Northwest Community Healthcare www.nch.org/CHNA
- Swedish Hospital www.swedishcovenant.org/CHNA

Implementation Strategy Plans (ISP) are developed to outline how the hospital plans to address prioritized health needs and are meant to align the hospital's initiatives and programs with goals, objectives and indicators that address significant community health needs. ISPs relating to each entity are included later in this report.

Shared Community Commitment

NS-EEH is united around the shared belief that the best healthcare is local and it serves as an anchor in its community for health, wellbeing and economic development. Below are some of the ways in which the organization serves its communities. NS-EEH:

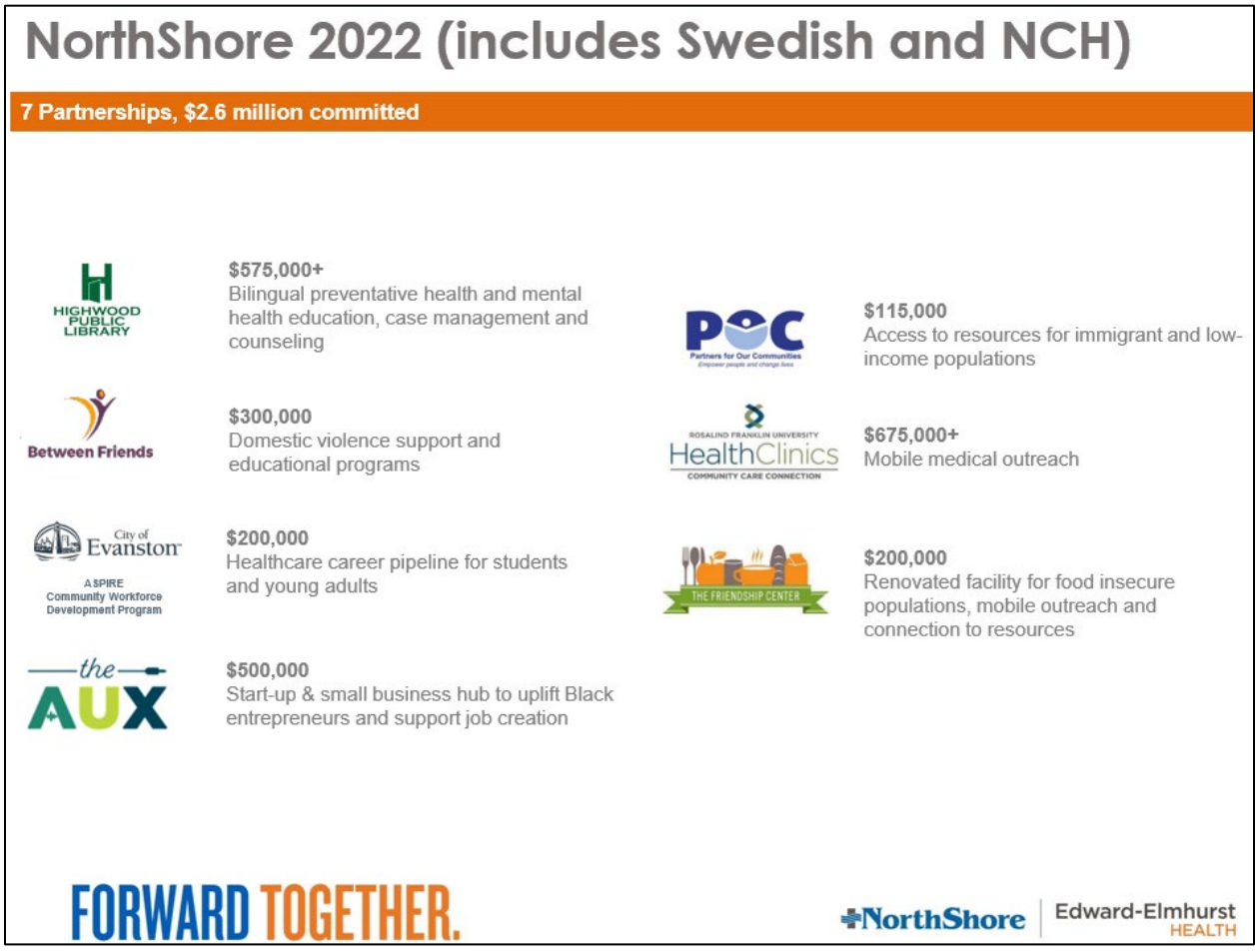
- Uses a **community needs assessment** process to steer planning.
- Addresses health holistically and focuses on **social determinants of health.**

- Actively collaborates with **local community organizations.**
- **Supports the underserved** with services, education and financial assistance.
- Employs staff who **live and work in their communities.**
- Serves as **largest employers** in respective communities.
- Supports its local communities through **Community Investment Funds.**
- **Engages civic leaders** to partner around important community issues.

Community Investment Fund

The NS-EEH Community Investment Funds are intended to support sustainable projects and programs that create meaningful impact within the communities served by NS-EEH. As a prominent feature of the NorthShore and Edward-Elmhurst Health merger, each organization committed an initial $100 million to their respective communities, for a combined total of $200 million. These funds will generate millions of dollars annually to enhance health and wellbeing, advance health equity and support local economic growth.

In 2022, more than $6.6 Million was awarded to 21 community organizations who were selected based on alignment with Community Investment Fund objectives, including health equity, social determinants of health and community economic security.



Edward-Elmhurst Health 2022

14 Partnerships, +$3.9 million committed

DuPage Health Coalition
$250,000
Medical debt relief and financial literacy

Greater Family Health
$400,000
New Health Center in Franklin Park

Naperville 203 NEF Education Foundation
$250,000
Nutrition, housing, physical/mental health support

Southwest Suburban Immigrant Project
$250,000
Health Justice Program

LISTE Food Pantry
$250,000
Expanded food storage and distribution

Loaves&Fishes Community Services
$325,500
Mobile food delivery program

Bridge Communities
$292,500
Transitional housing for families facing homelessness

DuPagePads
$250,000
Emergency housing and stabilization services

KidsMatter
$250,000
Workforce training and Mental Health First Aid for high school students

VNA Health Care
$93,000
Nursing Workforce Pathway Program

easterseals DuPage & Fox Valley
$250,000
Support mental health of children with disabilities and their families

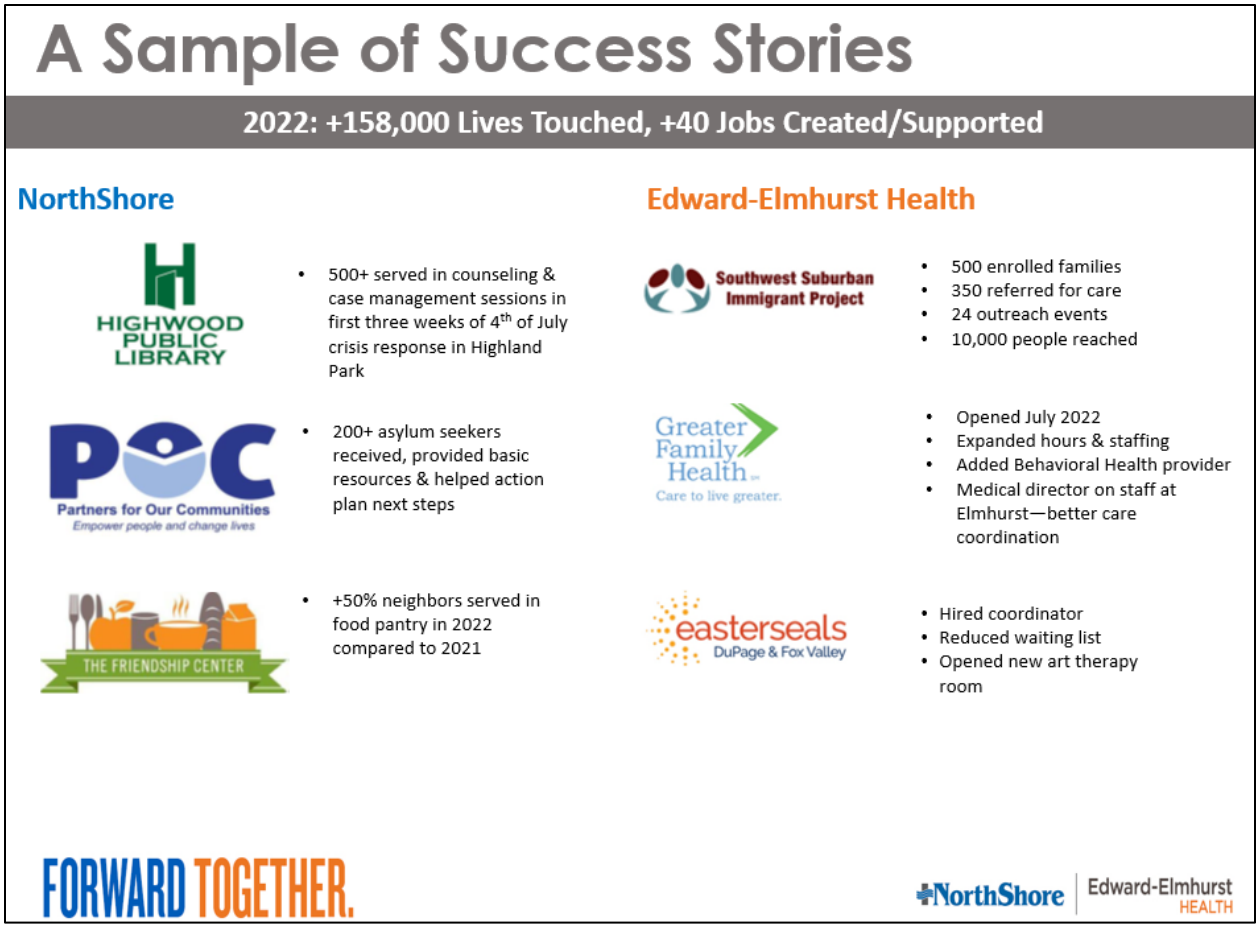
Indian Prairie School District 204
$500,000
Mental health, wellness and health equity resources

Outreach Community Ministries
$333,200
Access to affordable mental health services

Stepping Stones Celebrating 50 Years!
$300,000
Recovery home for women with children

FORWARD TOGETHER.

NorthShore | Edward-Elmhurst HEALTH



Commitment to Address Health Equity and Reduce Health Disparities

Diversity, equity and inclusion (DE&I) is core to fulfilling NS-EEH's mission and means being there for patients and each other with compassion, respect and empathy. NS-EEH believes that its strength resides in its differences and in connecting its best to provide community-connected healthcare for all. NS-EEH commits to:

- Seeing, hearing, and valuing all team members and patients
- Connecting its best to serve its diverse communities
- Doing everything it can to help its communities achieve their full potential in work, life, and health

NS-EEH commits to accelerating:

Inclusion: The ability to be our authentic selves impacts our life, health and happiness. NS-EEH is committed to being a place where all team members and patients feel like they belong.

Opportunity: NS-EEH is becoming a better reflection of the world we live in, investing in community partnerships and leadership development to enhance diversity across the organization.

Health Equity: NS-EEH is addressing disparities in health and well-being, advancing access and patient outcomes across all the communities it serves.

Direct actions by NS-EEH to address health equity and reduce health disparities include:

- Accelerating system-wide strategies for inclusion, opportunity and health equity and developing communication outlets to amplify this work, including the EEH Voices of Diversity blog and NorthShore Community Checkup videos.
- Improving collection and training on Race, Ethnicity and Language (REAL) data, including development of a REAL scorecard to better understand patient demographics and drive future initiatives (additional detail below).
- Participating in the IHA Racial Equity in Healthcare Progress Report, which serves as a long-term accountability tool to document progress toward achieving racial health equity.
- Engaging Health Equity and DE&I Committees to prioritize areas such as diabetic screening/treatment and breast cancer screening.
- Integrating health equity into a systemwide quality framework.
- Improving collection of social determinants of health indicators (additional detail below).
- Providing/requiring implicit bias training for care providers and team members.
- Investing in community organizations via the newly established Community Investment Funds to enhance health and wellbeing, advance health equity and support local economic growth.
- Sourcing more than $11 million in FY22 from diverse, local suppliers representing Veteran-owned, woman-owned or minority-owned businesses, as well as those classified as: Hub Zone, Small Disadvantaged Business, Service Disabled Vet, Small Business, LGBTQ or Disabled Owned Business Enterprise. Goals for 2023 include increasing minority diversity spend, implementing a supplier diversity program and implementing a systemwide supply chain diversity policy along with system-wide supply chain communications

System REAL Data Improvement Initiative – As a system, NS-EEH is working to better understand its patients through a campaign to gather and confirm patient race, ethnicity, and preferred language information. By improving data collection efforts in these areas, NS-EEH is able to better understand its patients, which allows the organization to 1) use preferred language to **improve communication**, **understanding**, and **build better relationships** between patients and caregivers and 2) identify groups of patients that are not receiving the same desired high-quality care and/or results. Knowing current status/baseline will help improve care through clinical process improvement and improve health through partnerships with community organizations. In the next few years, NS-EEH plans to achieve best practice of <5% of its patients in a general category of “other,” “declined,” or “unknown” category for race and ethnicity. Each part of the organization has an improvement goal over last year with the exception of NCH, which is already in the best practice range (and their goal is to maintain best practice).

Entity	Current %	Goal for 2022
EEH	5.6%	5.0%
NS	16.0%	18.2%
NCH	3.4%	4.0%
Swedish	16.1%	17.7%

Social Determinants of Health (SDOH) – Enhancing screening opportunities for SDOH allows for better understanding of challenges and barriers that community members face, providing the opportunity for navigation to critical resources and services they may need. NS-EEH is piloting collection of social determinants of health in five areas, including:

1. Food insecurity
2. Housing instability
3. Barriers to transportation
4. Interpersonal violence
5. Financial resource strain

This information helps strengthen understanding to adjust plans of care to meet patients where they are at and/or connect patients to important community resources, such as a food pantry. Starting in January of 2024, NS-EEH will collect SDOH for all individuals admitted to one of its hospitals. In addition to asking patients these questions, NS-EEH is integrating two new pieces of technology to support this work:

- A Natural Language Processing tool to review notes that physicians and the care team have previously documented in the patient chart. Anywhere it has been documented that a patient is/was in need of resources for one of these areas of SDOH, this technology will highlight and bring the note to the care teams' attention.
- Find Help tool integration into electronic health records. This "directory" will help care teams identify groups in the community that may be able to connect the patient to resources in these SDOH areas.

Mission, Vision, Values

NS-EEH's new Mission, Vision and Values were adopted in July 2022.

Mission: To help everyone in our communities be their best. It is the reason we come to work each day and inspires our actions.

Vision: Safe, seamless and personal. Every person, every time. It is what happens when we fulfill our mission. Our values are the beliefs and behaviors that guide us on the journey.

Values:

- **Act with Kindness** – Meet people where they are and show empathy through listening.
- **Earn Trust** – Act with integrity and accountability to earn and maintain trust.
- **Respect Everyone** – Champion diversity, equity and inclusion for all through mutual respect.
- **Build Relationships** – Develop meaningful connections that have a positive impact on everyone who crosses our path.
- **Pursue Excellence** – Seek out ways to keep learning and growing so we can deliver the best care to all, every time.

Prior to July 2022, the following mission statements existed for each organization:

- **Edward-Elmhurst Health:** Advancing the health of our communities.
- **NorthShore Hospitals (Evanston, Glenbrook, Highland Park, Skokie):** To preserve and improve human life.
- **Northwest Community Healthcare:** To improve the health of the communities we serve and to meet individuals' healthcare needs.

- **Swedish Hospital:** To serve the physical, spiritual and emotional needs of our diverse community with professional excellence and human kindness.

2023-2025 Strategic Plan

NS-EEH's roadmap for vibrant, community-connected care outlines the main tenets of its 2023-2025 strategic plan, including major areas of focus and the core strategies to be executed in the years ahead.

The vision statement: "Safe, seamless and personal. Every person, every time," is what the community expects and what community-connected care is all about. Given significant industry and market headwinds and challenges, NS-EEH needs to build this vision upon a sustainable platform. This requires a laser focus in three areas – **One System, Financial Stewardship, and Growth, Access and Experience.**

One System – Take full advantage of the size and scale of the combined organization. This includes building a culture and identity that reinforces its mission, vision and values and the delivery of a common brand promise to the communities served.

Financial Stewardship – To ensure long term sustainability – and the ability to deliver on its mission--focus on building cost efficiencies and returning to profitability.

Growth, Access and Experience – NS-EEH operates in an incredibly competitive environment with many strong health systems. Key to success is providing better access, better navigation and a better experience than any other provider.

Five core strategies will support these focus areas and provide direction and focus in the years ahead – Workplace of Choice, Strong Physician Enterprise, Cost-Effective Care, Exceptional Patient Access, and Robust Clinical Institutes.

While executing on these strategies, it is non-negotiable to maintain a full commitment to quality, health equity and community-connected care.

NorthShore Hospitals
(includes Evanston, Glenbrook, Highland Park and Skokie Hospitals)

Evanston Hospital is a comprehensive acute-care facility and the flagship hospital of NorthShore University HealthSystem. Evanston Hospital is a leader in cardiac care, cancer care via the NorthShore Kellogg Cancer Center and a variety of surgical specialties. The hospital is also the regional center for high-risk obstetrics with the Infant Special Care Unit and the Women's Hospital offering the latest technology and a highly trained staff. Key highlights include NorthShore Cardiovascular Institute, Center for Breast Health, Infant Special Care Unit (ISCU), NorthShore Kellogg Cancer Center, Level I Trauma Center, Primary Stroke Center, Regional Center for High-Risk Obstetrics and Women's Hospital.

Glenbrook Hospital is a comprehensive medical center providing advanced diagnostic and therapeutic interventions, as well as superior medical and surgical care for all specialties. Key highlights include NorthShore Cardiovascular Institute, Center for Breast Health, Eye and Vision Center, Gastroenterology, NorthShore Kellogg Cancer Center, Level II Trauma Center, NorthShore Neurological Institute, NorthShore Orthopaedic Institute, Primary Stroke Center and the John and Carol Walter Center for Urological Health. Construction is currently underway for a new, 170,000-square-foot, premier Cardiovascular Institute (CVI) pavilion on the Glenbrook Hospital campus. The $170 million pavilion will serve as NorthShore's central hub for elective cardiac and vascular procedures, catheterizations and interventions, as well as structural heart procedures and electrophysiology studies. The complex will also become a focus for the development of women's heart health, sports cardiology, cardio-oncology and cardiac rehabilitation; and will house six new CVI-dedicated operating rooms and nine new labs.

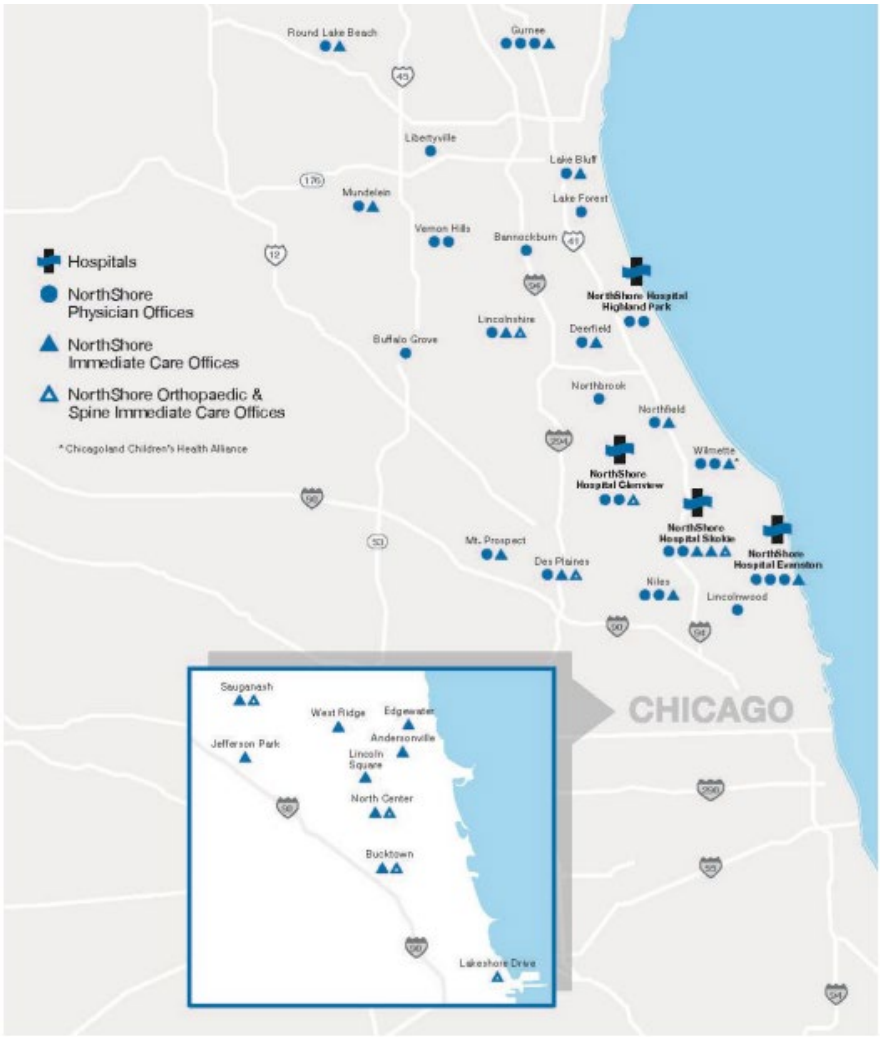
Highland Park Hospital has provided high-quality healthcare and a wide range of clinical programs for the people of Lake County and beyond for over a century. The hospital is the site of the first open-heart surgery in Lake County and continues to provide a full range of cardiac diagnosis and intervention services. Highland Park Hospital's Kellogg Cancer Center offers the most comprehensive subspecialty care for oncology patients. Key additional highlights include Adolescent Behavioral Health, Bariatric Center of Excellence, NorthShore Cardiovascular Institute, Center for Breast Health, Center for Pelvic Health, Gastroenterology, Level II Trauma Center, Primary Stroke Center and Women's Hospital.

Skokie Hospital is home to Illinois' only specialty hospital dedicated to orthopaedic and spine care, and it also offers emergency and outpatient services to meet the needs of the local community. The Orthopaedic & Spine Institute provides advanced care and is designed for both outpatient and inpatient procedures, including joint replacement, fracture care and complex spine surgeries. Key highlights include NorthShore Orthopaedic & Spine Institute, Comprehensive Emergency Department, Clinical Cardiology Services, Comprehensive Outpatient Services that include GI Lab and Outpatient Laboratory, Mammography, Outpatient Pharmacy, Radiology (CAT Scan, MRI, Ultrasound, X-Ray), Primary Care and Specialty Care Physician Offices.

Service Area

NorthShore's total service area is 1,607,577 and includes 55 zip codes within Lake and Cook Counties in Illinois.

- **Lake County:** Fort Sheridan, Grayslake, Gurnee, Highland Park, Highwood, Lake Bluff, Lake Forest, Libertyville, Lincolnshire, Long Grove, Mundelein, North Chicago, Round Lake, Vernon Hills, Waukegan, Zion
- **Cook County – North Suburbs:** Arlington Heights, Buffalo Grove, Des Plaines, Evanston, Glencoe, Glenview, Golf, Kenilworth, Morton Grove, Mount Prospect, Niles, Northbrook/Techny, Prospect Heights, Skokie, Wheeling, Wilmette, Winnetka
- **Cook County – Chicago North Side Communities:** Edgewater, Forest Glen, Irving Park, North Park, Norwood Park, Ravenswood, Rogers Park, Uptown, Lincolnwood, West Ridge



NorthShore Service Area Zip Codes

Arlington Heights	60004
Arlington Heights	60005
Deerfield	60015
Des Plaines	60016
Glencoe	60022
Glenview	60025
Glenview	60026
Golf	60029
Grayslake	60030
Gurnee	60031
Highland Park	60035
Fort Sheridan	60037
Highwood	60040
Kenilworth	60043
Lake Bluff	60044
Lake Forest	60045
Long Grove	60047
Libertyville	60048
Morton Grove	60053
Mount Prospect	60056
Mundelein	60060
Vernon Hills	60061
Northbrook/Techny	60062
North Chicago	60064
Northbrook/Techny	60065
Great Lakes	60068
Lincolnshire	60069

Prospect Heights	60070
Round Lake	60073
Skokie	60076
Skokie	60077
Northbrook/Techny	60082
Waukegan	60085
Waukegan	60087
Buffalo Grove	60089
Wheeling	60090
Wilmette	60091
Winnetka	60093
Zion	60099
Evanston	60201
Evanston	60202
Evanston	60203
Evanston	60208
Ravenswood	60625
Rogers Park	60626
Norwood Park	60631
Uptown	60640
Irving Park	60641
West Ridge	60645
Forest Glen	60646
North Park	60659
Edgewater	60660
Lincolnwood	60712
Niles	60714

Key Highlights for NorthShore Hospitals

Evanston Hospital Community Health Center – The Evanston Hospital Community Health Center offers an array of free and discounted care, including internal medicine, obstetrics/gynecology, general surgery, orthopaedics and diabetes education for those who are economically disadvantaged and are unable to obtain healthcare services through private providers. Resident physicians and registered nurses provide care under the supervision of NorthShore senior attending physicians.

Evanston Township High School Health Center – Launched in 1996, the school-based health center at Evanston Township High School (ETHS) is a collaborative partnership between Evanston Hospital, ETHS and Evanston's Health & Human Services Department. Staffed and funded by NorthShore, the Center provides free care for all students whose parents register them.

Community Health Equity Liaison – In 2022, NorthShore hired a Community Health Equity Liaison, who has been reaching out to patients who missed mammograms. This liaison plays a critical role, providing outreach and breast cancer screening navigation to its most vulnerable communities. With her help, NorthShore has reached its highest-ever rate of mammogram screening for the communities around

Evanston, Skokie, Highland Park and Glenbrook hospitals. This is an important step in early detection and care for patients experiencing breast cancer.

Food Waste Diversion Project – Glenbrook Hospital partners with Northfield Township to donate leftover food from the kitchen and café that has been carefully frozen using strict health guidelines. The frozen prepacked meals are picked up by Northfield Township volunteers for distribution at local food pantries.

Collaboration with Erie HealthReach Waukegan Health Center – Erie HealthReach Waukegan formed a partnership with NorthShore to move their small hospital delivery team to Highland Park for the care of their high-risk pregnancy patients. The partnership aligns both organizations' commitment to provide community-focused, high-quality and affordable care with access to a team of OB/GYN physicians delivering 24/7 care at Highland Park Hospital's Labor, Delivery and Postpartum unit.

Collaboration with Turning Point – Turning Point Behavioral Health Care Center's innovative "The Living Room" project provides psychiatric respite care for patients dealing with mental health issues. The unique program, supported by Skokie Hospital, uses peer counselors (adults in recovery from their own mental health challenges) and reports a 98% success rate in keeping in-crisis patients out of hospital emergency rooms.

Collaboration with Village of Skokie Farmers Market – NorthShore provides an annual grant to the Village of Skokie Farmers Market to help connect low-income consumers (LINK card holders) with fresh local produce. NorthShore matches LINK card purchases at Farmers Markets dollar-for-dollar for the purchase of fresh produce.

Community Advisory Committees – To ensure accountability to the communities it serves, NorthShore has Community Advisory Committees (CACs) at Evanston, Glenbrook, Highland Park and Skokie hospitals. These committees advise NorthShore administration on various services and initiatives from a community perspective. The CACs also identify community resources that work to strengthen NorthShore and improve the overall health of families across the region. CACs are comprised of area residents and local faith, business and community leaders.

Community Investment Fund (CIF) – The NS-EEH Community Investment Funds are intended to support sustainable projects and programs that create meaningful impact within the communities served by NS-EEH. Organizations were selected based on alignment with Community Investment Fund objectives, including health equity, social determinants of health and community economic security. In 2022, four organizations within the NorthShore hospitals' service area were awarded CIF funds:

- ASPIRE Evanston Community Healthcare Workforce Development Program - Aligning the commitment and resources of the City of Evanston and partners such as Evanston Township High School and iKit, the Evanston Work Ethic (WE) Program, Youth Job Center, NorthShore University HealthSystem and many others to help teens and young adults explore healthcare careers through career fairs, job shadowing, internships, certification programs and more. In 2022, 45 students were reached through the career exploration phase and 33 students participated in internships with NorthShore. In 2023, this program expands to Lake County.
- The AUX - Supporting the build of a new hub for startups, small businesses, Black entrepreneurs and Evanston job creation. In addition to its NorthShore award, it has raised nearly $6 million

toward building costs through grants and investors (55% of the way towards the estimated renovation/building costs). NorthShore was the first, largest and most visible donor, bringing credibility to the fundraising efforts.

- Highwood Library and Community Center - Delivering bilingual preventative health and mental health education, case management and family counseling. It served more than 4,300 community members in 2022 (surpassing goal of 2,000 individuals) with 95% demonstrating increased knowledge of tools to prevent or manage disease. In the three weeks following the 4th of July parade mass shooting, the team provided 547 counseling and case management sessions to 337 people.
- Rosalind Franklin University's Community Care Connection - Expanding mobile medical services in Lake County to improve health equity and long-term health outcomes. As a result of funds in 2022, the Community Care Connection was able to invest in staff recruitment and retention and support workforce development. It also improved community access to vital health services by 37 percent in 2022.

Key Accomplishments from CHNA Implementation Strategy Plan

Mental Health

- NorthShore collaborated with The Josselyn Center to provide virtual Mental Health First Aid (MHFA) training in NorthShore's service area. The training teaches community members how to identify and respond to mental health emergencies. Thus far, 136 responders have been trained through this partnership. Additionally, NorthShore partnered with Josselyn to provide MHFA instructor trainings, focused on underrepresented/under-resourced populations and community organizations. In 2022, 11 instructors were trained and provided with wraparound support, to enable them to train other community responders. Communities included Des Plaines, Waukegan, Glencoe and Chicago.
- NorthShore supported expanded access to mental health services at Evanston Township High School (ETHS) with additional therapy and medication management clinic services. A NorthShore LCSW is on staff at ETHS Monday – Friday, along with a psychiatrist/fellow who provide services at ETHS.
- The Perinatal Depression Program identified women who were suffering from perinatal depression and offered referrals for those who may need additional help. The program screened women for perinatal depression during and after their pregnancy and offered a 24/7 crisis hotline for women and their family members who may have found themselves in an emergent situation. All services were provided free of charge. The Perinatal Family Support Center responded to more than 600 referrals in FY22.
- The Perinatal Family Support Center provided a wide array of services free of charge to women and their families who experienced challenges related to pregnancy, birth, prematurity or perinatal loss. Services were provided in both inpatient and outpatient settings and included groups, sibling tours and a literacy program in the child and adolescent clinic. The Perinatal Family Support Center responded to more than 1,500 referrals in FY22.

- Bridges Early Childhood and Adolescent Program provided comprehensive, multidisciplinary mental health intervention and direct care to insured and uninsured children between the ages of three and 18 living in NorthShore communities.
- The Phoenix Program served adult community residents with chronic and persistent mental illnesses, as well as community patients without sufficient financial resources to afford outpatient psychiatric care.
- NorthShore provided substantial financial support for Turning Point Behavioral Health Care Center's innovative "The Living Room" project and provided psychiatric respite care for patients dealing with mental health issues. The unique program, supported by Skokie Hospital, uses peer counselors (adults in recovery from their own mental health challenges) and reports a 98% success rate in keeping in-crisis patients out of hospital emergency rooms.

Health Literacy and Navigating the Healthcare Environment

- Interpretive Services provided comprehensive, in-person and telephonic translation and interpretation services for patients and family members who received medical treatment at any of the NorthShore facilities. NorthShore provided nearly $2 million in interpretive services.
- NorthShore is one of the partners in a Value-Based Contract that served the Medicaid population managed in partnership by Meridian Health Plan. NorthShore coordinated care and quality programs designed to improve access and ensure high-quality care for a Medicaid population of approximately 6,000 patients annually.
- NorthShore's certified application counselors assisted patients and the public with questions about enrollment in the insurance exchange (Affordable Care Act/Insurance Exchange Enrollment).

Access and Coordination of Care

- NorthShore implemented a SDOH screening referral tool within the Community Health Center (CHC), ETHS Health Center, medical group practices, and Emergency Departments. Thus far, 11.8% screened as med-high risk and were navigated to additional resources.
- Charity Care (free or discounted care) was provided to all NorthShore patients who qualified based upon federal poverty guidelines. Charity care was valued at nearly $23 million.
- The CHC at Evanston Hospital provided medical care to adults who lack private medical insurance. Medical services included, but were not limited to: Primary Care, Obstetrics/Gynecology, General Surgery, Orthopedics, Diabetes Education and Podiatry. Evanston Hospital's Community Health Center provided care for 3,611 patients and 8,052 visits from Oct 1, 2021 – December 31, 2022.
- NorthShore provided primary, mental and dental care services to under/uninsured patients of the Erie Evanston/Skokie Health Center and community. Over 2,000 Erie Evanston/Skokie Health Center client received specialty care services at NorthShore on an annual basis.
- The Dental Center at Evanston Hospital provided primary dental care services and special consultations for medically underserved adult patients, pre-screenings for cardiovascular patients, management for oral complications in oncology patients and refractory dental problems. Annually, the Dental Center served approximately 10,500 underserved individuals.

- Evanston Township High School Health Center is a school-based health clinic funded by NorthShore, which provided physical exams, immunizations, treatment of acute and chronic illnesses, individual counseling, health education, gynecological care, and support groups to students whose parents allow them to enroll in the health center. An average of 900 ETHS students made 3,500 visits to the Health Center annually.
- NorthShore's Medication Assistance Program (MAP) offers aid to patients who need help paying for prescription drugs. MAP assisted 2,103 patients, filling 33,649 prescriptions valued at a cost of $1,529,395.

Substance Use Disorder

The Doreen E. Chapman Center at Evanston Hospital, provided chemical dependency services to adults 18 years and older and their families. The Chapman Center offered effective, coordinated services to individuals living with a substance use disorder. An average of 350 patients received care on an annual basis.

Please see the 2023-2024 Implementation Strategy Plan for a complete listing of all initiatives addressing the priority needs of the community identified in the 2022 Community Health Needs Assessment.

Community Benefit Report

2022
Oct 1, 2021–
Dec 31, 2022

Total Community Benefit:
$288.6M

Donations: **$5.1M**

Volunteer Services: **$314K**

Government Sponsored: **$142M**

Charity Care:
$23M

Research: **$3.3M**

Education:
$42M

NorthShore University HealthSystem

Government-Sponsored Program Services: **$2.0M**

Bad Debts: **$14.8M**

Subsidized Health Services:
$54M

Language Assistance Services:
$2M

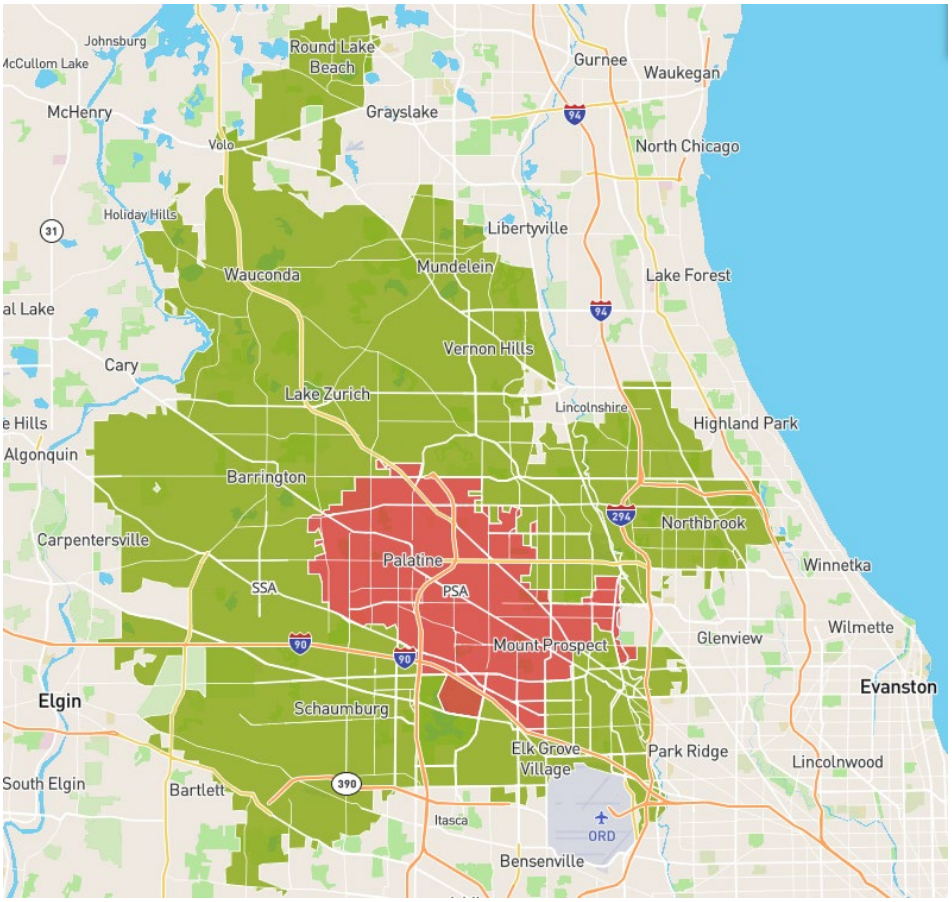
Other Community Benefit:
$430K

Northwest Community Healthcare

Serving Chicago's northwest suburbs since 1959, Northwest Community Healthcare (NCH) is a not-for-profit comprehensive healthcare system dedicated to providing outstanding care in the communities they serve. NCH combines compassionate care with a healing environment, cutting-edge clinical expertise and state-of-the-art facilities. Throughout the northwest suburbs, NCH has 23 doctor's offices, five immediate care centers, seven physical rehabilitation sites and 13 lab locations. NCH offers a full range of services, including primary and specialty care through the NCH Medical Group. Major clinical services include: Level III NICU, Level II Trauma Center, a dedicated pediatric emergency department, acute inpatient and outpatient rehab services, behavioral health services, cancer services, heart and vascular services, neurosciences and orthopedics.

Service Area

NCH's community, as defined for the purposes of the CHNA, includes each of the ZIP codes that comprise the hospital's Total Service Area (TSA). The TSA is comprised of both the hospital's Primary Service Area (PSA) and Secondary Service Area (SSA). The geographic footprint is illustrated in the following map along with a chart that lists the zip codes and names of towns. The total population of NCH's service area is 989,487.



Primary Service Area (PSA)	
60004	Arlington Heights
60005	Arlington Heights
60008	Rolling Meadows
60056	Mt. Prospect
60067	Palatine
60074	Palatine
Secondary Service Area (SSA)	
60007	Elk Grove Village
60010	Barrington
60015	Deerfield
60016	Des Plaines
60018	Des Plaines
60042	Island Lake
60047	Lake Zurich/Kildeer
60060	Mundelein
60061	Vernon Hills
60062	Northbrook
60070	Prospect Heights
60073	Round Lake
60084	Wauconda
60089	Buffalo Grove
60090	Wheeling
60107	Streamwood
60133	Hanover Park
60169	Hoffman Estates
60172	Roselle
60173	Schaumburg
60192	Hoffman Estates
60193	Schaumburg
60194	Schaumburg
60195	Schaumburg

Key Highlights for NCH

NCH has a proud and longstanding tradition of outreach to the medically underserved within its northwest suburban service area. NCH is dedicated to addressing the needs of not only its patients, but of everyone who lives and works in the northwest Chicago suburbs. The Community Services Department utilizes hospital strengths alongside those of other well-established community partners to identify unmet health needs of the community and to develop strategic initiatives to address them. Working collaboratively allows NCH to better understand and reach the most vulnerable sectors with the ultimate goal of improving the community's health status by ensuring everyone has access to care and by empowering individuals to make healthy life choices.

Highlights include:

Community Resource Center (CRC) – In 1998, Northwest Community Hospital (NCH), along with additional support from an anonymous donor, purchased a building at 1585 N. Rand Road in Palatine and converted the space into a community resource center. NCH financially supports the building, and the not-for-profit organization, Partners for Our Communities (POC), established in 1994, coordinates the services of the providers and employs a skilled staff that provides multi-lingual direct service, referrals, and other assistance to those from the community who are seeking to improve their lives. The CRC is home to 16 different not-for-profit organizations that provide services including: health and wellness, education and literacy, food and clothing, employment, counseling and social service, leadership and youth development. The CRC has approximately 150,000 visits annually and is embraced as a vital resource by the community it serves. NCH and POC work collaboratively to identify and address the changing needs of the community through the services offered at the center.

Charitable Donations – NCH recognizes it cannot address all of the community's healthcare needs without assistance from community partners. Therefore, NCH allocates funding for local not-for-profit organizations. Each year, an annual Charitable Donation Program is announced and financial awards are made to organizations that align best with the hospital's mission and current needs of the community.

Mobile Dental Clinic – In response to an overwhelming need for dental services for low-income residents, NCH launched the northwest suburbs' first Mobile Dental Clinic (MDC) in 2003. The MDC provides dental care to community residents in NCH's service area who do not have adequate access to dental services due to financial barriers. While many dental health clinics focus on treating emergencies, NCH's program emphasizes the importance of overall oral health by helping patients develop a habit of routine cleanings and exams and strives to provide a dental home for its patients. The MDC also provides extractions and restorative work such as fillings, crowns, and dentures. The clinic is staffed with a full-time dentist, manager/hygienist and a bilingual dental assistant. The MDC has a long-standing relationship with the University of Illinois College Of Dentistry (UIC COD). The UIC COD fourth-year dental student interns have monthly rotations providing dental care for MDC patients. In addition, community members volunteer their time to help with day to day clinic operations. The clinic is funded by contributions from collaborative partners, grant funding from donors, reimbursement from public aid, patient co-pays, and NCH covers the remaining costs. Palatine, Elk Grove, and Wheeling Townships have been partners since the inception of the clinic, and they have continuously provided financial support. Schaumburg Township joined as a partner in 2012. This Township collaboration has been successful for 20 years.

Emergency Medical Services (EMS) Resource Hospital – The NCH EMS System was founded in 1972 by Stanley M. Zydlo, MD, FACEP who worked with the Illinois Department of Public Health Division of EMS (IDPH) to create the program for Illinois. EMS Systems are led by Resource Hospitals. Through their EMS Medical Director, they assume responsibility for the entire program, including the clinical aspects, operations and

education programs. As the state's first Resource Hospital, NCH has long been a leader in EMS planning, education, and operation. The NCH EMS System includes 24 EMS Agencies and more than 1500 paramedics, Emergency Medical Technicians, pre-hospital registered nurses and Emergency Medical Responders. The receipt, management and disposition of requests for EMS responses are handled by Public Service Answering Points (Dispatch Centers) who employ specially educated and credentialed Emergency Medical Dispatchers. NCH collaborates with five Associate Hospitals that employ Emergency Communication Registered Nurses who provide online medical control to EMS personnel. The System covers ~440 square miles extending from Mount Prospect to Hoffman Estates and Wauconda to Bloomingdale. It serves a population exceeding one million persons, 24 hours a day, every day of the year and responded to over 83,280 calls in 2022. The System cares for persons of all ages and respects their rights without regard to age, race, ethnicity, national origin, religion, culture, language, physical or behavioral health disability, socioeconomic status, sex, sexual orientation, gender identity or expression, or any other status, protected by and consistent with applicable laws. EMS educators are responsible for facilitating entry level course offerings and continuing education for each discipline. The EMT and paramedic courses are affiliated with Harper College and hold multiple accreditations. The programs consistently meet or exceed outcomes measures for student enrollment, attrition, pass rates on national exams, employment, and satisfaction. Over 95 continuing education classes are held monthly for System personnel.

Key Accomplishments from CHNA Implementation Strategy Plan

Behavioral Health
From October 2021 through December 2022, NCH provided 1,043 bedside behavioral health assessments for patients hospitalized with medical conditions. This early intervention is key to identifying and addressing behavioral health issues.

Obesity
From October 2021 through December 2022, the Community Cares Food Pantry that NCH is a collaborative partner in provided food to almost 57,316 individuals. Access to healthy food is key strategy that NCH is committed to in addressing obesity.

Access to Healthcare for the Under-Resourced
From October 2021 through December 2022, NCH Community Health Workers had 7,662 client visits with Spanish speaking, majority low-income, patients and community members. They provided help with discharge instructions, connections to medical homes and other community resources and with prenatal tours.

Cancer
From October 2021 through December 2022, NCH provided 1,626 lung screenings. Early detection and treatment significantly impacts the outcomes of those diagnosed with lung cancer.

Chronic Diseases (Diabetes, Heart/Stroke, High Blood Pressure)
From October 2021 through December 2022, the Atherton Outpatient Clinic provided 2,862 patient visits for individuals with congestive heart failure. Local treatment that is easy to access is key to helping individuals with congestive heart failure manage their disease.

Please see the 2022-2023 Implementation Plan for a complete listing of all initiatives addressing the priority needs of the community identified in the 2021 Community Health Needs Assessment.

Community Benefit Report

2022
Oct 1, 2021–
Dec 31, 2022

Donations:
$1.5 MILLION

Total Community Benefit:
$68.3 MILLION

Volunteer Services: **$522K**

nch Northwest Community Healthcare
Part of NorthShore

Government-Sponsored Healthcare:
$48.2M

Education:
$3.8M

Bad Debts:
$5.1M

Charity Care:
$5.1M

Subsidized Health Services:
$1.9M

Language Assistance Services:
$1.4M

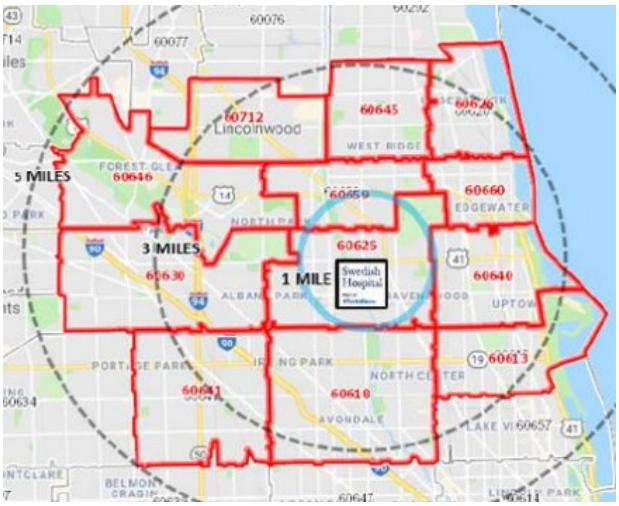
Other Community Benefit:
$440K

Swedish Hospital

Swedish Hospital 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 provides a full range of comprehensive health and wellness services including an acute care hospital, primary care and specialists in the medical group, strong community outreach programs and Chicago's only certified medical fitness center, Galter LifeCenter. Swedish Hospital offers more than 50 medical specialties with practices, including several Immediate Care Centers, conveniently placed throughout the hospital's campus and on multiple sites throughout Chicago's north side communities.

Service Area

The total population in Swedish's service area is 686,000 and is comprised of twelve zip codes. 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.



Swedish Service Area Zip Codes (by Chicago Community Areas)

Lake View, North Center, Uptown	60613
North Center, Avondale, Irving Park	60618
Albany Park, North Park, Lincoln Square	60625
Rogers Park	60626
Jefferson Park, Irving Park, Albany Park, Forest Glen, Portage Park	60630
Uptown, Edgewater, Lincoln Square	60640
Portage Park, Irving Park	60641
West Ridge, Rogers Park	60645
Forest Glen, Jefferson Park	60646
West Ridge, North Park	60659
Edgewater	60660
Lincolnwood	60712

Key Highlights for Swedish Hospital

Swedish Hospital has a robust offering of community health and outreach programs designed to serve the needs of its diverse community while 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 and in deep partnership with area organizations. More details are available at SwedishCovenant.org/communitywellness.

Programs include:

Pathways – The Pathways Program was developed to strengthen the hospital's ability to identify and assist patients who are survivors of interpersonal violence.

Food Connections – The Food Connections Program was developed to strengthen the hospital's ability to address food insecurity and remove food access as a barrier to health.

Nutrition and Diabetes Center – This program offers comprehensive education, resources and support to patients diagnosed with type 1 or type 2 diabetes, prediabetes, and gestational diabetes, as well as individual nutrition education to patients with various nutrition needs.

Community Outreach Registered Dietitian (CORD) – This community-facing dietitian engages in educational activities, outreach and public benefit education and enrollment assistance.

Healthy Chicago Equity Zones (HCEZ) – Thanks to a grant from the City of Chicago and the Chicago Department of Public Health, Swedish Hospital serves as Regional Lead for the North/Central area of the HCEZ initiative. This program focuses on collaborating alongside trusted, local community organizations and leaders to identify and confront the social and environmental issues that contribute to health and racial inequity.

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

Community Investment Fund (CIF) – The NS-EEH Community Investment Funds are intended to support sustainable projects and programs that create meaningful impact within the communities served by NS-EEH. Organizations were selected based on alignment with Community Investment Fund objectives, including health equity, social determinants of health and community economic security. In 2022, two organizations within the Swedish Hospital service area were awarded CIF funds:

- Between Friends - Expanding domestic violence support programs to end the cycle of abuse, including a 24-hour helpline and counseling services. Funds in 2022 supported the onboarding of a bilingual counselor and provided wellbeing programs to more than 150 domestic violence survivors and their families at three special *A Night Out* events.
- The Friendship Center - Supporting low-stigma food pantry, mobile outreach and accessibility to public benefits and resources in Chicago. The center doubled its population served since receiving CIF funds and increased pounds of food rescued by more than 300%.

Key Accomplishments from CHNA Implementation Strategy Plan

Addressing Access to Health and Social/Structural Determinants of Health

- Swedish developed robust strategies to address health and racial disparities through community partnership and program development via its Regional Lead role for North/Central Zone of Healthy Chicago Equity Zones initiative, a collaboration with Chicago Department of Public Health. During the FY22 time period, the Swedish HCEZ team participated in 167 events.

- A Community Wellness Center launched in October 2022 as a hub for educational programming, support groups and wellness offerings, including collaboration with area organizations.
- The Pathways Program strengthened Swedish Hospital's capacity to respond to survivors of sexual and intimate partner violence. This included creating a culture of safety and awareness, with more than 275 patients served annually who have been impacted by sexual assault, domestic violence or human trafficking. The program provided extensive de-escalation, trauma, domestic violence, human trafficking and sexual assault training to medical providers, and staff, with more than 40 trainings held annually and more than 500 people trained. Additionally, a Pathways staff support group launched in late 2022.
- A SDOH screening tool launched in late 2022 and helped navigate screened individuals to services and resources.
- Swedish expanded efforts to support benefits enrollment for under-resourced community members, including initiating process to enroll patients who screen positive for food insecurity in various programs (LINK, SNAP, WIC, food pantries).
- A Healthcare Transformation Program with FQHC partners increased access to specialty care and diabetes education.

Addressing Chronic Conditions and Wellness

- The organization addressed high blood pressure, diabetes and preventative cancer screenings through targeted interventions and outreach, including navigating patients with no record of mammogram history to Breast Health Center and funding opportunities for free screening as needed. More than 1,100 no-charge cancer detection services were provided in 2022.
- Swedish enhanced partnerships with local community organizations to better address chronic health conditions, including deeper collaboration within local FQHCs via the Transformation Program to care for under-resourced patients managing chronic health conditions.
- Swedish expanded education and outreach to community and patients, promoting nutrition, healthy lifestyle choices and wellbeing. Programs included but were not limited to:
    - Food Connections (addressing food insecurity for patients, community and staff)
    - Veggies for Health program (8-week nutrition class)
    - Nutrition & Diabetes Center (1-1 and group support)
    - Bystander CPR & AED Training (1-hour community class – no certification)
- Via free special events and programs, Swedish expanded community education programming about the importance of healthy eating and physical activity. Efforts included partnership with Swedish's Healthy Chicago Equity Zones and the Community Outreach Registered Dietitian to outreach into local underserved communities. Programs included cooking demonstrations, bike helmet giveaways and safety tips, healthy eating tips with the interactive Smoothie Bike and more.
- Swedish provided four smoking cessation programs in FY22 (each program included eight one-hour sessions), including discounted fees for underresourced individuals.
- Galter LifeCenter (GLC) enhanced offerings to support health and wellbeing, including approximately 80 discounted scholarship memberships based on financial and medical need as well as Fundamental Fitness and Eat, Move, Lose programs. GLC also supported the Integrated Cancer Care Program (ICCP) via free services such as support groups, integrative therapies (massage, acupuncture, etc.), fitness programming, nutrition counseling and more.

Improving Mental Health

- Swedish continued its robust partnership with Lutheran Social Services of Illinois (LSSI) via Project IMPACT (within the ED), via The Welcoming Center (outpatient setting on hospital campus) and through the LSSI Mobile Crisis Team. This includes treatment for patients in need of medical stabilization for substance or alcohol abuse.
- An integrated, team-based approach co-located a clinical psychologist among sixteen primary care providers to better facilitate warm handoffs and streamlined connection to behavioral health services.
- A free weekly support group, as well as other community education programs with local organizations supported new moms.
- Swedish Hospital Foundation's Women's Care Fund provided more than $50,000 worth of free counseling services to uninsured or underinsured women.
- Swedish applied for and was awarded a $100,000 grant from Cigna Foundation for an LCSW to be hired to provide psychoeducation in the community and expand individual services. Funds were received in December 2022 – to begin in 2023.
- Swedish featured "Boosting Your Mental Health" in Healthy Driven ABC TV spots, along with online content, provided by health psychologist Dr. Katie Hanson.
- Swedish initiated a suboxone opioid addiction clinic pilot within Emergency Department.

Please see the 2023-2024 Implementation Strategy Plan for a complete listing of all initiatives addressing the priority needs of the community identified in the 2022 Community Health Needs Assessment.

Community Benefit Report

2022
Oct 1, 2021–
Dec 31, 2022

Donations:
$1.2 MILLION

Total Community Benefit:
$68.5 MILLION

Volunteer Services: **$129K**

Charity Care:
$12M

Government-Sponsored Indigent Healthcare:
$36.6 MILLION

Bad Debts:
$4.5M

Swedish Hospital
Part of NorthShore

Education: **$6.3M**

Subsidized Health Services:
$6.3M

Language Assistance Services:
$1.2M

Other Community Benefit:
$164K

Edward-Elmhurst Health (EEH) Hospitals (Includes Edward, Elmhurst and Linden Oaks)

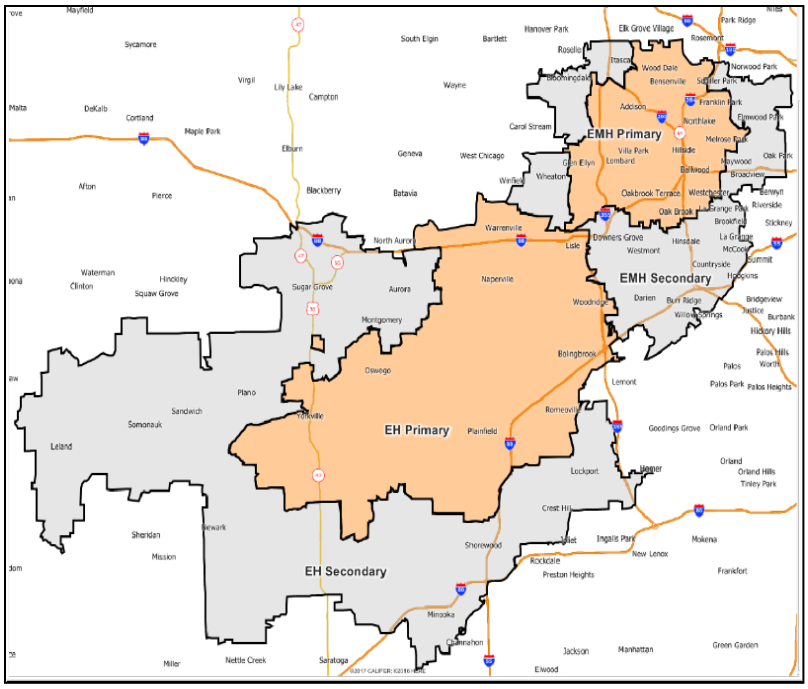
Edward Hospital (EH) is a full-service, regional healthcare provider offering access to complex medical specialties and innovative programming, with more than 80 medical and surgical specialties and subspecialties. EH has earned a reputation as a healthcare leader by providing advanced cardiac care at Edward Heart Hospital and state-of-the-art cancer diagnosis and treatment at Edward Cancer Center. World class stroke care is provided through the Edward Neurosciences Institute in affiliation with Northwestern Medicine. The Institute features the most advanced interventional neurosurgery techniques and drug therapies to treat strokes and other neurological disorders. The hospital is also home to the first Ronald McDonald Family Room in Illinois, developed through a partnership between the Edward Foundation and Ronald McDonald House Charities of Chicagoland and Northwest Indiana. EH is the largest employer in Naperville and one of the largest in DuPage County. Edward is the 11th largest hospital in the Chicago area according to Crain's Chicago Business and is among the busiest non-teaching hospitals in the Chicago area for inpatient discharges, outpatient visits, births, emergency room visits, surgeries performed, cardiac catheterization procedures and cardiac surgeries.

Elmhurst Memorial Hospital (EMH) is a comprehensive health system with multiple locations and services designed to enhance the health of the communities and customers served. It is a state-of-the-art acute care hospital with a modern emergency department and technologically advanced surgical suites, incorporating the latest trends in healthcare facility design and home to some of the area's most advanced technology. EMH, the 16th largest hospital in the Chicago area according to Crain's, is one of only 97 healthcare organizations worldwide, one of 22 in the U.S. and the only one in Illinois to be awarded Gold Certification for Excellence in Person-Centered Care by Planetree International. Elmhurst, first designated in 2012 and re-designated in 2015, is one of only 10 hospitals in the world to earn Planetree's Designation with Distinction.

Linden Oaks Hospital (LOH) is a behavioral health hospital on Edward Hospital's Naperville campus with outpatient and ambulatory offices in Naperville, Plainfield, St. Charles, Woodridge, Mokena, Hinsdale, Addison, and Orland Park. 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 employs doctors with expertise in mood disorders, anxiety, personality disorders, schizophrenia and other psychotic disorders.

Service Area

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	
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

Key Highlights for Edward-Elmhurst Health Hospitals

Health Aware Assessment Tools – These online assessments provide a quick analysis of various health topics and suggested next steps if an individual is found to be at risk. The five-minute assessments gauge the risk of developing diseases or disorders that can weaken health and affect lifestyle. Health Aware topics include Heart Aware, Anxiety Aware, Stroke Aware, Sleep Aware, Breast Aware, Diabetes Aware, Addiction Aware, Depression Aware, Lung Aware, Colon Aware and Weight Aware.

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.

Young Hearts for Life (YH4L) – This is the largest cardiac detection program in the United States for the prevention of sudden cardiac death for youths. Over recent years, EEH provided over $100,000 in financial support to YH4L. This donation allowed for screenings at many schools throughout the community.

Collaboration with DuPage Health Coalition – This 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.

Healthy Driven Chicago – This program focuses on providing educational resources and information to feel empowered and in control of one's health. It is provided through a partnership between Edward-Elmhurst Health and ABC7 Chicago.

Healthy Driven Families – This community facing electronic platform was created to educate, guide and support parents and families in a preventive 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.

Patient/Family Advisory Committee – The Patient/Family Advisory Committee (PFAC) strives to incorporate the perspective of patients and families into the design and evaluation of Edward-Elmhurst Health processes, services, environment, equipment and patient communication. The committee includes patients, their family members and employees.

Community Investment Fund – In August 2021, the EEH Board of Trustees approved the establishment of a Community Investment Fund with an initial $100 million investment to provide annual grant funding to community organizations aligned with the following goals:

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

This fund was a key component of EEH's merger with NorthShore University Health System to form NorthShore – Edward-Elmhurst Health, demonstrating the organization's commitment to vibrant, community-connected care. With 46 applicants and requests in excess of $41M, EEH awarded nearly

$4M in Community Investment Fund grants to 14 organizations in EEH's service area during the inaugural year of this program. These organizations are addressing a broad spectrum of identified community needs including mental health programming, access to services, health literacy, food insecurity, housing, job creation and career development. A liaison program was established to connect EEH leaders with each funded organization to discuss the program and its progress on key performance metrics as well as any obstacles and potential for additional partnership opportunities.

Key Accomplishments from CHNA Implementation Strategy Plan

Addressing Access to Healthcare

- EEH'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.
- 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 appropriate next steps based on their unique financial circumstances.
- EEH's ongoing partnership with DuPage Health Coalition is an important component of the Access to Healthcare strategy.

Chronic Disease (Improving Early Detection, Prevention and Wellness)

Obesity

- 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 the planning cycle, 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 300 bariatric surgical procedures were performed.
- Led by a registered dietitian and trained lifestyle coach, 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. 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.
- The Healthy Driven Families robust 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.
- In collaboration with community partners, EEH sponsored a community Take a Hike 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.

Diabetes

- Given the positive patient outcomes and demand for services, EEH expanded Diabetes Center access points over the past few years – collectively services are now offered in Elmhurst, Naperville, Bolingbrook, Plainfield and Yorkville.
- 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

- EEH continued to support and participate in the Young Hearts for Life program.
- EEH continues to provide many community education programs focused on heart health and stroke prevention. These webinars reached hundreds of community members annually, providing education on awareness, prevention, and symptom identification.
- 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. The monthly Healthy Driven Newsletter, with a distribution of over 300,000, covered various heart healthy lifestyle topics.

Cancer Care

- EEH enhanced its website allowing for streamlined patient navigation based on individual diagnosis. The dedicated Breast Cancer page was launched, and work began to expand 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.
- Regular news, email, blog and newsletter content is provided to the community by EEH on variety of topics associated with cancer prevention. The monthly Healthy Driven Newsletter, with a distribution of over 300,000, included prevention lifestyle and informative articles, including topics on cancer care.

Addressing 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 social determinants of health (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.

Connections to Community Resources

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.

Mental Health/Substance Use

Access to Behavioral Health Services

- Recruitment continues in a very competitive market with a 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.
- 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.
- Behavioral Health Integration 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 continues to expand this care delivery model to additional primary care and specialty clinic locations.
- Care coordination within ED and medical floors of acute care hospitals has been re-engineered. 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:

- 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 via Community Provider Think Tank events; topics included COVID reactivation plans and the newly formed Centralized Admission Inpatient Unit.
- 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.
- 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).

EEH Opioid Initiative

EEH continues to take 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:

- The Midwest Alternative to Opioids Project (ALTO) 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.
- 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.
- 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, during the first phase 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 were expanded to Elmhurst Hospital.
- 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.

Please see the 2023-2024 Implementation Strategy Plan for a complete listing of all initiatives addressing the priority needs of the community identified in the 2022 Community Health Needs Assessment.

Community Benefit Report

2022
July 1, 2021–
Dec 31, 2022

Total Community Benefit:
$226.4M

Donations: **$2.1M**

Volunteer Services: **$1M**

Government Sponsored: **$172M**

Healthy Driven
Edward-Elmhurst HEALTH

Research: **$2.8M**

Bad Debts: **$16M**

Education:
$2.1M

Charity Care:
$14M

Subsidized Health Services:
$15.1M

Language Assistance Services:
$1.5M

Other Community Benefit:
$168K

2022 Community Health Needs Assessment

NorthShore University HealthSystem

- CHNA Executive Summary
- About our Community
- Key Health Indicators
- Community Input
- Prioritized Health Needs

NorthShore University HealthSystem 2022 CHNA

NorthShore – Edward-Elmhurst Health is a fully integrated healthcare delivery system committed to providing access to quality, vibrant, community-connected care, serving an area of more than 4.2 million residents across six northeast Illinois counties. Our more than 25,000 team members and more than 6,000 physicians aim to deliver transformative patient experiences and expert care close to home across more than 300 ambulatory locations and eight acute care hospitals – Edward (Naperville), Elmhurst, Evanston, Glenbrook (Glenview), Highland Park, Northwest Community (Arlington Heights) Skokie and Swedish (Chicago) – all recognized as Magnet hospitals for nursing excellence. Located in Naperville, Linden Oaks Behavioral Health, provides for the mental health needs of area residents.

NorthShore – Edward-Elmhurst Health desires to continue providing clinical programs and services to meet community health needs, while also pursuing continuous improvement in existing and future programs to improve the overall health of individuals in the communities it serves. As such, hospitals within the NorthShore – Edward-Elmhurst Health system conduct Community Health Needs Assessments (CHNA's) every three years, using primary and secondary data, to ensure community benefit programs and resources are focused on significant health needs as perceived by the community at large, as well as alignment with NorthShore – Edward-Elmhurst Health's mission, services and strategic priorities.

This joint CHNA was conducted by the following hospitals within NorthShore – Edward-Elmhurst Health: Evanston, Glenbrook, Highland Park and Skokie. These four hospitals collectively serve the same communities within NorthShore University HealthSystem (NorthShore). For the remainder of this report "NorthShore" will refer to these four hospitals. Please note that Edward-Elmhurst Health, Swedish Hospital and Northwest Community Healthcare develop and release their own separate CHNAs.

NorthShore University HealthSystem 2022 CHNA

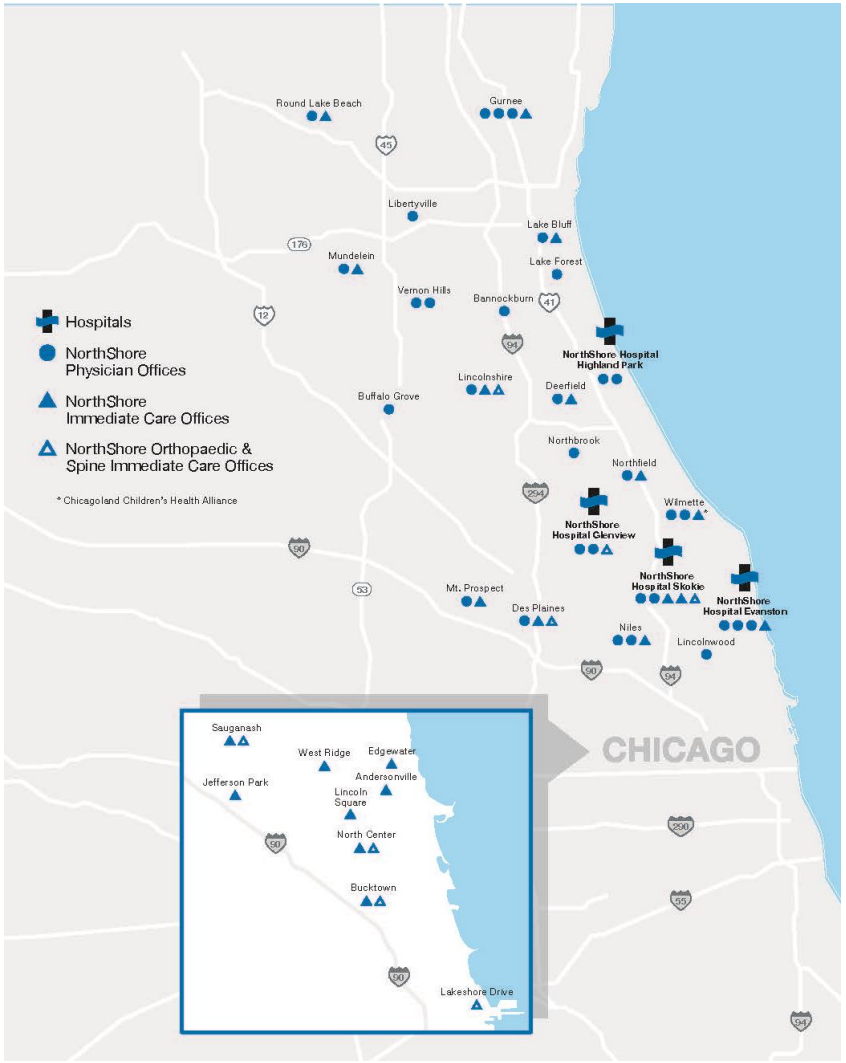
NorthShore has defined its “community” to include 54 zip codes within Lake and Cook Counties in Illinois. Defining the CHNA community similarly to its primary service area will allow NorthShore to more effectively focus its resources to address identified significant health needs, targeting areas of greatest need and health disparities.

NorthShore obtained input from 63 leaders representing public health, major employers, public schools, social services, NorthShore leaders and the community at-large through five focus groups. Primary input was also obtained by conducting an online community health survey distributed to members of the community.

Secondary data was assessed including:

- Demographics (population, age, sex, race)
- Socioeconomic indicators (household income, poverty, unemployment, educational attainment)
- Key health indicators

Information gathered in the above steps was reviewed and analyzed to identify health issues in the community.



NorthShore University HealthSystem 2022 CHNA

The process identified the following health issues listed in alphabetical order:

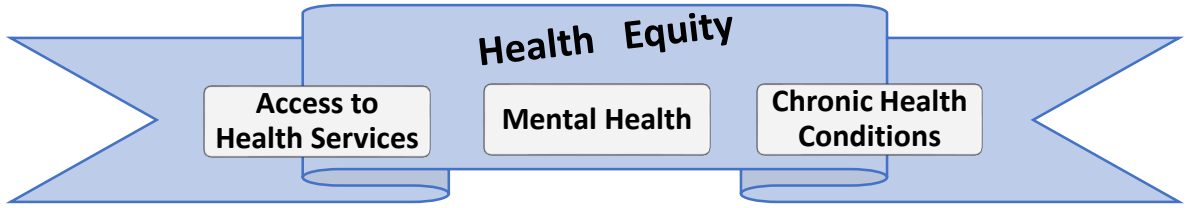
- Access to Health Services (Cost, Language, Navigating Healthcare System)
- Affordability of Healthcare
- Cancer
- Chronic Health Conditions (Diabetes and High Blood Pressure)
- Health Inequity/Discrimination
- Food Insecurity
- Heart Disease
- Health Literacy
- Lack of Affordable Housing
- Maternal and Child Health
- Mental/Behavioral Health
- Obesity
- Poverty
- Preventative Care
- Violence/Safety
- Youth Mental Health/Substance Abuse

Health needs were prioritized with input from a broad base of key NorthShore stakeholders, by utilizing a scoring guide. Representation included:

- Key Stakeholders within Health Equity and/or Diversity, Equity & Inclusion
- Key Stakeholders from NorthShore's Black Leadership Forum
- Key Stakeholders from NorthShore's LGBTQ+ affinity group (True North)
- Key Stakeholders serving Community
- Senior Organization Leaders

A review of existing community benefit and outreach programs was also conducted as part of this process and opportunities for increased community collaboration were explored.

Based on the information gathered through this CHNA and the prioritization process described above, NorthShore University HealthSystem chose the needs below to address over the next three years. Opportunities for health improvement exist in each area. NorthShore University HealthSystem will work to identify areas where NorthShore can most effectively focus its resources to have significant impact and develop an Implementation Strategy for fiscal years ending 2023-2024. It is important to note that Health Equity is woven throughout these areas and will be an integral element of the three priority areas: Access to Health Services, Mental Health and Chronic Health Conditions.

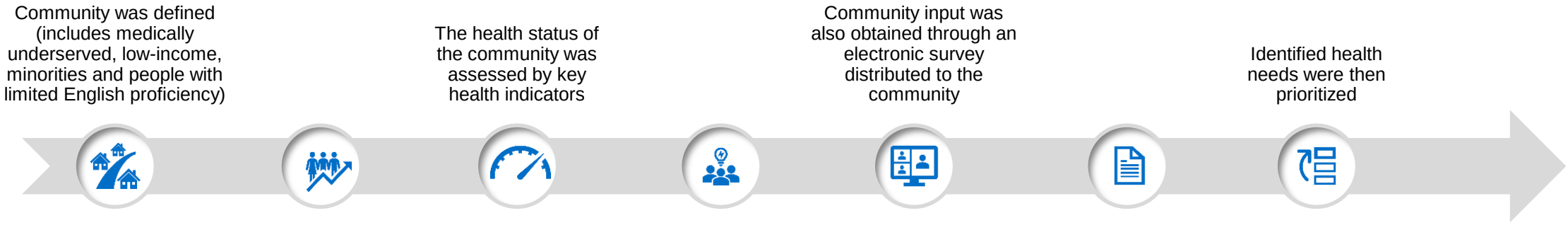


How the Assessment was Conducted

NorthShore conducted a CHNA to support its mission responding to the needs in the community it serves and to fulfill the requirements established by the Patient Protection and Affordable Care Act of 2010 and comply with federal tax-exemption requirements. This is the fourth CHNA conducted by NorthShore. The goals were to:

- ✓ Identify and prioritize health issues and social determinants of health in the NorthShore service area, particularly for vulnerable and under-represented populations.
- ✓ Ensure that programs and services closely match the priorities and needs of the community.
- ✓ Strategically address those needs to improve the health of the communities served by NorthShore facilities.

Based on current literature and other guidance from the United States Department of the Treasury, the following steps were conducted as part of NorthShore's CHNA:



Limitations and Information Gaps

Our Commitment to Address Health Equity and Reduce Health Disparities

Diversity, equity and inclusion is at the core of who we are, being there for our patients and each other with compassion, respect and empathy. We believe that our strength resides in our differences and in connecting our best to provide community-connected healthcare for all. At NorthShore, we:

- See, hear and value all team members and patients
- Connect our best to serve our diverse communities
- Do everything we can to help you achieve your full potential in work, life and health

We commit to ***accelerating***:

Inclusion

The ability to be our authentic self impacts our life, health and happiness. NorthShore is making this a place where all team members and patients feel like they belong.

Opportunity

We are becoming a better reflection of the world we live in, investing in community partnerships and leadership development to enhance diversity across NorthShore.

Health Equity

We are becoming a better reflection of the world we live in, investing in community partnerships and leadership development to enhance diversity across NorthShore.

Direct Actions by NorthShore University HealthSystem:

- Accelerating system-wide strategies for inclusion, opportunity and health equity
- Improving collection and training on REAL data
- IHA Racial Equity In Healthcare Progress Report
- North Region Health Equity Committee
- Integrating heath equity into systemwide quality framework
- Improving collection of social determinants of health indicators
- Implicit bias training for care providers and team members
- Community Investment Fund Partners – investing in community organizations to enhance health and wellbeing, advance health equity and support local economic growth

Acknowledgements

The CHNA for NorthShore supports the organization's mission to *"preserve and improve human life."* This CHNA was made possible because of the commitment toward addressing the health needs in the community. Many individuals across the organization devoted time and resources to the completion of this assessment.

NorthShore would like to thank leaders from the following community organizations who participated in focus groups and interviews and provided valuable information to be used in the assessment:

- Catholic Charities
- Childcare Network of Evanston
- City of Evanston, Health & Human Services
- Community Partners for Affordable Housing
- Erie Evanston/Skokie Health Center
- Evanston Fire & Life Safety Services
- Faith in Action
- Family Service of Glencoe
- Frisbie Senior Center
- Glenview Police Department
- Great Lakes Adaptive Sports Association
- Lake County Health Department
- McGaw YMCA
- Moraine Township
- NAMI Cook County North Suburban
- Niles Township
- Niles Township High School District 219
- North Shore Congregation Israel
- North Shore School District 112
- Northfield Township
- Oakton Community College
- Rosalind Franklin University
- School District 113
- Second Baptist Church
- Skokie Community Foundation
- Skokie Fire Department
- Skokie Library
- The Josselyn Center
- Turning Point
- Village of Glenview - Senior Services
- Village of Skokie Health Department
- Village of Wilmette

This CHNA has been facilitated by Crowe LLP ("Crowe"). Crowe is one of the largest public accounting, consulting, and technology firms in the United States. Crowe has significant healthcare experience including providing services to hundreds of large healthcare organizations. Community health needs assessments and community benefit consulting are provided to hospitals across the country. For more information about Crowe's healthcare expertise visit www.crowe.com/industries/healthcare.

This CHNA has been approved by the NorthShore Board of Directors in 2022.

Written comments regarding the health needs that have been identified in the current CHNA should be directed to:

Jenise Celestin
Director, Community Relations
NorthShore Hospitals
jcelestin@schosp.org
(773) 907-3076

Hania Fuschetto
Manager, Community Relations
NorthShore Glenbrook and Highland Park Hospitals
hfuschetto@northshore.org
(847) 480-2630

Mark Schroeder
Manager, Community Relations
NorthShore Evanston and Skokie Hospitals
mschroeder@northshore.org
(847) 933-6004

Overview of Our Hospitals Included in this CHNA

NorthShore Evanston Hospital - With a history dating back to 1891, Evanston Hospital is a comprehensive acute-care facility and the nucleus of NorthShore University HealthSystem. Evanston Hospital is a leader in cardiac care, cancer care via the NorthShore Kellogg Cancer Center and a variety of surgical specialties. Evanston Hospital is also the regional center for high-risk obstetrics with the Infant Special Care Unit and the Women's Hospital offering the latest technology and a highly trained staff.

Key Specialties
- NorthShore Cardiovascular Institute
- Center for Breast Health
- Infant Special Care Unit (ISCU)
- NorthShore Kellogg Cancer Center
- Level I Trauma Center
- Primary Stroke Center
- Regional Center for High-Risk Obstetrics
- Women's Hospital

NorthShore Glenbrook Hospital - Established in 1977, Glenbrook Hospital is a comprehensive medical center providing advanced diagnostic and therapeutic interventions, as well as superior medical and surgical care for all specialties. In 2011, Glenbrook Hospital opened a new 25,000 square-foot Emergency Department featuring 30 private exam/treatment rooms. A more recent hospital expansion project further enhanced Glenbrook Hospital's ability to meet the healthcare needs of the growing community.

Key Specialties
- NorthShore Cardiovascular Institute
- Center for Breast Health
- Eye and Vision Center
- Gastroenterology
- NorthShore Kellogg Cancer Center
- Level II Trauma Center
- NorthShore Neurological Institute
- NorthShore Orthopaedic Institute
- Primary Stroke Center
- John and Carol Walter Center for Urological Health

Overview of Our Hospitals Included in this CHNA

NorthShore Highland Park Hospital - Founded in 1918, Highland Park Hospital has provided high-quality healthcare and a wide range of clinical programs for the people of Lake County and beyond for over a century. The hospital is the site of the first open-heart surgery in Lake County, and continues to provide a full range of cardiac diagnosis and intervention services. Highland Park Hospital's Kellogg Cancer Center offers the most comprehensive subspecialty care for oncology patients.

Key Specialties

- Adolescent Behavioral Health
- Bariatric Center of Excellence
- NorthShore Cardiovascular Institute
- Center for Breast Health
- Center for Pelvic Health
- Gastroenterology
- NorthShore Kellogg Cancer Center
- Level II Trauma Center
- Primary Stroke Center
- Women's Hospital

NorthShore Skokie Hospital - Skokie Hospital is not only home to Illinois' only specialty hospital dedicated to orthopaedic and spine care, but it also offers emergency and outpatient services to meet the needs of the local community. The Orthopaedic & Spine Institute provides advanced care and is designed for both outpatient and inpatient procedures, including joint replacement, fracture care and complex spine surgeries. Skokie Hospital completed a seven-year, multimillion-dollar renovation and expansion ensuring the hospital continues to provide patients with exceptional medical care for years to come.

Key Specialties

- NorthShore Orthopaedic & Spine Institute
- Comprehensive Emergency Department
- Clinical Cardiology Services
- Comprehensive Outpatient Services that include GI Lab and Outpatient Laboratory
- Mammography
- Outpatient Pharmacy
- Radiology (CAT Scan, MRI, Ultrasound, X-Ray)
- Primary Care and Specialty Care Physician Offices

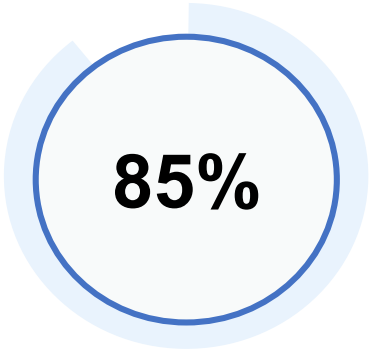
Who We Serve

NorthShore's patients collectively come from a large geographic area. For purposes of this report, the community served by NorthShore includes 54 zip codes in Lake County, northern Cook County and the north side of Chicago. The map to the right shows the level to which each zip code utilizes NorthShore's services and is based on inpatient, outpatient and emergency room visits. Cities, villages and communities included in the CHNA community are also reflected.

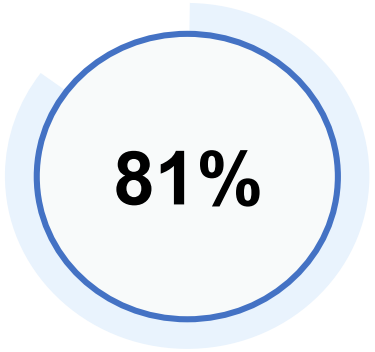
Between October 1, 2020 and September 30, 2021, 85% of NorthShore's inpatient discharges and 81% of its outpatient visits came from patients residing in these 54 zip codes.

CHNA Community:

Includes 54 zip codes within Lake County, northern Cook County and the north side of Chicago

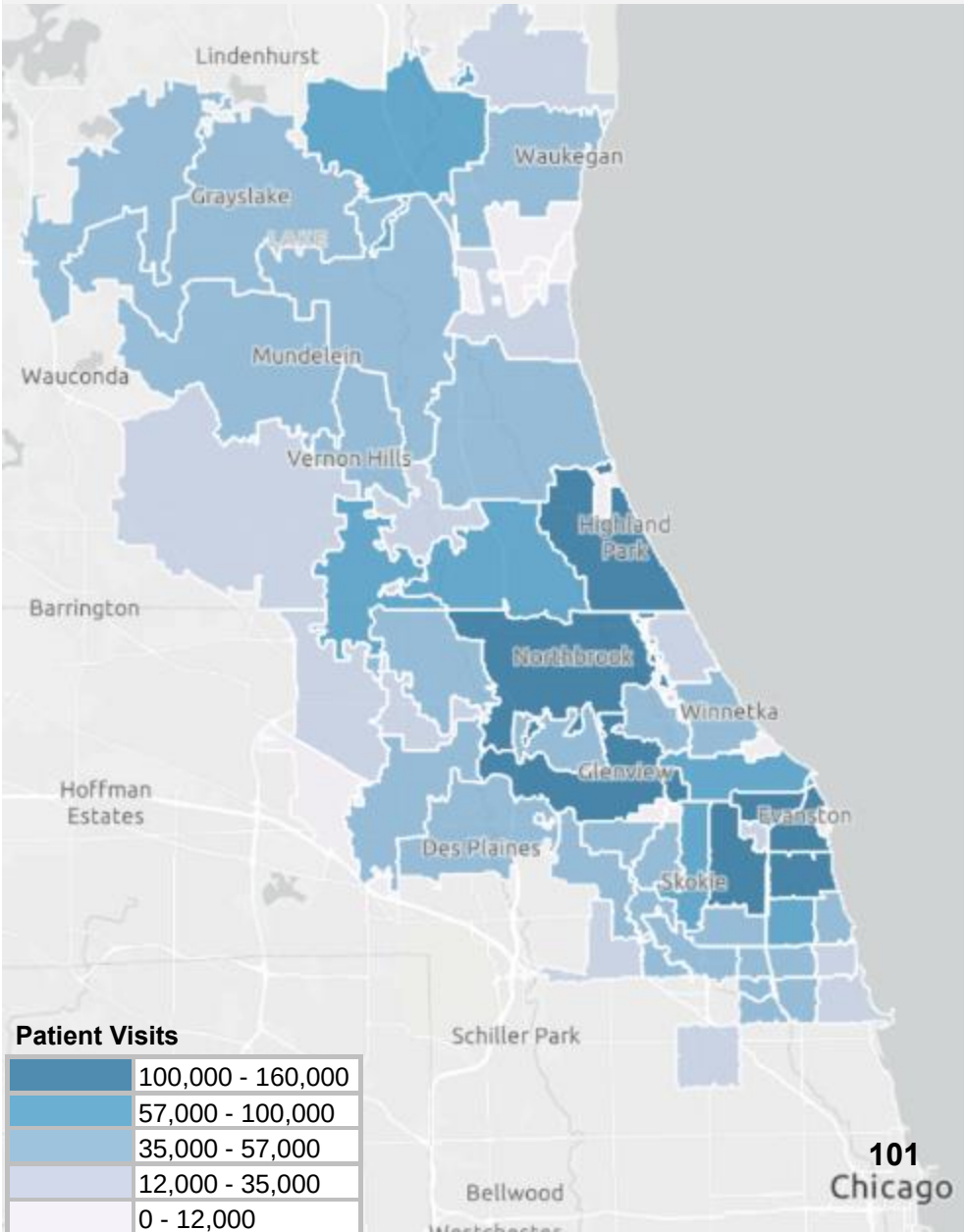


Inpatient Discharges from CHNA Community



Outpatient Visits from CHNA Community

Total Patient Visits – October 1, 2020 to September 30, 2021



Community Overview

Demographic Data

To understand the profile of NorthShore's CHNA community the demographic and health indicator data was analyzed for the population within the defined service area. Data was analyzed for the CHNA community as a whole as well as Lake County, Cook County North Suburbs and Cook-County – Chicago North Side communities.

To provide additional insight into underserved populations, data was further reviewed for zip codes with high economic needs according to Dignity Health's Community Need Index (CNI). Based on demographic and economic statistics, the CNI provides a score for every populated zip code in the United States on a scale of 1.0 to 5.0. A score of 1.0 indicates a zip code with the least need, while a score of 5.0 represents a zip code with the most need. The CNI is strongly linked to variations in community healthcare needs and is a good indicator of a community's demand for a range of healthcare services. Zip codes with a CNI score above 3.4 have higher socioeconomic needs related to factors such as income, education, language, insurance and housing.

The CHNA community has a total population of 1,607,577 according to the U.S. Census Bureau American Community Survey 2015-2019 5-year estimates. The percentage of population by combined race and ethnicity is made up of 58.0% Non-Hispanic White, 19.8% Hispanic or Latino, 12.4% Non-Hispanic Asian, 6.8% Non-Hispanic Black, 2.5% Non-Hispanic Multiple Races and .5% Non-Hispanic some other race. The demographic makeup of the CHNA community is as follows:

$145,116

Average Family Income

50%

People 25+ with a Bachelor's Degree or Higher

10.2%

of people are living in poverty (160,285 persons)

8.08%

Population without Health Insurance Coverage (127,593 persons)

66%

Population 16+ in Civilian Labor Force

8%

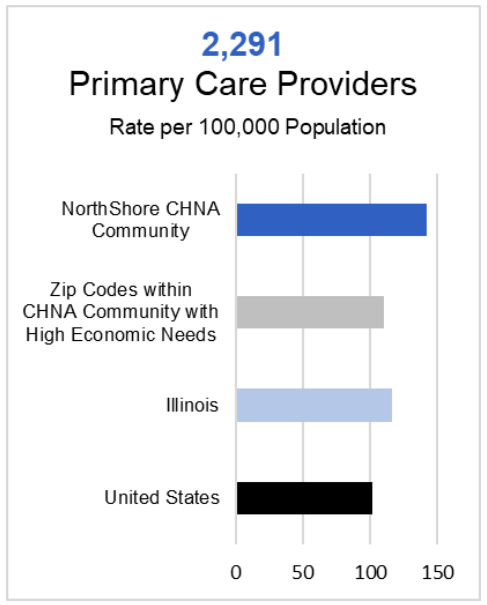
122,423 persons living in Limited English speaking households

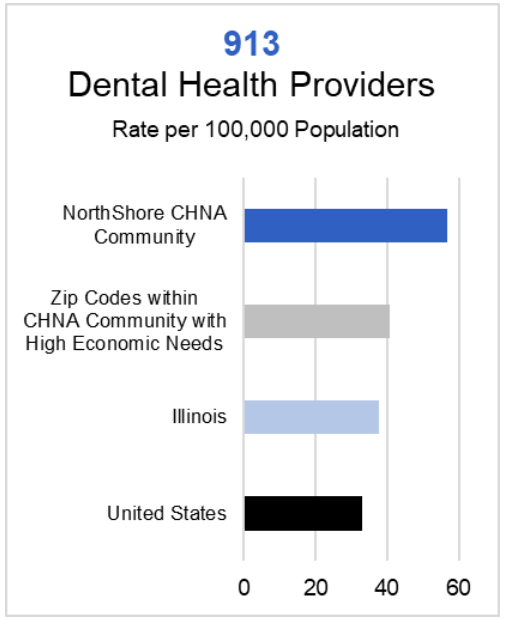
Access to Services

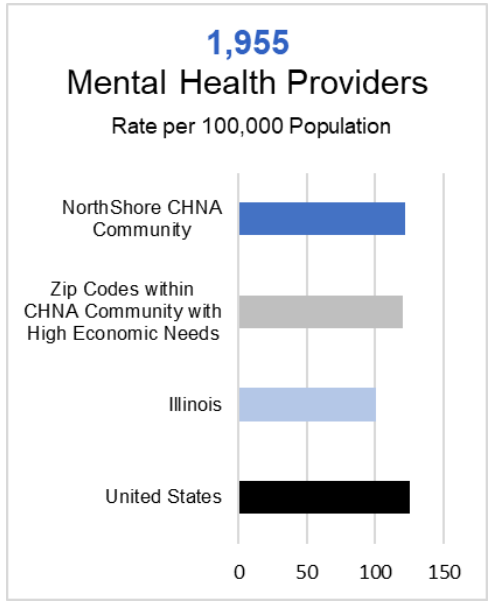
Data Tables

A lack of access to care presents barriers to good health. The supply and accessibility of facilities and physicians affect access. As shown below, the rate of health care providers within NorthShore's CHNA community is higher than state and national benchmarks. However, the rates of health care providers in zip codes with high economic needs is significantly lower than the rate for the CHNA community as a whole for primary care and dental health providers.

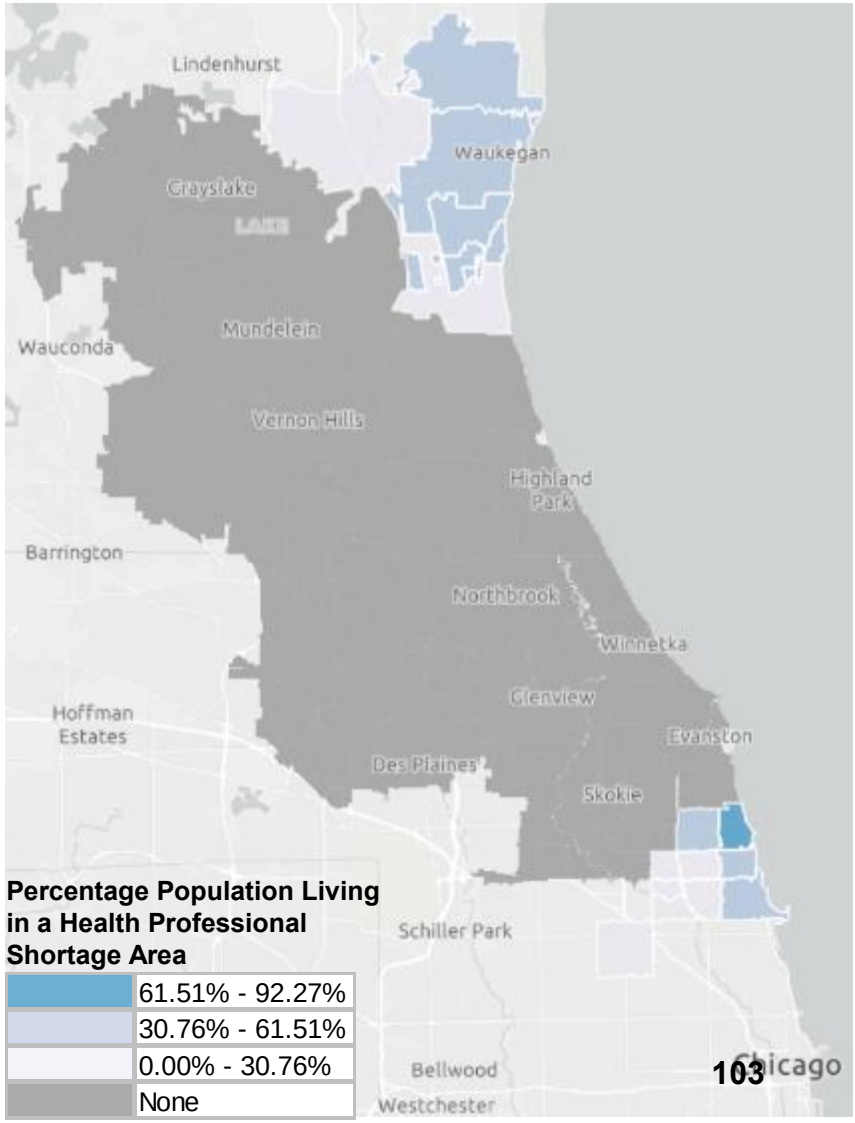
The map to the right reports the percentage of population that is living in a geographic area designated as a "Health Professional Shortage Area" (HPSA). Within the CHNA community, there are 224,611 people living in a HPSA. This represents approximately 13% of the total population.







Population Living in a Health Professional Shortage Area

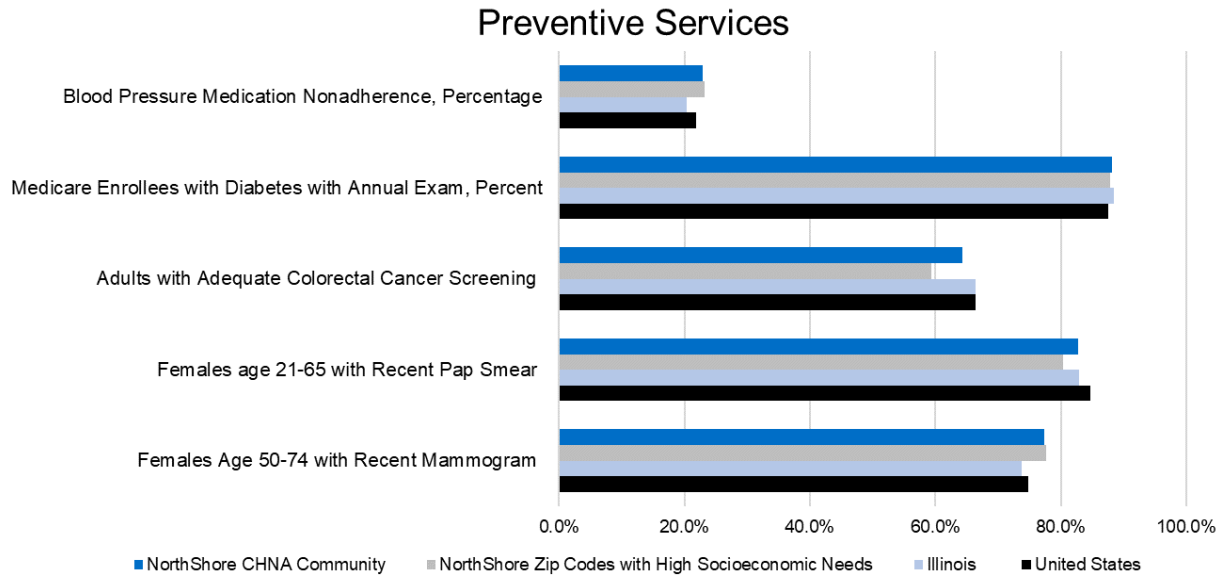


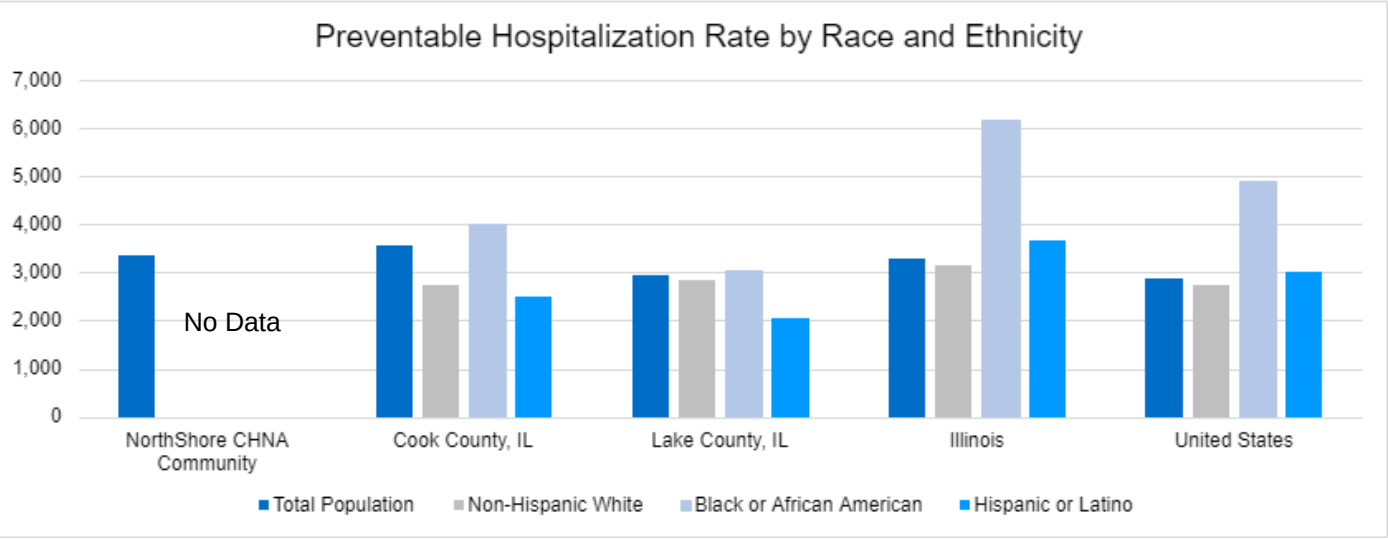
Clinical Preventative Services

Rates of morbidity, mortality, and emergency hospitalizations can be reduced if community residents access services such as health screenings, routine tests, and vaccinations. Prevention indicators can call attention to a lack of access or knowledge regarding one or more health issues and can inform program interventions.

Only **27.4%** of women 65+ in the community are up-to-date with core preventative services compared to the national benchmark of 28.4%.

35.0% of men 65+ in the community are up-to-date with core preventative services compared to the national benchmark of 32.4%.





Preventable hospitalizations include hospital admissions for one or more of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection.

- The rate for preventable hospitalizations in the CHNA Community is slightly unfavorable to state and national rates. However, the rate has significantly improved since 2018 .
- Preventable hospitalizations are significantly higher for Black and African American residents compared to Non-Hispanic White and Hispanic or Latino residents.

Data Tables

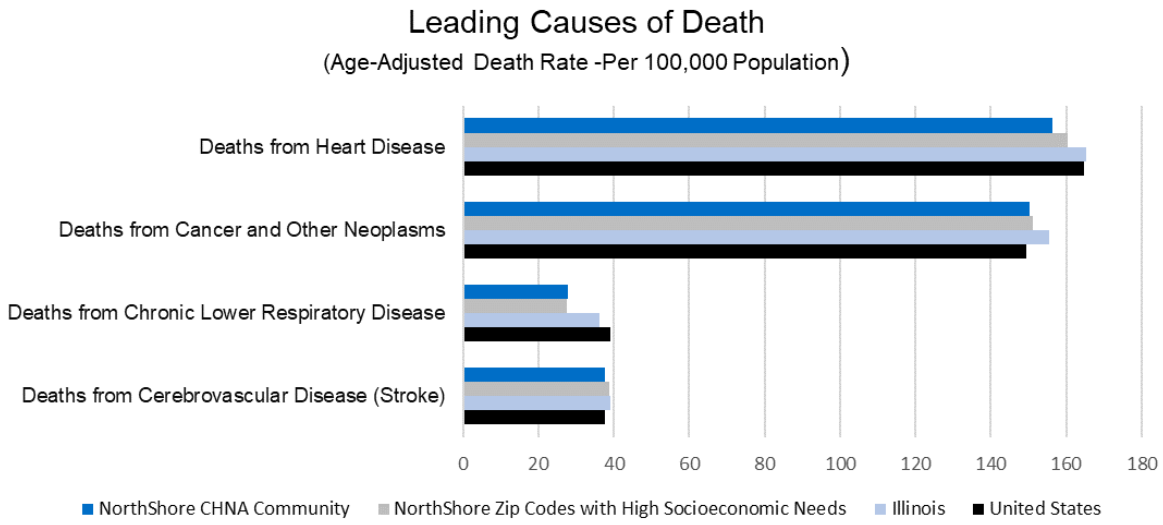
Health Outcomes & Mortality

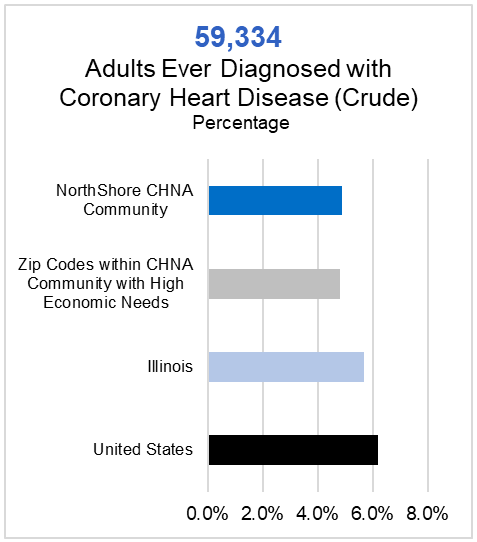
NorthShore's community has a significant number of adults who have been diagnosed with chronic illnesses. The prevalence of chronic diseases in the NorthShore community is favorable to state and national percentages, with slightly higher rates for diabetes in zip codes with high economic needs. Approximately 28% of the population, 339,053 adults, have high blood pressure.

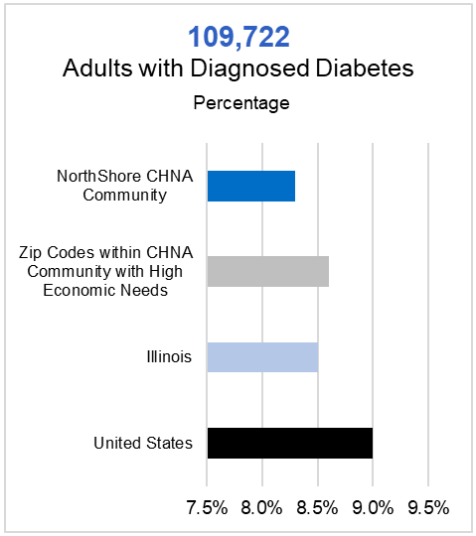
More than 45,000 Medicare beneficiaries have six or more chronic conditions in the community and almost 120,000 Medicare beneficiaries have two or more chronic conditions.

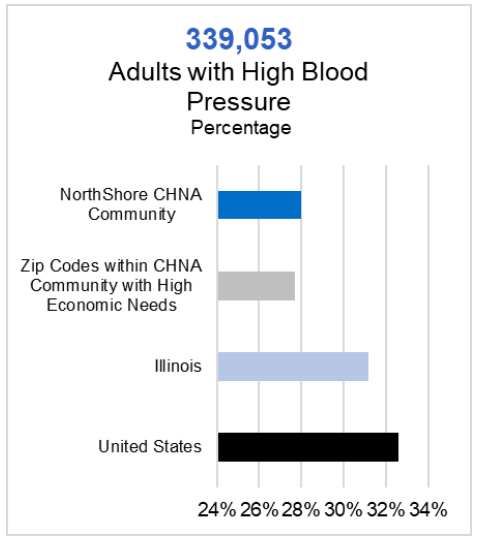
Coronary heart disease, cancer, lung disease and stroke are leading causes of death in the United States. Adjusted death rates for the community are slightly favorable to state and national rates.

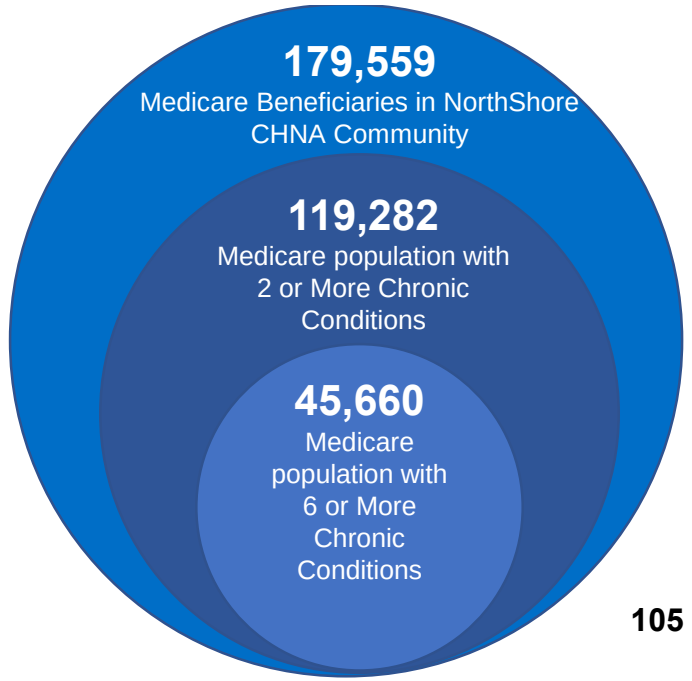
Data Tables











Injury and Violence

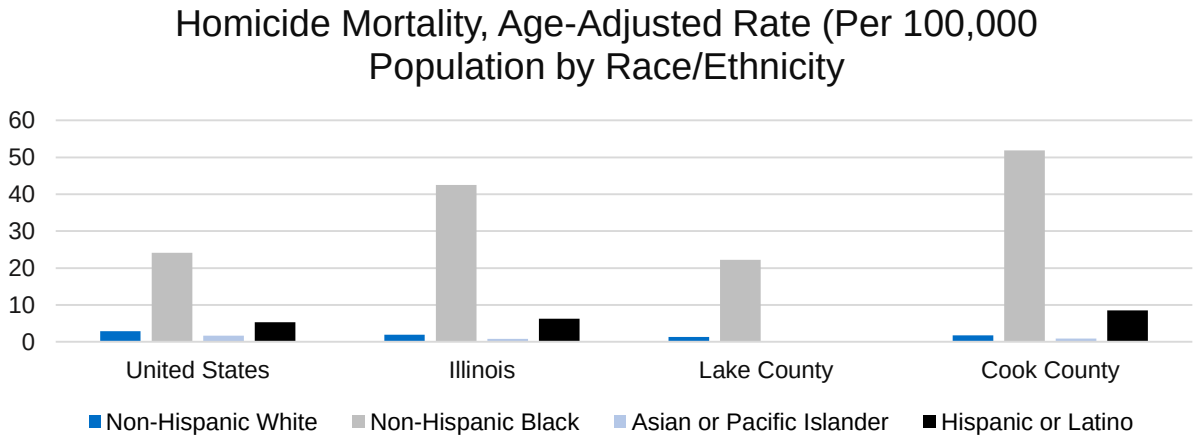
Data Tables

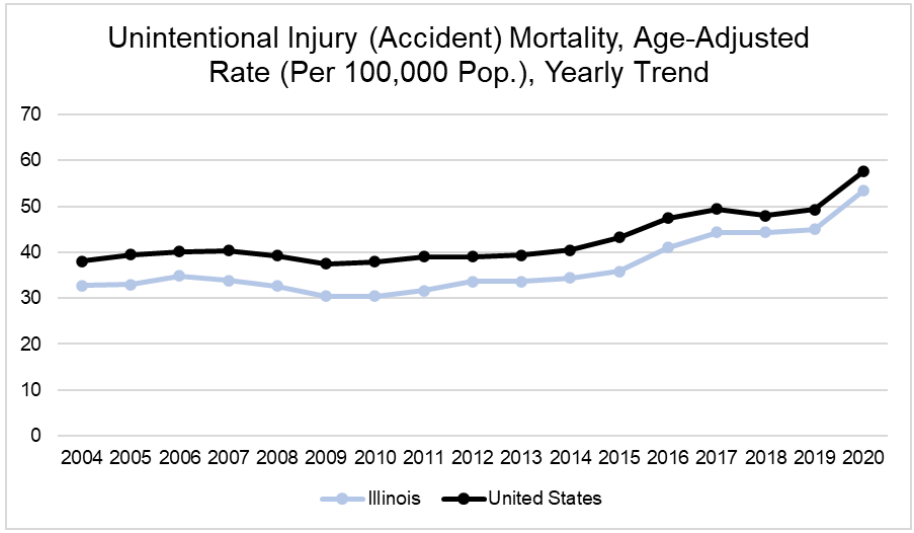
Crime rates are very different for the two counties primarily served by NorthShore with Lake County having favorable rates compared to state and national rates and Cook County having rates higher than state and national rates. The violent crime rate for Cook County is three times the rate of Lake County and significantly higher than state and national rates.

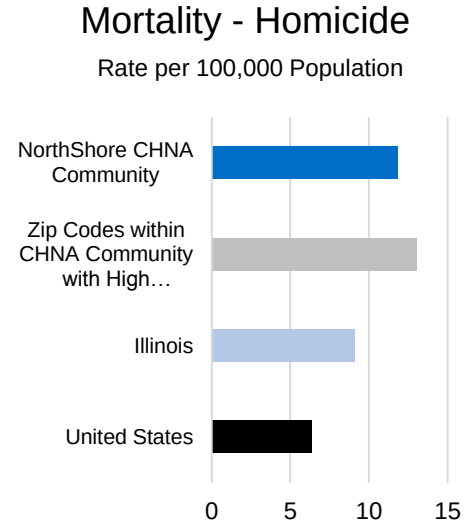
The age-adjusted death rate per 100,000 population for homicide is 11.8 for NorthShore's CHNA community compared to 6.4 for the United States.

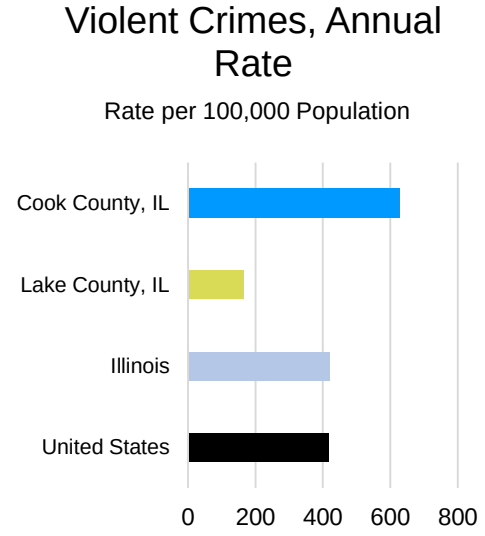
- Nearly 90% of the homicides in the community are male homicides.
- Homicides among Non-Hispanic Black population in Cook County are more than double the national benchmark of 24.1 for Non-Hispanic Black population.

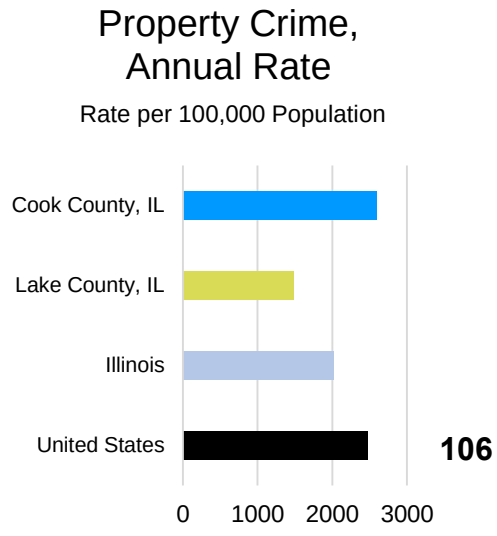
The age-adjusted death rate per 100,000 population for unintentional injury based on the 2016-2020 average is 41.2 compared to the national benchmark of 50.4. Since 2014, the death rate related to unintentional injury has increased significantly for Illinois as well as the United States.









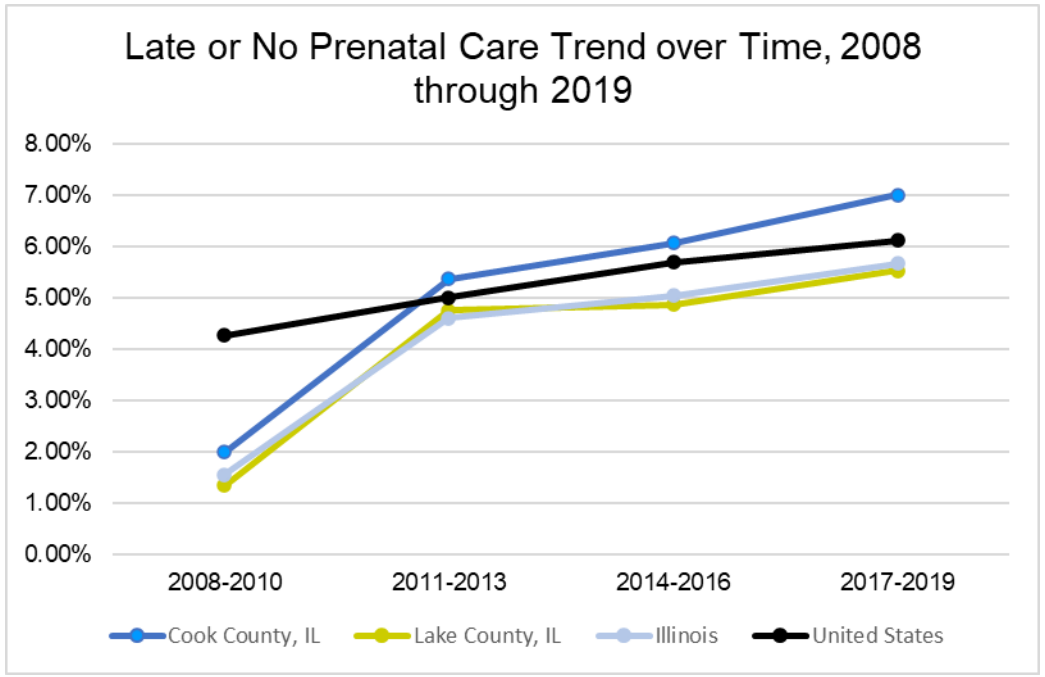


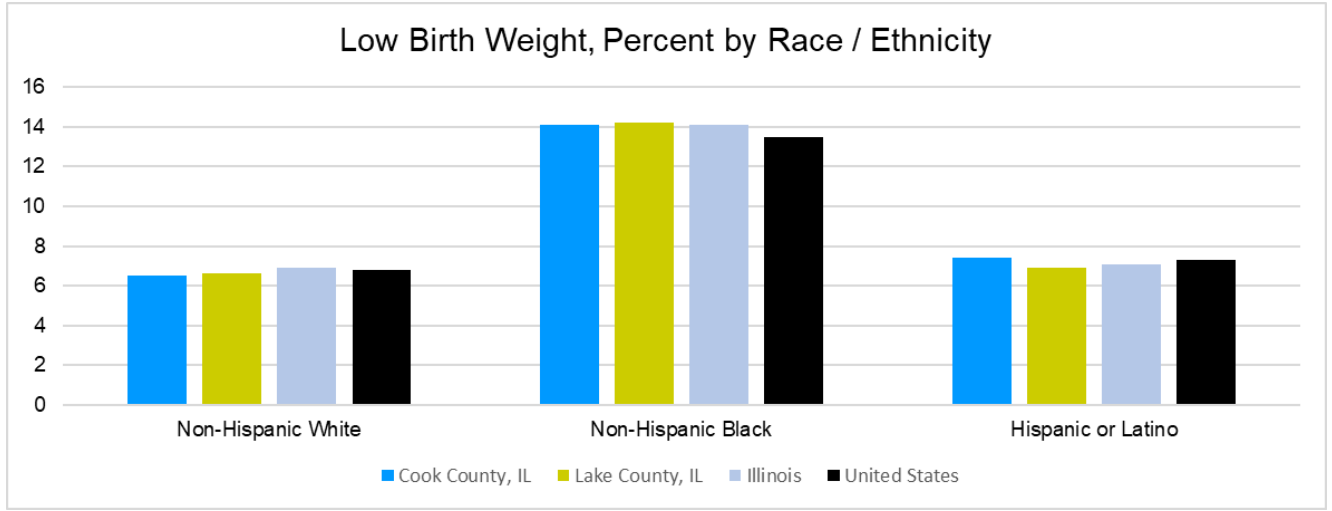
Maternal, Infant and Child Health

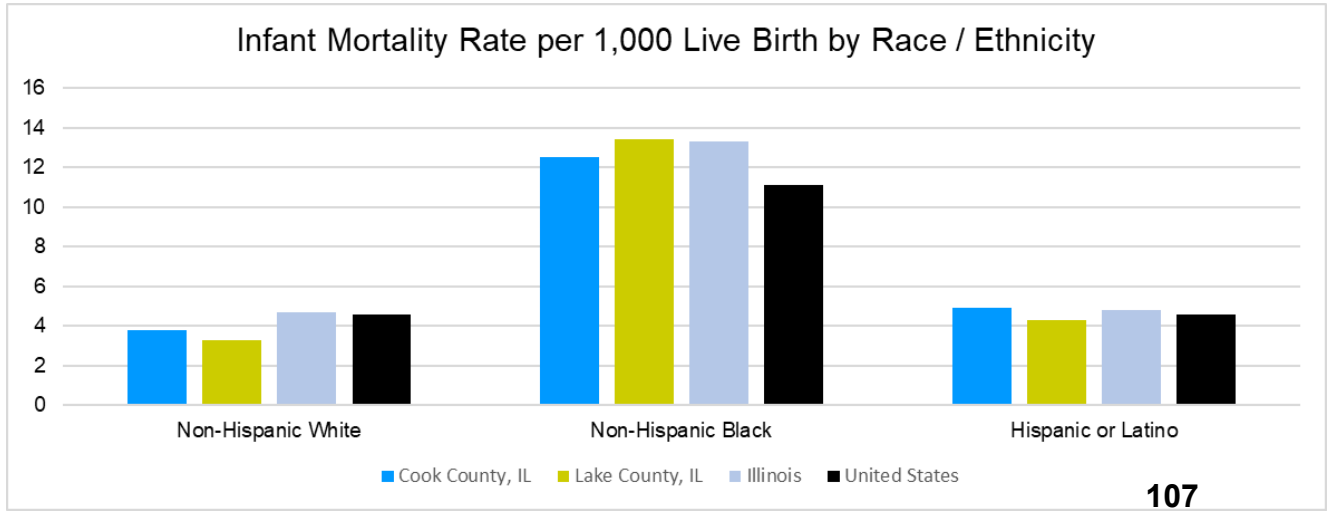
The percentage of births with late or no prenatal care in the community has more than tripled over the last 10 years. Approximately 13,000 births in Cook County and 1,200 births in Lake County had late or no prenatal care between 2017 and 2019. The percentage of births with late or no prenatal care for the CHNA community was 7.01% between 2017 and 2019 which is higher than the national average of 6.12%.

Indicators for Low Birth Weight and Infant Mortality indicate significantly higher rates for Non-Hispanic Black population.

Data Tables







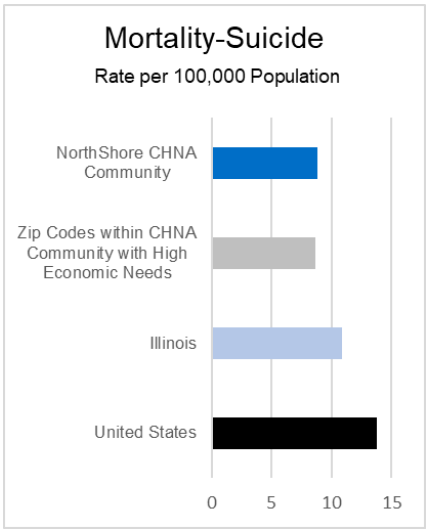
Mental Health

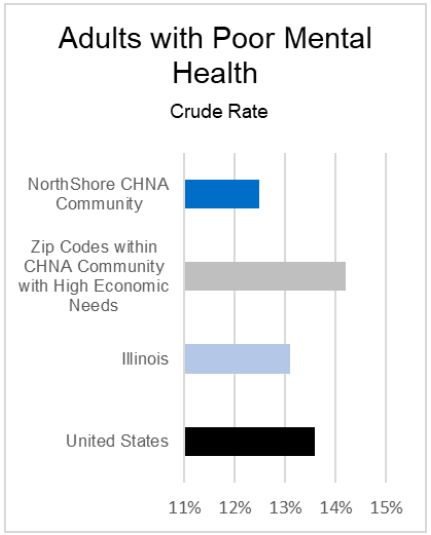
The map to the left reports the percentage of adults (ages 18 years and older) reporting 14 days or more of poor mental health per month. Zip codes with the highest percentages reported include 60088, 60064, 60085 and 60099.

The Illinois Behavioral Health Barometer, measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services, is one of a series of national, regional, and state reports that provide a snapshot of behavioral health in the United States.

A summary of select mental health indicators from the Illinois Behavioral Health Barometer is presented below. Significant increases have occurred from previous surveys for depression, suicide and mental illness among youth.

Data Tables



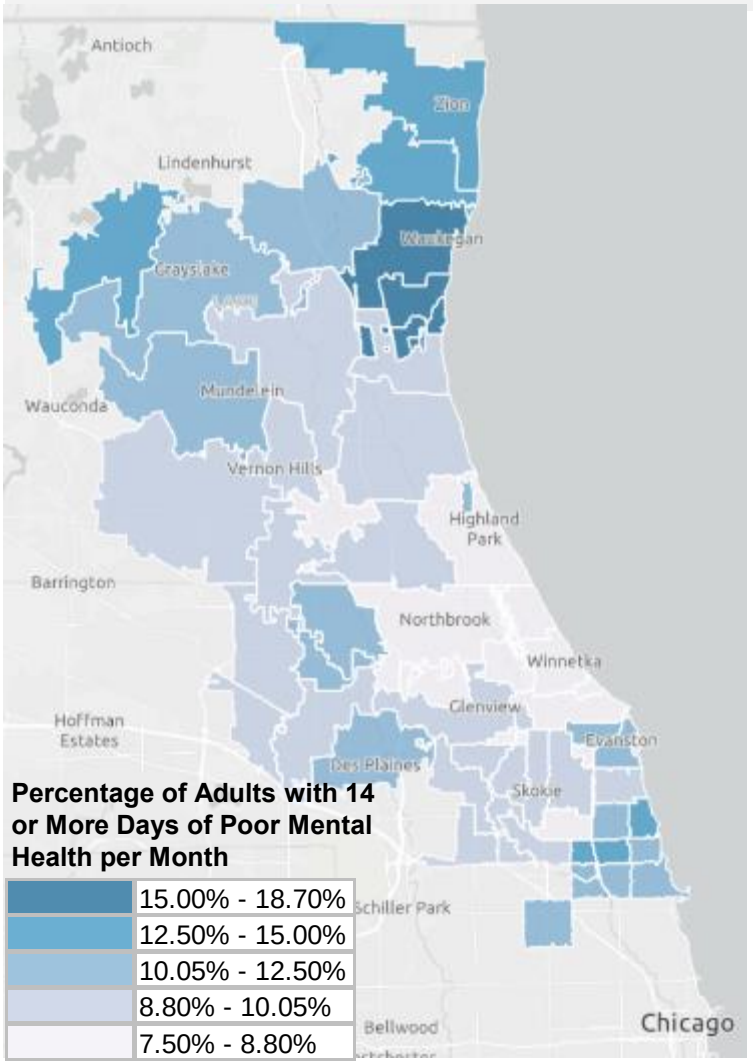


Illinois Behavioral Health Barometer – Youth Mental Health

Prior Survey	2019	
7.5%	15.1%	Among youth aged 12–17 in Illinois, the annual average percentage with a major depressive episode in the past year increased between 2004–2007 and 2016–2019. During 2016–2019, the annual average prevalence of past-year major depressive episode in Illinois was 15.1% (or 145,000), similar to both the regional average (15.2%) and the national average (14.0%).
6.7%	11.1%	Among young adults aged 18–25 in Illinois, the annual average percentage with serious thoughts of suicide in the past year increased between 2008–2010 and 2017–2019. During 2017–2019, the annual average prevalence of past-year serious thoughts of suicide in Illinois was 11.1% (or 145,000), similar to both the regional average (12.2%) and the national average (11.1%).
3.5%	8.7%	Among young adults aged 18–25 in Illinois, the annual average percentage with serious mental illness in the past year increased between 2008–2010 and 2017–2019. During 2017–2019, the annual average prevalence of past-year SMI in Illinois was 8.7% (or 115,000), similar to both the regional average (8.7%) and the national average (7.9%).

Source: Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Illinois, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA–20–Baro–19–IL. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

Frequent Mental Distress



Data Source: Centers for Disease Control (CDC), CDC PLACES: Local Data for Better Health (2020)

Nutrition, Physical Activity and Obesity

Healthy diets and physical activity contribute to healthy lifestyles and overall well-being. These factors are relevant because current behaviors are determinants of future health and well-being and these indicators may be linked to significant health issues, such as obesity and poor cardiovascular health.

- Approximately 444,000 persons live in food deserts in the CHNA community.
- Over 13% of the population (214,207 persons) have low food access.
- Over 330,000 persons, or 28% of adults, are obese in the CHNA community. Obesity rates have increased by 7% over the last 15 years.
- 20.4% of adults, age 20 and older, self-report no active leisure time physical activity.

The map to the right reports the percentage of the low-income population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket or large grocery store. The low-income population with low food access in the community is 34,381 with the following zip codes reporting the highest percentages: 60088, 60044, 60031 and 60030.

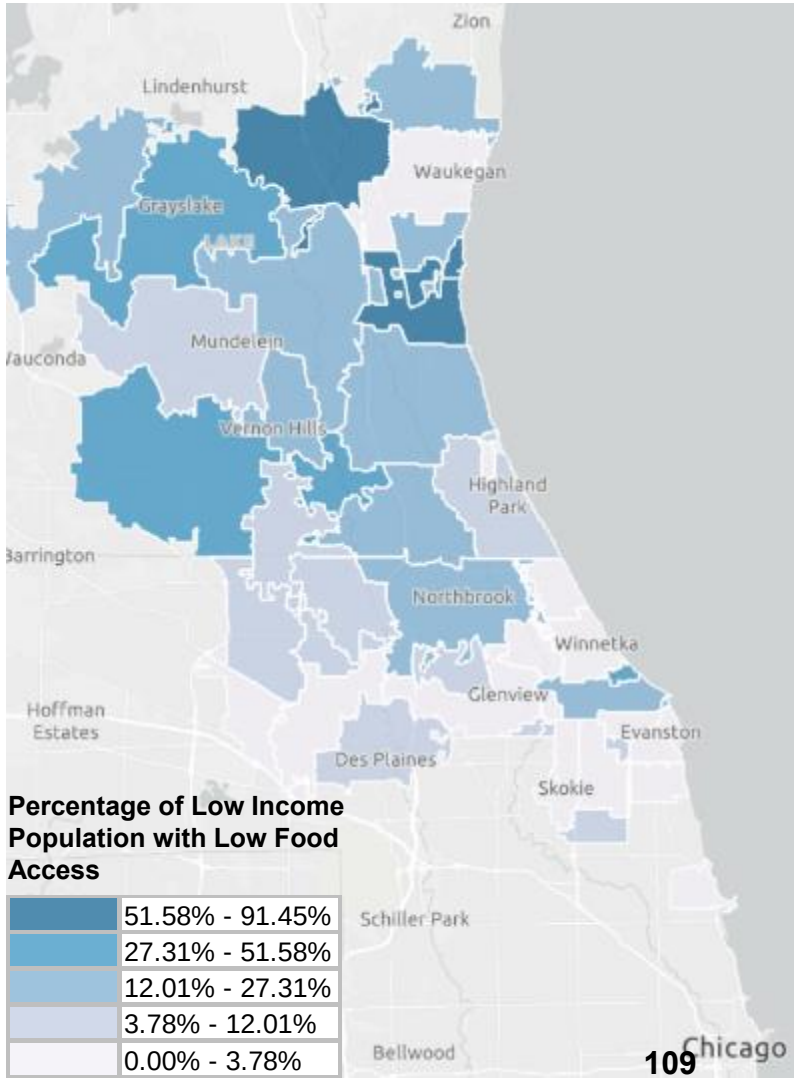
Data Tables

214,207
Food Insecure Population

336,823
Adults with BMI>30 (Obese)

127,854
Students Eligible for Free or Reduced- Price Lunch

Population with Limited Food Access, Low Income Percent by Tract



Physical Environment

The structure of housing and families and the condition and quality of housing units and residential neighborhoods are important because housing issues like overcrowding and affordability have been linked to multiple health outcomes, including infectious disease, injuries, and mental disorders.

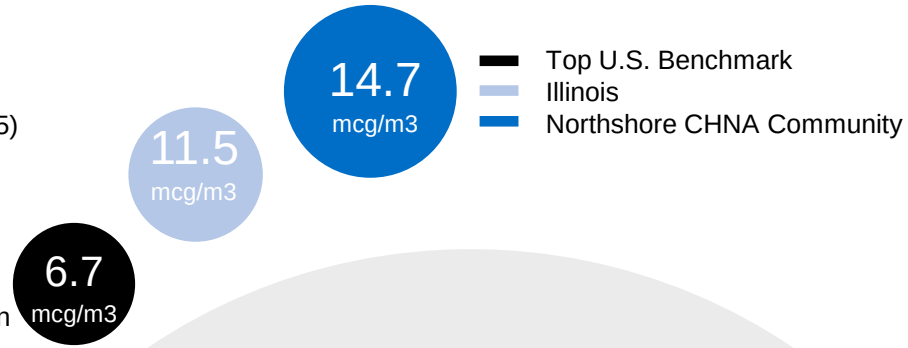
Within the community, 203,874 households, or 34% of households, have housing costs that are 30% or more of the total household income and are classified as “cost-burdened households”.

A large number of seniors in the community, age 65+ live alone. This is important because older adults who live alone may have challenges accessing basic needs, including health needs.

Data Tables

Air Pollution-Fine Particulate Matter-Annual

Air pollution is the percentage of days per year with fine particulate matter 2.5 (PM2.5) levels above the National Ambient air Quality Standard of 35 micrograms pers cubic meter. According to the American Lung Association’s 2022 State of the Air, Chicago, Illinois is ranked 22 for annual particulate pollution out of 202 metropolitan areas.

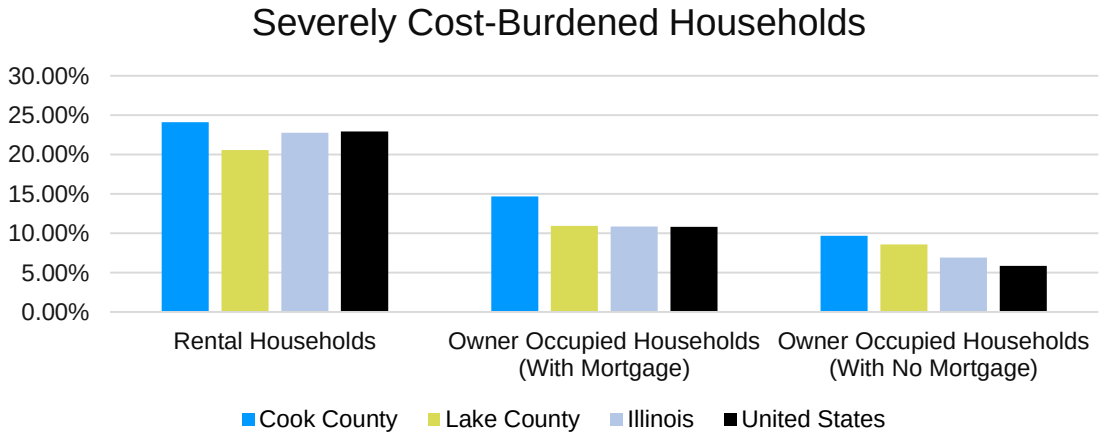


34% of households in the community, 203,874 households, are cost burdened households meaning housing costs exceed 30% of household income. **93,982** households have housing costs that **exceed 50%** of household income.

It is estimated that **13.8%** of households within the community have no or slow internet.

35% housing units have one or more substandard conditions.

69,580 Seniors (age 65+) live alone.



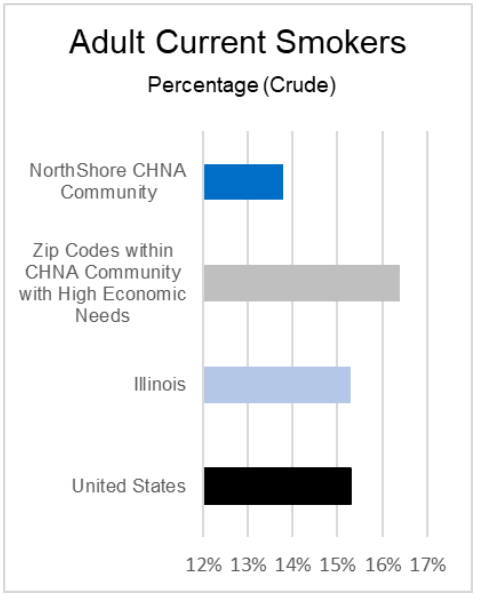
Substance Abuse

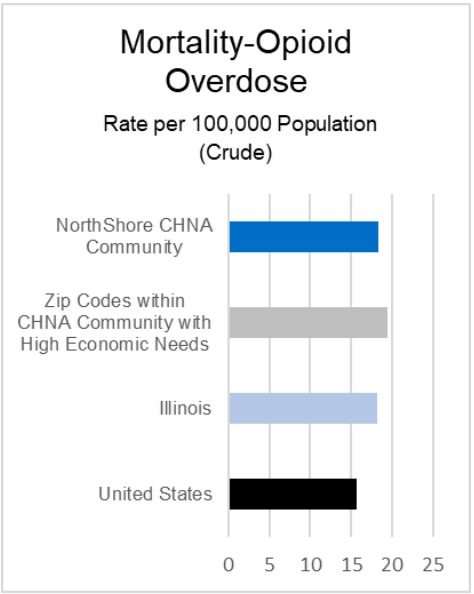
The percentage of adults in the CHNA community who currently smoke is 13.8% and is favorable to state and national benchmarks. The percentage of adults who smoke in zip codes within the CHNA community with high economic needs is slightly higher than the national benchmark.

The 2020 Illinois Youth Survey reports the prevalence of substance use in students from 8th through 12th grade for each county in Illinois. The table below reports the percentage of students who reported alcohol and prescription drugs during the past year and e-cigarettes in the past 30 days. Percentages for 2019 are also shown.

The prevalence of substance use increases significantly from 8th grade to 12, particularly for alcohol and e-cigarettes.

Data Tables





ILLINOIS YOUTH SURVEY

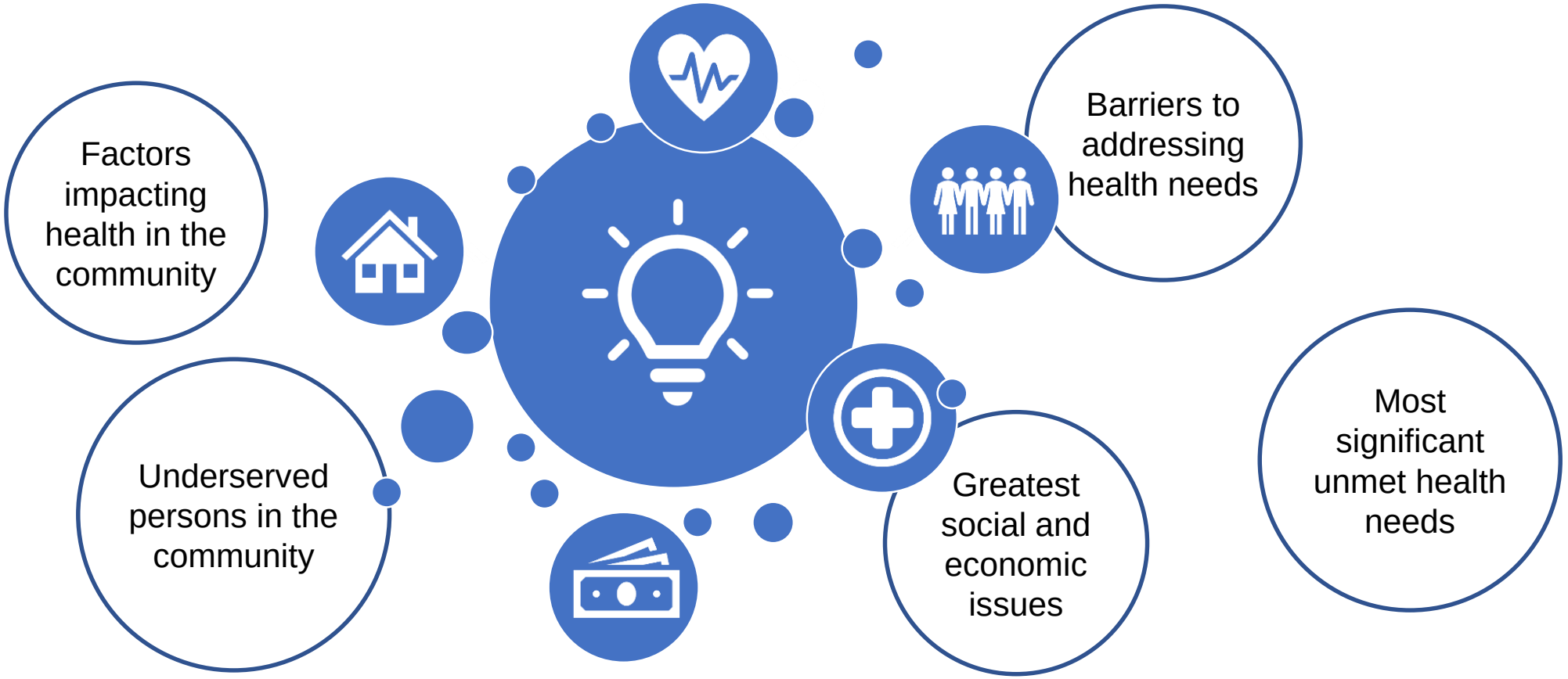
	2019			2020		
	8th Grade	10th Grade	12th Grade	8th Grade	10th Grade	12th Grade
Cook County-Non-Chicago						
Used alcohol during the past year	24%	45%	57%	27%	44%	56%
Used prescription drugs to get high during the past year	1%	3%	6%	1%	2%	3%
Used E-cigarettes in the past 30 days	8%	21%	30%	5%	13%	22%
Lake County						
Used alcohol during the past year	22%	38%	58%	25%	36%	55%
Used prescription drugs to get high during the past year	2%	3%	7%	1%	2%	3%
Used E-cigarettes in the past 30 days	7%	20%	31%	5%	10%	18%

Source: https://iys.cprd.illinois.edu/results/county

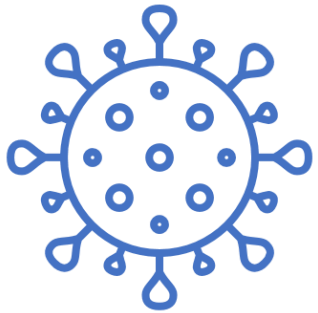
Focus Groups

Written Summary of Focus Groups

NorthShore obtained input from 63 leaders representing public health, major employers, public schools, social services, representatives from the underserved community, NorthShore leaders and the community at-large through five focus groups. Focus groups were conducted throughout January 2022. Focus groups explored multiple areas to identify significant health needs of the community as well as potential ways to address identified needs including the areas below.



Focus Groups



Impact of COVID-19 on Community Health: The COVID-19 pandemic has had significant negative and widespread impact on health within the community. Input from key stakeholders has been provided on how the pandemic influenced related health factors.

Mental Health

The pandemic has stressed and worried nearly everyone and has negatively impacted the economy and housing and caused significant grief and loss. The pandemic is exacerbating mental health issues and making them more obvious and mental health issues and drug abuse are escalating.

Social Isolation

Social isolation resulting from the extended duration of the pandemic (affecting all age groups) was discussed by focus group participants. A sense of belonging has been compromised due to isolation.
There has been an increase in violence among teens due to isolation and lack of supervision.

Financial Impact

The financial impact of the pandemic continues to loom, as people lose their homes and suffer other financial stresses. and the community is seeing the impact of the COVID-19 pandemic on adolescents and young adults.

Physical Health

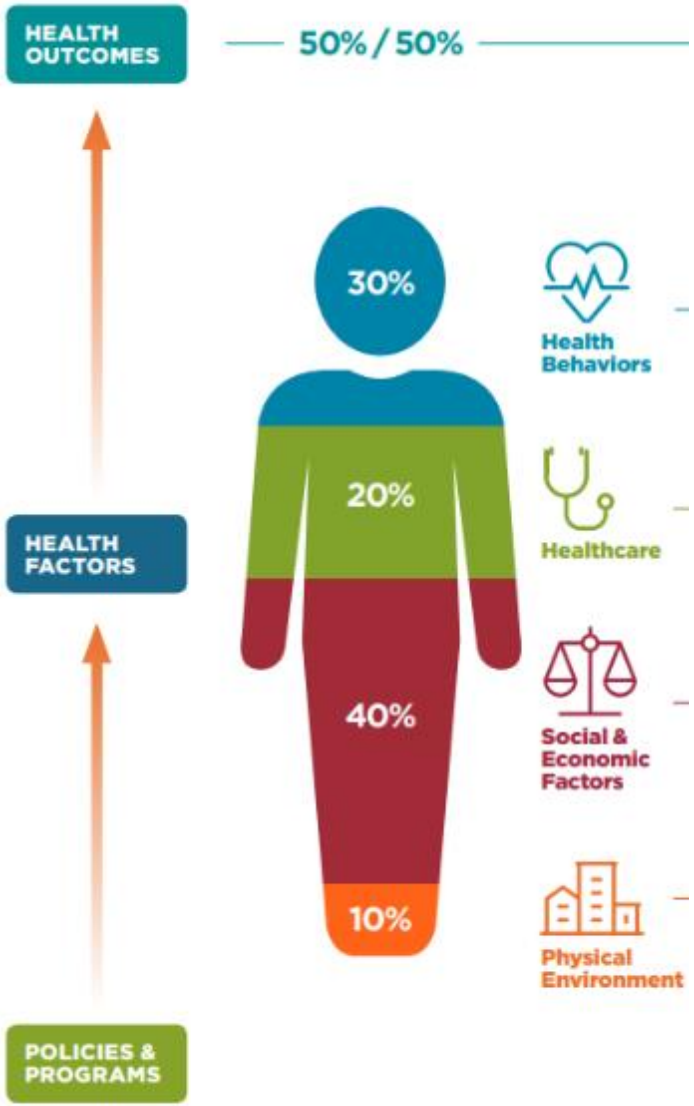
Physical health has declined during the pandemic—due to, among other things, a lack of screening services and delayed health screenings (sometimes even if there are symptoms present). The result of these actions may be late-stage diagnosis and ongoing health issues over a period of years.

Impact on Youth

The fact that youth were out of school for an extended time due to the pandemic has led to numerous issues including an increase in mental health issues and suicide among youth. Teachers have not been able to observe children in the classroom and identify potential healthcare issues due to schools transitioning to in-home learning.

Focus Groups

Written Summary of Focus Groups



Factors Impacting Health in the NorthShore Community

- Certain Members of Community are Not Participating in Healthcare
- Choosing Between Basic Needs and Health Needs
- Delay of Preventative Care
- Distrust of Healthcare System
- Isolation (Youth and Elderly Population)
- Lack of Health Literacy

- Complexity of Healthcare System
- Health Inequity
- Hospital Reimbursement Structure
- Increased Need for Inclusive and Culturally Competent Care
- Lack of Mental Health Providers
- Lack of Statistically Diverse Workforce
- Telehealth

- Economic Disadvantages
- Lack of Access to Resources for Low-Income/Minority Populations
- Poverty
- Structural Racism

- Limited Food Access
- Safe and Affordable Housing

Focus Groups - Most Significant Unmet Healthcare Needs

Written Summary of Focus Groups

Mental Health

- Increased demand for mental health services
- Lack of mental health professionals
- Cost of mental health care

Access to Healthcare; Navigating the Healthcare System

- Insufficient number of medical providers
- Lack of effective communication of health information and available resources
- Patient advocates are needed to:
  - assist with understanding how insurance works and calculating costs
  - educate and direct patients to available social services

Primary and Preventative Care

- Access for uninsured and underinsured
- Medication assistance
- Comprehensive wellness visits

Discrimination/Health Inequity/Mistrust

- Resurgence of discrimination
- Diverse and culturally competent workforce
- Lack of trust in the healthcare system

Housing/Employment/Food Insecurity

- Lack of affordable housing
- Lack of stability with basic needs

Identification of Most Underserved Populations

- People who are low-income, uninsured / underinsured, or homeless
- People with serious mental illness / behavioral health issues
- Members of Black and Brown populations, minority populations and indigenous communities
- Immigrants, undocumented workers and individuals who are not U.S. residents
- LGBTQ+ (including youth)
- Elderly populations
- People with disabilities

Community Survey

In order to develop a broad understanding of community health needs, NorthShore conducted an online community survey from January to February of 2022. The survey was available in English and Spanish. Links to the survey were distributed via e-mail, social media and word of mouth to the community at-large. Signage, including information regarding the community survey and survey links, was posted at community clinics and federally qualified health centers in the CHNA Community. A total of 947 surveys were completed.

Link to Community Survey Summary

Health issues that impact the community most	Cost of Health Care	Mental Health	Obesity/ Overweight	Assistance with Navigating the Healthcare System	High Blood Pressure/Stroke
Weaknesses in the community	Economic Disparities	Racism	Lack of Availability of Mental Health Services	Violence and Safety	Language Barriers to Care
What would improve the quality of life within the community?	More Affordable Housing	Behavioral Health Services	Connections to Resources and Community Agencies	Community Safety	Health Care Access

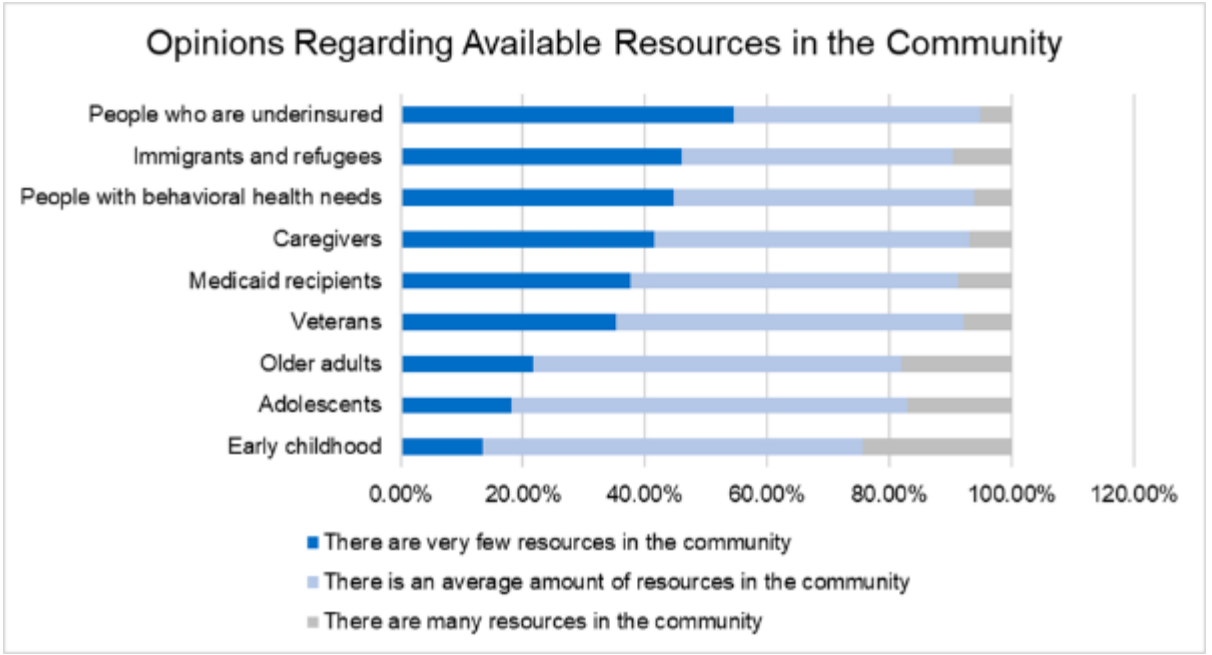
Access to Care Health Outcomes Mental Health Social Determinants of Health

Community Survey

Key Findings

- Almost **65%** of the survey respondents indicated they are always able to visit a doctor when needed.
- Approximately **62%** of the respondents agreed or strongly agreed with eating five fruits and vegetables each day. Significantly less, **35**%, exercise at least 30 minutes a day, five days a week.
- Over **40%** of the respondents indicated there were few resources in the community to assist with health needs of the specific populations below:
  - People who are underinsured
  - Immigrants and refugees
  - People with behavioral health needs
  - Caregivers
- **17%** of the survey respondents indicated transportation to and from doctor appointments is challenging.
- **10%** of the survey respondents disagreed that the housing they lived in was affordable and safe.
- Respondents indicated the biggest source of stress in their daily life was financial stability and relationships.
- The biggest challenges related to the COVID-19 pandemic are mental health and social isolation and juggling work and family.

Available Resources in the Community



Link to Community Survey Summary

Evaluation of the Impact of Actions Taken Since the Last CHNA

Link to Detailed Evaluation of Prior Implementation Strategy

The CHNA is an opportunity for hospitals to do more and be more in the communities they serve. NorthShore provides a broad array of services that provide benefit to the community. Below is a summary of some of NorthShore's significant community benefit programs and services, as well as community partnerships and services available to respond to each priority area. A comprehensive evaluation, including outcomes for each initiative, is provided for each of the four hospitals in Appendix D.

Access to Behavioral Health

- Perinatal Depression Program*
- Perinatal Family Support Center*
- Mental Health First Aid (MHFA)
- Bridges Early Childhood and Adolescent Program*
- Phoenix Program (Adult Mental Health)
- Turning Point Behavioral Health Care Center's "The Living Room" (Mental Health Crisis Support)

Health Literacy and Navigating the Healthcare Environment

- Interpretive Services*
- Partnership with Meridian Health Plan*
- Affordable Care Act/Insurance Exchange Enrollment Support*

NorthShore University HealthSystem

Access and Coordination of Care

- Charity Care (Financial Assistance)*
- Community Health Center*
- Erie Evanston/Skokie Health Center
- Dental Center for Medically Underserved*
- Evanston Township High School Health Center*
- Heartland Community Health Center
- Responding to COVID-19 Pandemic*

Substance Abuse

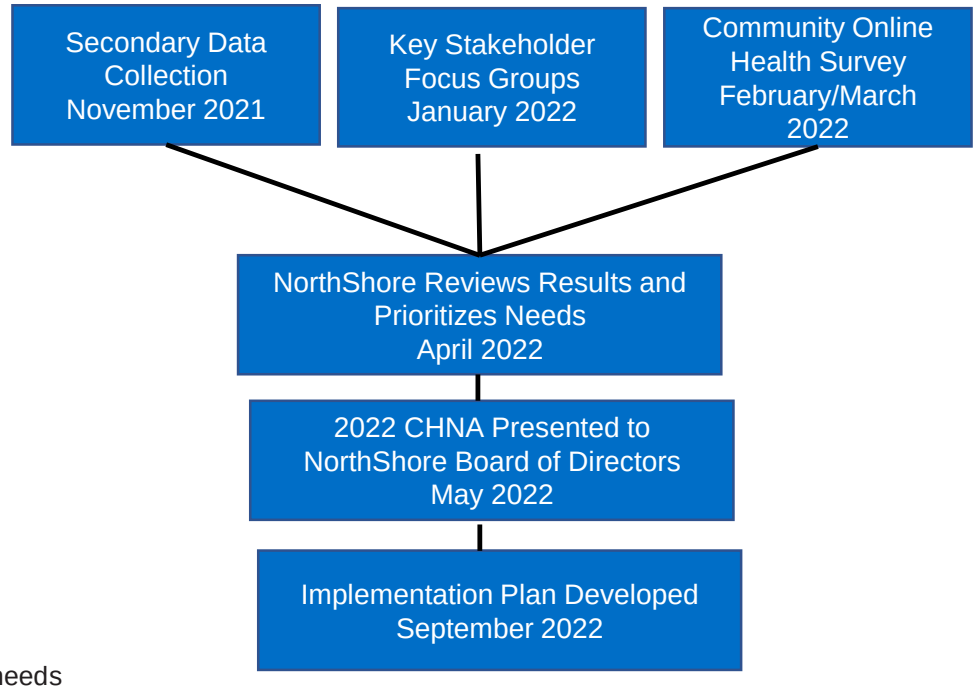
- The Doreen E. Chapman Center*
- Peer Services
- Nicasa
- Lake County Health Department Outpatient Substance Abuse Program

*Community Benefit Programs and Services provided directly by NorthShore

Prioritization of Identified Health Needs

Primary and secondary data was gathered and compiled from November 2021 to March 2022. Based on the information gathered through the CHNA process, the following summary list of needs was identified. Identified health needs are listed in alphabetical order.

- Access to Health Services (Cost, Language, Navigating Healthcare System)
- Affordability of Healthcare
- Cancer
- Chronic Health Conditions (Diabetes and High Blood Pressure)
- Health Inequity/Discrimination
- Food Insecurity
- Heart Disease
- Health Literacy
- Lack of Affordable Housing
- Maternal and Child Health
- Mental/Behavioral Health
- Obesity
- Poverty
- Preventative Care
- Violence/Safety
- Youth Mental Health/Substance Abuse

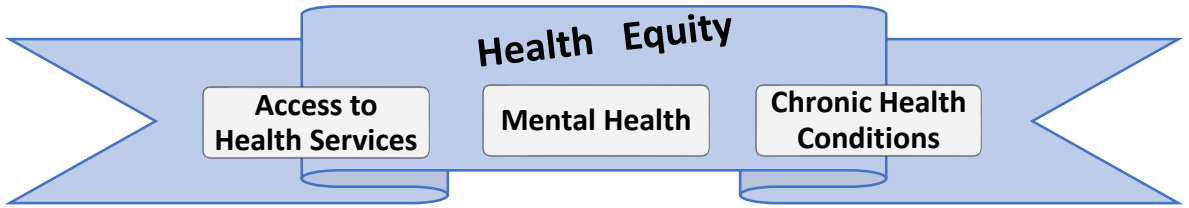


Health needs were prioritized with input from a broad base of key NorthShore stakeholders, by utilizing a scoring guide. See Appendix E for a description of the prioritization process.

Representation included:

- Key Stakeholders within Health Equity and/or Diversity, Equity & Inclusion
- Key Stakeholders from NorthShore's Black Leadership Forum
- Key Stakeholders from NorthShore's LGBTQ+ affinity group (True North)
- Key Stakeholders serving Community
- Senior Organization Leaders

Based on the information gathered through this CHNA and the prioritization process described above, NorthShore chose the needs below to address over the next three years. It is important to note that Health Equity is woven throughout these areas and will be an integral element of the three priority areas: Access to Health Services, Mental Health and Chronic Health Conditions.



Appendix A

Return to Report

Population by Age & Gender

	Age 0-17	Age 18-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65+	Total	Male	Female
NorthShore CHNA Community	**358,942**	**138,986**	**218,669**	**214,392**	**219,762**	**207,797**	**249,029**	**1,607,577**	**794,678**	**812,899**
Cook Chicago North	91,166	39,821	88,575	70,285	60,491	52,163	59,331	461,832	229,840	231,992
Cook North Suburb	143,519	44,658	73,007	81,819	88,574	91,858	123,637	647,072	313,749	333,323
Lake County	124,257	54,507	57,087	62,288	70,697	63,776	66,061	498,673	251,089	247,584
State / National Benchmark										
Illinois	2,891,526	1,192,806	1,770,290	1,644,531	1,672,220	1,656,724	1,942,534	12,770,631	6,272,172	6,498,459
United States	73,429,392	30,646,327	45,030,415	40,978,831	42,072,620	41,756,414	50,783,796	324,697,795	159,886,919	164,810,876

	Age 0-17	Age 18-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65+	Total	Male	Female
NorthShore CHNA Community	**22.3%**	**8.6%**	**13.6%**	**13.3%**	**13.7%**	**12.9%**	**15.5%**	**100.0%**	**49.4%**	**50.6%**
Cook Chicago North	19.7%	8.6%	19.2%	15.2%	13.1%	11.3%	12.8%	100.0%	49.8%	50.2%
Cook North Suburb	22.2%	6.9%	11.3%	12.6%	13.7%	14.2%	19.1%	100.0%	48.5%	51.5%
Lake County	24.9%	10.9%	11.4%	12.5%	14.2%	12.8%	13.2%	100.0%	50.4%	49.6%
State / National Benchmark										
Illinois	22.6%	9.3%	13.9%	12.9%	13.1%	13.0%	15.2%	100.0%	49.1%	50.9%
United States	22.6%	9.4%	13.9%	12.6%	13.0%	12.9%	15.6%	100.0%	49.2%	50.8%

Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Population by Ethnicity & Race

Return to Report

	Non-Hispanic/ Latino	Hispanic/ Latino	Total	White	Black	Asian	Other Race	Multiple Races	Total
NorthShore CHNA Community	**1,289,061**	**318,516**	**1,607,577**	**1,134,648**	**113,465**	**201,088**	**105,979**	**52,397**	**1,607,577**
Cook Chicago North	345,952	115,880	461,832	300,395	48,481	54,602	38,903	19,451	461,832
Cook North Suburb	572,188	74,884	647,072	468,721	28,929	106,403	25,252	17,767	647,072
Lake County	370,921	127,752	498,673	365,532	36,055	40,083	41,824	15,179	498,673
State / National Benchmark									
Illinois	10,584,244	2,186,387	12,770,631	9,134,903	1,813,590	698,524	795,168	328,446	12,770,631
United States	266,218,425	58,479,370	324,697,795	235,377,662	41,234,642	17,924,209	19,397,380	10,763,902	324,697,795

	Non-Hispanic/ Latino	Hispanic/ Latino	Total	White	Black	Asian	Other Race	Multiple Races	Total
NorthShore CHNA Community	**80.2%**	**19.8%**	**100.0%**	**70.6%**	**7.1%**	**12.5%**	**6.6%**	**3.3%**	**100.0%**
Cook Chicago North	74.9%	25.1%	100.0%	65.0%	10.5%	11.8%	8.4%	4.2%	100.0%
Cook North Suburb	88.4%	11.6%	100.0%	72.4%	4.5%	16.4%	3.9%	2.7%	100.0%
Lake County	74.4%	25.6%	100.0%	73.3%	7.2%	8.0%	8.4%	3.0%	100.0%
State / National Benchmark									
Illinois	82.9%	17.1%	100.0%	71.5%	14.2%	5.5%	6.2%	2.6%	100.0%
United States	82.0%	18.0%	100.0%	72.5%	12.7%	5.5%	6.0%	3.3%	100.0%

Combined Race and Ethnicity

	Non-Hispanic White	Hispanic/ Latino	Non-Hispanic Asian	Non-Hispanic Black	Non-Hispanic Multiple Races	Some Other Race	Total
NorthShore CHNA Community	**58.0%**	**19.8%**	**12.4%**	**6.8%**	**2.5%**	**.5%**	**100.0%**
Cook Chicago North	49.3%	25.0%	11.7%	10.2%	3.2%	.6%	100.0%
Cook North Suburb	65.2%	11.6%	16.3%	4.3%	2.2%	.4%	100.0%
Lake County	56.9%	25.6%	7.9%	7.0%	2.2%	.4%	100.0%
State / National Benchmark							
Illinois	61.3%	17.1%	5.4%	13.9%	1.9%	.4%	100.0%
United States	60.7%	18.0%	5.5%	12.3%	2.5%	1.0%	100.0%

Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Household Income and Poverty

Return to Report

	Percentage of Population Below 100% FPL	Percentage of Population under Age 18 in Poverty	Average Family Income	Percentage of Children Eligible for Free/Reduced Price Lunch
NorthShore CHNA Community	**10.23%**	**12.81%**	**$145,116**	**34.36%**
Cook Chicago North	16.02%	22.13%	$106.504	65.59%
Cook North Suburb	7.42%	8.02%	$160,866	22.93%
Lake County	8.54%	12.89%	$145,311	32.42%
Zip Codes with High Socioeconomic Need	**16.55%**	**23.92%**	**$92,422**	**62.94%**
Cook Chicago North				
60625 - Chicago	13.44%	19.85%	$110,761	70.28%
60626 - Chicago	24.96%	34.17%	$76,881	88.16%
60640 - Chicago	18.95%	24.27%	$118,763	68.43%
60641 - Chicago	10.72%	15.40%	$98,075	81.22%
60645 - Chicago	19.52%	27.44%	$89,624	81.39%
60659 - Chicago	23.49%	36.30%	$78,770	72.13%
60660 - Chicago	15.99%	17.34%	$95,223	75.61%
Cook North Suburb				
60070 - Prospect Heights	9.98%	14.97%	$110,939	21.78%
60077 - Skokie	10.67%	14.24%	$98,592	37.04%
60090 - Wheeling	9.61%	16.52%	$98,390	45.94%
Lake County				
60040 - Highwood	16.79%	29.40%	$113,455	22.21%
60064 - North Chicago	24.24%	32.38%	$58,148	74.14%
60085 - Waukegan	19.84%	28.18%	$63,992	62.20%
60087 - Waukegan	11.18%	19.73%	$77,305	52.68%
State / National Benchmark				
Illinois	12.49%	17.13%	$88,279	48.67%
United States	13.42%	18.52%	$77,263	49.63%

Poverty and Average Family Income Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Free and Reduced Price Lunch Data Source: National Center for Education Statistics, NCES - Common Core of Data. 2019-20. Source geography: Address

Average Family Income
This indicator reports average family income based on the latest 5-year American Community Survey estimates. A family household is any housing unit in which the householder is living with one or more individuals related to him or her by birth, marriage, or adoption. Family income includes the incomes of all family members age 15 and older.

Children Eligible for Free/Reduced Price Lunch
Free or reduced price lunches are served to qualifying students in families with income between under 185 percent (reduced price) or under 130% (free lunch) of the US federal poverty threshold as part of the federal National School Lunch Program (NSLP).

Uninsured Population

Return to Report

Uninsured Population
This indicator reports the percentage of non-institutionalized population are without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

Row Labels	Total Population (For Whom Insurance Status is Determined)	Uninsured Population	Uninsured Population, Percent
NorthShore CHNA Community	**1,579,294**	**127,593**	**8.08%**
Cook Chicago North	455,651	48,373	10.6%
Cook North Suburb	640,229	41,102	6.4%
Lake County	483,414	38,118	7.9%
Zip Codes with High Socioeconomic Need	**595,156**	**75,610**	**12.70%**
Cook Chicago North	398,209	46,523	
60625 - Chicago	78,622	10,383	13.2%
60626 - Chicago	48,861	6,101	12.5%
60640 - Chicago	68,009	5,678	8.4%
60641 - Chicago	69,593	9,536	13.7%
60645 - Chicago	46,753	5,934	12.7%
60659 - Chicago	42,425	5,356	12.6%
60660 - Chicago	43,946	3,535	8.0%
Cook North Suburb	81,372	9,880	
60070 - Prospect Heights	15,890	2,213	13.9%
60077 - Skokie	27,454	2,396	8.7%
60090 - Wheeling	38,028	5,271	13.9%
Lake County	115,575	19,207	
60040 - Highwood	5,184	725	14.0%
60064 - North Chicago	15,262	2,699	17.7%
60085 - Waukegan	69,100	12,413	18.0%
60087 - Waukegan	26,029	3,370	13.0%
State / National Benchmark			
Illinois	12,591,483	859,612	6.8%
United States	319,706,872	28,248,613	8.8%

Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Population in Limited English Households

Return to Report

Limited English Households
This indicator reports the percentage of the population aged 5 years and older living in Limited English speaking households. A limited English speaking household is one in which no household member 14 years old and over speaks only English at home, or no household member speaks a language other than English at home and speaks English "very well".

	Total Population Age 5+	Population in Limited English Households	Percentage of Population in Limited English Household
NorthShore CHNA Community	**1,510,707**	**122,423**	**8.1%**
Cook Chicago North	432,354	50,192	11.6%
Cook North Suburb	609,089	46,350	7.6%
Lake County	469,264	25,881	5.5%
Zip Codes with High Socioeconomic Need	**564,095**	**70,141**	**12.4%**
Cook Chicago North	378,123	47,210	12.5%
60625 - Chicago	73,682	10,435	14.2%
60626 - Chicago	47,693	4,511	9.5%
60640 - Chicago	66,453	6,491	9.8%
60641 - Chicago	65,495	7,951	12.1%
60645 - Chicago	42,848	6,524	15.2%
60659 - Chicago	39,463	6,401	16.2%
60660 - Chicago	42,489	4,897	11.5%
Cook North Suburb	76,677	9,886	12.9%
60070 - Prospect Heights	14,652	1,911	13.0%
60077 - Skokie	25,863	3,424	13.2%
60090 - Wheeling	36,162	4,551	12.6%
Lake County	109,295	13,045	11.9%
60040 - Highwood	4,872	539	11.1%
60064 - North Chicago	14,425	1,385	9.6%
60085 - Waukegan	65,118	9,457	14.5%
60087 - Waukegan	24,880	1,664	6.7%
State / National Benchmark			
Illinois	12,003,438	494,435	4.1%
United States	304,930,125	12,982,993	4.3%

Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Educational Attainment

Return to Report

Education
Education metrics can be used to describe variation in population access, proficiency, and attainment throughout the education system, from access to pre-kindergarten through advanced degree attainment. These indicators are important because education is closely tied to health outcomes and economic opportunity.

Row Labels	Total Population Age 25+	Population Age 25+ with No High School Diploma	Population Age 25+ with No High School Diploma, Percent	Population Age 25+ with Bachelor's Degree or Higher, Percent
NorthShore CHNA Community	**1,109,649**	**113,119**	**10.2%**	**49.9%**
Cook Chicago North	330,845	44,869	13.6%	45.9%
Cook North Suburb	458,895	33,966	7.4%	55.2%
Lake County	319,909	34,284	10.7%	46.4%
Zip Codes with High Socioeconomic Need	**418,326**	**67,954**	**16.2%**	**39.9%**
Cook Chicago North	288,145	42,101	14.6%	45.8%
60625 - Chicago	56,639	7,976	14.1%	49.7%
60626 - Chicago	34,717	4,086	11.8%	46.2%
60640 - Chicago	55,212	5,508	10.0%	57.5%
60641 - Chicago	48,896	10,031	20.5%	30.3%
60645 - Chicago	31,252	5,007	16.0%	44.4%
60659 - Chicago	27,817	5,819	20.9%	34.6%
60660 - Chicago	33,612	3,674	10.9%	52.7%
Cook North Suburb	58,655	7,422	12.7%	40.6%
60070 - Prospect Heights	10,731	1,738	16.2%	35.6%
60077 - Skokie	19,992	1,889	9.4%	43.8%
60090 - Wheeling	27,932	3,795	13.6%	40.3%
Lake County	71,526	18,431	25.8%	15.6%
60040 - Highwood	3,509	621	17.7%	38.8%
60064 - North Chicago	9,275	2,791	30.1%	11.6%
60085 - Waukegan	41,686	11,657	28.0%	14.0%
60087 - Waukegan	17,056	3,362	19.7%	16.8%
State / National Benchmark	**229,308,375**	**27,409,303**	**12.0%**	**32.2%**
Illinois	8,686,299	937,042	10.8%	34.7%
United States	220,622,076	26,472,261	12.0%	32.1%

Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Areas Affected by a Health Professional Shortage Area (HPSA)

Return to Report

Areas Affected by a Health Professional Shortage Area
This indicator reports the percentage of the population that is living in a geographic area designated as a "Health Professional Shortage Area" (HPSA), defined as having a shortage of primary medical care, dental or mental health professionals. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

	Population Living in an Area Affected by a HPSA	Total Population (5 year estimate)	Percetage of Population Living in an Area Affected by a HPSA
NorthShore CHNA Community	**224,611**	**1,707,425**	**13.2%**
Cook Chicago North	173,797	563,401	30.8%
Cook North Suburb	-	646,880	0.0%
Lake County	50,814	497,144	10.2%
Zip Codes with High Socioeconomic Need	**218,754**	**704,895**	**31.0%**
Cook Chicago North	173,797	505,751	34.4%
60625 - Chicago	12,414	79,773	15.6%
60626 - Chicago	46,266	50,143	92.3%
60640 - Chicago	45,537	131,794	34.6%
60641 - Chicago	9,896	70,361	14.1%
60645 - Chicago	20,800	47,931	43.4%
60659 - Chicago	11,040	42,736	25.8%
60660 - Chicago	27,845	83,013	33.5%
Cook North Suburb	-	81,432	0.0%
60070 - Prospect Heights	-	15,406	0.0%
60077 - Skokie	-	27,186	0.0%
60090 - Wheeling	-	38,840	0.0%
Lake County	44,957	117,712	38.2%
60040 - Highwood	-	5,377	0.0%
60064 - North Chicago	6,821	15,405	44.3%
60085 - Waukegan	27,325	70,322	38.9%
60087 - Waukegan	10,812	26,608	40.6%
State / National Benchmark			
Illinois	3,271,660	12,770,631	25.6%
United States	73,493,673	324,697,795	22.6%

Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database. May 2021. Source geography: HPSA

Access to Healthcare Services

Return to Report

	Dental Care		Mental Care		Primary Care	
	Providers per 100,000 Population	Number of Providers	Providers per 100,000 Population	Number of Providers	Providers per 100,000 Population	Number of Providers
NorthShore Counties	**56.79**	**913**	**121.61**	**1,955**	**142.51**	**2,291**
Cook County, IL	44.85	2,366	107.93	5,684	151.00	7,966
Lake County, IL	52.36	374	95.75	684	103.45	739
State / National Benchmark						
Illinois	37.82	4,846	100.43	12,868	116.25	14,894
United States	33.09	110,751	124.85	417,923	102.27	342,350

Dental Care Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). 2021. Source geography: Address

Mental Care Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). Accessed via County Health Rankings. 2020. Source geography: County

Primary Care Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Area Health Resource File. Accessed via County Health Rankings. 2017. Source geography: County

Dental Care
This indicator reports the number of oral health care providers with a CMS National Provider Identifier (NPI). Providers included in this summary are those who list "dentist", "general practice dentist", or "pediatric dentistry" as their primary practice classification, regardless of sub-specialty. Data are from the latest Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file.

Mental Care
This indicator reports the number of mental health providers in the report area as a rate per 100,000 total area population. Mental health providers include psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care. Data from the 2020 Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file are used in the 2021 County Health Rankings.

Primary Care
This indicator reports the number of primary care physicians per 100,000 population. Doctors classified as "primary care physicians" by the AMA include General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs and General Pediatrics MDs. Physicians aged 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Preventative Services – Core Preventable Services

Return to Report

	Percentage of Males age 65+ Up to Date on Core Preventative Services	Percentage of Females age 65+ Up to Date on Core Preventative Services
NorthShore CHNA Community	**35.0%**	**27.4%**
Cook Chicago North	30.7%	26.8%
Cook North Suburb	35.9%	30.1%
Lake County	37.6%	24.5%
Zip Codes with High Socioeconomic Need	**30.3%**	**25.2**
Cook Chicago North		
60625 - Chicago	31.0%	27.8%
60626 - Chicago	28.0%	24.6%
60640 - Chicago	31.0%	26.9%
60641 - Chicago	29.2%	26.1%
60645 - Chicago	30.3%	26.1%
60659 - Chicago	28.7%	25.5%
60660 - Chicago	30.5%	27.3%
Cook North Suburb		
60070 - Prospect Heights	34.9%	30.1%
60077 - Skokie	33.3%	28.0%
60090 - Wheeling	32.2%	27.6%
Lake County		
60040 - Highwood	36.2%	21.8%
60064 - North Chicago	26.9%	17.3%
60085 - Waukegan	27.8%	17.9%
60087 - Waukegan	34.3%	22.3%
State / National Benchmark		
Illinois	32.9%	29.5%
United States	32.4%	28.4%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2018. Source geography: Tract

Male Preventative Services
This indicator reports the percentage of males age 65 years and older who report that they are up to date on a core set of clinical preventive services. Services include: an influenza vaccination in the past year; a PPV ever; and either a fecal occult blood test (FOBT) within the past year, a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or a colonoscopy within the past 10 years.

Female Preventative Services
This indicator reports the percentage of females age 65 years and older who report that they are up to date on a core set of clinical preventive services. Services include: an influenza vaccination in the past year; a pneumococcal vaccination (PPV) ever; either a fecal occult blood test (FOBT) within the past year, a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or a colonoscopy within the previous 10 years; and a mammogram in the past 2 years.

Preventative Services – Blood Pressure, Diabetes, and Preventable Hospitalizations

Return to Report

	Blood Pressure Medication Nonadherence	Medicare Enrollees with Diabetes with Annual Exam	Preventable Hospitalizations, Rate per 100,000 Beneficiaries
NorthShore Counties	**22.82%**	**88.13%**	**3,375**
Cook County, IL	23.2%	87.3%	3,548
Lake County, IL	19.6%	89.7%	2,946
State / National Benchmark			
Illinois	20.4%	88.8%	3,275
United States	21.8%	87.3%	2,865

Blood Pressure Medication Nonadherence Data Source: Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke . 2018. Source geography: County

Diabetes Annual Exam Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2017. Source geography: County

Preventable Hospitalizations Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2020. Source geography: County

Blood Pressure
This indicator reports the number and percentage of Medicare beneficiaries not adhering to blood pressure medication schedules. Nonadherence is defined having medication coverage days at less than 80%.

Diabetes Annual Exam
This indicator reports the percentage of diabetic Medicare patients who have had a hemoglobin A1c (hA1c) test, a blood test which measures blood sugar levels, administered by a health care professional in the past year. This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

Preventable Hospitalizations
This indicator reports the preventable hospitalization rate among Medicare beneficiaries for the latest reporting period. Preventable hospitalizations include hospital admissions for one or more of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection. Rates are presented per 100,000 beneficiaries.

Preventative Services – Cancer Screenings

Return to Report

	Adults with Adequate Colorectal Cancer Screening	Females age 21-65 with Recent Pap Smear	Females Age 50-74 with Recent Mammogram
NorthShore CHNA Community	**64.3%**	**82.8%**	**77.3%**
Cook Chicago North	60.4%	81.0%	78.5%
Cook North Suburb	66.7%	83.0%	78.3%
Lake County	64.8%	84.1%	74.9%
Zip Codes with High Socioeconomic Need	**59.3%**	**80.4%**	**77.6%**
Cook Chicago North			
60625 - Chicago	59.6%	80.8%	78.5%
60626 - Chicago	59.0%	80.2%	79.8%
60640 - Chicago	61.3%	82.4%	79.5%
60641 - Chicago	58.3%	81.4%	77.5%
60645 - Chicago	58.8%	79.0%	78.2%
60659 - Chicago	56.4%	75.5%	77.3%
60660 - Chicago	61.8%	81.0%	79.5%
Cook North Suburb			
60070 - Prospect Heights	64.7%	82.0%	77.5%
60077 - Skokie	63.0%	78.7%	77.3%
60090 - Wheeling	61.9%	81.0%	77.2%
Lake County			
60040 - Highwood	62.3%	84.0%	73.9%
60064 - North Chicago	56.9%	79.9%	76.1%
60085 - Waukegan	54.0%	79.5%	74.0%
60087 - Waukegan	62.5%	83.2%	74.0%
State / National Benchmark			
Illinois	64.4%	82.9%	73.7%
United States	66.4%	84.7%	74.8%

Colorectal Cancer Screening
This indicator reports the percentage of adults with adequate colorectal cancer screening.

Pap Smear Screening
This indicator reports the percentage of females age 21–65 years who report having had a Papanicolaou (Pap) smear within the previous 3 years.

Mammogram Screening
This indicator reports the percentage of females age 50-74 years who report having had a mammogram within the previous 2 years.

Colorectal Cancer Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2018.

Pap Smear Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2018.

Mammogram Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2018.

Health Outcomes and Mortality – Cancer Incidence Rates

Return to Report

Cancer Incidence Rates
These indicators report the age adjusted incidence rate (cases per 100,000 population per year) of individuals with cancer adjusted to 2000 U.S. standard population age groups (Under Age 1, 1-4, 5-9, ..., 80-84, 85 and older).

	Breast Cancer Incidence Rate (Per 100,000 Population)	Colorectal Cancer Incidence Rate (Per 100,000 Population)	Lung Cancer Incidence Rate (Per 100,000 Population)	Prostate Cancer Incidence Rate (Per 100,000 Population)
NorthShore CHNA Community	**135.2**	**40.5**	**56.2**	**112.7**
Cook Chicago North	132.2	42.3	57.0	116.0
Cook North Suburb	132.1	42.2	57.0	116.1
Lake County	142.0	36.8	54.2	106.0
State / National Benchmark				
Illinois	133.7	42.1	63.0	111.5
United States	126.8	38.0	57.3	106.2

	Breast Cancer New Cases Annual Average	Colorectal Cancer New Cases Annual Average	Lung Cancer New Cases Annual Average	Prostate Cancer New Cases Annual Average
NorthShore CHNA Community	**1,271**	**714**	**989**	**968**
Cook Chicago North	352	211	285	275
Cook North Suburb	506	303	410	396
Lake County	414	201	293	298
State / National Benchmark				
Illinois	10,389	6,243	9,538	8,174
United States	249,261	143,200	222,811	200,677

Data Source: State Cancer Profiles. 2014-18. Source geography: County

Health Outcomes and Mortality – Chronic Conditions

Return to Report

	Percentage of Adults with Diagnosed Diabetes	Percentage of Adults Ever Diagnosed with Coronary Heart Disease (Crude)	Percentage of Adults with High Blood Pressure
NorthShore CHNA Community	**8.3%**	**4.9%**	**28.0%**
Cook Chicago North	8.9%	4.7%	27.0%
Cook North Suburb	8.8%	5.2%	28.7%
Lake County	7.1%	4.7%	27.9%
State / National Benchmark			
Illinois	8.5%	5.7%	31.2%
United States	9.0%	6.2%	32.6%

Diabetes Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019.
Source geography: County

Coronary Heart Disease and High Blood Pressure Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2019

Diabetes
This indicator reports the number and percentage of adults age 20 and older who have ever been told by a doctor that they have diabetes. This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

Coronary Heart Disease
This indicator reports the percentage of adults age 18 and older who report ever having been told by a doctor, nurse, or other health professional that they had angina or coronary heart disease.

High Blood Pressure
This indicator reports the percentage of adults age 18 who report ever having been told by a doctor, nurse, or other health professional that they have high blood pressure. Women who were told high blood pressure only during pregnancy and those who were told they had borderline hypertension were not included.

Health Outcomes and Mortality – Mortality

Return to Report

Cancer Deaths
This indicator reports the 2016-2020 five-year average rate of death due to malignant neoplasm (cancer) per 100,000 population.

Heart Disease Deaths
This indicator reports the 2016-2020 five-year average rate of death due to heart disease (ICD10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population.

Lung Disease Deaths
This indicator reports the 2016-2020 five-year average rate of death due to chronic lower respiratory disease per 100,000 population.

	Cancer Death Rate (Per 100,000 Population)	Heart Disease Death Rate (Per 100,000 Population)	Lung Disease Death Rate (Per 100,000 Population)	Stroke Death Rate (Per 100,000 Population)
NorthShore CHNA Community	**150.4**	**156.4**	**27.8**	**37.7**
Cook Chicago North	152.5	169.2	27.0	41.2
Cook North Suburb	152.5	169.2	27.1	41.2
Lake County	145.7	128.5	29.3	30.1
State / National Benchmark				
Illinois	155.4	165.3	36.1	39.1
United States	149.4	164.8	39.1	37.6

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

Injury and Violence – Mortality - Homicide

Return to Report

Mortality - Homicide
This indicator reports the 2016-2020 five-year average rate of death due to assault (homicide) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because homicide rate is a measure of poor community safety and is a leading cause of premature death.

	Five Year Total Deaths, 2016-2020 Total	Unintentional Injury Five Year Total Deaths, 2016-2020 Total
NorthShore Counties	**929**	**11.8**
Cook County, IL	3,986	15.5
Lake County, IL	104	3.1
State / National Benchmark		
Illinois	5,603	9.1
United States	101,419	6.4

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

Injury and Violence – Unintentional Injuries

Return to Report

Death due to Unintentional Injury (Accident)
This indicator reports the 2016-2020 five-year average rate of death due to unintentional injury (accident) per 100,000 population.

	Unintentional Injury Death Rate (Per 100,000 Population)	Unintentional Injury Five Year Total Deaths, 2016-2020 Total
NorthShore Counties	**41.2**	**3,417**
Cook County, IL	43.70	11,982
Lake County, IL	35.20	1,242
State / National Benchmark		
Illinois	45.60	30,808
United States	50.40	872,432

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

Injury and Violence – Violent Crime and Property Crime

Return to Report

Violent Crime
Violent crime includes homicide, rape, robbery, and aggravated assault.

Property Crime
This indicator reports the rate of property crime offenses reported by law enforcement per 100,000 residents. Property crimes include burglary, larceny-theft, motor vehicle theft, and arson. This indicator is relevant because it assesses community safety.

	Violent Crime		Property Crime	
	Violent Crimes, Annual Rate (Per 100,000 Pop.)	Violent Crimes, 3-year Total	Property Crimes, Annual Rate (Per 100,000 Pop.)	Property Crimes, Annual Average
NorthShore Counties				
Cook County, IL	627.40	99,295	2,587.50	133,275.00
Lake County, IL	165.20	3,385	1,485.10	10,175.00
State / National Benchmark				
Illinois	420.90	162,592	2,022.60	259,698.00
United States	416.00	4,579,031	2,466.10	7,915,583.00

Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2014; 2016. Source geography: County

Maternal, Infant, and Child Care – Infant Deaths, Low Weight Births, Birth Care

Return to Report

	Number of Infant Deaths	Infant Deaths per 1,000 Live Births	Number of Low Birthweight Births	Low Birthweight Births, Percentage	Number of Births with Late/No Care	Births with Late/No Care, Percentage
NorthShore Counties						
Cook County, IL	2,988	6.40	41,105	9.0%	12,978	7.0%
Lake County, IL	244	4.60	4,057	7.7%	12,978	7.0%
State / National Benchmark						
Illinois	12,644	6.20	177,366	8.4%	24,653	5.7%
United States	301,832	5.80	4,440,508	8.2%	697,581	6.1%

Infant Deaths and Low Birthweight Births Data Source: University of Wisconsin Population Health Institute, County Health Rankings. 2013-2019. Source geography: County

Births with Late/No Care Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research. 2019. Source geography: County

Infant Deaths
This indicator reports information about infant mortality, which is defined as the number of all infant deaths (within 1 year) per 1,000 live births.

Low Birthweight Births
This indicator reports the percentage of live births where the infant weighed less than 2,500 grams (approximately 5 lbs., 8 oz.). These data are reported for a 7-year aggregated time period.

Births with Late/No Care
This indicator reports the percentage of women who did not obtain prenatal care until the 7th month (or later) of pregnancy or who didn't have any prenatal care, as of all who gave birth during the three-year period from 2017 to 2019. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

Mental Health – Adult Mental Health

Return to Report

	Adults with Poor Mental Health. Percent (Crude)	Crude Suicide Death Rate (Per 100,000 Population)	Suicide Five Year Total, 2016-2020
NorthShore CHNA Community	**12.5%**	**9.1**	**723**
Cook Chicago North	13.6%	8.8	196
Cook North Suburb	11.2%	8.8	283
Lake County	13.1%	9.8	244
Zip Codes with High Socioeconomic Need	**14.2%**	**9.0**	**277**
Cook Chicago North			172
60625 - Chicago	13.2%	8.8	34
60626 - Chicago	15.5%	8.8	22
60640 - Chicago	13.1%	8.8	29
60641 - Chicago	13.7%	8.8	31
60645 - Chicago	14.3%	8.8	20
60659 - Chicago	15.0%	8.8	17
60660 - Chicago	13.7%	8.8	19
Cook North Suburb			28
60070 - Prospect Heights	12.5%		
60077 - Skokie	11.6%	8.8	12
60090 - Wheeling	12.9%	8.8	16
Lake County			77
60040 - Highwood	13.5%		29
60064 - North Chicago	17.3%		
60085 - Waukegan	16.9%	9.9	35
60087 - Waukegan	14.7%	9.9	13
State / National Benchmark			
Illinois	13.1%	11.3	7,178
United States	13.6%	14.3	233,972

Poor Mental Health
This indicator reports the percentage of adults age 18 and older who report 14 or more days during the past 30 days during which their mental health was not good.

Suicides
This indicator reports the 2016-2020 five-year average rate of death due to intentional self-harm (suicide) per 100,000 population.

Poor Mental Health Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2019. Source geography: Tract

Suicide Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

Nutrition, Physical Inactivity Obesity – Food Environment

Return to Report

		Food Desert		Low Food Access		SNAP Authorized Retailers	
	Total Population (2010)	Food Desert Population	Food Desert Population, Percent	Population with Low Food Access	Population with Low Food Access, Percent	Total SNAP-Authorized Retailers	SNAP-Authorized Retailers per 10,000 Population
NorthShore CHNA Community	**1,591,962**	**444,335**	**27.9%**	**214,207**	**13.5%**	**908**	**5.83**
Cook Chicago North	448,191	-	0.0%	-		290	6.62
Cook North Suburb	645,110	141,081	21.9%	50,220	7.8%	318	5.04
Lake County	498,661	303,254	60.8%	163,987	32.9%	300	6.14
Zip Codes with High Socioeconomic Need	**592,362**	**32,757**	**5.5%**	**20,147**	**3.4%**	**428**	**7.46**
Cook Chicago North	392,373	-	0.0%	-		277	7.25
60625 - Chicago	78,651	-	0.0%	No Data		52	6.59
60626 - Chicago	50,139	-	0.0%	No Data		42	8.51
60640 - Chicago	65,790	-	0.0%	-		45	7.40
60641 - Chicago	71,663	-	0.0%	No Data		42	5.82
60645 - Chicago	45,274	-	0.0%	No Data		45	10.13
60659 - Chicago	38,104	-	0.0%	No Data		35	9.28
60660 - Chicago	42,752	-	0.0%	No Data		16	4.13
Cook North Suburb	80,459	10,296	12.8%	6,795	8.4%	36	4.81
60070 - Prospect Heights	16,001	3,920	24.5%	2,143	13.4%	5	3.58
60077 - Skokie	26,825	-	0.0%	84	0.3%	14	5.32
60090 - Wheeling	37,633	6,376	16.9%	4,568	12.1%	17	4.92
Lake County	119,530	22,461	18.8%	13,352	11.2%	115	9.86
60040 - Highwood	5,431	-	0.0%	3	0.1%	1	1.94
60064 - North Chicago	15,407	4,502	29.2%	4,802	31.2%	14	9.07
60085 - Waukegan	71,714	2,306	3.2%	1,496	2.1%	75	10.78
60087 - Waukegan	26,978	15,653	58.0%	7,051	26.1%	25	9.46
State / National Benchmark							
Illinois	12,830,632	1,242,939	9.7%	2,589,942	20.2%	9,294	7.38
United States	308,745,538	39,074,974	12.7%	68,611,398	22.2%	248,526	7.47

Food Deserts
This indicator reports the number of neighborhoods in the report area that are within food deserts. The USDA Food Access Research Atlas defines a food desert as any neighborhood that lacks healthy food sources due to income level, distance to supermarkets, or vehicle access.

Low Food Access
This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store.

SNAP Authorized Retailers
This indicator reports the number of SNAP-authorized food stores as a rate per 10,000 population. SNAP-authorized stores include grocery stores as well as supercenters, specialty food stores, and convenience stores that are authorized to accept SNAP (Supplemental Nutrition Assistance Program) benefits.

Food Desert and Low Food Access Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019. Source geography: Tract
SNAP Authorized Retailers Data Source: US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator. Additional data analysis by CARES. 2021. Source geography: Tract

Nutrition, Physical Inactivity Obesity – Obesity and Physical Activity

Return to Report

		Obesity		Physical Activity	
	Population Age 20+	Adults with BMI > 30.0	Adults with BMI > 30.0, Percent	Adults with No Leisure Time Physical Activity	Adults with No Leisure Time Physical Activity, Percent
NorthShore CHNA Community	**1,205,036**	**336,823**	**27.95%**	**246,045**	**20.42%**
Cook Chicago North	352,243	93,697	26.60%	73,971	21.00%
Cook North Suburb	494,582	132,446	26.78%	103,763	20.98%
Lake County	358,211	110,680	30.90%	68,311	19.07%
State / National Benchmark					
Illinois	9,523,557	2,673,824	28.08%	2,043,592	21.43%
United States	243,082,729	67,624,774	27.82%	54,200,862	22.60%

Obesity Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019. Source geography: County

Physical Activity Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019. Source geography: County

Obesity
This indicator reports the number and percentage of adults aged 20 and older self-report having a Body Mass Index (BMI) greater than 30.0 (obese). Body mass index (weight [kg]/height [m]2) was derived from self-report of height and weight. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

Physical Activity
This indicator is based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?" This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as obesity and poor cardiovascular health.

Physical Environment – Cost Burdened Households

Return to Report

	Total Households	Cost Burdened Households (30%)	Percentage of Cost Burdened Households	Households with No or Slow Internet, Percent	Substandard Housing Conditions, Percent
NorthShore CHNA Community	**599,588**	**203,874**	**34.0%**	**13.8%**	**34.8%**
Cook Chicago North	186,255	72,967	39.2%	19.1%	40.4%
Cook North Suburb	243,191	78,543	32.3%	12.3%	32.8%
Lake County	170,142	52,364	30.8%	10.3%	31.5%
Zip Codes with High Socioeconomic Need	**233,127**	**92,973**	**39.9%**	**18.2%**	**41.3%**
Cook Chicago North	163,259	66,507	40.7%	19.1%	42.1%
60625 - Chicago	29,668	10,895	36.7%	16.4%	37.8%
60626 - Chicago	22,995	10,700	46.5%	21.2%	48.6%
60640 - Chicago	35,466	13,721	38.7%	19.8%	38.4%
60641 - Chicago	24,557	9,411	38.3%	20.2%	39.5%
60645 - Chicago	16,004	6,681	41.7%	18.9%	44.1%
60659 - Chicago	13,485	6,482	48.1%	17.1%	51.2%
60660 - Chicago	21,084	8,617	40.9%	19.6%	42.8%
Cook North Suburb	30,212	11,215	37.1%	14.3%	39.1%
60070 - Prospect Heights	5,625	2,088	37.1%	17.3%	42.1%
60077 - Skokie	10,146	3,938	38.8%	14.1%	38.9%
60090 - Wheeling	14,441	5,189	35.9%	13.3%	38.1%
Lake County	39,656	15,251	38.5%	17.4%	40.1%
60040 - Highwood	1,897	775	40.9%	17.5%	45.2%
60064 - North Chicago	5,108	2,130	41.7%	21.6%	43.6%
60085 - Waukegan	23,235	9,462	40.7%	18.4%	42.5%
60087 - Waukegan	9,416	2,884	30.6%	12.9%	31.2%
State / National Benchmark					
Illinois	4,846,134	1,468,277	30.3%	17.3%	30.8%
United States	120,756,048	37,249,895	30.8%	17.3%	31.9%

Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Cost Burdened Households
This indicator reports the percentage of the households where housing costs are 30% or more total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels. The following zip codes have the highest percentage of households with severe cost burden of housing.

Internet Access
This indicator reports the percentage of households who either use dial-up as their only way of internet connection, or have internet access but don't pay for the service, or have no internet access in their home, based on the 2014-2019 American Community Survey estimates.

Substandard Housing
This indicator reports the percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30%, and 5) gross rent as a percentage of household income greater than 30%. Selected conditions provide information in assessing the quality of the housing inventory and its occupants. This data is used to easily identify homes where the quality of living and housing can be considered substandard.

Physical Environment – Environment and Housing

Return to Report

	Percent Population within 1/2 Mile of a Park	Percent Population Using Public Transit for Commute to Work	Percentage of Days Exceeding Ozone Standards	Average Daily Ambient Ozone Concentration
NorthShore CHNA Community	**52%**	**14.4%**	**0.9%**	**165.5**
Cook Chicago North	29%	30.0%	2.0%	250.6
Cook North Suburb	60%	10.2%	0.6%	155.7
Lake County	63%	4.7%	0.0%	133.8
Zip Codes with High Socioeconomic Need	**37%**	**23.7%**	**1.6%**	**214.55**
Cook Chicago North				
60625 - Chicago	23%	33.4%	3.0%	382.1
60626 - Chicago	10%	41.7%	2.1%	278.9
60640 - Chicago	34%	45.4%	2.6%	329.5
60641 - Chicago	55%	20.7%	2.6%	328.7
60645 - Chicago	10%	18.6%	1.7%	224.6
60659 - Chicago	21%	16.7%	1.4%	186.2
60660 - Chicago	11%	40.8%	1.8%	238.2
Cook North Suburb				
60070 - Prospect Heights	86%	2.7%	0.0%	83.6
60077 - Skokie	73%	8.5%	1.0%	133.6
60090 - Wheeling	47%	3.3%	0.0%	187.9
Lake County				
60040 - Highwood	42%	9.7%	0.0%	35.3
60064 - North Chicago	54%	4.8%	0.0%	113.9
60085 - Waukegan	50%	4.7%	0.0%	333.7
60087 - Waukegan	66%	1.3%	0.0%	147.5
State / National Benchmark				
Illinois	59%	9.5%	0.0%	36.1
USA	46%	5.0%	0.3%	37.9

Living Near a Park
This indicator reports the percentage of population living within 1/2 mile of a park. This indicator is relevant because access to outdoor recreation encourages physical activity and other healthy behaviors.

Public Transit
This indicator reports the percentage of population using public transportation as their primary means of commuting to work. Public transportation includes buses or trolley buses, streetcars or trolley cars, subway or elevated rails, and ferryboats.

Living Near a Park Data Source: Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network. 2015. Source geography: Tract

Public Transit Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Substance Abuse – Adult Alcohol and Tobacco Use

Return to Report

	Percentage of Adults Binge Drinking in the Past 30 Days	Percentage of Adult Current Smokers
NorthShore CHNA Community	**21.9%**	**13.8%**
Cook Chicago North	23.3%	15.5%
Cook North Suburb	21.7%	12.3%
Lake County	20.7%	14.2%
Zip Codes with High Socioeconomic Need	**22.3%**	**16.4%**
Cook Chicago North		
60625 - Chicago	25.0%	14.4%
60626 - Chicago	23.7%	17.0%
60640 - Chicago	24.3%	14.9%
60641 - Chicago	24.1%	15.8%
60645 - Chicago	20.4%	17.2%
60659 - Chicago	19.8%	18.8%
60660 - Chicago	24.3%	14.9%
Cook North Suburb		
60070 - Prospect Heights	23.2%	14.4%
60077 - Skokie	19.2%	13.6%
60090 - Wheeling	23.0%	15.1%
Lake County		
60040 - Highwood	20.3%	14.8%
60064 - North Chicago	18.1%	20.8%
60085 - Waukegan	19.0%	20.0%
60087 - Waukegan	19.8%	17.0%
State / National Benchmark		
Illinois	20.4%	15.3%
United States	16.7%	15.3%

Adult Alcohol Use
This indicator reports the percentage of adults age 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

Adult Tobacco Use
This indicator reports the percentage of adults age 18 and older who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.

Alcohol Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2019. Source geography: Tract

Tobacco Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2019. Source geography: Tract

Substance Abuse – Opioid Overdose

Return to Report

Opioid Overdose
This indicator reports the 2016-2020 five-year average rate of death due to opioid drug overdose per 100,000 population. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because opioid drug overdose is the leading cause of injury deaths in the United States, and they have increased dramatically in recent years.

	Unintentional Injury Death Rate (Per 100,000 Population)	Opioid Overdose Five Year Total Deaths, 2016-2020 Total
NorthShore Counties	**18.4**	**1,480**
Cook County, IL	21.6	5,809
Lake County, IL	10.7	340
State / National Benchmark		
Illinois	18.2	11,559
United States	16.0	256,428

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

Appendix B – Summary of Focus Groups

Return to Report

Five focus groups were conducted during the month of January, 2022. Four focus groups were comprised of leaders representing public health, major employers, public schools, social services, NorthShore leaders and the community at-large. A fifth focus group was conducted with leaders from public health.

Focus groups explored multiple areas to identify significant health needs of the community as well as potential ways to address identified needs. The areas included 1.) factors impacting health in the community; 2.) greatest unmet health needs; 3.) health status in the community; 4.) barriers to addressing health needs, 5.) underserved groups, and 6.) greatest economic social issues.

This section of the report summarizes what the key stakeholders said without assessing the credibility of their comments.

1. Factors Impacting Health in the Community

Focus group participants were first asked to generally indicate what is impacting health within the community. Some positive factors were mentioned by focus group participants that have improved health within the community, including the great health and education resources in the community, increases in research leading to better care, improvement in telehealth and technology, great not-for-profit organizations that collaborate on issues (which has improved from the past), and a high vaccination status (in general, including COVID). However, numerous negative factors were cited by focus group participants included the following:

a. COVID-19 Pandemic

Numerous focus group participants believed that the COVID-19 pandemic has significantly negatively impacted health within the community and that the impact is widespread. The pandemic has stressed and worried nearly everyone and has negatively impacted the economy and housing and caused significant grief and loss. Social isolation resulting from the extended duration of the pandemic (affecting all age groups) was discussed by focus group participants. A sense of belonging has been compromised due to isolation. The financial impact of the pandemic continues to loom, as people lose their homes and suffer other financial stresses. Mental health issues and drug abuse are escalating, and the community is seeing the impact of the COVID-19 pandemic on adolescents and young adults.

The pandemic has also made it more difficult for individuals to take care of chronic health conditions. Focus group participants noted that physical health has declined during the pandemic—due to, among other things, a lack of screening services and delayed health screenings (sometimes even if there are symptoms present). The result of these actions may be late-stage diagnosis and ongoing health issues over a period of years. Additionally, people were forced to put healthy lifestyles on hold (such as going to the gym) and to find other ways to proactively manage health when resources were closed or reallocated due to the pandemic.

It was noted by one focus group participant that the pandemic has created a “moment of crisis” for children. The fact that youth were out of school for an extended time due to the pandemic has led to numerous issues, including an increase in mental health issues and suicide, an inability to observe children in the classroom and identify potential healthcare issues, and an increase in violence due to lack of supervision. Furthermore, staffing shortages in the classroom due to the pandemic has negatively impacted quality of life. Lastly, work-life changes in the family have impacted childcare in many homes.

In general, the pandemic is exacerbating numerous healthcare issues and making them more obvious.

Return to Report

b. Mental Health

Focus group participants mentioned that the mental and social wellbeing of the community continues to be a struggle – which has been exacerbated by the pandemic – and that mental health ultimately affects physical health. Isolation caused by the pandemic and by winter weather contributes to mental health issues. Many people are lonely and do not have a sense of belonging. People need community for mental strength. The stigma associated with mental health must be addressed. While the pandemic has been a time that calls for increased mental health therapy and psychosocial support, access to these resources has been limited, especially for youth.

c. Economic Disadvantages

For certain members of the population, a lack of financial security negatively impacts their health. This is true for those individuals who live in poverty—especially those who experience intergenerational poverty. Many in the community are experiencing employment and education challenges. Focus group participants noted that the economically disadvantaged population is growing, and that healthcare costs, housing costs, and early childcare costs are rapidly rising. Due to financial constraints, individuals sometimes make decisions that negatively impact physical and mental wellbeing (for example, they must decide on whether to pay for medication or food). Some lack insurance coverage due to unemployment or underemployment. For the underinsured, knowing what insurance will pay impacts preventative care.

d. Housing / Food / Safety

There were several aspects of housing mentioned by focus group participants that impact health within the community. First, there are vast disparities within the community and segregation of housing, rather than an integrated community. Second, it was mentioned that housing has a significant impact on health, and that research shows the great impact that housing stability, quality, and affordability, and the neighborhood in which one lives, has on individual health outcomes. Third, housing can create an unsafe physical environment, for example, when lead pipes are present in the home.

Food insecurity was raised by focus group participants as a negative factor impacting community health.

Regarding safety, a general collapse of civility was discussed. Because interactions among people have worsened (compared to 20 years ago), people are not as willing to help each other, resulting in many people feeling unsafe.

e. Fractured Healthcare System

One focus group participant referred to a “fractured health system” where there are disparities in treatment and access, and part of the community is not even participating in healthcare. For example, there are many people without access to healthcare, such as the middle-income population, who have a hard time accessing specialists and mental health providers. Also, there are long wait times for appointments and issues with scheduling appointments due to an overwhelmed system creating a scheduling backlog. Even getting to an appointment can be challenging for some individuals, as there is a lack of affordable escorted transportation for individuals who cannot afford caregivers (for those who need services beyond a traditional taxi).

Return to Report

Navigating the healthcare system was also discussed by focus group participants—specifically, that navigating the health system is extremely complicated, even for those in the healthcare system. For example, people are unsure of who to call, when to call, where to follow through, etc. Focus group participants pointed out that there is a lack of onsite health advocates—people who can interpret healthcare "speak" to common persons, especially in the senior population. Also, help is needed navigating uninsured and underinsured individuals through the healthcare system by communicating available financial resources.

Focus group participants discussed the prohibitive cost of healthcare services and prescription drugs. With the cost of healthcare being high, there is a lack of education of the availability of affordable healthcare options and a need for better transparency of fee structures. Oftentimes, people do not understand healthcare costs. Thus, even if health issues are identified, there may be a lack of access to follow-up care due to prohibitive cost.

Another aspect of the healthcare system that needs addressed is understaffing of healthcare institutions, a workforce shortage, and provider burnout. As healthcare workers continue to experience stress, employers should address employee wellness.

Another aspect of the healthcare system that needs addressed is how hospitals are compensated by payors.

Furthermore, racism, implicit bias, homophobia, and ageism are present within the healthcare system, leading to unequal access to healthcare. Also, there is a lack of providers with whom patients can connect, such as psychiatrists of color. Immigration status is also an issue that impacts an individual's willingness to access healthcare because individuals are unsure if they can seek treatment.

Communication of healthcare information to the community through social media has been very positive in some respects, but there is also a lot of misinformation circulating, which hospitals are working to combat. Varying levels of health literacy exist throughout the community.

f. Schools / Childcare Resources

Because of remote learning, youth is a population that has been missed within our healthcare system during the pandemic. Many children are primarily interacting through social media; however, they need more face-to-face social and emotional interaction, and gaps have been broadened.

Focus group participants noted that in Illinois there has been a loss of available adolescent beds and resources, and there are insufficient resources to respond to the needs of this population.

g. Fear / Lack of Trust of the Healthcare System

Focus group participant indicated that there is an "unhealthy skepticism of public leaders" in the community, particularly in certain groups of color. This lack of trust instills fear in people and makes them withdraw. One root cause of the lack of trust mentioned by a focus group participant was previous illegal medical practices experimented on African Americans. At the present time, that lack of trust is leading to mistrust of vaccines. Generally, there is a hesitancy or reluctance to get healthcare, to go to the hospital, to get vaccinations, etc. among certain groups of color.

Return to Report

2. Greatest Unmet Health Needs

a. Mental Health / Behavioral Health

Focus group participants mentioned access to mental health/behavioral health services (including for youth and adolescents, and including therapy and psychosocial support), among the greatest unmet health needs within the community. If people present at the emergency department, they are often screened out at this level. Access is a challenge, as providers are booked for months, and there is a lack of available beds. Increases are seen in suicides, post-natal depression, and families dealing with added stressors and anxiety.

b. Physical Health

Physical health was mentioned by focus group participants as one of the greatest unmet health needs, as people are not seeking preventative care. The cause may be due to a variety of reasons, including economic circumstances, lack of transportation, high cost (including medication costs), lack or insurance, or lack of knowledge. Furthermore, preventative screenings are hard to access for certain populations, such as uninsured adults. Federally Qualified Health Centers do not have access to certain preventative screening services in-house (such as colonoscopy and mammogram). Also, people may delay preventative care due to the pandemic or other concerns. There must be a greater focus on preventative care, health maintenance and physicals. It was noted by one focus group participant that the sense of overwhelm in the healthcare system impacts workers and is stemming people from wanting preventative care, so the system is becoming crisis oriented. Vaccines in the most vulnerable communities are needed. There is needed focus on overall wellness of people and communities holistically (mind, body, spirit). People must be educated on where and how they can get help (for example, the location of food pantries)—and it is important to distinguish between a lack of resources and a lack of awareness of resources. Dignity and self-respect come into play (some people may not want to seek help), as well as some people using resources that they may not need as much as others. An increased social services network is needed so that people can find availability of services and have one-stop care.

c. Access to Healthcare

Access to healthcare was also mentioned by focus group participants as one of the greatest unmet healthcare needs. There must be continued affordability and access to services. While great strides have been made in providing community-level programs, more work is needed. There are continued access challenges for the undocumented and those with Medicaid—for example, NorthShore does not accept Medicaid in primary care clinics. This creates a segregated healthcare system for those individuals. Access to supportive care and resources is also needed, as well as more healthcare options, to improve the quality of healthcare.

Resources to assist individuals navigate the complex healthcare system are needed (such as navigating the preauthorization process), as there is a lack of understanding in that regard, especially among the elderly. Language barriers must be overcome, and resources must be current (address outdated websites, etc.)

Health education and awareness in disease prevention and care is lacking as well as health literacy. More classes and support groups are needed in the community. Access to correct information is needed—and educating people on how to determine what information is true or false, and what sources they can trust.

Return to Report

d. Lack of Healthcare Providers

A lack of healthcare providers (including primary care physicians) was mentioned as one of the greatest unmet health needs, both in general and among diverse providers, as well as a lack of specialty providers in free/reduced cost clinics. No-shows may be causing a lack of offerings due to capacity in some instances. It was noted that a lack of diverse providers impacts communication with patients and fails to combat the lack of trust.

e. Under-Resourced Populations and Structural Racism

Under-resourced populations include Black/African American, Latino, medical refugees, recent immigrants, and persons with disabilities. The healthcare system must acknowledge structural racism and must be designed to address these barriers. Gender-affirming care is needed for pediatric and adolescent patients.

f. Social Determinants of Health

Safe, stable, and affordable housing were mentioned by focus group participants as some of the greatest unmet health needs in the community (including housing for individuals after discharge), as well as food insecurity, education, and unemployment.

3. Whether Health of the Community Improved, Declined or Stayed the Same

Whenever asked whether the health of the community has improved, declined, or stayed the same over the past few years, most respondents believed that health is declining. Some specifically indicated that mental health is declining. Some specified that health has improved for the insured and wealthy but declined for the poor and uninsured.

The pandemic was cited as a primary cause of the decline for several reasons—isolation has led to increased drug use and mental and behavioral health issues, people are not seeking care (including preventative care) for fear of COVID, and statistically there is an increased rate of death. Also, college-age students and young adults have felt the effects of the pandemic and experienced anxiety. Also due to the pandemic, poverty has increased, people have lost jobs and health insurance, and education has been permanently altered. Also, burnout has impacted all industries, and has impacted available healthcare services. The pandemic has also uncovered disparities among minority patient populations, and exposed segregation and discrimination (including Black and Latino populations), conditions which have existed for decades. Pandemic healthcare difficulties have also exposed a declining safety net that has existed for a long time, as there is a decreased ability to help underserved communities. The pandemic has also compromised basic resources such as access to workout facilities. The decline has created an environment that is reactive, versus focusing on the long-term.

Focus group participants noted that a few good things may have come from the pandemic. For example, one positive factor is the recognition of integrated needs (mental health, physical health, and financial health) needing to be addressed at all levels. Also, communication has improved due to need.

4. Barriers to Addressing Health Needs

Return to Report

Focus group participants mentioned the following barriers to addressing health needs within the community and noted that strong leadership support to solve the issues and challenges is needed.

a. Mental Health Resources

Focus group participants indicated that many more therapists, nurses, and technicians are needed to serve mental health patients. The pandemic has caused "pandemic fatigue" – burnout and complacency depending on the circumstances and ability to access resources. The new reality or sense of "normal" is causing uncertainty in people's daily lives and is causing people to become scared, confused, or to feel unsettled. Isolation brought on by the pandemic is also a barrier.

The stigma surrounding mental healthcare still exists and is a barrier to tapping into services. Also, the virtual environment of accessing mental healthcare services due to the pandemic is a barrier. In the healthcare treatment context, virtual meetings dehumanize some of the interactions.

The structure of the mental health system is a barrier, as it is based on a "band-aid approach" versus a wholistic approach.

b. Lack of Healthcare Providers

Focus group participants noted that there is a lack of healthcare providers—especially mental health providers with immediate availability (all age groups). There is a shortage of primary care providers and preventative care options. Also, more providers are needed that patients can identify with (more providers of color are needed), and there is a lack of a strategic plan and/or pipeline to match diverse providers to patients.

Focus group participants noted that "community-based primary care" is needed. Healthcare is needed in places that are easier for people to access, and more community clinics would respond to this need. With the overcrowding of facilities and provider offices, the fear of COVID is deterring people from seeking care. Furthermore, scheduling and availability are limited.

Staffing shortages and pandemic burnout (on the provider side) were also discussed by focus group participants. There is a lack of providers and support professionals, and many have left the industry. This situation is causing high turnover, long hours, and much stress for those who work in healthcare, and there are currently many open positions. Healthcare organizations must offer a work environment that prioritizes employee care and allows employees to take the time off work for their own healthcare.

c. Poverty

Focus group participants observed that there is a lot of unemployment and poverty in the community, and people who do not have financial resources often do not prioritize health and have limited resources and services available to them. Also noted was that there is a lack of healthcare information distributed to this population. Finally, many people do not have resources for medications. Given these factors, there is a general sense that systems/resources are unable to keep people safe and protected.

d. Complexity of Healthcare System

Return to Report

Focus group participants noted that the complexity of the healthcare system is a barrier to addressing the healthcare needs within the community. First and foremost, focus group participants discussed the difficulty of navigating the healthcare system in general. People do not know where to sign up for insurance, how their insurance works, or how to navigate the healthcare system. People are unfamiliar with Federally Qualified Health Centers and what care is available there. People question what services exist, how to find providers, how to get to provider locations and access the services, and who will pay for their care. People need to know how to navigate the healthcare system—ambassadors or navigators are needed to help people know how or where to get help. This would give people a sense of mastery over the requirements that must be met to understand the healthcare system and get the help they need.

Focus group participants discussed the current lack of temporary/transitional services available within the community. Essentially, there are not places for people to land, and there is a long wait for services to assist people with mental health, housing, food, and employment. Fulfilling the need for downstream resources is important because providing these services will decrease the need for resources in the future. Medicare/Medicaid do not provide a complete chain of help for people. There is a decrease in supporting services due to low funding and high demand. Focus group participants noted that, while there are a lot of ideas, a lack of funding exists.

Finally, focus group participants noted that a significant barrier to addressing the health needs of the community is the compensation model of healthcare providers (which is based on cash versus care).

e. Access to Healthcare

Focus group participants discussed how “access to healthcare” is a barrier to addressing health needs within the community. Numerous factors negatively impact access to healthcare.

Focus group members noted that the high cost of healthcare is a barrier, as well as a lack of insurance, a lack of understanding of insurance, and a decreasing number of medical facilities that will treat patients without insurance. Within the community, there is little awareness and knowledge regarding health issues and awareness of available programs, a lack of primary care, and long wait times for appointments. The Community Health Center was mentioned, although focus group participants noted that there is a lack of knowledge of or access to the center, and that the center is the only point in the system accommodating underserved populations.

Healthcare is particularly difficult to access for those individuals who lack residency. Undocumented persons are not able to access services as there is a fear of being turned away and subject to legal action impacting residency. One focus group participant noted that it is impossible to access primary care if you are uninsured or undocumented—and that you have no choice but to use the emergency room.

According to focus group participants, transportation systems and routes to healthcare services are not available in suburban areas. Transportation for persons with physical disabilities is a barrier—and there currently is no such transportation. Financial and safety barriers also exist. People may be able to find transportation to the hospital, but not for follow-up visits or referrals from the emergency room. People also need transportation to pharmacies to get their medications.

Finally, focus group participants discussed the issues of health literacy and technological ability. Information is changing so fast that it is hard to keep up, and attention must be paid to information versus misinformation. Technological ability is a barrier, however. One focus group participant asked, if people do not know how to use the technology, how are they going to access information and care? It was noted that there is too much emphasis on technology for a population that is not proficient in the use of technology.

f. Social Determinants of Health

Focus group participants noted that job opportunities are needed within the community with livable wages, as well as job-training programs and workforce training, so people can get the resources they need. Affordable housing is also needed, and people do not have resources for food. Childcare is also needed within the community, because obtaining childcare impacts the ability to make healthcare appointments (for example, women with young children scheduling mammograms).

g. Diversity and Inclusion

Focus group participants noted that different populations within the community face different levels of opportunities and challenges. For example, language access for non-English speaking populations is a problem (for example, electronic medical records are only produced in English), and healthcare institutions must commit to being anti-racist/diverse and be able to deliver information through language barriers and provide it to a diverse community. One participant noted that antisemitism, racism, all the “isms” and phobias are heightened in the current environment and will play a large role going forward, and that there must be a commitment to serve everyone in the community. Another participant noted that, while there may be improvements in some parts of the city, there is historic disinvestment in Black neighborhoods. Focus group participants commented that within the community there is a cultural/historical distrust of the healthcare system and of the government, along with disparities in care, and that the gap is widening.

h. Other

There were several other barriers to addressing health needs within the community discussed by the focus group participants. Discussion was held regarding barriers experienced by the elderly population. To that end, the “digital divide” was mentioned – that there is a technology gap for certain populations – and how to make technology accessible and understandable by certain populations. Also, technology/internet access is needed. With an aging society and life expectancy increasing, it is important for the elderly to be able to navigate the healthcare system and to be able to remain independent. Also, the elderly need hearing and vision services, and more time with their physicians.

Focus group participants also discussed a shortage of childcare and day programs for children within the community, day patient spots, and the ability for youth and teens to receive assistance across the board. One barrier in this regard has been space.

Finally, focus group participants discussed the need for people to understand how to take care of themselves through preventative care, healthy eating, and exercise.

5. Underserved Groups

Return to Report

Focus group participants were asked to identify who are the most underserved groups within the community. An overarching theme discussed by focus group participants was that it must be understood that underserving a subset of the population impacts the overall health of the *entire community*. The following were identified by focus group participants as the most underserved groups within the community:

People who are low-income, uninsured/underinsured, or homeless, and other traditionally marginalized groups, are underserved. Medical care is expensive, and people in this group think they cannot afford doctors or medications. This population may not know how to navigate healthcare system. There are disparities in treatment, and differing treatment based on insurance plans. People in this group may be bypassing regular healthcare and may be unable (or afraid) to access care. The pandemic has created less access to help for these individuals.

People with serious mental illness/behavioral health issues are also underserved. These individuals often have no political power or voice within the community.

Members of Black and Brown populations, minority populations, and indigenous communities are underserved. There is a history of systemic racism and overall lack of equality among these populations. Relationships with these populations need to be reframed, and the lack of diversity in the healthcare system must be addressed. Children need to be exposed to different professions at an early age, and programs must be established in schools to teach children about medical professions. Also, healthcare provider education is needed to teach cultural education and communication skills and empathy to healthcare providers as well as how to combat mistrust (which must be addressed through targeted education and meeting individuals where they are located).

Immigrants, undocumented workers, and individuals who are not U.S. residents are underserved. Language barriers exist, and these individuals may experience fear and feel as though they are “in the shadows.” Characteristic of this group is a lack of representation in government and feeling like they have no voice politically.

People with disabilities are underserved and are often overlooked and sidelined. Many people in this group do not have the resources to become independent.

Numerous other populations were identified by focus group participants as being underserved within the community, including the elderly (especially those without an advocate, caregiver, or family), children and disconnected youth, young adults, LGBTQ (including youth), the uneducated (communications may not meet their needs), those who do not have access to technology or who are unable/unsure how to use technology, single moms with children, the “sandwiched” population (the generation between children and aging population who often take no time for themselves for mental health), those who need access to vaccines and boosters (currently, the system is not “friendly”), frontline workers who suffer from exhaustion, and NorthShoreConnect users (as there are significant disparities for those who access the system).

6. Greatest Economic Social Issues

Return to Report

Focus group participants were asked to identify the greatest social economic issues within the community. The following issues were discussed by focus group participants:

Poverty – Poverty has widespread effects and impacts one's ability to access proper food and affordable housing. Often there is a significant lag time when submitting applications for federal or state resources—for example, people may have utilities shut off before they obtain help. There are numerous causes of poverty, including intergenerational poverty and fixed income constraints for older generations.

Mental Health – Currently, there is high demand for mental health services, but a low supply of providers and resources, and stigmas still exist around the need for mental health support.

Access to Healthcare – Access to healthcare is hindered by many obstacles—including the cost of care (even for those who are insured), obtaining insurance, and the coordination of deductibles and costs. New families or people that are new to the community are unsure of what to do and where to go for assistance.

Health Literacy – Health literacy is an issue among various populations due to language differences and different levels of education. Also, if parents have low health literacy and are unaware of health matters, their children may suffer as a result.

Safe and Affordable Housing – Safe and affordable housing is an important issue, along with environmental matters that come into play if people have mold or lead in their household. People must sometimes wait for years to have home repairs competed. One focus group participant noted that 49.5% of the county residents pay more than 30% of income for housing.

Employment – Employment is challenging for many people for various reasons, including difficulty navigating employment sites/online job boards, lack of skills, and lack of mentorship. While there are many open positions, there is a lack of qualified candidates to fill those positions. Thus, emphasis must be placed on how to train people to fill positions, workforce development, getting into schools to increase awareness of healthcare careers, and recognizing that the "typical" college path is not needed. Employment is also challenging for people with disabilities.

Racism and Cultural Differences – Racism and cultural differences prevent opportunities for people to advance economically. It helps people to see people that look like themselves—there is safety in that, and it makes people feel like they can bring their full self.

Other – Other economic social issues raised by focus group participants include transportation, drugs, and the uncertainty of COVID and what it means in our daily lives.

7. Most Significant Unmet Healthcare Needs (and How to Address Those Needs)

Return to Report

Focus group participants were first asked to identify the most significant unmet healthcare needs within the community, and then to discuss how to address those health needs. Their responses are summarized below.

a. Mental Health

Description of Health Need: Focus group participants identified mental health as one of the most significant unmet healthcare needs of the community—in general, affecting all populations—from childhood diagnosis to adult depression and medication, and at all levels. Demand for mental health services has increased for a variety of reasons, including stressors related to the pandemic and resulting loneliness, isolation, frustration, and helplessness. There is a lack of mental health professionals, and mental health services are expensive and economically out of reach, even with insurance. Low reimbursement rates also an issue for providers. While state legislators have been focusing on mental health, demand and strain are outweighing what has been accomplished, and it is still difficult for people to get the kind of care they need. Addressing mental health needs is very important because proper mental health care helps individuals from a physical health perspective, too.

How to Address: A common theme focus group participants raised to address mental health within the community is to rework the model of care make the services more accessible to people. Ideas to make services more accessible included establishing mental health clinics in the middle of residential areas; expanding mental health services into schools (for example, Evanston High School has a social worker); expanding telehealth services and mobile clinics; expanding real-time tools to assist people in a mental health crisis (such as hotlines); and integrating mental health screenings into wellness visits. Additionally, people need assistance overcoming the cost of accessing mental health services. Access to care is made difficult by the fact that public assistance is not accepted by most mental health providers.

Training was also raised as a fundamental means to address mental health, including culturally relevant mental healthcare training on a community level, increasing public awareness of mental health concerns and communication of care, mental health first aid training (for example, the mental health first aid training program at the Josselyn Center), and training lay populations to bring education to the community. A proactive approach in supporting mental wellbeing was suggested, such as by engaging friends, parents, teachers of children to help identify mental health issues and improve the network around youth.

Focus group participants discussed the need for an expanded and diversified workforce and increased pipeline of mental health service providers, initiatives to assist the immediate need with acute care, and retooling the system for long-term mental health care. Mental health care providers are faced with inadequate breaks and increasing restrictions, and there is a heavy focus on seeing more patients, resulting in less time spent with patients (which raises trust and ethical concerns).

b. Access to Healthcare; Navigating the Healthcare System

Return to Report

Description of Health Need: Focus group participants noted that access to healthcare is being hindered in various ways. First, there are not enough healthcare providers and staff. Many people are leaving the profession or supplementing their income (especially primary care providers). Second, there is a lack of effective communication of health information and resources to the community. While there may be information and resources to help those in need, people need confidence and support to better access the information and find resources. Third, people have difficulty navigating the healthcare system and many are "falling through the cracks" (particularly the elderly). Patient advocates are needed to help people figure out the costs of care, how their insurance works, what community social services are available, and where to go to receive services. People who do not understand technology may need assistance and support that is not computer based.

How to Address: Focus group participants next discussed how to improve access to healthcare and navigation of the healthcare system.

As to a shortage of healthcare providers and staff, focus group participants had various recommendations, including creating a Workforce Development Task Force, exposing youth to health knowledge and medical professions in school and developing a progressive curriculum, and mentoring people to go into the medical field. In the workplace, the need to reduce workload and stress for healthcare workers was discussed, along with considering financial rewards to incentivize healthcare workers to remain in their role (although it was recognized that for some people financial incentives not worth it compared to stress of the profession).

As to a lack of effective communication of health information and resources to the community, a recommendation was made to focus on making sure that the community knows about available services and resources and to reconsider the how health information is getting out to community members in need of assistance. For example, it was also mentioned that people may not be aware of certain rebate programs.

As to difficulty navigating the healthcare system, more robust care navigation assistance is needed to help people find safety net services/resources. Oftentimes, services/resources exist but people are not aware of what is available. Investment in a healthcare navigation program is needed to effect real change. More social workers, patient navigators, and patient ambassadors are needed because they are familiar with the healthcare system and can identify gaps. One focus group participant suggested creating a career path for people to act as consultants on insurance—potentially a government office that people could go for help with insurance. If people lose insurance or find out that their insurance is no longer accepted, healthcare providers should give a list of resources to people, so they do not fall through the cracks.

c. Primary and Preventative Care

Description of Health Need: Better access to primary care is needed, particularly for the uninsured and underinsured, as it is known that poverty contributes to health problems remaining unaddressed. Medication assistance is also needed, with a focus on diabetes and long-term medication management, especially in the senior population. Thorough and complete wellness visits are needed for more effective preventative care, and visits need to be more comprehensive. Also, there is an imbalance of focus on body health versus brain health. Finally, people need to better understand healthy life skills, including healthy eating habits.

Return to Report

How to Address: Focus group participants discussed the need for better access to primary care within the community. Numerous suggestions were made, including to expand or add locations to NorthShore's Community Health Center, create new or expanded collaborations among organizations that target underserved communities (such as Erie Family Health Centers), increase mobile services within communities (including for dental and preventative services), innovate school-based services models (such as by expanding clinic hours to accommodate parents getting flu shots in the evening), improve access to healthcare for NorthShore employees, and improve access to providers at NorthShore to get as many people seen as possible (including through same-day appointments).

As to addressing preventative care, numerous focus group participants emphasized the importance of providers taking the time to understand what patients need, which would involve increasing the length of time of wellness visits (especially in youth). Also, physicians need to spend more time to help manage and coordinate care. Consideration should be given to utilizing technologies to obtain input from the patients, and then actually responding to that input by following through on next steps (which is currently lacking). Preventative care in youth can be bolstered through parenting classes and programs that help parents model good health and wellbeing. Furthermore, expanded outreach to young adults at colleges and high schools regarding health literacy should be considered. To that end, suggestions included speaking at schools and sending providers into schools, establishing means to see healthcare providers outside of a healthcare setting, and leveraging social media.

Focus group participants suggested that creating better access to primary and preventative care may require taking a step back and getting back to basics, and essentially rebuilding healthcare programs and redetermining priorities. Also, influential organizations within the community should engage in advocacy efforts and use their voices to make healthcare more affordable. The power of insurance companies must be balanced with the power of providers to be able to make decisions that benefit patients and the community.

d. Discrimination / Health Inequity / Mistrust

Description of Health Need: Focus group participants discussed a resurgence of discrimination in this country. Those feeling the brunt of this discrimination are impacted the health needs described in this report. The community lacks access to providers with whom patients can identify, as well as a statistically diverse and culturally competent workforce that matches the geographical area of care. Also, healthcare inequities exist within the healthcare system and there is a lack of inclusive care. Focus group participants also discussed a general lack of trust in the healthcare system and noted that a healthcare system is needed that puts patients first and that is welcoming and fosters engagement, access, and trust.

How to Address: Focus group participants emphasized the need to combat discrimination within the healthcare system. Patients need healthcare providers to whom they can relate (including clinical and administrative staff) – providers that look like them – and they need providers that will meet them where they are. To improve diversity among healthcare providers, the community must develop a diverse talent pipeline, and start early to develop these careers. Suggestions included considering a middle/high school mentorship program to foster these careers and recruiting with an intentional focus on diversity at every level of the organization. Also, healthcare providers must commit to hiring and training people of color—for all levels of jobs, from low-level to executive level, and should also look at their own workforce to elevate or groom people of color for positions of authority and decision-making. Diversity of clinical and administrative staff would help develop trust in the community.

Focus group participants also discussed the need for intentional education of providers on the importance of cultural competency and implicit racial biases (for providers and administration). This step can help build trust with vulnerable communities and lead to better healthcare outcomes.

Community healthcare must include population-focused programs that offer inclusive care. To that end, it is important for NorthShore to understand who is in its service area, and to ensure all patient voices and experiences are represented. Welcoming spaces must be created for all people (regardless of culture, language, etc.) This may involve the utilization of community healthcare workers (not clinicians, but rather people who can interface with clinicians). Marketing communications must be in all relevant languages, and efforts must be made to identify language barriers and provide interpreter services.

Return to Report

To combat discrimination, health inequity, and mistrust, there must be community collaboration that includes key partners. There are numerous organizations that need to be included in the dialogue about issues and solutions, and all groups must be represented, including immigrants, Muslims, LGBTQ, etc. Also, community organizations can use their buying power to show support for black and brown and other minority-owned businesses within the community.

e. Housing / Employment / Food Insecurity

Description of Health Need: Focus group participants observed the need for access to home ownership and for people to experience stability and wealth within the community. More affordable housing is needed, as well as more multi-unit housing. There is a great need for stability in people's lives, especially given the challenges brought on by the pandemic, which compromised mental health outcomes, children's wellbeing, employment, food security, and more.

How to Address: Focus group participants supported an increase in the supply of affordable housing within the community. Also, an emphasis on employment was suggested, perhaps utilizing partnerships to guarantee employment upon completion of a certification or degree program. Also, food pantry deliveries to seniors in need was suggested.

Within the discussion of significant health needs and how to best address those needs, it was mentioned that no single group can "do it alone," and that the community working together will have the greatest impact on addressing health needs, such as through Community-Connected Care, an organization that helps those within the community who need healthcare services and that is funded by philanthropic support from generous community partners.

Appendix B – Summary of Focus Groups: Public Health Department Input

Return to Report

Public health officials from the City of Evanston Department of Health, Lake County Health Department, and the Village of Skokie Health Department were interviewed to obtain additional input on the health needs of the community. The officials were asked three questions regarding community health, their responses to which are summarized as follows.

First, the officials were asked for their input regarding the most significant health needs within the community and their thoughts on recommended strategies for how to address those needs.

Mental health was cited as a significant health need for numerous reasons, including the unwillingness of providers to accept Medicaid or Medicare, a lack of available inpatient mental health care, a lack of psychiatry providers (including a lack of diverse providers), the stigma surrounding seeking mental health treatment, and a lack of means to better identify and refer individuals with mental health needs. Suggestions to address the need for mental health services in the community include mental health first aid training and establishing a mental health “living room” program. A mental health “living room” model aims to have a dedicated building for mental health living rooms, which offer people experiencing a mental health crisis a calm and safe environment.

Access to healthcare was also mentioned as a significant health need. Access to healthcare is hindered by numerous factors, including a lack of insurance, the high cost of care, staffing and resource constraints (due to retirements and people leaving the industry), and high volume and long wait times to obtain help. The officials stated that all healthcare services should be accessible to everyone. Several suggestions were made to address this health need, including better identifying patients and improving referrals (which requires an investment in digital technology and investment in resources to which individuals are referred), helping channel people to other resources rather than going through emergency rooms, and continuing to utilize telehealth (which has helped capacity by decreasing the no-show rate and improving continuity of care).

Other significant health needs mentioned by the officials included a lack of trust in the healthcare system (especially among the African American community), the challenge of moving primary care diagnoses to specialty care, intergenerational poverty, nutrition, and inactive lifestyles. Social determinants of health that need addressed within the community include education (particularly how education is funded), the ability to earn a living wage, better housing, and food.

Second, the officials were asked for their input regarding health disparities within the community and their thoughts on what populations in the community are most underserved. Individuals at lower socio-economic levels experience health disparities within the community, and a guaranteed income program was instituted in Evanston to help individuals who have experienced extreme hardships during the pandemic. Undocumented residents also experience health disparities. While there is some governmental funding, the number of undocumented residents within the community is unknown and resources are limited. Undocumented residents may have a fear of seeking healthcare and may be unable to access care once diagnosed or when they become sick. Minority populations within the community—including African American, Brown, and Hispanic communities—experience health disparities. Structural racism must be addressed, as well as the ability for minorities to earn a living wage. Many essential workers were unable to work from home during the pandemic. Because they needed income, they were forced to go into the workplace, which increased their likelihood of exposure to COVID, leading to more deaths and infections. Individuals who speak English as a second language, or those who do not speak English at all (including immigrants, South Asians, and Middle Eastern populations) experience health disparities within the community, and deeper connections must be made with these communities. The elderly population also experiences health disparities in the community, as long-term care facilities are not investing in disease prevention (as seen with COVID). Also, individuals with mental health needs experience health disparities in the community.

Return to Report

Third, the officials were asked their opinion regarding emerging health needs within the community. Poor diet and lack of exercise were discussed, with contributing factors including socio-economic status, the digital environment, and the pandemic. Another emerging health need discussed was negativity or hesitancy toward vaccines, especially given the threat of other infectious diseases and the future of COVID-19. Lessons learned from COVID may inform future responses to emerging new infectious diseases. There is a need for resources, staffing, and funding (particularly an increased investment in prevention). While improving public health infrastructure is important, the current trend is reduced governmental funding as states try to find a COVID exit strategy. While it is hard to predict the future, it is important to build off lessons learned from COVID. Additional emerging health issues identified by the officials include coordination and intake processes to help individuals in the health care system, and crime and violence. Evanston is seeking to put programs and initiatives in place to keep youth engaged and away from crime and violence.

Appendix C – Community Survey Summary

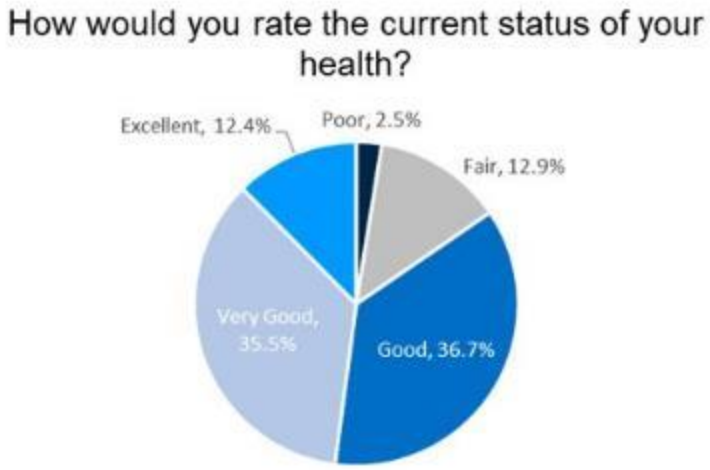
Return to Report

In order to develop a broad understanding of community health needs, NorthShore conducted a community survey during February and March of 2022. A link to the survey was distributed via e-mail, social media and word of mouth to the community at-large. A total of 947 surveys were completed.

- The majority of respondents were White/Caucasian (76%), 9% identified as Hispanic or Latino, 7% of the respondents identified as Asian, and 4% identified as Black or African American. The remaining 4% identified with other racial or ethnic identities.
- Respondents by age group were as follows:
- Age Group Percent of Total Respondents
  18-34 7%
  35-44 15%
  45-54 23%
  55-64 21%
  65+ 34%
- Females represented 78% of the respondents while males represented 21%. The remaining 1% of respondents identified as other genders or chose not to answer.

Given the reported demographics above, care should be taken with interpreting the survey results. The ethnicities, ages and gender of survey respondents do not match demographics for the CHNA Community. Specifically, the survey reached more whites and more females compared to demographic information for the community. Additionally, the majority of survey respondents were adults, aged 55+.

Survey respondents were asked to rate the current status of their health. The majority of the respondents indicated the status of their health was good.



Almost **65%** of the survey respondents indicated they are always able to visit a doctor when needed. When asked for about the reasons why they are unable to visit a doctor when needed, respondents indicated the fact that doctors are not taking new patients, limited appointments are available and/or appointments are not available for months, inability to afford the doctor visit, and getting time off work as primary reasons why they could not visit the doctor when needed. The majority of respondents, over **74%,** have had a routine physical in the last year.

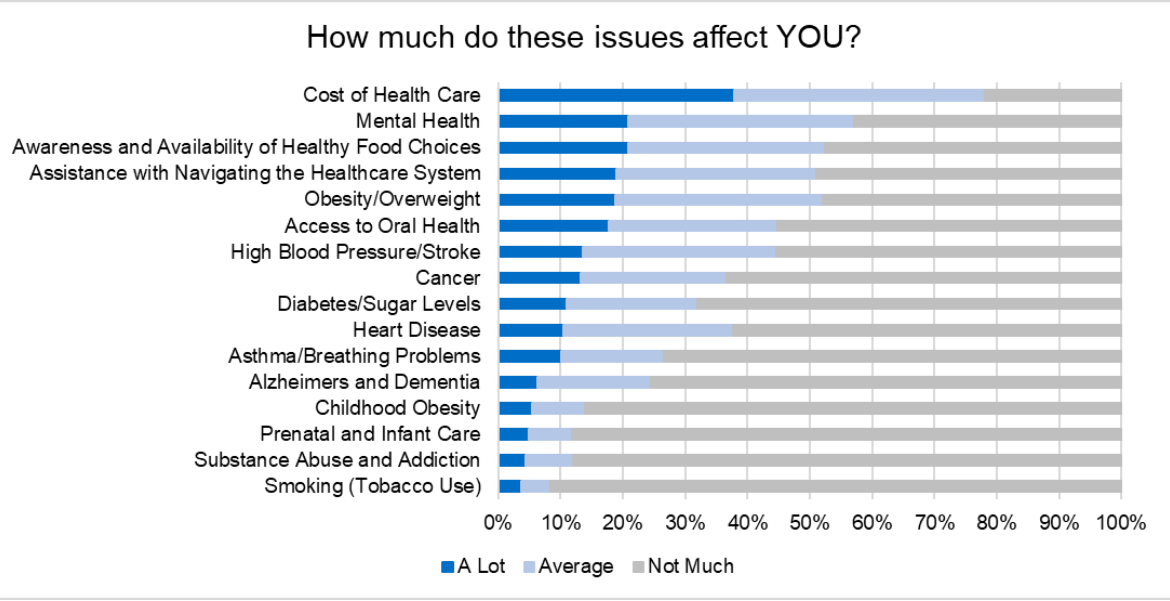
Respondents indicated the biggest source of stress in their daily life was financial stability and relationships. In addition, respondents indicated the biggest challenges related to the COVID-19 pandemic were mental health and social isolation and juggling work and family.

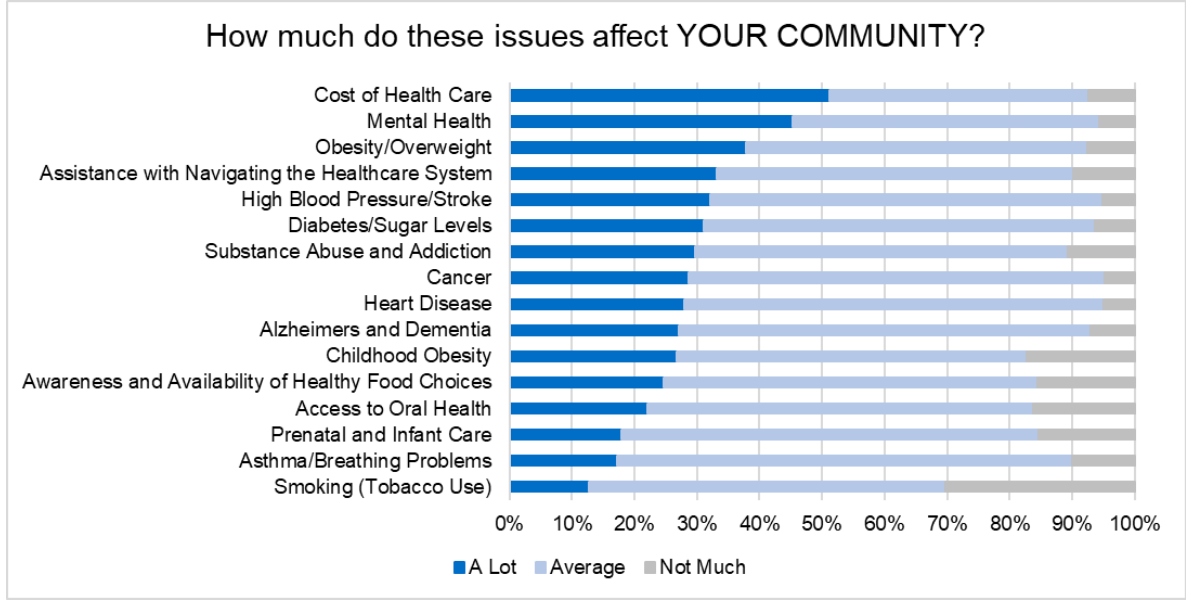
Appendix C – Community Survey Summary

Return to Report

When asked "How much do these health issues affect YOU?" cost of health care, mental health, awareness and availability of healthy food choices and assistance with navigating the healthcare system were the issues that affected respondents most.

When asked to rate how the same issues impacted the community, respondents identified cost of health care, mental health, obesity and assistance with navigating the healthcare system as the issues that affected the community most. The charts below summarize all of the responses to these questions.





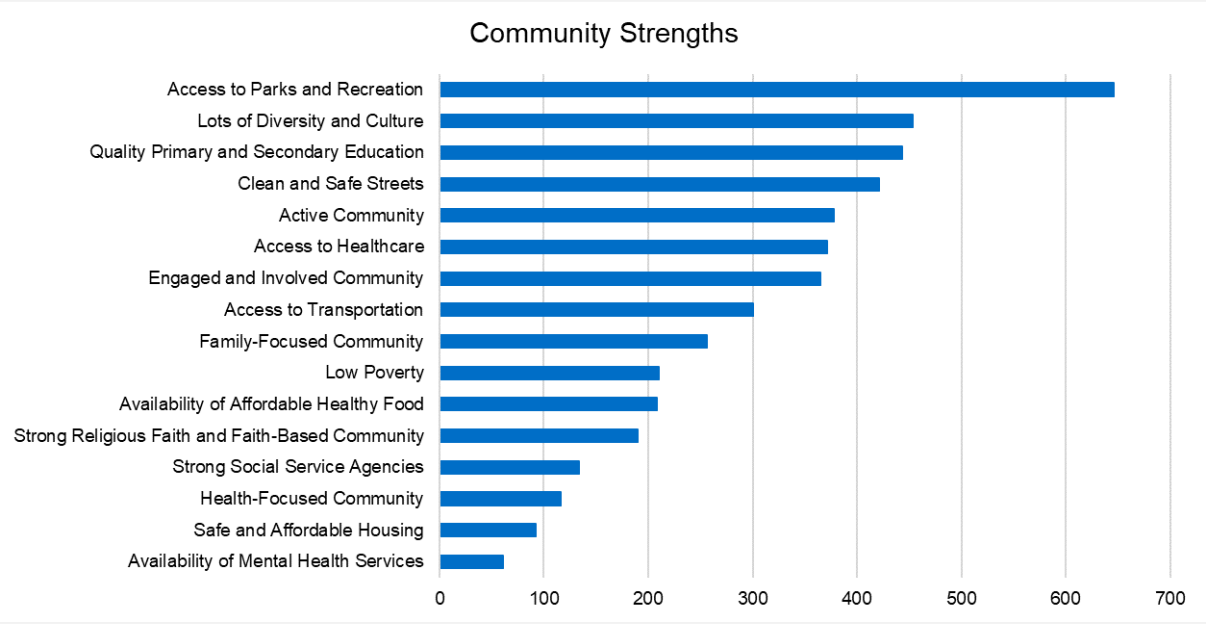
Appendix C – Community Survey Summary

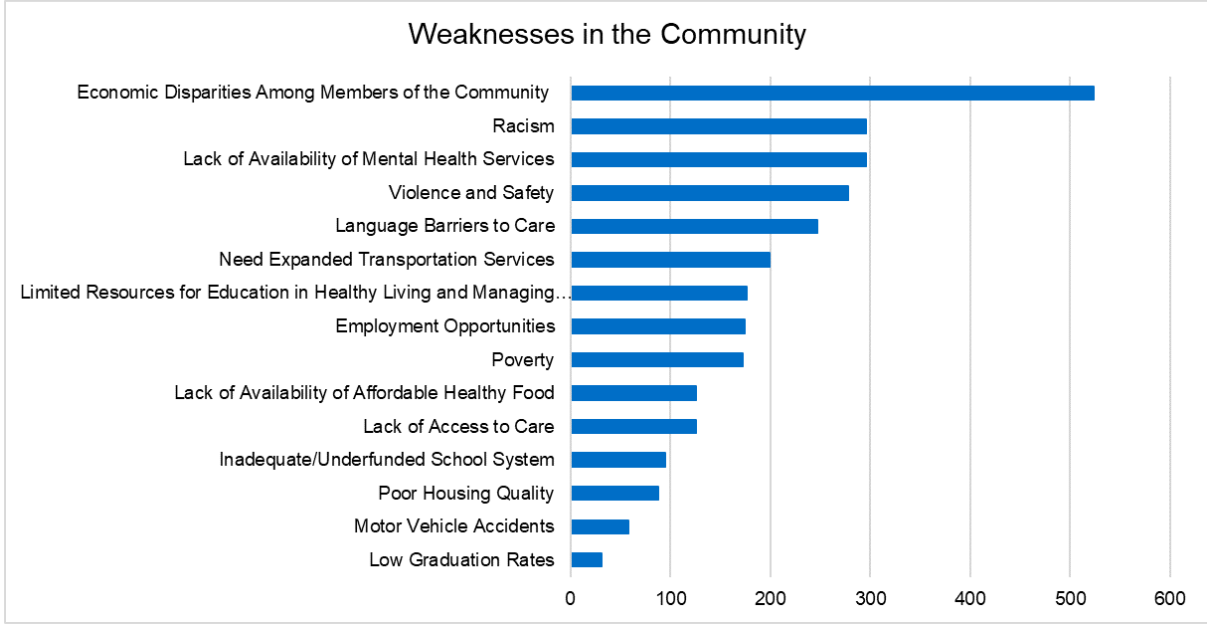
Return to Report

The survey asked the following two questions:

- What do you believe are the current STRENGTHS of your community?
- What do you believe are the WEAKNESSES in your community?

The survey provided predetermined responses that could be selected from the list. Respondents were instructed to mark up to five selections. Below is a summary of strengths and weaknesses identified.

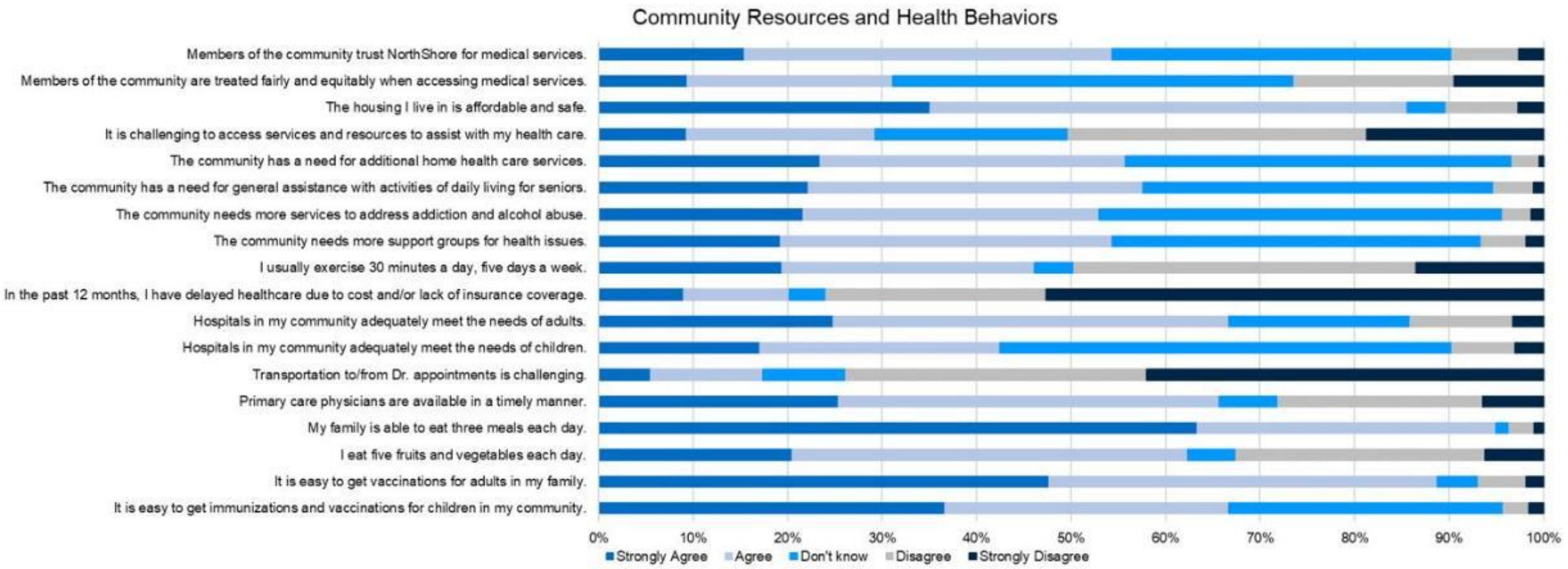




Appendix C – Community Survey Summary

Return to Report

Below is summary of the survey results regarding specific statements regarding community resources and health behaviors. Key findings are summarized on the following page.

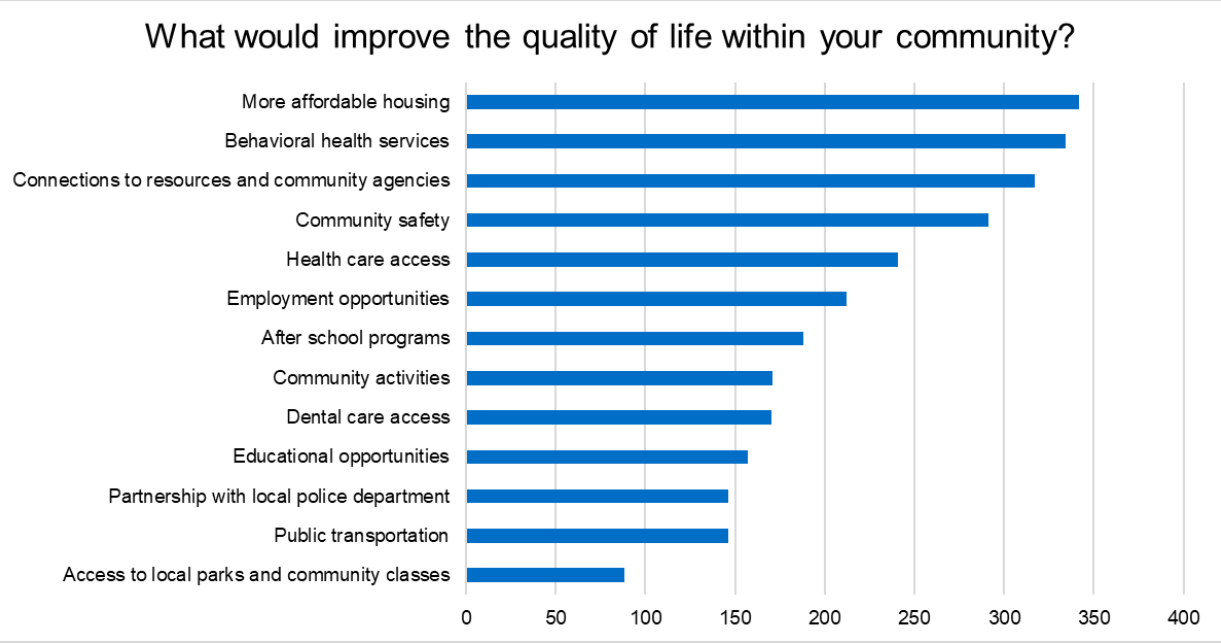


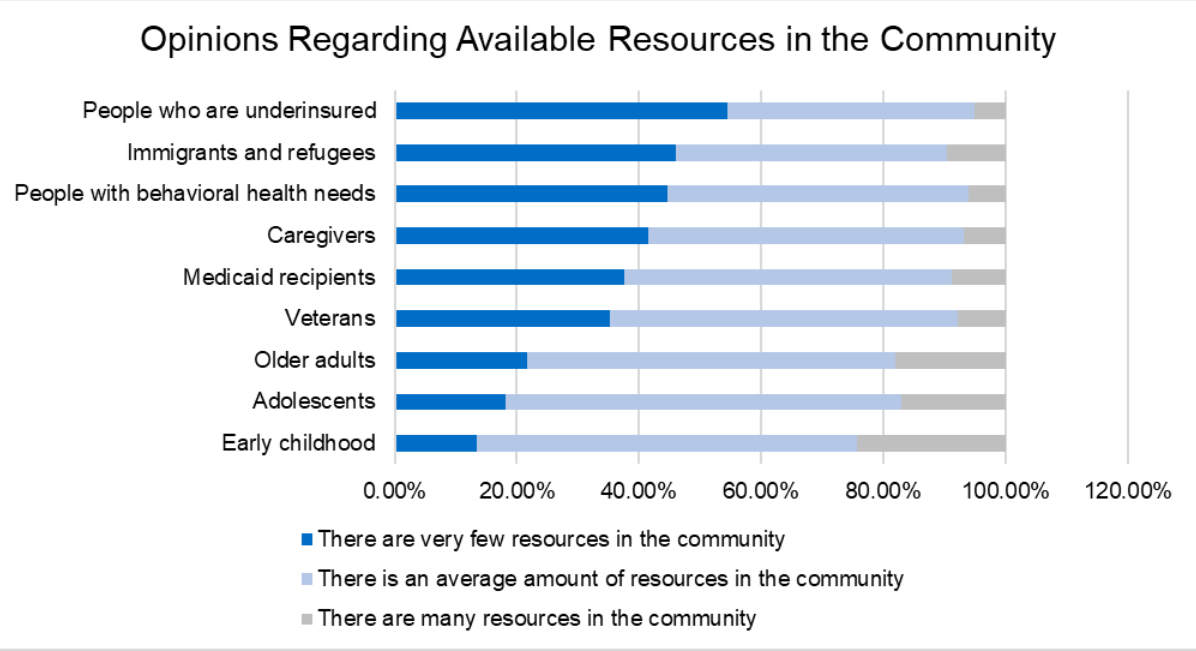
Appendix C – Community Survey Summary

Return to Report

Community Resources and Health Behaviors – Key Findings

- Approximately **62%** of the respondents agreed or strongly agreed with eating five fruits and vegetables each day. Significantly less, **35**%, exercise at least 30 minutes a day, five days a week.
- **17%** of the survey respondents indicated transportation to and from doctor appointments is challenging.
- **10%** of the survey respondents disagreed that the housing they lived in was affordable and safe.





Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA

Return to Report

Evaluation of the Impact of Actions Taken Since the Last CHNA

NorthShore University HealthSystem (NorthShore) implements a three-fold strategy to address the identified health needs of the communities that it serves as follows:

1. Community benefits programs and partnerships will address a need identified in the CHNA (CHNA) conducted by NorthShore. If an identified health need is not to be addressed by NorthShore, rationale will be provided.

2. Community benefits programs, initiatives and partnerships will address a need requested by the community.

3. Community benefits programs, initiatives and partnerships will be aligned with the guiding principles outlined in Advancing the State of the Art of Community Benefits for Nonprofit Hospitals. The guiding principles are: Disproportionate Unmet Health-Related Needs; Primary Prevention; Seamless Continuum of Care; and, Build Community Capacity and Community Collaboration.

NorthShore places priority on providing community benefits and services in the communities located nearest to our hospitals, where we believe we have the greatest capacity and responsibility to serve.

Community health needs data is used in NorthShore's annual planning processes. Stakeholder participation is critical and influences NorthShore's prioritization and execution of its community benefits programs. In addition, collaboration with local leadership allows NorthShore to detect urgent and growing needs that may be under-represented or absent from aggregate data, in a timely and effective manner. Lastly, collaboration with local leaders has facilitated the development of programs and partnerships to provide real time solutions to critical health challenges.

Overview of Anticipated Impact: For the fiscal year 2019 CHNA and Implementation Strategy Plan, NorthShore evaluated the anticipated impact of the initiatives listed for each hospital outlined in the strategic plan by collecting data on how many individuals utilized components of the initiative. Measurement of the impact also assessed by gathering ongoing feedback from the hospitals' Community Advisory Committees, senior leadership and physician leadership.

In accordance with Internal Revenue Code §501(r) and final regulations outlined in §1.501(r)-3(b)(6)(i)(F), NorthShore presents the following review and evaluation of implementation activities carried out over the past three years related to the fiscal year 2022 CHNA and Implementation Strategy (2019-2020).

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA

Return to Report

Priority Health Needs Identified in 2019 Implementation Strategy Plan

Based on the review and analysis by NorthShore's leadership, the following health issues were determined as priority health needs, divided into "External Factors Impacting Community Health" and "Disease Conditions," which NorthShore addressed over the past three years.

External Factors Impacting Community Health (rank order):

- Access to Behavioral Health
- Health Literacy and Navigating the Healthcare Environment
- Access and Coordination of Care (affordability, education, transportation, specialty care, cultural competency)
- Substance Abuse

Disease Conditions (rank order):

- Behavioral Health (mental health and substance abuse, psychiatry and community based services)
- Chronic Risk Factors (prevention and management of obesity, tobacco use, hypertension)
- Alzheimer's/Dementia (prevention, management, caregiver support, long-term care)
- Oral Health
- Diabetes
- Cardiovascular Disease and Stroke
- Cancer
- Lung Health
- Maternal and Child Health (infant mortality, low birth weight)

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA

Return to Report

Key Initiatives to Address Identified Health Priorities

The following health issues were identified as priority health needs addressed since the previous Implementation Strategy Plan of 2019. Below are key initiatives throughout the NorthShore system that addressed those needs.

Access to Behavioral Health

- **Perinatal Depression Program** identified women who are suffering from perinatal depression and offered referrals for women who may need additional help. The program screened women for perinatal depression during and after their pregnancy and offered a 24/7 crisis hotline for women and their family members who may have found themselves in an emergent situation. All services were provided free of charge. *The Perinatal Family Support Center responded to more than **600 referrals** annually.*

- The **Perinatal Family Support Center** provided a wide array of services free of charge to women and their families who experienced challenges related to pregnancy, birth, prematurity or perinatal loss. Services were provided in both inpatient and outpatient settings and included groups, sibling tours and a literacy program in the child and adolescent clinic. *The Perinatal Family Support Center responded to more than **1,500 referrals** annually.*

- NorthShore collaborated with The Josselyn Center to develop a pilot program that provided virtual **Mental Health First Aid** (MHFA) training in NorthShore's service area. The collaboration consisted of community based programs on how to identify and respond to mental health emergencies. *In its first year, 2020, a total of **six** MHFA sessions were conducted that trained a total of **120 participants**.*

- **Bridges Early Childhood and Adolescent Program** provided comprehensive, multidisciplinary mental health intervention and direct care to insured and uninsured children between the ages of three and 18 living in NorthShore communities.

- The **Phoenix Program** served adult community residents with chronic and persistent mental illnesses, as well as community patients without sufficient financial resources to afford outpatient psychiatric care.

- NorthShore provided substantial financial support for **Turning Point Behavioral Health Care Center's** innovative **"The Living Room"** project provided psychiatric respite care for patients dealing with mental health issues. The unique program, supported by Skokie Hospital, uses peer counselors (adults in recovery from their own mental health challenges) and reports a 98% success rate in keeping in-crisis patients out of hospital emergency rooms.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA

Return to Report

Health Literacy and Navigating the Healthcare Environment

- **Interpretive Services** provided comprehensive, in-person and telephonic translation and interpretation services for patients and family members who received medical treatment at any of the NorthShore facilities. *NorthShore provided over **$4 million** worth of interpretive services.*
- NorthShore is one of the partners in a **Value Based Contract** that served the Medicaid population managed in partnership by Meridian Health Plan. NorthShore coordinated care and the quality programs designed to improve access and ensure high quality care for a Medicaid population. *NorthShore coordinates care and the quality programs designed to improve access and ensure high quality care for a Medicaid population of approximately **6,000 patients** annually.*
- NorthShore's certified application counselors assisted patients and the public with questions about enrollment in the insurance exchange (**Affordable Care Act/Insurance Exchange Enrollment**).

Access and Coordination of Care

- **Charity Care** (free or discounted care) was provided to all NorthShore patients who qualified based upon federal poverty guidelines. *Charity care was provided to over **57,000 patients** valued at over **$58 million**.*
- The **Community Health Center** at Evanston Hospital provided medical care to adults who lack private medical insurance. Medical services included, but were not limited to: Primary Care, Obstetrics/Gynecology, General Surgery, Orthopedics, Diabetes Education and Podiatry. *Evanston Hospital's Community Health Center provided care for **10,005 adult patients** with **29,019 visits**.*
- NorthShore provided primary, mental and dental care services to under/uninsured patients of the **Erie Evanston/Skokie Health Center** and community. *Over **2,000** Erie Evanston/Skokie Health Center client received specialty care services at NorthShore on an annual basis.*
- The **Dental Center** at Evanston Hospital provided primary dental care services and special consultations for medically underserved adult patients, pre-screenings for cardiovascular patients, management for oral complications in oncology patients and refractory dental problems. *Annually, the Dental Center served approximately **10,500 underserved individuals**.*
- **Evanston Township High School Health Center** is a school-based health clinic funded by NorthShore, which provided physical exams, immunizations, treatment of acute and chronic illnesses, individual counseling, health education, gynecological care, and support groups to students whose parents allow them to enroll in the health center. *An average of **900 ETHS students** made **3,500 visits** to the Health Center annually.*
- NorthShore responded to the **COVID-19 pandemic** by providing ongoing and updated safety and vaccine information to the public through numerous communication channels including virtual meetings with organizations and community leaders. The organization provided free vaccinations in several community settings and donated personal protective equipment (PPEs) to community organizations.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA

Return to Report

Substance Abuse

- **The Doreen E. Chapman Center** at Evanston Hospital, provided chemical dependency services to adults 18 years and older and their families. The Chapman Center offered effective, coordinated services to individuals who have addiction and a co-occurring psychiatric illness or chronic pain. *An average of **350 patients** received care on an annual basis.*

****

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Evanston Hospital)

Comprehensive List of Initiatives by NorthShore Hospital Pavilions

The table below lists the initiatives based out of the **Evanston Hospital** campus, which addressed the health needs identified in the NorthShore 2019 CHNA.

Implementation Strategy Plan Activities/Initiatives/Events and Programs Reporting:

1. Initiatives identified by named hospital are managed from that site
2. Corporate/System initiatives are applied to all four NorthShore hospitals
3. Financial contributions to community organizations correlate as indirect impact to identified community health needs

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
NorthShore collaborated with The Josselyn Center to develop a sustainable program to provide virtual **Mental Health First Aid (MHFA)** training in NorthShore's service area. The collaboration consisted of community based programs on how to identify and respond to mental health emergencies.	Access and Coordination of Care Behavioral Health		A total of **six** MHFA sessions were conducted that trained a total of **120** participants. The long term goal of the partnership is to train additional instructors to meet the increased demands from community organizations during the next implementation strategy cycle.
The **Community Health Center** provided medical care to adults and children who lack private medical insurance. Medical services include, but are not limited to: Primary Care, Obstetrics/Gynecology, General Surgery, Orthopedics, Diabetes Education and Podiatry.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	Evanston Hospital's Community Health Center provided care for **10,005** adult patients with **29,019** visits.
Emergency Departments within NorthShore are staffed 24/7 with physicians, nurses and technicians who are trained to respond to medical emergencies. Evanston Hospital provides Level 1 trauma services.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health	On an annual basis, the Emergency Departments at NorthShore had approximately **118,500** patient visits.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Evanston Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
Evanston Hospital's Emergency Department provided **Care for Sexual Assault Patients** from ED nurses who received specialized education and training and provide survivors of sexual assault with comprehensive medical-forensic care.	Access and Coordination of Care Behavioral Health Community Request	Over the last three years, 155 individuals received care from a nurse examiner trained in supporting sexual assault patients.
The **Dental Center** provided primary care dental services and special consultations for medically underserved adult patients, pre-screenings for cardiovascular patients, management for oral complications in oncology patients and refractory dental problems.	Access and Coordination of Care Chronic Disease Risk Factors Cancer Diabetes Oral Health	Annually, the Dental Center served approximately 10,500 underserved individuals.
The **Cardiovascular Institute** provided comprehensive cardiology services, with combined expertise of cardiologists and cardiac surgeons working together to provide patients with exceptional heart care including cardiac imaging, cardiovascular surgery, clinical cardiology, electrophysiology, heart failure, interventional cardiology and a women's heart program.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke	NorthShore hospitals had an average of **123,000** cardiology procedures each year including open-heart surgeries, coronary interventions, echocardiograms, and stress tests.
The **Primary Stroke Center** follows national standards and guidelines that include an Acute Stroke Team for rapid diagnosis and treatment. A team of neurologists plans to staff the center 24 hours a day, 7 days a week.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke	NorthShore maintains Primary Stroke Centers at each hospital with an Acute Stroke Team available 24 hours a day, seven days a week, for rapid diagnosis and treatment.
The **Kellogg Cancer Center** provided comprehensive, compassionate cancer care and treatments for oncology patients and their families. Our collaborative cancer treatment model focuses on each patient's individual needs, providing medical, surgical, radiation, psychological and emotional care.	Access and Coordination of Care Cancer	The Kellogg Cancer Centers at Evanston, Glenbrook, and Highland Park Hospitals had an average of **92,000** patient visits each year.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Evanston Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **Gastroenterology (GI) Department** provided a full complement of services including early diagnosis and prevention of colorectal, esophageal, pancreatic cancer, Inflammatory Bowel Disease and other GI conditions.	Access and Coordination of Care Cancer	NorthShore hospitals had an average of **38,000** GI procedures each year including colonoscopies, endoscopies, and advanced therapeutics.
The **Division of Pulmonary, Allergy and Critical Care Medicine** provided consultative services, diagnosis, and treatment of all aspects of lung disease in adults including allergy, asthma, lung cancer, bronchiectasis, COPD, cystic fibrosis, pulmonary fibrosis, persistent cough, shortness of breath, lung infections, and other diseases of the lung.	Access and Coordination of Care Chronic Disease Risk Factors Cancer Lung Health	The NorthShore Division of Pulmonary, Allergy, and Critical Care had an average of **23,000** patient visits each year.
The **Division of Endocrinology, Diabetes and Metabolism** provided consultative services, diagnosis and management of diseases of the endocrine system. The program offers a multidisciplinary approach to diabetes, gestational diabetes and those requiring insulin pumps. The staff consists of physicians, nurses, dietitians and certified diabetes educators who work together for diabetes management.	Access and Coordination of Care Chronic Disease Risk Factors Diabetes	The NorthShore Division of Endocrinology, Diabetes and Metabolism had an average of **26,500** patient visits each year.
The **Neurological Institute** provided therapies to slow brain aging to reduce the risk for Alzheimer's disease and other aging brain disorders include medical, physical, cognitive, dietary and integrative approaches.	Access and Coordination of Care Alzheimer's/Dementia	NorthShore Neurological Institute had an average of **138,000** patient visits each year.
The **Maternal Health** department at Evanston Hospital provided comfortable, high-tech birthing facilities.	Access and Coordination of Care Maternal and Child Health	NorthShore Maternal Health Department saw an average of **3,500** patients per year.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Evanston Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **Pediatric Rehabilitation Clinic** provided a wide array of outpatient services for young patients (from birth through adolescence) with special needs. A team of licensed physical, occupational and speech therapists specializing in pediatric care provide one-on-one individualized treatment as well as group classes to help patients achieve or regain functional skills.	Access and Coordination of Care Maternal and Child Health	NorthShore's Pediatric Rehabilitation Clinic saw an average of **9,000** patients per year.
The Perinatal Depression Program identifies women suffering from perinatal depression and offers referrals for women who may need additional help. The program screened women for perinatal depression during and after their pregnancy and offers a 24/7 crisis hotline for women and their family members who may find themselves in an emergent situation. All services are provided free of charge.	Access and Coordination of Care Behavioral Health Maternal and Child Health	The Perinatal Family Support Center responded to more than **600** referrals annually.
The **Perinatal Family Support Center** provided a wide array of services free of charge to women and their families experiencing challenges related to pregnancy, birth, prematurity or perinatal loss. Services are provided in both inpatient and outpatient settings and include groups, sibling tours and a literacy program in the Child and Adolescent Clinic.	Access and Coordination of Care Behavioral Health Maternal and Child Health	The Perinatal Family Support Center responded to more than **1,500** referrals annually.
Child Passenger Safety & Injury Prevention Services provided one-on-one training to new parents on proper car seat placement, harness placement and infant/child safety.	Maternal and Child Health Community Request	On average, **20** child passenger safety inspections were offered on an annual basis.
Interpretive Services provided comprehensive, in-person and telephonic translation and interpretation services for patients and family members receiving medical treatment at any of the NorthShore facilities.	Access and Coordination of Care Community Request	Over the last three years, over **$4,000,000** was provided for interpretive services.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Evanston Hospital)

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
The **Medication Assistance Program** provided assistance with the cost of prescriptions for patients of the Community Health Center.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer Diabetes Lung Health		NorthShore provided an average of **27,000** prescriptions per year to approximately **2,300** low-income patients.
NorthShore provided **Healthcare Services** to patients of the **Erie Evanston/Skokie Health Center**, a Federally Qualified Health Center by providing primary, mental and dental care services to under and uninsured patients in the community.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer Diabetes	Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	Over **2,000** Erie Evanston/Skokie Health Center clients received specialty care services at NorthShore on an annual basis.
NorthShore provided **Financial Support** to a variety of national and local non-profit organizations that supports NorthShore's mission to preserve and improve human life and to help NorthShore connect with the communities it serves. Fund allocations are focused to those organizations who address an identified health need in our communities.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	Over the last three years, NorthShore donated a total of **$ 5.5 million** to an average of **80** organizations per year.
Inpatient and intensive outpatient **Mental Health Services** were provided for adults and children along a continuum of care including group, individual and family services.	Access and Coordination of Care Behavioral Health		On a yearly average, NorthShore provided mental health services that included **3,000** intake calls. In addition, over **3,700** emergency department crisis visits occurred with an additional **3,500** crisis hotline calls.
The Bridges Early Childhood and Adolescent Program provided comprehensive, multidisciplinary mental health intervention and direct care to insured and uninsured children between the ages of 3 and 17 living in the Evanston community.	Access and Coordination of Care Behavioral Health		The program focused on comprehensive, multidisciplinary mental health intervention and direct care to insured and uninsured children between the ages of 3 and 17 living in the Evanston community. The Bridges team also treated children in other communities surrounding NorthShore.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Evanston Hospital)

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
MRW LIFE: Living in the Future Cancer Survivorship Program provided cancer patients with individualized cancer treatment summaries along with recommendations for long-term and late effects of cancer treatment; recovery for post treatment and healthy lifestyle recommendations.	Cancer		The LIFE program provided more than **2,000** cancer treatment summaries for Kellogg Cancer Center patients in the last three years.
Health Education Programs were provided through Evanston Hospital.	Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore provided **555** health education programs in its service area to more than **10,000** individuals.
Experts from Evanston Hospital provided **Speaking Engagements** to organizations throughout the NorthShore service area. Presentations range from health related topics to issues relevant to communities and hospitals.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore provided an average of **50** speaking engagements in its service area to nearly **2,200** individuals per year.
Staff members, from Evanston Hospital, participated in community **Health Fairs** throughout the year.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Lung Health Maternal and Child Health Community Request	NorthShore participated in **24** health fairs over the last three years.
Health Screenings were provided through Evanston Hospital, as well as in NorthShore's service area.	Chronic Disease Risk Factors Cardiovascular Disease/Stroke Cancer Diabetes Community Request		NorthShore provided on average **100** health screenings in its service area to nearly **1,300** individuals per year.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Evanston Hospital)

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
Evanston Hospital addressed health needs through **Employee Volunteerism** opportunities by collaborating with diverse local community agencies and assisting with civic and social service programs and initiatives.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore employees volunteer to carry out community service projects that met community needs and promoted goodwill. Countless charitable organizations and schools benefited from the generosity and hard work of NorthShore volunteers.
Rethink Your Drink is a public education campaign to increase public awareness about the negative health impact of consuming sugar-sweetened beverages. NorthShore served as a financial sponsor and program partner with the City of Evanston's Public Health Department in the campaign's planning, implementation and measurement.	Chronic Disease Risk Factors Cardiovascular Disease/Stroke Diabetes Maternal and Child Health Community Request		A NorthShore physician was available to conduct lessons and provide staff training on the health impact of sugar-sweetened beverages. Additionally, NorthShore purchased filtered water bottle refilling stations at Willard and Chute Elementary schools.
Evanston Township High School Health Center is a school-based health clinic, funded and staffed by NorthShore. NorthShore provided services including: physical exams, immunizations, treatment of acute and chronic illnesses, individual counseling, health education, gynecological care and support groups to students whose parents allow them to enroll in the health center.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Diabetes Lung Health Community Request		An average of **900** ETHS students made **3,500** visits to the Health Center annually.
Evanston Township High School Health Center Wellkits program is a clinic-based, healthy weight program at the school-based health center at Evanston Township High School. A NorthShore physician manages the program and dedicates at least five hours of work per week. The program is based upon six evidence-based goals that improve weight and overall health. Overweight and obese students are identified by clinic and school staff and asked to participate in the program.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke Diabetes		An estimated 50 students per year participate in the program. Additionally, a NorthShore physician collaborates with the physical education department to adopt components of Wellkits into the freshman curriculum of approximately **45** students.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Evanston Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
NorthShore provided a **Nurse Practitioner at Evanston/Skokie School District 65** to provide specific health care services one day per week for the students. The nurse makes in-school visits in addition to seeing students at the Evanston Township High School Health Center.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Diabetes Community Request	Over a three-year period, the nurse made an average of **275** student visits per year.
Connections for Pregnant & Parenting Teens partnered with a consortium of agencies to network and share resources to provide education and assistance to pregnant and parenting teens.	Access and Coordination of Care Behavioral Health Maternal and Child Health	NorthShore provided services to nearly **50** teenagers and their families on an annual basis.
NorthShore assisted the **Cancer Wellness Center, Northbrook** through financial contributions and presenters for programs and services that addressed the needs of cancer patients, cancer survivors, family members and caregivers.	Access and Coordination of Care Behavioral Health Cancer	NorthShore Kellogg Cancer Center donated more than **$7,500** to Cancer Wellness to sustain programs and services.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Glenbrook Hospital)

Comprehensive List of Initiatives by NorthShore Hospital Pavilions

The table below lists the initiatives based out of the **Glenbrook Hospital** campus, which addressed the health needs identified in the NorthShore 2019 CHNA.

Implementation Strategy Plan Activities/Initiatives/Events and Programs Reporting:

1. Initiatives identified by named hospital are managed from that site
2. Corporate/System initiatives are applied to all four NorthShore hospitals
3. Financial contributions to community organizations correlate as indirect impact to identified community health needs

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
NorthShore collaborated with The Josselyn Center to develop a sustainable program to provide virtual **Mental Health First Aid (MHFA)** training in NorthShore's service area. The collaboration consisted of community based programs on how to identify and respond to mental health emergencies.	Access and Coordination of Care Behavioral Health		A total of **six** MHFA sessions were conducted that trained a total of **120** participants. The long term goal of the partnership is to train additional instructors to meet the increased demands from community organizations during the next implementation strategy cycle.
Emergency Departments within NorthShore are staffed 24/7 with physicians, nurses and technicians who are trained to respond to medical emergencies. Glenbrook Hospital provides Level 2 trauma services.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health	On an annual basis, the Emergency Departments at NorthShore had approximately **118,500** patient visits.
Glenbrook Hospital's Emergency Department maintained a program to support **care for sexual assault** patients from ED nurses who received specialized education and training and provided survivors of sexual assault with comprehensive medical-forensic care.	Access and Coordination of Care Behavioral Health Community Request		Over the last three years, **155** individuals received care from a nurse examiner trained in supporting sexual assault patients.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Glenbrook Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **Cardiovascular Institute** provided comprehensive cardiology services, with combined expertise of cardiologists and cardiac surgeons working together to provide patients with exceptional heart care including cardiac imaging, cardiovascular surgery, clinical cardiology, electrophysiology, heart failure, interventional cardiology and a women's heart program.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke	NorthShore hospitals had an average of **123,000** cardiology procedures each year including open-heart surgeries, coronary interventions, echocardiograms, and stress tests.
The **Primary Stroke Center** follows national standards and guidelines that include an Acute Stroke Team for rapid diagnosis and treatment. A team of neurologists plans to staff the center 24 hours a day, 7 days a week.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke	NorthShore maintains Primary Stroke Centers at each hospital with an Acute Stroke Team available 24 hours a day, seven days a week, for rapid diagnosis and treatment.
The **Kellogg Cancer Center** provided comprehensive, compassionate cancer care and treatments for oncology patients and their families. Our collaborative cancer treatment model focuses on each patient's individual needs, providing medical, surgical, radiation, psychological and emotional care.	Access and Coordination of Care Cancer	The Kellogg Cancer Centers at Evanston, Glenbrook, and Highland Park Hospitals had an average of **92,000** patient visits each year.
LIFE: Living in the Future Cancer Survivorship Program provided cancer patients with individualized cancer treatment summaries along with recommendations for long-term and late effects of cancer treatment; recovery for post treatment and healthy lifestyle recommendations.	Cancer	The LIFE program provided more than **2,000** cancer treatment summaries for Kellogg Cancer Center patients in the last three years.
The **Gastroenterology (GI) Department** provided a full complement of services including early diagnosis and prevention of colorectal, esophageal, pancreatic cancer, Inflammatory Bowel Disease and other GI conditions.	Access and Coordination of Care Cancer	NorthShore hospitals had an average of **38,000** GI procedures each year including colonoscopies, endoscopies, and advanced therapeutics.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Glenbrook Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **Division of Pulmonary, Allergy and Critical Care Medicine** provided consultative services, diagnosis, and treatment of all aspects of lung disease in adults including allergy, asthma, lung cancer, bronchiectasis, COPD, cystic fibrosis, pulmonary fibrosis, persistent cough, shortness of breath, lung infections, and other diseases of the lung.	Access and Coordination of Care Chronic Disease Risk Factors Cancer Lung Health	The NorthShore Division of Pulmonary, Allergy, and Critical Care had an average of **23,000** patient visits each year.
The **Division of Endocrinology, Diabetes and Metabolism** provided consultative services, diagnosis and management of diseases of the endocrine system. The program offers a multidisciplinary approach to diabetes, gestational diabetes and those requiring insulin pumps. The staff consists of physicians, nurses, dietitians and certified diabetes educators who work together for diabetes management.	Access and Coordination of Care Chronic Disease Risk Factors Diabetes	The NorthShore Division of Endocrinology, Diabetes and Metabolism had an average of **26,500** patient visits each year.
The **Neurological Institute** provided therapies to slow brain aging to reduce the risk for Alzheimer's disease and other aging brain disorders include medical, physical, cognitive, dietary and integrative approaches.	Access and Coordination of Care Alzheimer's/Dementia	NorthShore Neurological Institute had an average of **138,000** patient visits each year.
The **Pediatric Rehabilitation Clinic** provided a wide array of outpatient services for young patients (from birth through adolescence) with special needs. A team of licensed physical, occupational and speech therapists specializing in pediatric care provide one-on-one individualized treatment as well as group classes to help patients achieve or regain functional skills.	Access and Coordination of Care Maternal and Child Health	NorthShore's Pediatric Rehabilitation Clinic saw an average of **9,000** patients per year.
The Perinatal Depression Program identifies women suffering from perinatal depression and offers referrals for women who may need additional help. The program screened women for perinatal depression during and after their pregnancy and offers a 24/7 crisis hotline for women and their family members who may find themselves in an emergent situation. All services are provided free of charge.	Access and Coordination of Care Behavioral Health Maternal and Child Health	The Perinatal Family Support Center responded to more than **600** referrals annually.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Glenbrook Hospital)

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
Interpretive Services provided comprehensive, in-person and telephonic translation and interpretation services for patients and family members receiving medical treatment at any of the NorthShore facilities.	Access and Coordination of Care Community Request		Over the last three years, over **$4,000,000** was provided for interpretive services.
NorthShore provided **Financial Support** to a variety of national and local non-profit organizations that support NorthShore's mission to preserve and improve human life and to help NorthShore connect with the communities it serves. Fund allocations were focused to those organizations who addressed an identified health need in our communities.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	Over the last three years, NorthShore donated a total of **$ 5.5 million** to an average of **80** organizations per year
The **Eye and Vision Center** hosted ophthalmology clinics for medically underserved clients referred through the Community Health Center at Evanston Hospital, providing a spectrum of pediatric and adult vision services.	Access and Coordination of Care		The Eye & Vision Center provides approximately **$780,000** in free services to medically underserved patients per year.
Experts from Glenbrook Hospital provided **Speaking Engagements** to organizations throughout the NorthShore service area. Presentations ranged from health related topics to issues relevant to communities and hospitals.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore provided an average of **50** speaking engagements in its service area to nearly **2,200** individuals per year.
Staff members, from Glenbrook Hospital, participated in community **Health Fairs** throughout the year.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Lung Health Maternal and Child Health Community Request	NorthShore participated in **24** health fairs over the last three years.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Glenbrook Hospital)

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
Health Screenings were offered at Glenbrook Hospital, as well as in NorthShore's service area.	Chronic Disease Risk Factors Cardiovascular Disease/Stroke Cancer Diabetes Community Request		NorthShore provided on average **100** health screenings in its service area to nearly **1,300** individuals per year.
Glenbrook Hospital addressed health needs through **Employee Volunteerism** opportunities by collaborating with diverse local community agencies and assisting with civic and social service programs and initiatives.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore employees volunteer to carry out community service projects that met community needs and promoted goodwill. Countless charitable organizations and schools benefited from the generosity and hard work of NorthShore volunteers.
NorthShore assisted the **Cancer Wellness Center, Northbrook** through financial contributions and presenters for programs and services that addressed the needs of cancer patients, cancer survivors, family members and caregivers.	Access and Coordination of Care Behavioral Health Cancer		NorthShore Kellogg Cancer Center donated more than **$7,500** to Cancer Wellness to sustain programs and services.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Highland Park Hospital)

Comprehensive List of Initiatives by NorthShore Hospital Pavilions

The table below lists the initiatives based out of the **Highland Park Hospital** campus, which addressed the health needs identified in the NorthShore 2019 CHNA.

Implementation Strategy Plan Activities/Initiatives/Events and Programs Reporting:

1. Initiatives identified by named hospital are managed from that site
2. Corporate/System initiatives are applied to all four NorthShore hospitals
3. Financial contributions to community organizations correlate as indirect impact to identified community health needs

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
NorthShore collaborated with The Josselyn Center to develop a sustainable program to provide virtual **Mental Health First Aid (MHFA)** training in NorthShore's service area. The collaboration consisted of community based programs on how to identify and respond to mental health emergencies.	Access and Coordination of Care Behavioral Health		A total of **six** MHFA sessions were conducted that trained a total of **120** participants. The long term goal of the partnership is to train additional instructors to meet the increased demands from community organizations during the next implementation strategy cycle.
Emergency Departments within NorthShore are staffed 24/7 with physicians, nurses and technicians who are trained to respond to medical emergencies. Highland Park Hospital provides Level 2 trauma services.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health	On an annual basis, the Emergency Departments at NorthShore had approximately **118,500** patient visits.
Highland Park Hospital's Emergency Department maintains a program to support **Care for Sexual Assault Patients** from ED nurses who received specialized education and training and provide survivors of sexual assault with comprehensive medical-forensic care.	Access and Coordination of Care Behavioral Health Community Request		Over the last three years, **155** individuals received care from a nurse examiner trained in supporting sexual assault patients.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Highland Park Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **Cardiovascular Institute** provided comprehensive cardiology services, with combined expertise of cardiologists and cardiac surgeons working together to provide patients with exceptional heart care including cardiac imaging, cardiovascular surgery, clinical cardiology, electrophysiology, heart failure, interventional cardiology and a women's heart program.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke	NorthShore hospitals had an average of **123,000** cardiology procedures each year including open-heart surgeries, coronary interventions, echocardiograms, and stress tests.
The **Primary Stroke Center** follows national standards and guidelines that include an Acute Stroke Team for rapid diagnosis and treatment. A team of neurologists plans to staff the center 24 hours a day, 7 days a week.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke	NorthShore maintains Primary Stroke Centers at each hospital with an Acute Stroke Team available 24 hours a day, seven days a week, for rapid diagnosis and treatment.
The **Kellogg Cancer Center** provided comprehensive, compassionate cancer care and treatments for oncology patients and their families. Our collaborative cancer treatment model focuses on each patient's individual needs, providing medical, surgical, radiation, psychological and emotional care.	Access and Coordination of Care Cancer	The Kellogg Cancer Centers at Evanston, Glenbrook, and Highland Park Hospitals had an average of **92,000** patient visits each year.
MRW LIFE: Living in the Future Cancer Survivorship Program provides cancer patients with individualized cancer treatment summaries along with recommendations for long-term and late effects of cancer treatment; recovery for post treatment and healthy lifestyle recommendations.	Cancer	The LIFE program provided more than **2,000** cancer treatment summaries for Kellogg Cancer Center patients in the last three years.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Highland Park Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **MRW Leadership Board** of Highland Park Hospital provided philanthropic support for breast cancer screenings for vulnerable and underserved community members.	Cancer	The MRW Leadership Board raised funds to provide **188** breast cancer screenings for clients of Lake County Health Department's Community Health Center.
The **Gastroenterology (GI) Department** provided a full complement of services including early diagnosis and prevention of colorectal, esophageal, pancreatic cancer, Inflammatory Bowel Disease and other GI conditions.	Access and Coordination of Care Cancer	NorthShore hospitals had an average of **38,000** GI procedures each year including colonoscopies, endoscopies, and advanced therapeutics.
The **Division of Pulmonary, Allergy and Critical Care Medicine** provided consultative services, diagnosis, and treatment of all aspects of lung disease in adults including allergy, asthma, lung cancer, bronchiectasis, COPD, cystic fibrosis, pulmonary fibrosis, persistent cough, shortness of breath, lung infections, and other diseases of the lung.	Access and Coordination of Care Chronic Disease Risk Factors Cancer Lung Health	The NorthShore Division of Pulmonary, Allergy, and Critical Care had an average of **23,000** patient visits each year.
The **Division of Endocrinology, Diabetes and Metabolism** provided consultative services, diagnosis and management of diseases of the endocrine system. The program offers a multidisciplinary approach to diabetes, gestational diabetes and those requiring insulin pumps. The staff consists of physicians, nurses, dietitians and certified diabetes educators who work together for diabetes management.	Access and Coordination of Care Chronic Disease Risk Factors Diabetes	The NorthShore Division of Endocrinology, Diabetes and Metabolism had an average of **26,500** patient visits each year.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Highland Park Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **Neurological Institute** provided therapies to slow brain aging to reduce the risk for Alzheimer's disease and other aging brain disorders include medical, physical, cognitive, dietary and integrative approaches.	Access and Coordination of Care Alzheimer's/Dementia	NorthShore Neurological Institute had an average of **138,000** patient visits each year.
The **Maternal Health** department at Highland Park Hospital provided comfortable, high-tech birthing facilities.	Access and Coordination of Care Maternal and Child Health	NorthShore Maternal Health Department saw an average of **1,300** patients per year.
The **Pediatric Rehabilitation Clinic** provided a wide array of outpatient services for young patients (from birth through adolescence) with special needs. A team of licensed physical, occupational and speech therapists specializing in pediatric care provide one-on-one individualized treatment as well as group classes to help patients achieve or regain functional skills.	Access and Coordination of Care Maternal and Child Health	NorthShore's Pediatric Rehabilitation Clinic saw an average of **9,000** patients per year.
The Perinatal Depression Program identifies women suffering from perinatal depression and offers referrals for women who may need additional help. The program screened women for perinatal depression during and after their pregnancy and offers a 24/7 crisis hotline for women and their family members who may find themselves in an emergent situation. All services are provided free of charge.	Access and Coordination of Care Behavioral Health Maternal and Child Health	The Perinatal Family Support Center responded to more than **600** referrals annually.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Highland Park Hospital)

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
Experts from Highland Park Hospital provided **Speaking Engagements** to organizations throughout the NorthShore service area. Presentations ranged from health related topics to issues relevant to communities and hospitals.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore provided an average of **50** speaking engagements in its service area to nearly **2,200** individuals per year.
Staff members, from Highland Park Hospital, participated in community **Health Fairs** throughout the year.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Lung Health Maternal and Child Health Community Request	NorthShore participated in **24** health fairs over the last three years.
Health Screenings were offered at Highland Park Hospital, as well as in NorthShore's service area.	Chronic Disease Risk Factors Cardiovascular Disease/Stroke Cancer Diabetes Community Request		NorthShore provided on average **100** health screenings in its service area to nearly **1,300** individuals per year.
Highland Park Hospital addressed health needs through **Employee Volunteerism** opportunities by collaborating with diverse local community agencies and assisting with civic and social service programs and initiatives.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore employees volunteer to carry out community service projects that met community needs and promoted goodwill. Countless charitable organizations and schools benefited from the generosity and hard work of NorthShore volunteers.
NorthShore assisted the **Cancer Wellness Center, Northbrook** through financial contributions and presenters for programs and services that addressed the needs of cancer patients, cancer survivors, family members and caregivers.	Access and Coordination of Care Behavioral Health Cancer		NorthShore Kellogg Cancer Center donated more than **$7,500** to Cancer Wellness to sustain programs and services.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Skokie Hospital)

Comprehensive List of Initiatives by NorthShore Hospital Pavilions

The table below lists the initiatives based out of the **Skokie Hospital** campus, which addressed the health needs identified in the NorthShore 2019 CHNA.

Implementation Strategy Plan Activities/Initiatives/Events and Programs Reporting:

1. Initiatives identified by named hospital are managed from that site
2. Corporate/System initiatives are applied to all four NorthShore hospitals
3. Financial contributions to community organizations correlate as indirect impact to identified community health needs

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
NorthShore collaborated with The Josselyn Center to develop a sustainable program to provide virtual **Mental Health First Aid (MHFA)** training in NorthShore's service area. The collaboration consisted of community based programs on how to identify and respond to mental health emergencies.	Access and Coordination of Care Behavioral Health		A total of **six** MHFA sessions were conducted that trained a total of **120** participants. The long term goal of the partnership is to train additional instructors to meet the increased demands from community organizations during the next implementation strategy cycle.
Emergency Departments within NorthShore are staffed 24/7 with physicians, nurses and technicians who are trained to respond to medical emergencies. Skokie Hospital provides Level 2 trauma services.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health	On an annual basis, the Emergency Departments at NorthShore had approximately **118,500** patient visits.
Skokie Hospital's Emergency Department provided **Care for Sexual Assault Patients** from ED nurses who received specialized education and training and provide survivors of sexual assault with comprehensive medical-forensic care.	Access and Coordination of Care Behavioral Health Community Request		Over the last three years, **155** individuals received care from a nurse examiner trained in supporting sexual assault patients.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Skokie Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **Cardiovascular Institute** provided comprehensive cardiology services, with combined expertise of cardiologists and cardiac surgeons working together to provide patients with exceptional heart care including cardiac imaging, cardiovascular surgery, clinical cardiology, electrophysiology, heart failure, interventional cardiology and a women's heart program.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke	NorthShore hospitals had an average of **123,000** cardiology procedures each year including open-heart surgeries, coronary interventions, echocardiograms, and stress tests.
The **Primary Stroke Center** follows national standards and guidelines that include an Acute Stroke Team for rapid diagnosis and treatment. A team of neurologists plans to staff the center 24 hours a day, 7 days a week.	Access and Coordination of Care Chronic Disease Risk Factors Cardiovascular Disease/Stroke	NorthShore maintains Primary Stroke Centers at each hospital with an Acute Stroke Team available 24 hours a day, seven days a week, for rapid diagnosis and treatment.
The **Gastroenterology (GI) Department** provided a full complement of services including early diagnosis and prevention of colorectal, esophageal, pancreatic cancer, Inflammatory Bowel Disease and other GI conditions.	Access and Coordination of Care Cancer	NorthShore hospitals had an average of **38,000** GI procedures each year including colonoscopies, endoscopies, and advanced therapeutics.
The **Division of Pulmonary, Allergy and Critical Care Medicine** provided consultative services, diagnosis, and treatment of all aspects of lung disease in adults including allergy, asthma, lung cancer, bronchiectasis, COPD, cystic fibrosis, pulmonary fibrosis, persistent cough, shortness of breath, lung infections, and other diseases of the lung.	Access and Coordination of Care Chronic Disease Risk Factors Cancer Lung Health	The NorthShore Division of Pulmonary, Allergy, and Critical Care had an average of **23,000** patient visits each year.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Skokie Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
The **Division of Endocrinology, Diabetes and Metabolism** provided consultative services, diagnosis and management of diseases of the endocrine system. The program offers a multidisciplinary approach to diabetes, gestational diabetes and those requiring insulin pumps. The staff consists of physicians, nurses, dietitians and certified diabetes educators who work together for diabetes management.	Access and Coordination of Care Chronic Disease Risk Factors Diabetes	The NorthShore Division of Endocrinology, Diabetes and Metabolism had an average of **26,500** patient visits each year.
The **Neurological Institute** provides therapies to slow brain aging to reduce the risk for Alzheimer's disease and other aging brain disorders include medical, physical, cognitive, dietary and integrative approaches.	Access and Coordination of Care Alzheimer's/Dementia	NorthShore Neurological Institute had an average of **138,000** patient visits each year.
The **Pediatric Rehabilitation Clinic** provided a wide array of outpatient services for young patients (from birth through adolescence) with special needs. A team of licensed physical, occupational and speech therapists specializing in pediatric care provide one-on-one individualized treatment as well as group classes to help patients achieve or regain functional skills.	Access and Coordination of Care Maternal and Child Health	NorthShore's Pediatric Rehabilitation Clinic saw an average of **9,000** patients per year.
The **Perinatal Depression Program** identifies women suffering from perinatal depression and offers referrals for women who may need additional help. The program screened women for perinatal depression during and after their pregnancy and offers a 24/7 crisis hotline for women and their family members who may find themselves in an emergent situation. All services are provided free of charge.	Access and Coordination of Care Behavioral Health Maternal and Child Health	The Perinatal Family Support Center responded to more than **600** referrals annually.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Skokie Hospital)

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
Interpretive Services provided comprehensive, in-person and telephonic translation and interpretation services for patients and family members receiving medical treatment at any of the NorthShore facilities.	Access and Coordination of Care Community Request		Over the last three years, over **$4,000,000** was provided for interpretive services.
NorthShore provided **Healthcare Services** to patients of the **Erie Evanston/Skokie Health Center**, a Federally Qualified Health Center by providing primary, mental and dental care services to under and uninsured patients in the community.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	Nearly **1,400** Erie Evanston/Skokie Health Center clients received specialty care services at NorthShore on an annual basis.
NorthShore provide **Financial Support** to a variety of national and local non-profit organizations that supports NorthShore's mission to preserve and improve human life and to help NorthShore connect with the communities it serves. Fund allocations are focused to those organizations who address an identified health need in our communities.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	Over the last three years, NorthShore donated a total of **$ 5.5 million** to an average of **80** organizations per year.
The **Eye and Vision Center** hosted ophthalmology clinics for medically underserved clients referred through the Community Health Center at Evanston Hospital, providing a spectrum of pediatric and adult vision services.	Access and Coordination of Care		The Eye & Vision Center provides approximately **$780,000** in free services to medically underserved patients per year.
MRW LIFE: Living in the Future Cancer Survivorship Program provided cancer patients with individualized cancer treatment summaries along with recommendations for long-term and late effects of cancer treatment; recovery for post treatment and healthy lifestyle recommendations.	Cancer		The LIFE program provided more than **2,000** cancer treatment summaries for Kellogg Cancer Center patients in the last three years.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Skokie Hospital)

Initiative	Community Health Need Assessed		Outcomes/Individuals Served
Health Education Programs were provided through Skokie Hospital.	Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore provided **555** health education programs in its service area to more than 10,000 individuals.
Experts from Skokie Hospital provided **Speaking Engagements** to organizations throughout the NorthShore service area. Presentations range from health related topics to issues relevant to communities and hospitals.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore provided an average of **50** speaking engagements in its service area to nearly **2,200** individuals per year.
Staff members, from Evanston Hospital, participated in community **Health Fairs** throughout the year.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Lung Health Maternal and Child Health Community Request	NorthShore participated in 24 health fairs over the last three years.
Health Screenings were offered through Skokie Hospital, as well as in NorthShore's service area.	Chronic Disease Risk Factors Cardiovascular Disease/Stroke Cancer Diabetes Community Request		NorthShore provided on average **100** health screenings in its service area to nearly **1,300** individuals per year.
Evanston Hospital addresses health needs through **Employee Volunteerism** opportunities by collaborating with diverse local community agencies and assisting with civic and social service programs and initiatives.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Cancer	Diabetes Oral Health Alzheimer's/Dementia Lung Health Maternal and Child Health Community Request	NorthShore employees volunteer to carry out community service projects that met community needs and promoted goodwill. Countless charitable organizations and schools benefited from the generosity and hard work of NorthShore volunteers.

Appendix D – Impact of Actions Taken to Address the Significant Health Needs Identified in the Prior CHNA (Skokie Hospital)

Initiative	Community Health Need Assessed	Outcomes/Individuals Served
Rethink Your Drink is a public education campaign to increase public awareness about the negative health impact of consuming sugar-sweetened beverages. NorthShore is a financial sponsor and program partner with the Village of Skokie's Public Health Department in the campaign's planning, implementation and measurement.	Chronic Disease Risk Factors Cardiovascular Disease/Stroke Diabetes Maternal and Child Health Community Request	The Village of Skokie's Health Department promoted the Rethink Drink campaign through various promotional vehicles, community events and at schools.
NorthShore assisted the **Cancer Wellness Center, Northbrook** through financial contributions and presenters for programs and services that addressed the needs of cancer patients, cancer survivors, family members and caregivers.	Access and Coordination of Care Behavioral Health Cancer	NorthShore Kellogg Cancer Center donated more than $7,500 to Cancer Wellness to sustain programs and services.
NorthShore provided a **Nurse Practitioner at Evanston/Skokie School District 65** to provide specific health care services one day per week for the students. The nurse makes in-school visits in addition to seeing students at the Evanston Township High School Health Center.	Access and Coordination of Care Chronic Disease Risk Factors Behavioral Health Cardiovascular Disease/Stroke Diabetes Community Request	Over a three-year period, the nurse made an average of **275** student visits per year.

Appendix E – Description of NorthShore's Prioritization Process

Using findings obtained through the collection of primary and secondary data, NorthShore completed an analysis to identify community health needs. This process identified 16 health needs listed below.

- Access to Health Services (Cost, Language, Navigating Healthcare System)
- Affordability of Healthcare
- Cancer
- Chronic Health Conditions (Diabetes and High Blood Pressure)
- Health Inequity/Discrimination
- Food Insecurity
- Heart Disease
- Health Literacy
- Lack of Affordable Housing
- Maternal and Child Health
- Mental/Behavioral Health
- Obesity
- Poverty
- Preventative Care
- Violence/Safety
- Youth Mental Health/Substance Abuse

To facilitate prioritization of identified health needs, a ranking process was used. Health needs were ranked based on the following five factors. Each factor received a score between 0 and 5.

1) **How many people are affected by the issue or size of the issue?** For this factor, ratings were based on the percentage of the community who are impacted by the identified need. The following scale was utilized: >25% of the community= 5; >15% and <25%=4; >10% and <15%=3; >5% and <10%=2 and <5%=1.

2) **What are the consequences of not addressing this problem?** Identified health needs which have a high death rate or have a high impact on chronic diseases received a higher rating.

3) **The impact of the problem on vulnerable populations.** Needs identified which pertained to vulnerable populations were rated for this factor.

4) **How important the problem is to the community.** Needs identified through community focus groups and the community survey were rated for this factor.

5) **Prevalence of common themes.** The rating for this factor was determined by how many sources of data (leading causes of death, health outcomes and factors and primary data) identified the need.

Appendix E – Description of NorthShore's Prioritization Process

In addition, 28 NorthShore stakeholders provided input by rating each health need for each of the following statements using a scale of 1 to 6.

1. NorthShore has the expertise and resources available to address the identified health need.
2. I believe a successful intervention on this health topic could make a real impact on this health issue.
3. There are There are existing or available opportunities to partner with other community organizations to address this health need. existing or available opportunities to partner with other community organizations to address this health need.

The summary table of rankings is provided below.

	CHNA Five-Factor Ranking						Input from NorthShore Stakeholders (Average Score)				
Identified Health Need	How Many People Are Affected by the Issue?	How Significant are the Consequences of Not Addressing the Problem?	How Significant is the Impact on Vulnerable Populations? (Health Equity)	How Important is it to the Community?	How Many Sources Identified the Need? (Focus Groups, Survey, Secondary	Subtotal	NorthShore has the expertise and resources available to address the identified health need.	I believe a successful intervention on this health topic could make a real impact on this health issue.	There are There are existing or available opportunities to partner with other community organizations to address this health need. existing or available opportunities to partner with other community organizations to address this health need.	NorthShore Stakeholder Subtotal	Total Score
Health Inequity/Discrimination	5	3	5	4	2	19	4	5.39	4.77	14.16	**33.16**
Lack of Affordable Housing	5	3	3	5	3	19	2.26	4.04	4.36	10.66	**29.66**
Access to Health Services (Cost, Language, Navigating Healthcare System)	5	4	5	2	2	18	4.61	5.7	5	15.31	**33.31**
Obesity	5	5	3	3	2	18	4.96	4.91	4.77	14.64	**32.64**
Affordability of Healthcare	2	4	5	5	2	18	3.96	4.74	4.64	13.34	**31.34**
Mental/Behavioral Health	3	4	3	4	3	17	4.57	5.52	5.32	15.41	**32.41**
Chronic Health Conditions (Diabetes and High Blood Pressure)	5	5	4	1	2	17	5.43	4.27	5.18	14.88	**31.88**
Preventative Care	5	3	3	3	2	16	5.52	5.43	5.27	16.22	**32.22**
Youth Mental Health/Substance Abuse	4	3	3	3	3	16	4.61	5.13	4.91	14.65	**30.65**
Health Literacy	5	3	3	3	2	16	4.17	5.22	5	14.39	**30.39**
Food Insecurity	5	5	4	0	2	16	2.91	4	4.91	11.82	**27.82**
Poverty	3	4	5	0	2	14	2.74	3.65	4.45	10.84	**24.84**
Heart Disease	2	5	3	0	1	11	5.48	5.13	5.09	15.7	**26.7**
Maternal and Child Health	2	3	4	0	1	10	5.3	5.52	5.27	16.09	**26.09**
Violence/Safety	1	2	3	2	2	10	3.22	3.96	4.36	11.54	**21.54**
Cancer	1	5	2	0	1	9	5.39	4.87	5	15.26	**24.26**

Limitations and Information Gaps

Return to Report

As with all data collection efforts, there are several limitations related to the assessment's research methods that should be acknowledged. Years of the most current data available differ by data source. In some instances, 2021 may be the most current year available for data, while 2014 may be the most current year for other sources. Likewise, survey data based on self-reports, such as the Behavioral Risk Factor Surveillance Survey (BRFSS), should be interpreted with particular caution. In some instances, respondents may over or under report behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked.

In addition, respondents may be prone to recall bias – that is, they may attempt to answer accurately, but they remember incorrectly. In some surveys, reporting and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys analyzed in this CHNA benefit from large sample sizes and repeated administrations, enabling comparison over time. Similarly, while the qualitative data collected for this study provide valuable insights, results are not statistically representative of a larger population due to nonrandom recruiting techniques and a small sample size. Data were collected at one point in time and among a limited number of individuals.

Therefore, findings, while directional and descriptive, should not be interpreted as definitive.

NorthShore
University HealthSystem

2023-2024 Implementation Strategy Plan

NorthShore – Edward-Elmhurst Health's Mission

The core mission of NorthShore – Edward Elmhurst is to "help everyone in our communities be their best."

Mission

Help everyone in our communities be their best.

Vision

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

Values

Act with Kindness

Meet people where they are and show empathy through listening

Earn Trust

Act with integrity and accountability to earn and maintain trust

Respect Everyone

Champion diversity, equity and inclusion for all through mutual respect

Build Relationships

Develop meaningful connections that have a positive impact on everyone who crosses our path

Pursue Excellence

Seek out ways to keep learning and growing so we can deliver the best care to all, every time

About NorthShore – Edward-Elmhurst Health

NorthShore – Edward-Elmhurst Health is a fully integrated healthcare delivery system committed to providing access to quality, vibrant, community-connected care, serving an area of more than 4.2 million residents across six northeast Illinois counties. Our more than 25,000 team members and more than 6,000 physicians aim to deliver transformative patient experiences and expert care close to home across more than 300 ambulatory locations and eight acute care hospitals – Edward (Naperville), Elmhurst, Evanston, Glenbrook (Glenview), Highland Park, Northwest Community (Arlington Heights) Skokie and Swedish (Chicago) – all recognized as Magnet hospitals for nursing excellence. Located in Naperville, Linden Oaks Behavioral Health, provides for the mental health needs of area residents.

NorthShore – Edward-Elmhurst Health desires to continue providing clinical programs and services to meet community health needs, while also pursuing continuous improvement in existing and future programs to improve the overall health of individuals in the communities it serves.

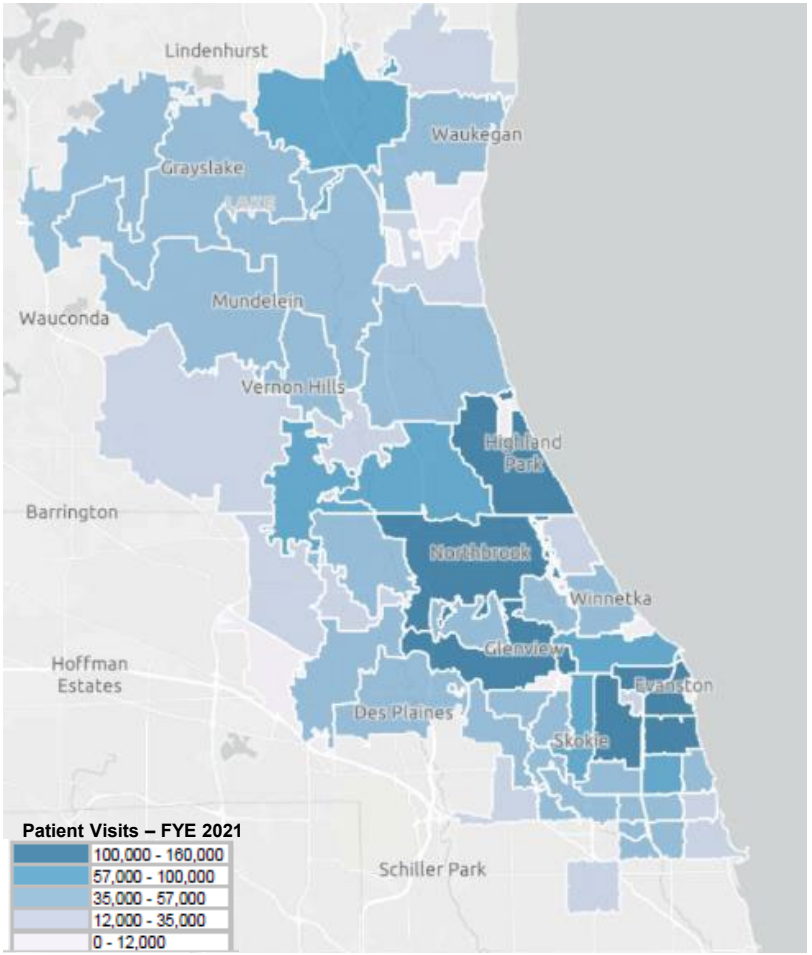
This joint Implementation Strategy Plan (ISP) was conducted by the following hospitals within NorthShore – Edward-Elmhurst Health: Evanston, Glenbrook, Highland Park and Skokie. These four hospitals collectively serve the same communities within NorthShore University HealthSystem (NorthShore). For the remainder of this report "NorthShore" will refer to these four hospitals. Please note that Edward-Elmhurst Health, Swedish Hospital and Northwest Community Healthcare develop and release their own separate ISPs.

Purpose of a Hospital's Implementation Strategy

An Implementation Strategy Plan (ISP) 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 ISP process is meant to align NorthShore University HealthSystem's (NorthShore) initiatives and programs with goals, objectives and indicators that address significant community health needs described in the CHNA.

Community Definition

NorthShore's patients collectively come from a large geographic area. For purposes of this report, the community served by NorthShore includes 54 zip codes in Lake County, northern Cook County and the north side of Chicago. The map to the right shows the level to which each zip code utilizes NorthShore's services and is based on inpatient, outpatient and emergency room visits.



How the CHNA Implementation Strategy was Developed

The ISP was developed after the comprehensive Community Health Needs Assessment (CHNA) was completed. Please refer to the complete CHNA for the full report. Strategies and action plans were developed based on a consensus among a steering committee comprised of NorthShore leaders after input from each of the respective disciplines. The organization intends to undertake the following strategies to meet the identified community health needs. Most of the strategies and initiatives will be coordinated and advanced through teams comprised of representatives from each of the four hospitals included in this joint implementation strategy. In instances where an initiative applies to a specific hospital facility, the hospital facility has been identified in the detailed action plans.

It is important to note that our health equity work is fundamental and integrated throughout our priority needs' strategies on the following pages.

This ISP will be reviewed annually during the two-year lifespan of the 2022 CHNA and updated as needed to ensure viability and impact. NorthShore's impact will be communicated regularly to reporting agencies and our community.

Access to Health Services

- Expand efforts to identify and respond to social determinants of health (SDOH), such as medication, transportation, housing.
- Explore ways to enhance access to services and/or partnerships via NorthShore or other community organizations.
- Increase the members in the community that have a medical home.
- Enhance partnerships with local community organizations addressing access to care.

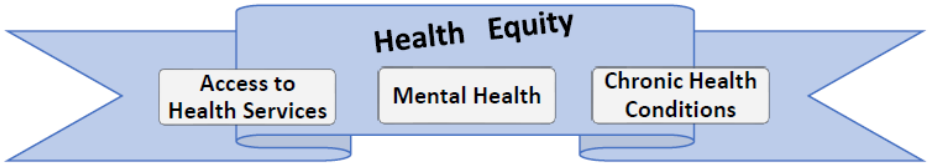
Mental Health

- Build community's capacity to understand and respond to mental health challenges and emergencies.
- Expand access to mental health resources in the community.
- Explore programs to reduce stigma surrounding mental health.
- Enhance partnerships with local community organizations addressing mental health.

Chronic Health Conditions

- Address high blood pressure and diabetes through targeted interventions and outreach.
- Enhance partnerships with local community organizations addressing chronic health conditions.
- Improve preventative cancer screening rates for breast, cervical and colorectal cancer.

Health Equity – Foundational to Our Approach



We are addressing disparities in health and well-being, advancing access and improving patient outcomes across all the communities we serve. This work is fundamental and integrated throughout our priority needs on the following pages of our ISP.

As an organization, we have key commitments around measurement, learning and action which are critical to our ongoing health equity work. By improving our data collection efforts on areas such as Race, Ethnicity and Language (REAL), we are able to get a more complete picture of our patient and community demographics, allowing us to improve the way we meet our community's needs and deliver care, all in a welcoming and affirming environment. Enhancing screening opportunities for Social Determinants of Health (SDOH) allows us to better understand challenges and barriers that our community members face, so we can navigate them to critical resources and services they may need. Finally, partnering with community organizations through our Community Investment Fund allows us to further address priority health needs in a powerful, collaborative way.

Health equity commitments include:

Measurement: We are working to accurately capture race, ethnicity, language and other preferences and to ensure that all of our patients' perspectives are captured in our measurement systems	• Reduce % of all patients who have had a face to face encounter at NorthShore who we document as "Other, Declined or Unknown" • Educate and engage front line staff on REAL and/or SOGI data collection improvement efforts
Learning: We are investing in leading practices and new ways to listen to our patients and community members, incorporating feedback to understand and impact social determinants of health	• Develop a consistent and reliable process to collect, visualize, and intervene on Social Determinants of Health (SDOH) data • Educate and engage team members on SDOH screening efforts
Action: We are investing in and partnering with like-minded community organizations to close the gap on health disparities.	• Enhance partnerships and provide funding through NorthShore's Community Investment Fund (CIF) to help local organizations build capacity and increase impact, with at least 80% of annual CIF awardee partners addressing CHNA priority needs • Build and expand Health Equity Community Liaison program to deepen community partnerships within under-resourced communities

NorthShore Steering Committee Members

Executive Co-Chairs

Mahalakshmi Halasyamani, MD System Chief Clinical Officer

Gabrielle Cummings, President, Legacy NorthShore Acute Care Operations & Highland Park Hospital

Christine Bloomfield, Senior Consultant, Transformation Management Office

Brandon Buchanan, Director, Health Equity

Jenise Celestin, Director, NorthShore Community Relations

Tameka Crump, Practice Manager, Evanston Hospital Community Health Center

Hania Fuschetto, Manager, Community Relations, Glenbrook & Highland Park Hospitals

Catherine Glunz, MD, Medical Director, Evanston Hospital Community Health Center

Jesse Peterson Hall, President, Glenbrook Hospital

Thomas Hensing, MD, Medical Oncology

Samantha Maras, Assistant Vice President, Ambulatory, Quality and Population Heath

Mark Schroeder, Manager, Community Relations, Evanston & Skokie Hospitals

Robyn Thurston, Director, Medical Group Operations

Jeffery Zakem, Manager, Office of Community Health Equity & Engagement

Access to Health Services

ACTIONS NORTHSHORE PLANS TO TAKE TO ADDRESS THE HEALTH NEED

Strategy	Initiatives/Programs	Reportable Metrics/Anticipated Impact	Collaborations
1. Expand efforts to identify and respond to social determinants of health (SDOH), such as medication, transportation, housing.	• Implement and expand SDOH screening referral tool within CHC, ETHS Health Center, medical group practices, and emergency departments.* • Continue to develop capacity at CHC to better service uninsured and underinsured.* (Evanston Hospital) • Explore ways to reduce transportation cost barrier.* • Educate NorthShore medical providers on the services available at the CHC and develop collateral to support navigation for under-resourced individuals.* (Evanston Hospital) • Explore opportunities to participate in community health fairs with CHC team members based on insights from SDOH screening.* (Evanston Hospital)	% of patients screened, % of patients with SDOH needs identified, % of patients connected to resources/services via referrals Increase the number of NorthShore patients with medical homes. # of parking vouchers/total amount # of providers educated # of health fairs and participants	SDOH referral platform; community based organizations addressing SDOH; local FQHCs; NorthShore Community Health Center; NorthShore Immediate Care sites; NorthShore medical residents
2. Explore ways to enhance access to services and/or partnerships via NorthShore or other community organizations.	• Explore opportunity to expand school-based health center.* • Partner with community organizations (including FQHCs and/or mobile medical providers) that serve underserved communities.* • Continue to partner with Erie Evanston/Skokie to provide specialty medical care services.* (Evanston and Skokie Hospitals)	# of students served $'s or clinics # of referrals/$'s of care provided	Evanston Township High School; local school systems; community based organizations; Erie Evanston/Skokie Health Center; Rosalind Franklin University
3. Increase the members in the community that have a medical home.	• Build and expand Health Equity Community Liaison program to offer navigation and support for underrepresented and/or under-resourced individuals.* • Explore ways to better connect individuals to a primary care physician/medical home, such as via collaborative public awareness campaign or other outreach tactics.*	$'s invested # of navigators # of individuals connected to a primary care physician/medical home	Local health departments; community healthcare organizations and FQHCs; NorthShore's Health Equity Team; NorthShore's SDOH Committee; NorthShore's Corporate Communications Team
4. Enhance partnerships with local community organizations addressing access to care.	• Provide funding through NorthShore's Community Investment Fund (CIF) to help local organizations build capacity and increase impact.*	$'s invested, >80% of annual CIF awardee partners addressing CHNA priority needs	Community based organizations; Community Investment Fund (CIF) partners; NorthShore's Office of Community Health Equity and Engagement

*denotes initiative with health equity integration

Mental Health

ACTIONS NORTHSHORE PLANS TO TAKE TO ADDRESS THE HEALTH NEED

Strategy	Initiatives/Programs	Reportable Metrics/Anticipated Impact	Collaborations
1. Build community's capacity to understand and respond to mental health challenges and emergencies.	• Collaborate with community partner(s) to train community members in Mental Health First Aid (MHFA). • Collaborate with local organizations/community stakeholders to provide MHFA "Train the Trainer" instructor trainings, with a focus on trainers serving underrepresented and under resourced populations.* • Partner with newly trained MHFA instructors to provide MHFA responder sessions in NorthShore's service area with a focus on underserved and communities of color.* • Partner with organizations serving non-English speaking (ESL) community members to develop mental health information sessions that address and destigmatize mental health issues.*	# of community sessions # of community members (responders) trained # of instructors trained # of languages supported # under-resourced communities reached	The Josselyn Center; community based organizations; faith communities; local FQHCs
2. Expand awareness and access to mental health resources in the community.	• Expand access to mental health services at Evanston Township High School (ETHS) with additional therapy and medication management clinic services.* • Evaluate NorthShore.org for ease of access for mental health resources and language around stigma.	Expand therapeutic services for students at Evanston Hospital and ETHS.	Evanston Township High School; community based organizations; NorthShore's Corporate Communications Team
3. Explore programs to reduce stigma surrounding mental health.	• Explore providing education and training in middle and high schools. • Explore marketing strategies (including social media or via other channels) to raise awareness and destigmatize mental health for youth and adults.	# of trainings # of students trained	Local school systems; community based organizations; NorthShore's Corporate Communications Team
4. Enhance partnerships with local community organizations addressing mental health.	• Provide funding through NorthShore's Community Investment Fund (CIF) to help local organizations build capacity and increase impact.*	$'s invested, >80% of annual CIF awardee partners addressing CHNA priority needs	Community based organizations; Community Investment Fund (CIF) partners; NorthShore's Office of Community Health Equity and Engagement

*denotes initiative with health equity integration

Chronic Health Conditions

ACTIONS NORTHSHORE PLANS TO TAKE TO ADDRESS THE HEALTH NEED

Strategy	Initiatives/Programs	Reportable Metrics/Anticipated Impact	Collaborations
1. Address high blood pressure and diabetes through targeted interventions and outreach.	• Utilize lens of equity tool to identify health disparities related to high blood pressure and diabetes. Target health screenings to populations identified through lens of equity tool.* • Direct navigation to a medical home for screened individuals in need of a primary care provider based on SDOH screening.* • Increase efforts around education for patients and providers and improve available data to help inform improvements efforts, inclusive of all patients.* • Dialogue about additional improvements with multidisciplinary leaders via system collaborative and weekly multidisciplinary meetings.	Quality improvement metrics Improve clinical processes to reduce outcome disparities Improve health and clinical outcomes across vulnerable populations Improve control of diabetes A1c and high blood pressure levels	NorthShore Medical Providers NorthShore Quality Department NorthShore Health Equity
2. Enhance partnerships with local community organizations addressing chronic health conditions.	• Improve partnerships within underserved communities re: BC screening rates.* • Provide funding through NorthShore's Community Investment Fund (CIF) to help local organizations build capacity and increase impact.*	$'s invested, >80% of annual CIF awardee partners addressing CHNA priority needs	Community based organizations; NorthShore's Office of Community Health Equity and Engagement

3. Improve preventative cancer screening rates for breast, cervical and colorectal cancer.	• Target outreach to patients overdue for preventive screenings.
	  • Increase access to screening appointments.
	  • Increase collaboration with affiliates.
	• Use Lens of Equity tool to better understand screening rate disparities, for example focused within lower median family income (MFI) communities.*
	• Build and expand Health Equity Community Liaison program to offer navigation and support for underrepresented and/or under-resourced individuals overdue for specific cancer screenings.*
		# of patients contacted; # of screenings completed
		Reductions in health disparities
		Increase screening rates for breast, cervical and colorectal screenings
			NorthShore Medical Providers
			NorthShore Quality Department
			NorthShore Health Equity
			Community based organizations
			Faith based organizations
			FQHC's and CHC's
			Public Schools

*denotes initiative with health equity integration

Significant Health Needs Not Addressed

IRS regulations require that the CHNA Implementation Strategy include a brief explanation of why a hospital facility does not intend to address any significant health needs identified through the CHNA.

Many of these needs are incorporated into other priority areas, which is additionally detailed on the following slide.

Identified Need	Reason for Not Addressing / How Need is Tied to Priorities and Health Equity
Affordability of Healthcare	While not a priority need, this is incorporated into Access to Health Services and Health Equity.
Cancer	While not a priority need, this is incorporated into Chronic Health Conditions and Health Equity.
Heart Disease	While not a priority need, this is incorporated into Chronic Health Conditions and Health Equity.
Health Literacy	While not a priority need, this is incorporated into Access to Health Services and Health Equity.
Maternal and Child Health	This need was not selected for further prioritization in the CHNA process due to focus groups/surveys. However, NorthShore continues to address this need via comprehensive services, as well as partnerships with local FQHCs and other organizations to raise awareness about this issue.
Obesity	While not a priority need, this is incorporated into Chronic Health Conditions and Health Equity.
Preventative Care	While not a priority need, this is incorporated into Chronic Health Conditions and Health Equity.
Food Insecurity	While not a priority need, this is incorporated into Access to Health Services priority via SDOH screening enhancements.
Lack of Affordable Housing	While not a priority need, this is incorporated into Access to Health Services priority via SDOH screening enhancements.
Poverty	While not a priority need, this is incorporated into Access to Health Services and Health Equity.
Violence/Safety	While not a priority need, this is incorporated into Access to Health Services priority via SDOH screening enhancements, as well as expanded Pathways Program.

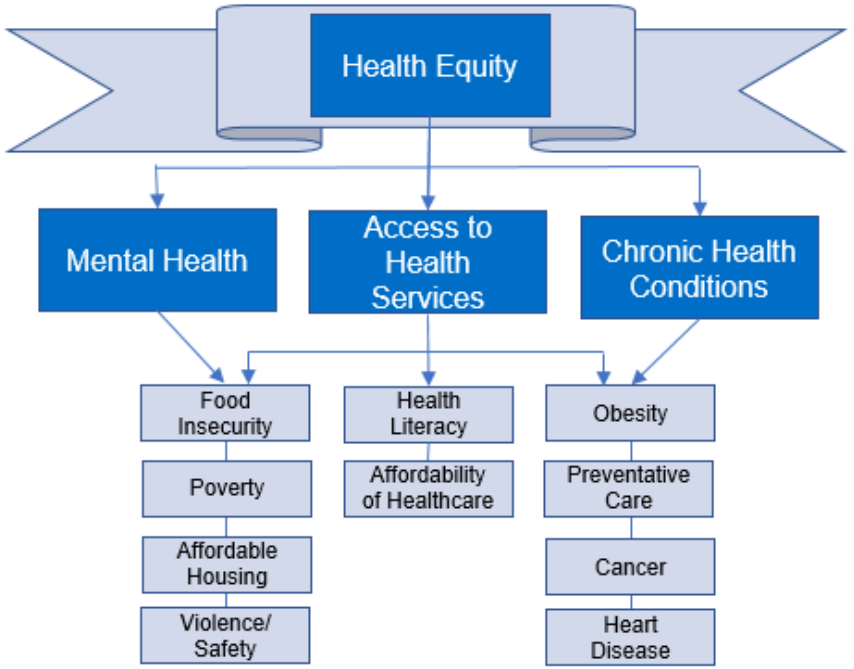
Incorporating Other Identified Needs Into Selected CHNA Priority Areas

NorthShore continues to address our community's health needs via comprehensive services as well as robust community partnerships. Although some identified needs were not selected as a Priority Need within this ISP, the visual below demonstrates how the many of the needs are tied to our selected priority areas.

As described in detail in the CHNA, NorthShore prioritized three significant health needs during the CHNA process:

- Access to Health Services
- Mental Health
- Chronic Health Conditions

NorthShore is also integrating health equity throughout strategies for each of the three prioritized areas above.



Conclusion

In partnership with internal and external stakeholders, including local public health departments, we have taken an in-depth look at the needs and assets in the communities we serve. We are committed to addressing those needs through implementation strategies, in partnership with communities most impacted by health inequities.

Comments regarding the Community Health Needs Assessment and/or Implementation Strategy can be submitted to the organization by contacting:

Jenise Celestin
Director, Community Relations
NorthShore Hospitals
jcelestin@schosp.org
(773) 907-3076

Hania Fuschetto
Manager, Community Relations
NorthShore Glenbrook and Highland Park Hospitals
hfuschetto@northshore.org
(847) 480-2630

Mark Schroeder
Manager, Community Relations
NorthShore Evanston and Skokie Hospitals
mschroeder@northshore.org
(847) 933-6004

Northwest Community Hospital

2021 Community Health Needs Assessment

nch Northwest Community Healthcare
Part of NorthShore

Introduction: About Northwest Community Healthcare

In 2021, Northwest Community Hospital (NCH) conducted a comprehensive Community Health Needs Assessment to identify and address the key health issues of its community.

In January 2021, Northwest Community Healthcare (NCH) joined NorthShore University HealthSystem. The NCH Arlington Heights campus features a 509-bed hospital with a Level II Trauma Center, Level III Neonatal Intensive Care Unit and dedicated pediatric emergency department. Throughout the northwest suburbs, NCH has 23 doctor's offices; five immediate care centers; seven physical rehabilitation sites; and 13 lab locations. A comprehensive listing of physicians and programs can be found at nch.org.

Headquartered in Evanston, NorthShore is a fully integrated healthcare delivery system that includes 6 hospitals—Evanston, Glenbrook, Highland Park, Skokie, Swedish and now NCH. Together, the NorthShore system provides clinical excellence and community-focused care across Chicagoland. NorthShore consistently ranks as a Top 15 Major Teaching Hospital in the United States, with an established reputation for exceptional patient care and is a national pioneer in the implementation of advanced health information technology. More information, can be found at NorthShore.org and SwedishCovenant.org.

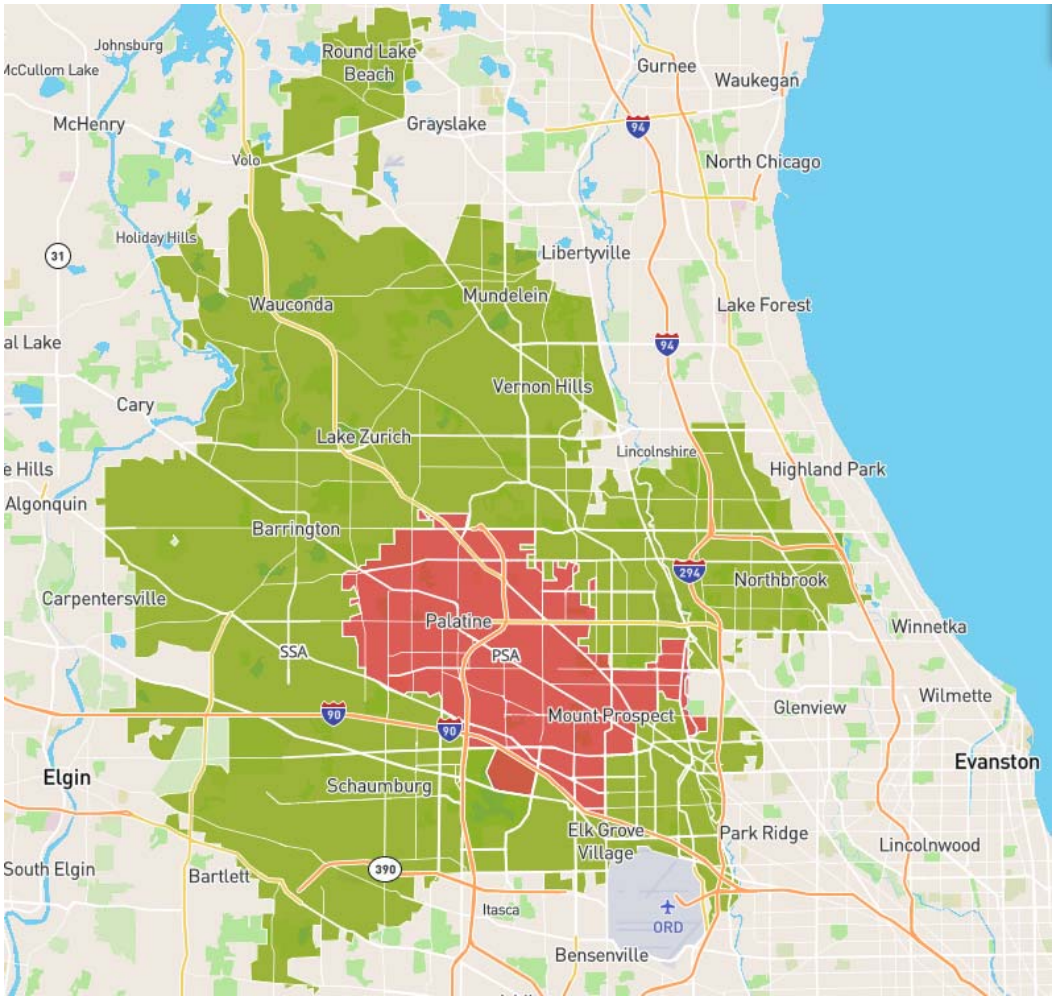
NCH has a proud and longstanding tradition of outreach to the medically underserved within its northwest suburban service area, and the recent year was no different. What was different; however, was NCH's ability to work swiftly and safely to meet the emerging needs of its community due to the COVID-19 pandemic. NCH had two of the initial cases of COVID-19 in Illinois in late February and early March of 2020 and understands it is the utmost health concern of the community. Throughout the first and second surge of the virus, NCH continued to care for the medically underserved of the community. As national and local attention focuses on vaccine availability and distribution, NCH continues to lead education efforts to promote vaccine adoption and supports its community's healing by recognizing social, economic and emotional impacts of the virus.

NCH maintains a Community Services Department dedicated to addressing the needs of not only its patients, but of everyone who lives and works in the community. The Community Services Department utilizes hospital strengths alongside those of other well-established community partners to identify unmet community health needs and to develop strategic initiatives to address them. Working collaboratively allows NCH to better understand and reach the most vulnerable sectors of the community with the ultimate goal of improving the community's health status by ensuring everyone has access to care and by empowering individuals to make healthy life choices.

Definition of the Community Served

NCH's community, as defined for the purposes of the CHNA, includes each of the ZIP codes that comprise the hospital's Total Service Area (TSA). The TSA is comprised of both the hospital's Primary Service Area (PSA) and Secondary Service Area (SSA). The geographic footprint is illustrated in the following map along with a chart that lists the zip codes and names of towns.

This community definition was determined because 82% of NCH's patients originate from the primary and secondary service areas.



Primary Service Area (PSA)	
60004	Arlington Heights
60005	Arlington Heights
60008	Rolling Meadows
60056	Mt. Prospect
60067	Palatine
60074	Palatine
Secondary Service Area (SSA)	
60007	Elk Grove Village
60010	Barrington
60015	Deerfield
60016	Des Plaines
60018	Des Plaines
60042	Island Lake
60047	Lake Zurich/Kildeer
60060	Mundelein
60061	Vernon Hills
60062	Northbrook
60070	Prospect Heights
60073	Round Lake
60084	Wauconda
60089	Buffalo Grove
60090	Wheeling
60107	Streamwood
60133	Hanover Park
60169	Hoffman Estates
60172	Roselle
60173	Schaumburg
60192	Hoffman Estates
60193	Schaumburg
60194	Schaumburg
60195	Schaumburg

Demographics and Chronic Disease Growth of the Community

POPULATION AND PROJECTED GROWTH

The population of NCH's total service area is currently 977,610 and is projected to remain relatively stable with a slight decline in the primary service area (-.06%) and no projected growth in the secondary service area.

By Service Area:

Zip Code	Town	2020	2025	% Change
Primary Service Area (PSA)				
60004	Arlington Heights	49,534	48,962	-1.2%
60005	Arlington Heights	29,787	29,448	-1.1%
60008	Rolling Meadows	22,618	22,641	0.1%
60056	Mt. Prospect	53,881	53,371	-0.9%
60067	Palatine	38,912	38,873	-0.1%
60074	Palatine	39,061	39,192	0.3%
	Total PSA	**233,793**	**232,487**	**-0.6%**
Secondary Service Area (SSA)				
60007	Elk Grove Village	32,512	32,134	-1.2%
60010	Barrington	44,873	44,912	0.1%
60015	Deerfield	25,833	25,491	-1.3%
60016	Des Plaines	59,512	59,604	0.2%
60018	Des Plaines	29,680	29,607	-0.2%
60042	Island Lake	8,457	8,455	0.0%
60047	Lake Zurich/Kildeer	40,955	41,247	0.6%
60060	Mundelein	37,278	37,120	-0.4%
60061	Vernon Hills	27,130	27,416	1.1%
60062	Northbrook	39,528	39,525	0.0%
60070	Prospect Heights	14,908	14,772	-0.9%
60073	Round Lake	60,575	61,614	1.7%
60084	Wauconda	16,994	17,383	2.3%
60089	Buffalo Grove	40,093	39,552	-1.3%
60090	Wheeling	38,421	38,592	0.4%
60107	Streamwood	39,501	39,444	-0.1%
60133	Hanover Park	37,355	37,240	-0.3%
60169	Hoffman Estates	31,759	31,395	-1.1%
60172	Roselle	24,481	24,425	-0.2%
60173	Schaumburg	13,229	13,384	1.2%
60192	Hoffman Estates	15,877	15,881	0.0%
60193	Schaumburg	39,675	39,368	-0.8%
60194	Schaumburg	20,020	19,784	-1.2%
60195	Schaumburg	5,131	5,137	0.1%
	Total SSA	**743,817**	**743,482**	**0.0%**
NCH Total Service Area (PSA + SSA)		**977,610**	**975,969**	**-0.2%**

Source: Sg2 Market Demographics

By Age:

The highest utilizers of healthcare services are patients 65 and over; the 65-84 age group is expected to grow 14.8% in the primary service area and 18.2% in the secondary service area over the next five years. During this same time period, the number of residents in all other younger age groups is expected to decrease by 1-6%.

Age Group	2020 Population	2025 Population	% Change
Primary Service Area (PSA)			
0-17	49,441	48,756	-1.4%
18-44	78,471	76,427	-2.6%
45-64	64,256	60,452	-5.9%
65-84	35,835	41,139	14.8%
85-up	5,790	5,713	-1.3%
Total PSA	**233,793**	**232,487**	**-0.6%**
Secondary Service Area (SSA)			
0-17	161,937	156,386	-3.4%
18-44	250,530	246,461	-1.6%
45-64	207,156	196,449	-5.2%
65-84	108,909	128,752	18.2%
84-up	15,285	15,434	1.0%
Total SSA	**743,817**	**743,482**	**0.0%**
NCH Total Service Area (PSA + SSA)	**977,610**	**975,969**	**-0.2%**

Source: Sg2 Market Demographics

By Gender:

The percentage of females and males is not projected to change from 2020 to 2025.

Gender	2020 Population	% of Total	2025 Population	% of Total	% Change
Female	496,809	51%	496,133	51%	-0.1%
Male	480,801	49%	479,836	49%	-0.2%
Total NCH TSA	**977,610**	**100.0%**	**975,969**	**100.0%**	**0.2%**

Source: Sg2 Market Demographics

By Ethnicity/Race:

NCH's service area is predominately non-Hispanic White (61%), but also has substantial Hispanics (19%) and Asians (15%). The number of Black and White Non-Hispanics is projected to decrease 1.4% and 5.3% respectively. The populations that are projected to have the largest growth are the Asian (10.7%), Multiple Races (8.9%) and the Hispanic/Latino (6.8%) populations.

This is further validated by data provided by Community Consolidated School District 15 (CCSD15), the second largest school district in the state, and located in NCH's primary service area. There are more than 80 languages spoken throughout the district and although 39% of its students are white, there are a significant number of Hispanic (35%) and Asian (19%) students.

Ethnicity/Race	2020	% of Total	2025	% Change
HISPANIC/LATINO				
American Indian/AK Native	3,450	0%	3,675	6.5%
Asian	690	0%	720	4.3%
Black/African American	1,807	0%	1,889	4.5%
Multiple Races	8,976	1%	9,506	5.9%
Native HI/PI	79	0%	87	10.1%
Other	76,735	8%	83,565	8.9%
White	97,559	10%	102,808	5.4%
Total Hispanic/Latino	189,296	19%	202,250	6.8%
NOT HISPANIC/LATINO				
American Indian/AK Native	856	0%	775	-9.5%
Asian	147,219	15%	162,962	10.7%
Black/African American	24,013	2%	23,667	-1.4%
Multiple Races	17,578	2%	19,145	8.9%
Native HI/PI	197	0%	203	3.0%
Other	1,175	0%	1,144	-2.6%
White	597,276	61%	565,823	-5.3%
Total Not Hispanic/Latino	788,314	81%	773,719	-1.9%
Total NCH TSA	**977,610**	**100%**	**975,969**	**-0.2%**

Source: Sg2 Market Demographics

By Language:

Spanish speakers make up 15% of the total population and this is projected to grow .4% between 2020 and 2025.

Language	2020	% of Total	2025	% Change
Asian Pacific, English Not at All	1,773	0%	1,705	-3.8%
Asian Pacific, English Not Well	7,977	1%	7,741	-3.0%
Asian Pacific, English Very Well	40,122	4%	39,598	-1.3%
Asian Pacific, English Well	15,428	2%	15,090	-2.2%
Indo-European, English Not at All	4,738	1%	4,624	-1.6%
Indo-European, English Not Well	14,491	2%	14,258	-1.6%
Indo-European, English Very Well	88,957	10%	88,292	-0.7%
Indo-European, English Well	29,907	3%	29,635	-0.9%
Only English	573,547	62%	574,931	0.2%
Other Language, English Not at All	313	0%	324	3.5%
Other Language, English Not Well	934	0%	954	2.1%
Other Language, English Very Well	7,321	1%	7,307	-0.2%
Other Language, English Well	1,901	0%	1,887	-0.7%
Spanish, English Not at All	6,691	1%	6,778	1.3%
Spanish, English Not Well	22,359	2%	22,499	0.6%
Spanish, English Very Well	77,563	8%	77,836	0.4%
Spanish, English Well	27,105	3%	27,191	0.3%
Total NCH TSA	**921,127**	**100%**	**920,650**	**-0.1%**
Spanish Total	**133,718**	**15%**	**134,304**	**0.4%**

Source: Sg2 Market Demographics

By Income:

The upper income brackets, $100k and higher, are projected to increase while all lower income brackets are projected to decrease.

Income	2020 Households	% of Total	2025 Households	% of Total	% Change
<$15K	17,923	4.9%	16,004	4.4%	-10.7%
$15-25K	20,033	5.5%	16,972	4.6%	-15.3%
$25-$50K	57,358	15.6%	52,025	14.2%	-9.3%
$50-75K	56,141	15.3%	51,439	14.0%	-8.4%
$75-100K	48,771	13.3%	46,330	12.6%	-5.0%
$100-200K	110,549	30.2%	114,921	31.3%	4.0%
>$200K	55,844	15.2%	69,551	18.9%	24.5%
Total NCH TSA	**366,619**	**100%**	**367,242**	**100%**	**.02%**

Source: Sg2 Market Demographics

By Education:

The majority, 68.9%, of persons living in the hospital's service area, have some college education and this is not projected to change significantly over the next five years.

Education*	2020 Households	% of Total	2025 Households	% of Total	% Change
Less than High School	31,420	4.6%	31,782	4.6%	1.2%
Some High School	27,118	4.0%	27,511	4.0%	1.4%
High School Degree	134,672	19.7%	136,097	19.8%	1.1%
Some College/Assoc. Degree	172,297	25.2%	173,715	25.2%	0.8%
Bachelor's Degree	197,148	28.8%	197,343	28.7%	0.1%
Greater than Bachelor's Degree	101,903	14.9%	101,996	14.8%	0.1%
Professional Degree	19,984	2.9%	20,066	2.9%	0.4%
Total NCH TSA	**684,542**	**100%**	**688,510**	**100%**	**0.6%**

**Excludes population age <25*

Source: Sg2 Market Demographics

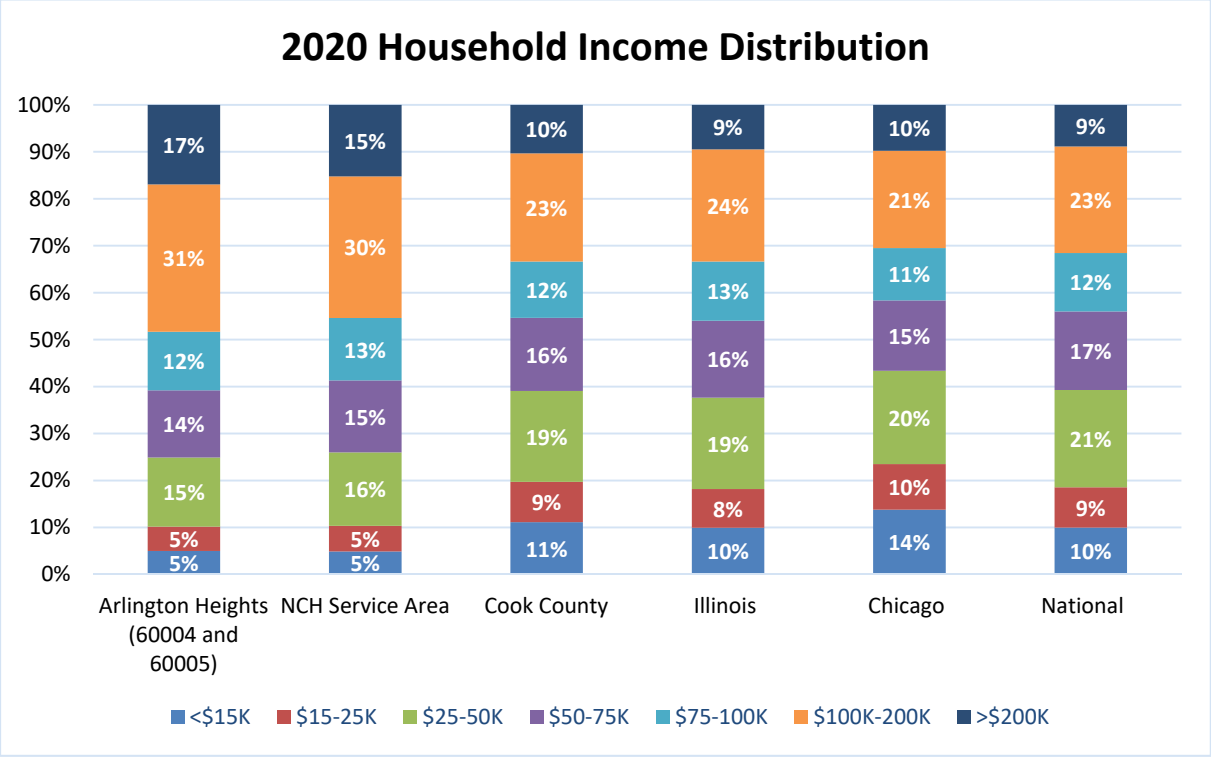
SERVICE AREA UNEMPLOYMENT STATISTICS

As indicated in the table below, Arlington Heights has a lower average unemployment rate than the Chicago-Naperville-Arlington Heights Metropolitan Division, Cook County, State of Illinois and the country. Also included in the table are the dramatically increased unemployment rates for June 2020, which are a direct result of the COVID-19 pandemic.

	Arlington Heights , Illinois	Chicago-Naperville-Arlington Heights Metropolitan Division	Cook County, IL	Illinois	USA
2019 Annual Average Unemployment Rates	3.1	3.6	3.8	4.0	3.7
June 2020	N/A	16.1	17.4	14.6	11.2

SERVICE AREA INCOME

The chart summarizes household income distribution of the population of Arlington Heights, NCH's total service area, Cook County, Illinois, Chicago and USA. The historical and projected household income levels of the total service area have exceeded and are projected to continue to exceed State of Illinois and national levels.



Source: Sg2 Market Demographics

INSURANCE COVERAGE (Pre-COVID)

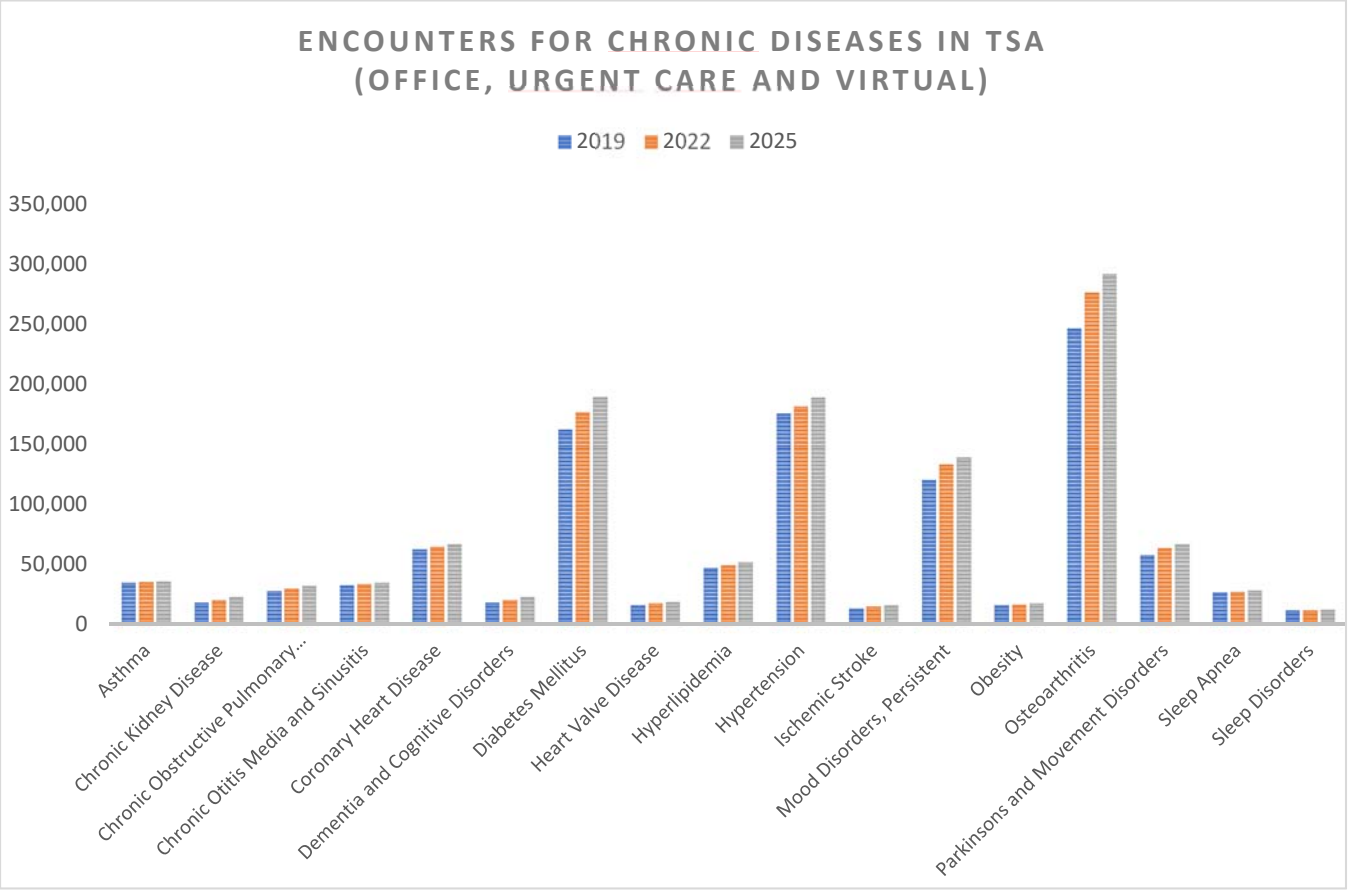
Although NCH's Total Service Area is dominated by Commercial insurance, there are still a substantial number of individuals on Medicaid (24,068) or uninsured (14,420).

Zip Code	Commercial	Medicaid	Medicare	Other	Uninsured	Veterans
60004	13,604	1,316	5,802	550	572	585
60005	8,674	1,030	3,456	323	484	392
60008	5,878	612	2,062	229	370	297
60056	13,695	1,730	5,804	550	818	662
60067	11,157	797	4,347	465	514	570
60074	9,735	1,543	3,175	318	776	449
Total NCH PSA	62,743	7,028	24,646	2,435	3,534	2,955
60007	8,925	783	3,778	377	505	511
60010	10,891	593	5,753	666	366	578
60015	6,550	327	3,109	360	173	298
60016	15,773	2,041	6,339	601	1,115	869
60018	6,746	907	2,536	260	551	376
60042	2,206	220	653	73	168	138
60047	9,722	512	4,143	507	286	445
60060	8,824	734	3,420	386	501	499
60061	7,607	560	2,126	241	342	340
60062	9,925	592	6,455	710	313	587
60070	3,783	525	1,630	156	324	238
60073	12,793	1,665	3,338	480	1,207	723
60084	4,289	394	1,564	192	296	240
60089	11,299	787	4,552	509	395	520
60090	9,939	1,227	3,631	357	703	511
60107	9,413	860	2,515	314	614	529
60133	7,767	817	2,127	255	602	472
60169	8,040	863	2,497	266	630	483
60172	6,507	479	2,488	268	311	371
60173	4,376	441	1,086	112	338	218
60192	3,970	196	1,339	169	113	171
60193	11,080	851	4,292	445	565	645
60194	5,695	478	2,043	221	312	324
60195	1,723	188	400	46	156	90
Total NCH SSA	187,843	17,040	71,814	7,971	10,886	10,176
NCH TSA	**250,586**	**24,068**	**96,460**	**10,406**	**14,420**	**13,131**

Source: Sg2 Market Demographics

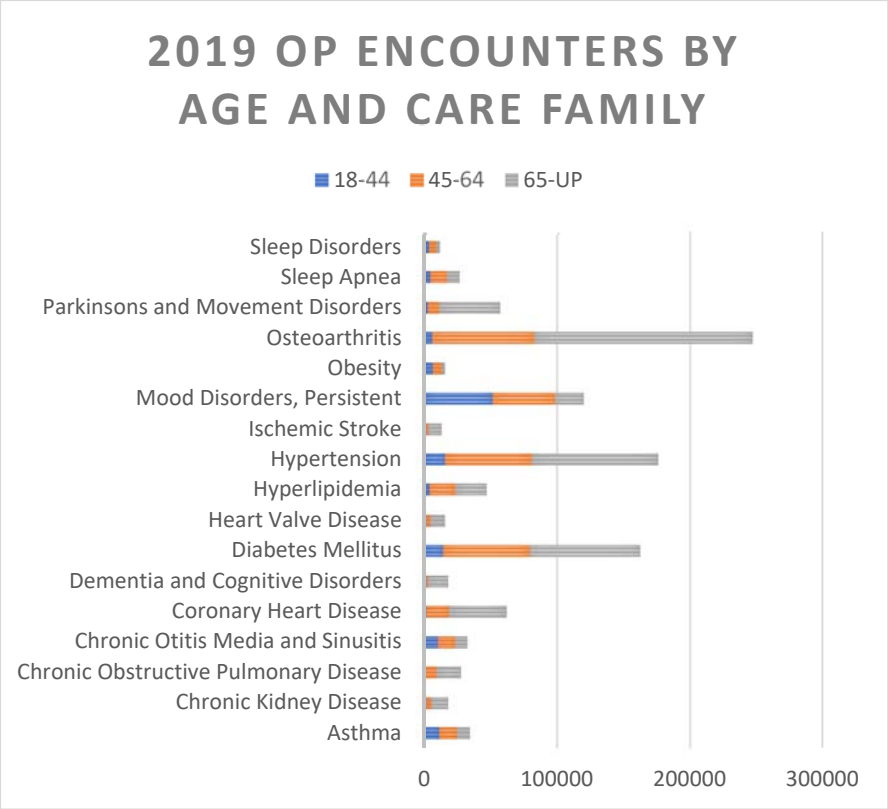
Chronic Disease Growth in NCH Service Area

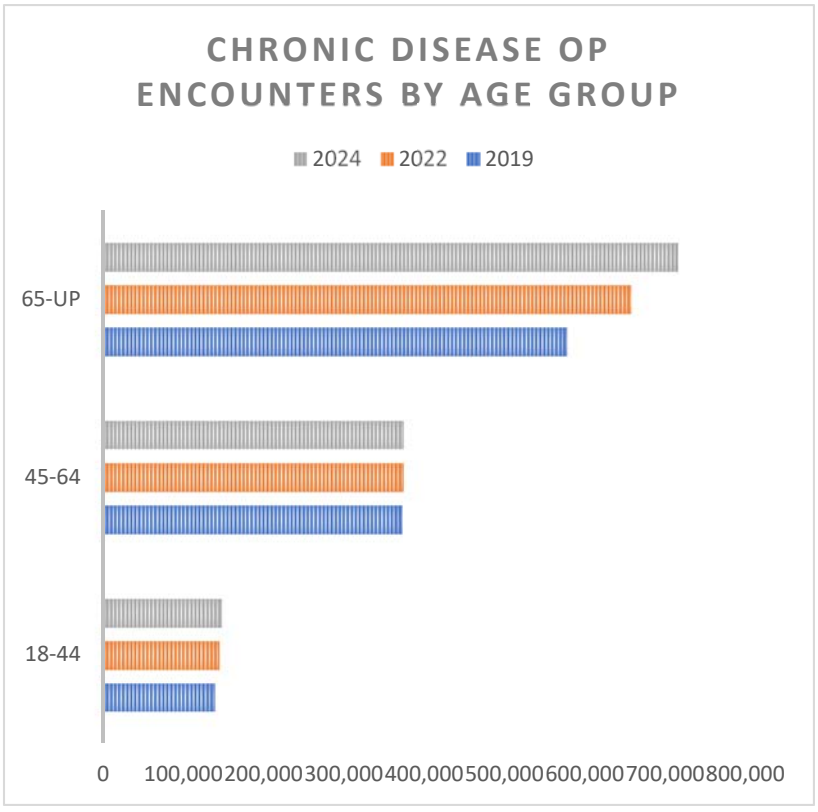
Notable growth is projected in the areas of diabetes, hypertension, osteoarthritis and persistent mood disorders by persons 65 and older.



Note this forecast does not include the impact of COVID
Source: Sg2 Market Demographics

Chronic Disease Growth in NCH Service Area





Note this forecast does not include the impact of COVID
Source: Sg2 Market Demographics

Existing Healthcare Facilities and Resources

Northwest Community Hospital is the only acute care facility located in the hospital's primary service area. NCH recognizes that there are other existing healthcare facilities and resources within the community that are available to respond to the health needs of residents. These organizations include the following:

- **Acute-Care Hospitals/Emergency Departments**
  - Advocate Good Shepherd (Barrington)
  - Amita Health Alexian Brothers Medical Center (Elk Grove)
  - Amita Health St. Alexius Medical Center (Hoffman Estates)

- **Federally Qualified Health Centers and Other Safety Net Providers**
  - ACCESS Northwest Family Health Center/FQHC (Arlington Heights)
  - Arlington Heights Health Center/Cook County (Arlington Heights)
  - Creekside Health Center/FQHC-Greater Elgin Family Care Center (Wheeling)
  - Genesis Health Center/FQHC-Greater Elgin Family Care Center (Des Plaines)

- **Immediate Care Centers**
  - Advocate (Des Plaines, Vernon Hills)
  - Advocate Clinics at Walgreens (Arlington Heights, Buffalo Grove, Elk Grove, Hanover Park, Lake Zurich, Mt. Prospect, Palatine, Wheeling)
  - Amita Health (Lake Zurich, Palatine, Mt. Prospect)
  - CVS Minute Clinic (Barrington, Buffalo Grove, Mundelein, North Brook, Rolling Meadows, Schaumburg, Vernon Hills)
  - Family Practice Center of Palatine and Immediate Care Palatine (Palatine)
  - NorthShore (Buffalo Grove)
  - Northwestern Medicine (Deerfield, Vernon Hills)
  - Physicians Immediate Care (Hanover Park)
  - Schaumburg Immediate Care Center (Schaumburg)

- **Behavioral Health Services/Facilities**
  - Advocate Addiction Program (Des Plaines)
  - Allendale Association (Lake Villa/Wauconda)
  - Amita Health Alexian Brothers Behavioral Health Hospital (Hoffman Estates)
  - Amita Health Alexian Brothers Center for Mental Health (Arlington Heights)
  - Arlington Center for Recovery (Arlington Heights)
  - Bridge Youth and Family Services (Palatine)
  - Catholic Charities Holbrook (Des Plaines, Mundelein)
  - Chicago Behavioral Health Hospital (Des Plaines)
  - Compass Health Center (Northbrook)
  - Eating Recovery Center (Northbrook)
  - FAIR (Families and Adolescents in Recovery) (Schaumburg)

- **Behavioral Health Services/Facilities (continued)**
    - Kenneth Young Center (Elk Grove)
    - Keys to Recovery (Des Plaines)
    - Latino Family Services (Arlington Heights)
    - Leyden Family Services-SHARE (Hoffman Estates)
    - Lutheran Social Services of Illinois (Des Plaines)
    - Omni Youth Services (Arlington Heights)
    - Nicasa (Round Lake Beach)
    - NorthShore Josselyn Center (Deerfield/Northfield)
    - Renfrew Center (Northbrook)
    - Salvation Army Family Services (Arlington Heights)
    - Streamwood Behavioral Health Hospital (Streamwood)
    - Vernon Hills Senior Center (Vernon Hills)
    - Youth Services of Glenview (Northbrook)

- **Oral Health Resources**
    - Arlington Heights Health Center/Cook County (Rolling Meadows)
    - Willow Creek Community Church Care Center (South Barrington)
    - University of Illinois College of Dentistry (out of service area but referral resource)

CHNA Goals and Objectives

The 2021 CHNA serves as a tool toward reaching three basic goals:

- **To improve residents' health status, increase their life spans and elevate their overall quality of life.** A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.
- **To increase accessibility to preventive services for all community residents**. More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

CHNA Data Collection/Methodology

The CHNA was completed by incorporating data from quantitative or a combination of quantitative and qualitative resources. Quantitative data included demographic information and secondary data and a combination of quantitative and qualitative data was gathered through focus groups, online community surveys and key informant surveys.

Quantitative Data

Demographic and Chronic Disease Growth Information
NCH contracted with Sg2, an industry leader in healthcare analytics and consulting, for a comprehensive demographic snapshot of the hospitals service area. Sg2 provided population growth projections for the community by town, age, gender, ethnicity/race, language, income and education. In addition, they forecasted the projected growth of chronic disease in the outpatient setting for NCH's service area. Changes in community demographics have a direct correlation with healthcare needs and how to address them.

Secondary Data
SparkMap (sparkmap.org) is a product of the Center for Applied Research and Engagement Systems (CARES) and hosted by the University of Missouri. SparkMap uses location-specific data to create maps and community assessments that inform, guide and transform the work of healthcare organizations. The goal of SparkMap is to increase the impact of those working toward healthy, equitable, and sustainable communities. The web portal allows access to data

in multiple categories which can be used to explore community health. Custom tools allow the user to filter data by zip code and create a report specifically for its community (*Appendix A*). It also allows the user to create a custom report which highlights its community's greatest areas of concern *(Appendix B)*.

The 2020 County Health Rankings and Roadmaps Report (countyhealthrankings.org), a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, ranked U.S. counties in every state on various health outcomes, health factors, social and economic conditions, and the physical environment. The major goal of the Rankings is to raise awareness about the many factors that influence health and that health varies from place to place. Although the Rankings provide valuable county-wide information it does not examine data at the sub-county level. Cook County is unique in that it is the second-most populous county in the United States after Los Angeles County, California. There are 130 incorporated municipalities partially or wholly within Cook County, the largest of which is Chicago, which is home to approximately 54% of the population of the county. The Cook County Department of Public Health recognizes the uniqueness of the county and identified indicators from the Rankings for which local data existed and created a report specifically for Suburban Cook County (*Appendix C*).

Quantitative/Qualitative Data

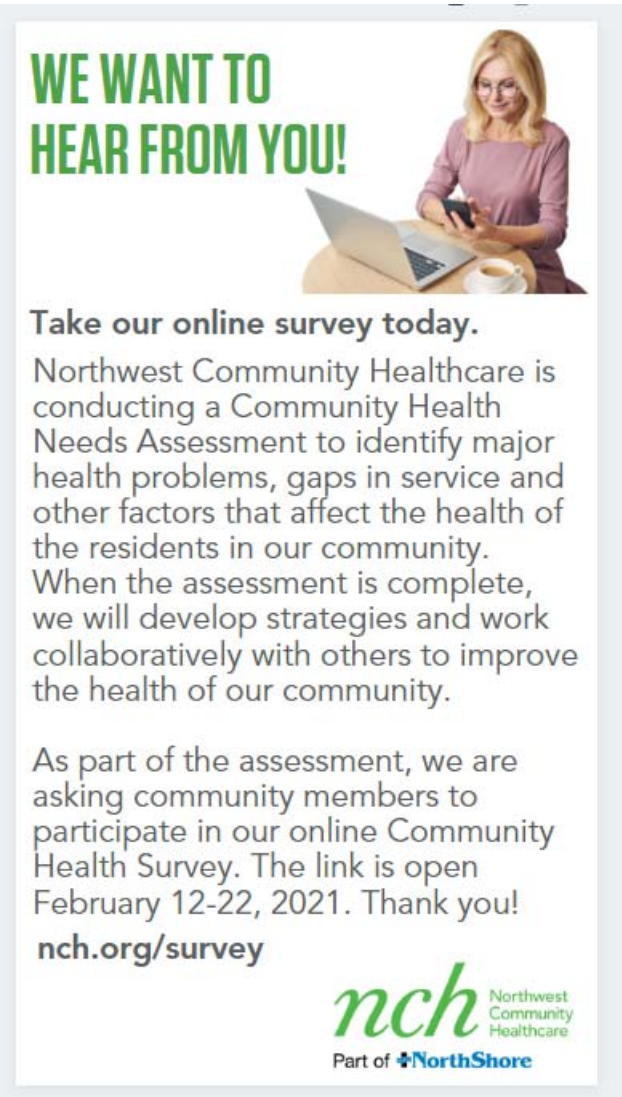
Focus Groups

NCH realized the importance of gathering opinions and feedback from vulnerable populations in the community who have some of the greatest healthcare needs. An independent moderator was hired to conduct two focus groups in February 2021: one with Spanish- speaking under-resourced community members and one with English-speaking under-resourced community members. These focus groups were held at the Community Resource Center in Palatine, located in the hospitals primary service area. Potential participants were given a short screening questionnaire to ensure they lived in the hospital's service area and so that participants would vary in age, gender, insurance status, income and educational levels if possible. The focus groups followed a guideline which mirrored questions included in the community and key informant surveys so that the information gathered could be used to compare with the survey results. The moderator summarized the results of the focus groups which were used as one of the tools in identifying the most predominant community needs (*Appendix D*).

NCH also conducted a focus group in February 2021 with its Patient Family Advisory Council, which is comprised of community members who use NCH as their medical home. The same format as the focus groups described above was used, and provided an opportunity to gather additional information on the community's beliefs and perceptions about the health of its community, which supplemented the data collected in the online Community Health Survey *(Appendix E)*.

Community Survey

NCH developed a comprehensive online community health survey in order to take into account input from persons who represent the broad interests of the community served by the hospital. The survey asked participants to share their beliefs and perceptions about access to care, behavioral health, chronic disease/health issues, modifiable risk factors/behaviors and other concerns. It also asked the participants to rank their "top three health concerns" for the community. The community was invited to participate in the online survey through a media release and a paid advertisement in a local newspaper, NCH's electronic community newsletter "A Healthier You", NCH's electronic volunteer and employee newsletters, social media and through an email announcement by NCH's Foundation to all donors. The survey link, located on the home page of the hospital's website (nch.org), was open from February 12 to 22, 2021 and 364 people responded. The majority of the respondents were Caucasian (99%), female (71%) and older adults (15% Age 55-64, 36% Age 65-74, and 32% Age 75 or older). The majority (73%) had attained a college degree (associates or higher) and had either Medicare (63%) or private insurance (34%). The majority (72%) live in the hospital's primary service area and the remainder (28%) live in the hospital's secondary service area. Results from the survey were summarized in a quantitative/qualitative report (*Appendix F*).



Key Informant Surveys

An additional online survey was implemented as part of the CHNA process specifically to solicit input from key informants; individuals who are considered experts in public health. Potential participants were chosen because of their ability to identify primary concerns of the community, including the medically underserved, low-income and minority populations served by the hospital.

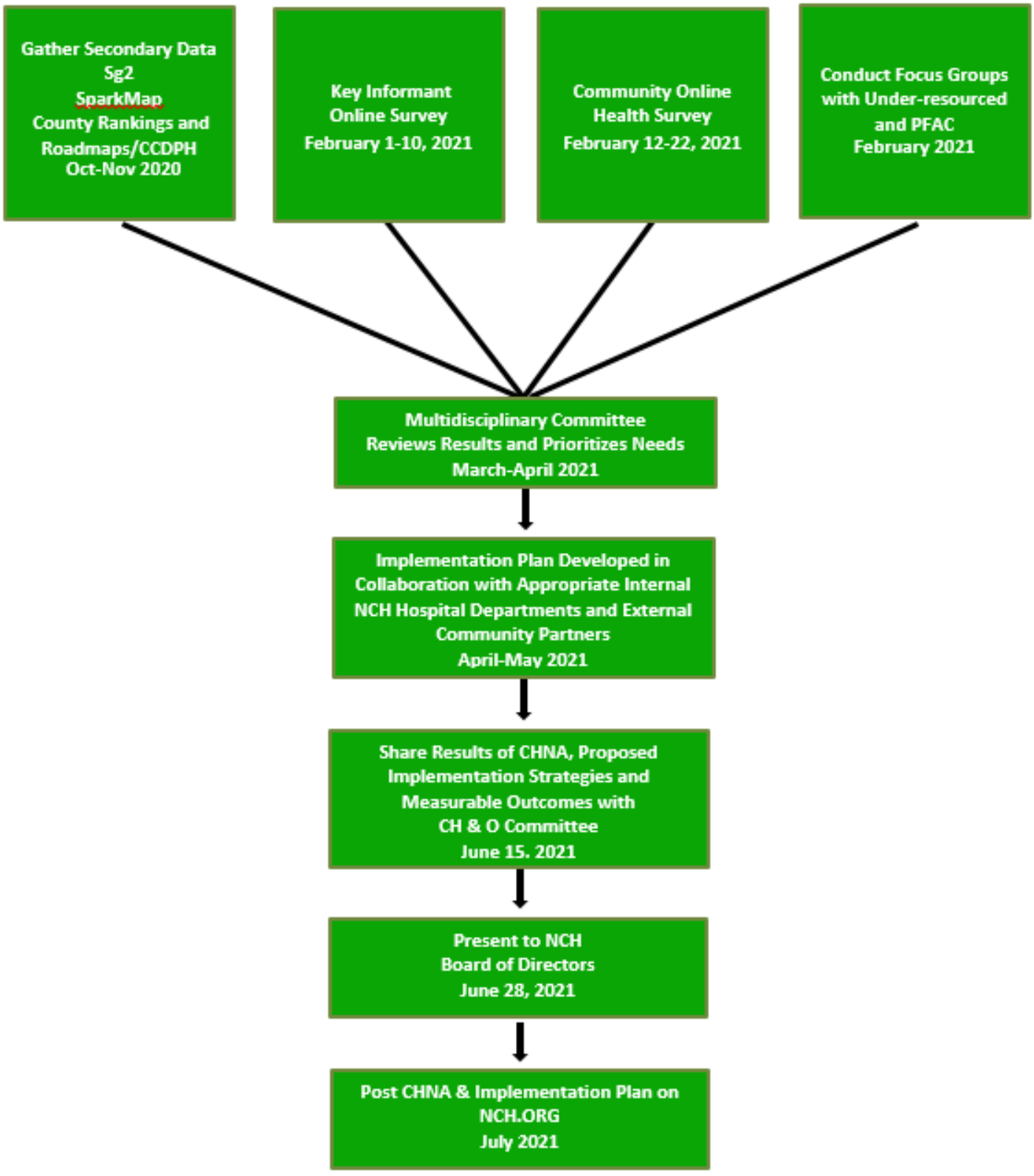
In January 2021, 44 potential key informants were identified and sent a letter from the hospital's President and CEO to explain the purpose of the survey and to invite them to participate. A link to the online survey was then emailed to each key informant and was open from February 1-10, 2021. A reminder email was sent to encourage participation. The key informants were asked the same questions as the community which focused on access to care, behavioral health, chronic disease/health issues, modifiable risk factors/behaviors and other concerns. It also asked them to rank their "top three health concerns" for the community. Results from the survey were summarized in both a quantitative (*Appendix G*) and qualitative (*Appendix H)* report.

In all, 24 of the 44 invited participants took part in the Online Key Informant Survey (below).

Key Informant Survey		
Key Informant Type	**Organizations Invited to Participate**	**Number Invited**
Community/ Business Leader	Arlington Heights Chamber of Commerce, Elk Grove Township, Lutheran Home, NCH Board of Directors, Palatine Township, Schaumburg Township, Wheeling Township, Village of Arlington Heights	9
Physicians	Arlington Heights Health Center (Cook County), Heartland Alliance, Northwest Community Healthcare	3
Other Health Provider	Arlington Heights Health Center (Cook County), Community Consolidated School District 15, Greater Elgin Family Care Center, Northwest Community Healthcare	8
Public Health Expert	Cook County Department of Public Health, Northwest Community Healthcare, Village of Arlington Heights Health & Human Services Department	3
Social Service Agencies	Asian Human Services, Bridge Youth and Family Services, Community Consolidated School District 15, Center for Teaching and Learning, City of Rolling Meadows, Elk Grove Township, Hopeful Beginnings/St. Mary's Services, Journeys, Northwest Community Hospital, Northwest Compass, Palatine Township, Partners for our Communities, Schaumburg Township, Village of Arlington Heights, Village of Mt. Prospect, Village of Palatine, Wheeling Township	21
Total		44

Through this process, input was gathered from individuals whose organizations work with low-income populations, minority populations (including African-Americans, Asians, Eastern Europeans, Hispanics, Indian, Japanese, Polish and Russian), or other medically underserved populations (including the disabled, the elderly, the homeless, Medicaid/Medicare beneficiaries, the mentally ill, pregnant teens, substance abusers, undocumented individuals, uninsured/underinsured residents, veterans, young adults and women).

2021 Community Health Needs Assessment
2022-2025 Implementation Plan
Timeline



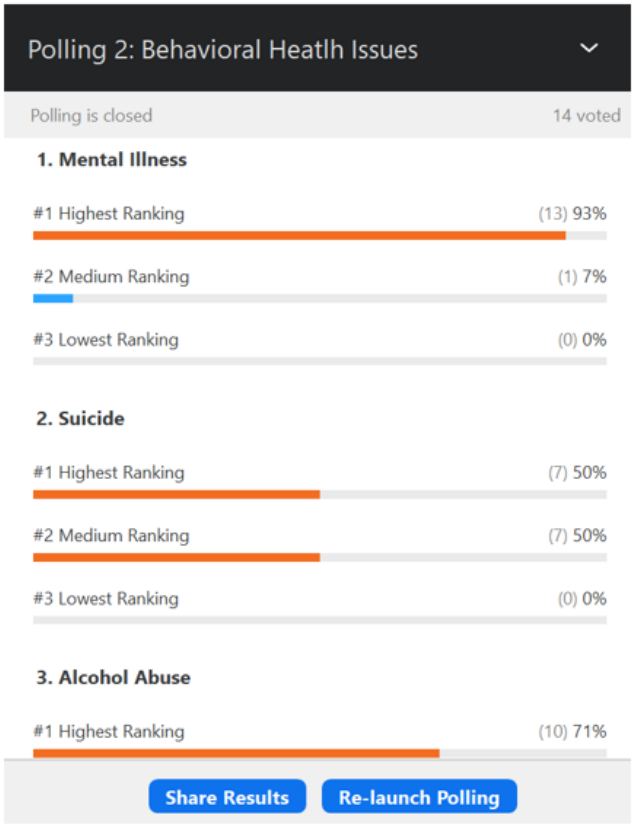
Prioritization Process

In March 2021, NCH convened an internal, multidisciplinary committee that met multiple times to review the results of the CHNA, affirm and prioritize needs and to identify the most qualified internal and external persons to develop implementation plans to address each priority need. Representatives from the following departments served on the committee: Behavioral Health, Care Coordination, Community Based Care, Community Services, Compliance, Diabetes Services, Emergency Department, EMS, Foundation, Guest Services, Immediate Care Centers, Medical Group, Nursing Excellence, Patient Access Services, Patient Experience, and Research. In addition, the chair of the Community Health and Outreach Committee of the NCH Board of Directors participated in the committee.

The committee members were provided with an overview of the community health needs assessment process and received a summary and comparison document (Appendix J) which was used as a tool to review all of the quantitative and qualitative findings. The findings from the focus groups, community survey and key informant survey were compared and the secondary data provided supplemental information. The most common themes and comments from the narrative portion of the surveys were also highlighted in the document.

In addition, the committee was given web access to the complete survey results, focus groups summaries and all secondary data. The committee was given time to review the summary and comparison document and to access the additional resources and then reconvened to rank or prioritize the issues. The committee then used the following criteria to identify which health needs would be addressed over the next three years:

- **Magnitude**: The size or extent of the issue and/or populations affected
- **Impact/Seriousness**: The degree to which the issue affects or exacerbates other quality of life and health-related issues
- **Feasibility**: The ability to reasonably impact the issue, given available resources
- **Consequences of Inaction**: The risk of not addressing the problem at the earliest opportunity
- **Professional Experience**: Health concerns committee members witnessed working at NCH during the recent year



Prioritization Results

Ranking of Health Concerns Ranking: 1-3 (1 is highest level of concern)	
Rank #1	Access to Care-Behavioral Health Services Substance Abuse-Alcohol and Drugs Mental Illness (Includes Suicide) Heart Disease/Stroke/High Blood Pressure Cancer Diabetes Obesity-Adults and Children Food Insecurity Physical Activity-Lack Of Child Abuse Domestic Violence Elder Abuse
Rank #2	Access to Care-Specialty, Oral Health, Preventative Screenings, Audiology, Vision Services and Prescription Medication Dementia/Alzheimer's Arthritis/Osteoporosis/Back Chronic Kidney Disease Oral Health Respiratory-Asthma Vision Nutrition Tobacco Usage Adequate-Affordable Housing Safe Neighborhoods Teen Births
Rank #3	Access to Care-Immunizations, Primary Care Hearing Loss Sexually Transmitted Diseases Infant/Child Health

NCH Priority Health Issues to Be Addressed

In consideration of the top health priorities identified through the CHNA process — and taking into account hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined that NCH would focus the majority of its efforts on developing and/or supporting strategies and initiatives to improve the following priority areas:

1. **Behavioral Health (Mental Health and Substance Abuse)**
   Concern about behavioral health was a consistent theme throughout the CHNA. This issue has no economic or societal boundaries; all data confirmed that mental health and substance abuse is a major and growing concern in NCH's service area. In addition, as noted previously, access to care for behavioral health is extremely difficult for under-resourced, often uninsured individuals. State and community-based resources have almost disappeared due to funding cuts and those that do remain often do not accept individuals without insurance or those who are on Medicaid which leaves no alternative other than using area emergency departments for care and medications. A vast majority of the qualitative feedback from the CHNA indicated significant concern about alcohol and drug abuse with opioids and heroin addiction being the most prevalent. Survey participants shared that treatment for behavioral health issues carries embarrassment and a stigma which discourage many from seeking help.

2. **Obesity**
   Obesity is another issue that was consistently expressed as a major health concern in all aspects of the CHNA. All three focus groups ranked obesity as a major concern for both adults and children and more than half of the key informants ranked it a major concern. Lack of physical activity, nutrition and food insecurity further solidified obesity as a health concern of epidemic proportion. Secondary data shows that 19.8 % of low-income people living in NCH's service area have low access to food; higher than the state rate of 14.68% and U.S. of 18.94%. In addition, there is a shortage of stores accepting SNAP (Supplemental Nutrition Assistance Program) benefits in the NCH Service Area. Food insecurity translates directly into poorer health-and more visits to the emergency department. A U.S. Department of Agriculture report found that food insecurity was linked to 10 of the costliest and deadliest preventable diseases in the country.

3. **Access to Healthcare for Under-Resourced**
   The committee spent a great deal of time discussing access to care and the inequities within the hospital's service area. The assessments rankings for access to care, and all of the health concerns, are representative of the entire broad community. Individuals with insurance have little issues with accessing healthcare services but the assessment clearly indicated that this is not the case with under-resourced, often uninsured individuals. Access to all areas of healthcare, including specialty, behavioral, oral, vision, screenings, and medication is challenging when financial resources are limited. (Note that although

access to primary care was not ranked a major concern, the committee thought it should be included in Implementation Plan as it is often a direct link to accessing specialty care). The CHNA showed that NCH's service area has a higher uninsured rate for both adults (11.32%) and children (3.65%) than the state (9.93% and 3.35%). In addition, NCH's service area has a higher percent of individuals with limited English proficiency (14.23%) than both the state (8.64%) and U.S. (8.40%) which often makes accessing healthcare difficult. Unemployment rates for NCH's service area (7.2%) are higher than both the state (6.5%) and U.S. (6.4%) and public transportation is extremely limited. Because of these factors, the committee selected "Access to Care for the Under-Resourced" as one of the key priority areas.

4. **Cancer (Including Tobacco)**
   Cancer is the second leading cause of death in the United States, exceeded only by heart disease. Approximately 608,570 Americans are expected to die of cancer in 2021, which translates to about 1,670 deaths per day. Illinois is expected to have 74,980 new cases of cancer and 23,070 cancer deaths in 2021. All three focus groups unanimously agreed that cancer is a major concern (100%) and more than half of the key informants surveyed (55%) and community surveyed (58%) agreed. Secondary data indicated that breast and prostate cancer are the most concerning, especially for the Medicare population. In addition, the low-income focus groups unanimously ranked tobacco a major concern (100%) which includes not only cigarettes but also e-cigarettes and chewing tobacco.

- **Chronic Disease (Diabetes, Heart Disease/Stroke, and High Blood Pressure)**
  Statistics show that in 2018, 34.2 million Americans had diabetes, and another 88 million U.S. adults had pre-diabetes, equating to $237 billion dollars in health care costs. Heart disease is the leading cause of death in the United States. Approximately 655,000 Americans die from heart disease each year-that is one in four deaths. The most common type of heart disease in the United States is coronary artery disease (CAD), which affects the blood flow to the heart. Decreased blood flow can cause a heart attack. Stroke is another form of heart disease and in the United States someone has a stroke every 40 seconds and dies from a stroke every 4 minutes. All three focus groups indicated that heart disease, stroke and diabetes are major health concerns. The key informant participants also ranked these as major concerns.

Once the priority areas were determined, the multidisciplinary committee identified key individuals to serve on issue specific committees to develop implementation strategies and tactics for each of the areas. These individuals also developed metrics to measure the success of the strategies which will be monitored and updated over the next three years.

In acknowledging the wide range of priority health issues that emerged from the CHNA process, NCH determined that it could only effectively focus on those which it deemed most pressing, most under-addressed, and most within its ability to influence. Responses to the remaining needs identified are noted below:

Access to Care for UR: Specialty and Vision	NCH believes access to these areas will be addressed through referrals from primary care physicians at community clinics and through screenings and support services offered by local school districts.
Child Abuse, Elder Abuse and Domestic Violence	NCH collaborates with four local not-for-profit community agencies (Catholic Charities, Children's Advocacy Center, Northwest CASA and WINGS) to address child abuse, elder abuse and domestic violence.
Dementia and Alzheimer's	NCH believes there are sufficient community resources available including primary care physicians to diagnose and nursing homes and memory care facilities to treat.
Teen Sexuality: Pregnancy and STD's	NCH collaborates with local school districts that provide sex education and support services and with local community clinics who address prevention and treatment.
Safe Neighborhoods and Affordable Housing	NCH is a healthcare facility and is not equipped to address housing issues. NCH relies on its local municipalities to address these concerns.

Previous CHNA and Implementation Plan

The needs identified in the 2021 CHNA were almost identical to the needs identified in the 2018 CHNA with the exception of Behavioral Health. The magnitude and seriousness of both mental health and substance abuse concerns increased significantly. This could have been impacted by the fact that the 2021 CHNA took place during the COVID-19 pandemic, a time when many people were feeling depressed, isolated or had situations that caused an increased amount of stress.

In 2020, despite the pandemic, NCH was able to meet more than half of the goals that were developed to measure the effectiveness of the strategies and tactics implemented to impact the needs identified in the 2018 CHNA. The pandemic negatively impacted NCH's ability to meet some of the goals because programs were suspended due to the stay at home order and so that hospital staff could focus their efforts on helping with COVID patients. For the FY22-FY24 Implementation plan, NCH will continue to utilize the strategies and tactics in the FY19-FY21 Implementation Plan which includes: screenings, education, treatment, support and improving access to care.

Public Dissemination

The CHNA was posted on NCH's hospital website, nch.org/chna, in July 2021. There is also a link which allows an opportunity for the public to submit any comments or questions they may have on the report. There were no comments or questions received regarding the previous assessment conducted in 2018.

NCH will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. NCH will also maintain at its facilities hard copies of the CHNA report that may be viewed by any who requests it.

Information Gaps

While this CHNA is quite comprehensive, NCH 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.

For example, certain population groups — such as institutionalized persons or those who only speak a language other than English or Spanish— are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses. In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

FY2022-FY2024 IMPLEMENTATION PLAN

Integration with Operational Planning

Community benefit is included in both NCH's strategic plan and operating budget.

Implementation Strategies

The Community Health Implementation Plan outlines NCH's plans to address the priority health issues chosen for action in the FY2022-FY2024 period. Note that these strategies are in addition to millions of dollars of Charity Care and Medicaid/Medicare shortfalls that NCH provides. The Implementation Plan, along with the full Community Health Needs Assessment, were reviewed and approved by the Community Health and Outreach Committee of the Board on June 15, 2021 and presented to the entire corporate board of directors on June 28, 2021. It was posted on nch.org on June 30, 2021.

Northwest Community Healthcare
Part of NorthShore

Community Health Implementation Plan FY22 FY24

Social Determinants of Health

Social determinants of health 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. NCH recognizes this and is committed to incorporating strategies to address these factors in its Community Health Implementation Plan.

BEHAVIORAL HEALTH

PRIORITY 1

1. Screenings and Referrals
2. Education
3. Treatment

OBESITY

PRIORITY 2

1. Access to Healthy Food
2. Opportunities for Physical Activity
3. Education and Treatment

ACCESS TO CARE FOR THE UNDER-RESOURCED

PRIORITY 3

1. Access to Primary/Specialty Care
2. Access to Oral Health Services
3. Access to Prescription Medication

CANCER

PRIORITY 4

1. Screenings and Education
2. Survivorship
3. Tobacco Cessation

CHRONIC DISEASES (DIABETES, HEART/STROKE, HIGH BLOOD PRESSURE)

PRIORITY 5

1. Screenings and Education
2. Support
3. Treatment

Key

- ★ Goal met
- Within 10% of goal
- Goal not met

Note: NCH changed its fiscal year to align with the other hospitals in the NorthShore-EE health system. Because of this, a stub year of 10/1-12/31, 2021 is being reported to be consistent with the IRS filing.

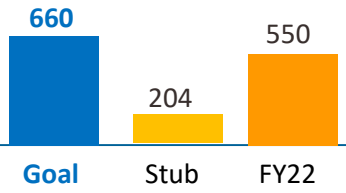
nch Northwest Community Healthcare
Part of NorthShore

1 BEHAVIORAL HEALTH

Assessment Clinic

GOAL: 660 assessments

Free in-person behavioral health assessments and referrals for community members



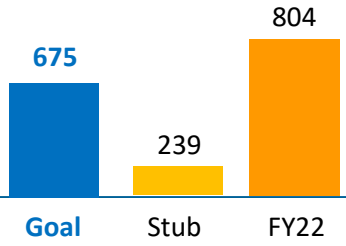
GOAL STATUS

Stub	NA
FY2022	83%
FY2023	

Care Coordination

GOAL: 675 assessments

Free behavioral health assessments and care coordination for patients hospitalized with medical issues



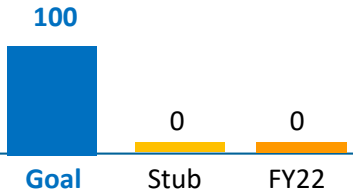
GOAL STATUS

Stub	NA
FY2022	★ 119%
FY2023	

Mental Health First Aid

GOAL: 100 people trained

A course that teaches how to help someone who is developing mental illness or substance abuse issues



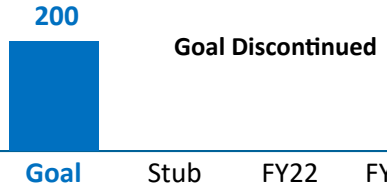
GOAL STATUS

Stub	NA
FY2022	0%
FY2023	

ED Ambulatory Detox

GOAL: 200 people assisted

Medication assistance and referrals to treatment for ambulatory detox



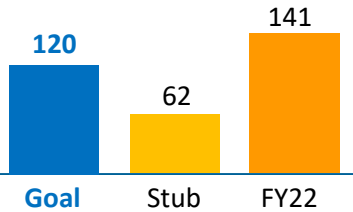
GOAL STATUS

Stub	NA
FY2022	Disc.
FY2023	

Outpatient Addictions Services

GOAL: 120 clients served

Physician led clinic which provides medication assisted treatment for alcohol, opioid and other substance use disorders



GOAL STATUS

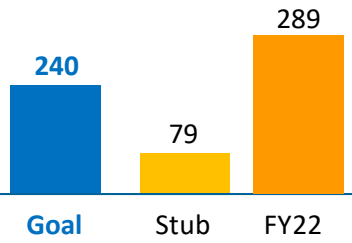
Stub	NA
FY2022	★ 118%
FY2023	

2 OBESITY

Food Insecurity Screening

GOAL: 240 patients supported

Number or patients that screened positive for food insecurity and were provided food and/or other resources before being discharged.



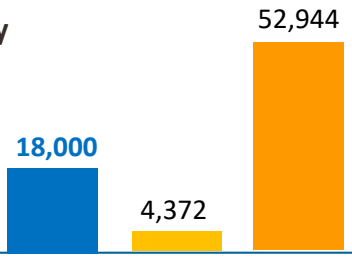
GOAL STATUS

Stub	NA
FY2022	★ 120%
FY2023	

Community Cares Food Pantry

GOAL: 18,000 served

Number of persons served by the collaborative food panty which NCH is a partner in



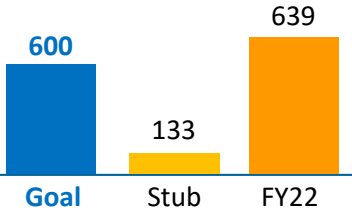
GOAL STATUS

Stub	NA
FY2022	★ 294%
FY2023	

MedFit Enrollments

GOAL: 600 enrollments

Low-cost 60-day guided customized exercise programs for Individuals referred by physicians.



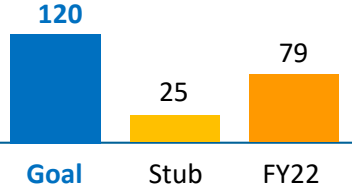
GOAL STATUS

Stub	NA
FY2022	★ 107%
FY2023	

Outpatient Nutrition Counseling

GOAL: 120 persons educated

Number of patients who received outpatient nutritional counseling by a registered dietician for obesity



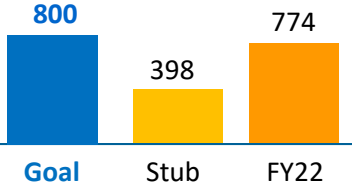
GOAL STATUS

Stub	NA
FY2022	● 66%
FY2023	

Weight Loss Clinic

GOAL: 800 patients supported

Physician-supervised medical weight loss program for adults



GOAL STATUS

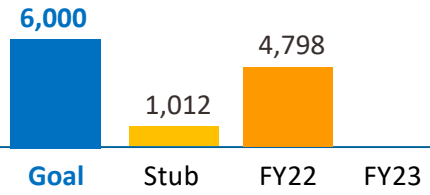
Stub	NA
FY2022	● 97%
FY2023	

3 ACCESS to HEALTHCARE for the UNDER-RESOURCED

Community Nursing Program

GOAL: 6,000 client visits

Free health education, chronic disease management, screenings and referrals



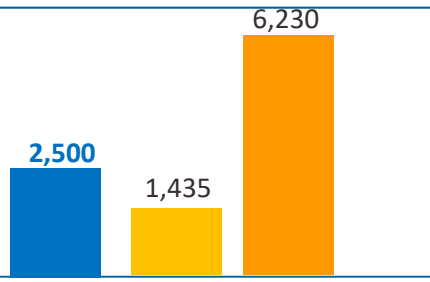
GOAL STATUS

Stub	NA
FY2022	80%
FY2023	

Community Health Worker

GOAL: 2,500 client visits

Free assistance with finding physicians, medical homes and other community resources



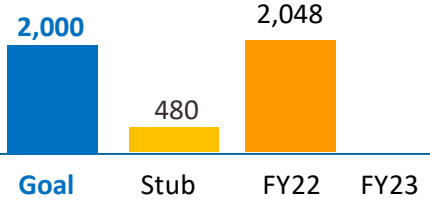
GOAL STATUS

Stub	NA
FY2022	249%
FY2023	

Mobile Dental Clinic

GOAL: 2,000 patient visits

Free or reduced fee oral healthcare services



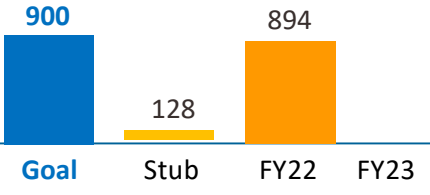
GOAL STATUS

Stub	NA
FY2022	102%
FY2023	

Charitable Prescription Program

GOAL: 900 Prescriptions

Free prescription medication for home-less, uninsured and underinsured



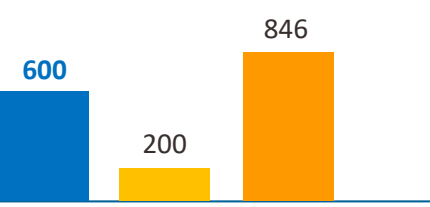
GOAL STATUS

Stub	NA
FY2022	99%
FY2023	

Free Transportation

GOAL: 600 Rides

Free taxi and courtesy van rides for low-income individuals to and from healthcare services



GOAL STATUS

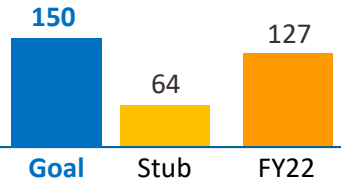
Stub	NA
FY2022	141%
FY2023	

4 CANCER

Gift-A-Mammogram

GOAL: 150 mammograms

Free mammograms for uninsured women over 40



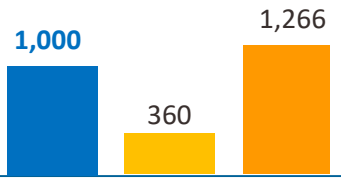
GOAL STATUS

Stub	NA
FY2022	85%
FY2023	

Lung Screenings

GOAL: 1,000 screenings

Screenings for early detection and treatment



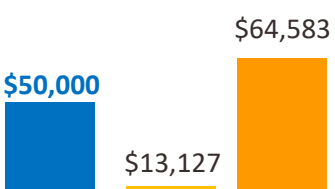
GOAL STATUS

Stub	NA
FY2022	127%
FY2023	

Cancer/Lung Patient Assistance Fund

GOAL: $50,000 in assistance

Financial assistance given to cancer patients struggling to pay their rent, utilities and other living expenses



GOAL STATUS

Stub	NA
FY2022	129%
FY2023	

Support Services

GOAL: 1,500 client encounters

Support groups, classes and survivor events to promote emotional healing after a cancer diagnosis

GOAL STATUS

Stub	NA
FY2022	55%
FY2023	

Tobacco Cessation

GOAL: 400 client encounters

Free tobacco cessation counseling and support to aid with lung cancer prevention

GOAL STATUS

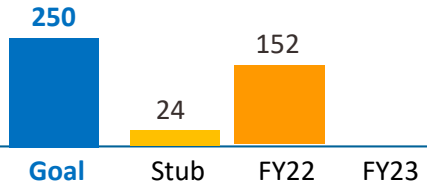
Stub	NA
FY2022	22%
FY2023	

5 CHRONIC DISEASES (DIABETES, HEART/STROKE, HIGH BLOOD PRESSURE)

Stroke Support & Risk Assessments

GOAL: 250 Encounters

Support group encounters to promote emotional healing after diagnosis and risk factor assessments and education to identify and prevent stroke



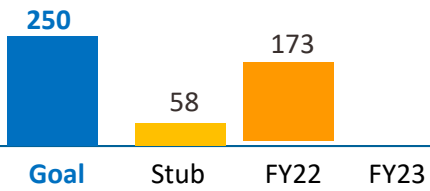
GOAL STATUS

Stub	NA
FY2022	61%
FY2023	

Diabetes Education & Support

GOAL: 250 Encounters

Free education and support for individuals with diabetes



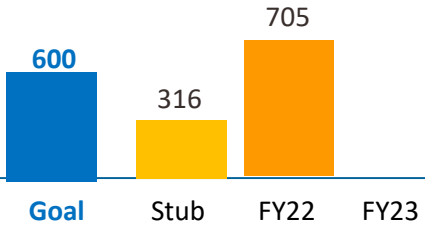
GOAL STATUS

Stub	NA
FY2022	69%
FY2023	

Patient Navigation

GOAL: 600 encounters

RN Navigator assists patients in the community with chronic care management and education



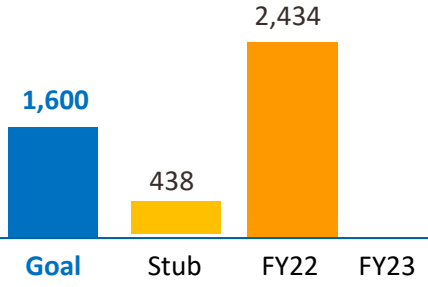
GOAL STATUS

Stub	NA
FY2022	118%
FY2023	

Atherton Outpatient Clinic

GOAL: 1,600 patient visits

Support for individuals with congestive heart failure



GOAL STATUS

Stub	NA
FY2022	152%
FY2023	

The CHIP was approved by the NCH Community Health and Outreach (CHO) Committee of the Board on June 15, 2021 and presented to the full NCH Board of Directors on June 28, 2021. Metrics are reviewed annually.

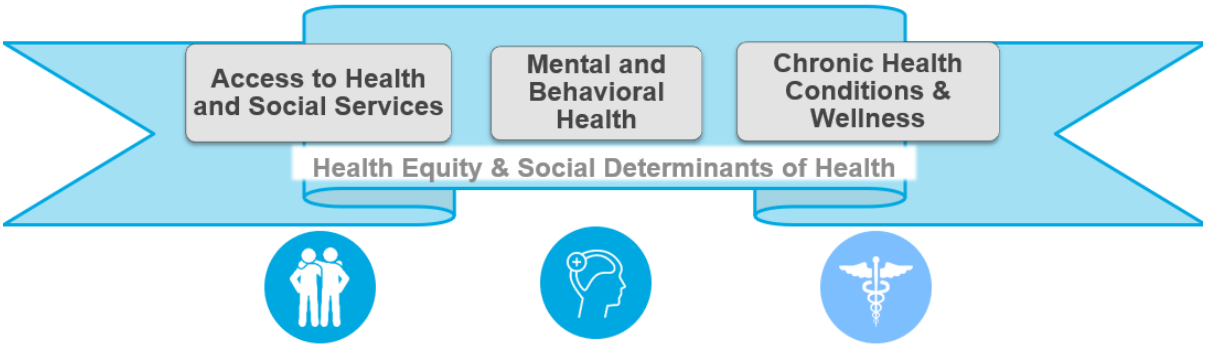
Swedish Hospital
Part of NorthShore

2022 Community Health Needs Assessment

Table of Contents

Introduction

Swedish Hospital (Swedish) and members of the Alliance for Health Equity (AHE), a collaborative of over 30 hospitals partnering with health departments and community based organizations, worked together throughout 2021-2022 to build a comprehensive Community Health Needs Assessment (CHNA) in Chicago and Cook County. Swedish Hospital and the Alliance for Health Equity adapted the Mobilizing for Action through Planning and Partnerships (MAPP) model for the CHNA, emphasizing the importance of community engagement, partnership development, and both primary and secondary data. The Alliance for Health Equity chose this inclusive, community-driven process to leverage and align with health department assessments and to actively engage stakeholders, including community members, in identifying and addressing strategic priorities to advance health equity. Swedish Hospital worked with the Alliance for Health Equity and local community partners in the communities we serve to identify and prioritize the following health needs within our community through 2024:



Swedish will continue to partner with members of Alliance for Health Equity and other key community partners within our service area to leverage existing resources and develop strategies which contribute to improving the most pressing health needs of our communities. The corresponding Community Health Implementation Plan will describe programs Swedish is undertaking over the coming years to address the prioritized health needs within our community. To access the full collaborative Community Health Needs Assessment for Chicago and Suburban Cook Counties, please visit https://allhealthequity.org/projects/2022-chna-report/

Our Hospital

This CHNA was conducted by the Alliance for Health Equity and pertains to Swedish Hospital. Swedish Hospital is part of NorthShore—Edward-Elmhurst Health.

NorthShore—Edward-Elmhurst Health is a fully integrated healthcare delivery system committed to providing access to quality, vibrant, community-connected care, serving an area of more than 4.2 million residents across six northeast Illinois counties. Our more than 25,000 team members and more than 6,000 physicians aim to deliver transformative patient experiences and expert care close to home across more than 300 ambulatory locations and eight acute care hospitals – Edward (Naperville), Elmhurst, Evanston, Glenbrook (Glenview), Highland Park, Northwest Community (Arlington Heights), Skokie, and Swedish (Chicago) – all recognized as Magnet hospitals for nursing excellence. Located in Naperville, Linden Oaks Behavioral Health, provides for the mental health needs of area residents. NorthShore –Edward-Elmhurst Health desires to continue providing clinical programs and services to meet community health needs, while also pursuing continuous improvement in existing and future programs to improve the overall health of individuals in the communities it serves. As such, hospitals within the NorthShore—Edward-Elmhurst Health system conduct Community Health Needs Assessments (CHNA's) every three years, using primary and secondary data, to ensure

community benefit programs and resources are focused on significant health needs as perceived by the community at large, as well as alignment with NorthShore—Edward-Elmhurst Health's mission, services, and strategic priorities.

This CHNA is focused on the communities served by Swedish Hospital. Edward-Elmhurst Health, NorthShore University HealthSystem (Evanston, Glenbrook, Highland Park and Skokie Hospitals) and Northwest Community Healthcare develop and release their own separate CHNAs.

Swedish Hospital - Services, Locations and Commitment to Community

Swedish Hospital serves the culturally-diverse residents of Chicago's north and northwest side communities, with a full-service hospital campus located in Lincoln Square at the intersection of Foster and California Avenues. Swedish Hospital provides a full range of comprehensive health and wellness services including an acute care hospital, primary care and specialists in the medical group, strong community outreach programs and Chicago's only certified medical fitness center, Galter LifeCenter.

Swedish offers more than 50 medical specialties with practices conveniently placed throughout hospital's campus and on multiple sites throughout Chicago's north side communities (including several Immediate Care Centers) to make care accessible to our patients, wherever they are.

Swedish maintains a department dedicated to addressing its outreach objectives of serving the entire community, not only those who come through its doors. Building on a long tradition of service, the Community Relations Department utilizes hospital strengths alongside those of other well-established community partners. This strategy allows Swedish to better understand and reach the most vulnerable sectors of the community, while meeting pressing healthcare needs. The goal is to improve the community's health status by empowering citizens to make healthy life choices.

Our Commitment to Address Health Equity and Reduce Health Disparities

Diversity, equity and inclusion is at the core of who we are, being there for our patients and each other with compassion, respect and empathy. We believe that our strength resides in our differences and in connecting our best to provide community-connected healthcare for all.

We commit to:

- See, hear, and value all team members and patients
- Connect our best to serve our diverse communities
- Do everything we can to help you achieve your full potential in work, life, and health

We commit to accelerating:

Inclusion: The ability to be our authentic selves impacts our life, health and happiness. We are committed to making this a place where all team members and patients feel like they belong.

Opportunity: We are becoming a better reflection of the world we live in, investing in community partnerships and leadership development to enhance diversity across NorthShore.

Health Equity: We are addressing disparities in health and well-being, advancing access and patient outcomes across all the communities we serve.

Actions by Swedish Hospital to Advance Health Equity

- Regional Lead for CDPH's Healthy Chicago Equity Zone (North/Central Region)
- Leader of Chicago North Side Collaborative, a Healthcare Transformation Program
- Swedish Hospital Foundation's investments in mission-driven programs addressing health equity
- Accelerating system wide strategies for inclusion, opportunity, and health equity
- Improving collection and training on REAL data
- Racial Equity in Healthcare Progress Report (Illinois Health and Hospital Association, IHA)
- Integrating health equity into systemwide quality framework
- Improving collection of social determinants of health indicators
- Implicit bias training for care providers and team members
- Community Investment Fund Partners investing in community organizations to enhance health and wellbeing, advance health equity and support local economic growth

Swedish Hospital's Highlighted Community Initiatives

Swedish Hospital has a robust offering of community health and outreach programs designed to serve the needs of our diverse community. Highlights include:

- **Pathways:** The Pathways Program was developed to strengthen the hospital's ability to identify and assist patients who are survivors of interpersonal violence.
- **Food Connections:** The Food Connections Program was developed to strengthen the hospital's ability to address food insecurity and remove food access as a barrier to health.
- **Nutrition and Diabetes Center:** This program offers comprehensive education, resources and support to patients diagnosed with type 1 or type 2 diabetes, prediabetes, and gestational diabetes, as well as individual nutrition education to patients with various nutrition needs.
- **Community Outreach Registered Dietician (CORD):** This community-facing dietician engages in educational activities, outreach and public benefit education and enrollment assistance.
- **Healthy Chicago Equity Zones (HCEZ):** Swedish was awarded a grant via the City of Chicago to serve as Regional Lead for the North/Central area of the HCEZ initiative. This program began in the summer of 2021 and focuses on collaboratively working alongside trusted, local community organizations and leaders to identify and confront the social and environmental issues that contribute to health and racial inequity.
- **Chicago North Side Collaborative:** This Healthcare Transformation Program helps to reduce barriers to care and other disparities by embedding specialty care and other supportive services into local Federally Qualified Health Centers (FQHCs) thanks to IL Dept. of Healthcare and Family Services (HFS) Transformation Funding.

As part of the hospital's community outreach efforts, the Community Ambassador Program and the Community Leader Engagement Program allow Swedish to further connect with the community. Swedish initiated a Community Ambassador Program in FY16 which consists of employees throughout the organization who live in the local community and serve as liaisons to further build bridges among neighbors. Ambassadors engage in dialogue with schools, churches, cultural groups and other local organizations to learn more directly about the community's unique needs. Ambassadors share feedback and insight with the Community Relations Department which helps guide development of programming and education to serve the community.

Swedish established a Community Leader Engagement Program in FY17 as an extension of the Ambassador Program, to invite leaders from throughout the community to convene several times per year to discuss community health needs and ways to collaborate for the benefit of all. Together, the group has worked on the following health initiatives: head

injury prevention/bike helmet safety, bystander CPR and community wellness (fitness, nutrition, mind/body, prevention). This Community Leader group consists of more than 100 social service organizations, health care providers, elected officials, schools and others. Members include: Apna Ghar, Between Friends, Budlong Elementary School, Centro Romero, Chicago Police – 20th District, Common Pantry, Erie Family Health, The Friendship Center, HANA Center, Hamdard Health, Hatzalah, Heartland Health Centers, ICNA Relief, Lutheran Social Services, Neighborhood Boys and Girls Club and Rohingya Culture Center.

As part of the CHNA process, Swedish's Community Leader group met with hospital leaders and the Alliance for Health Equity staff to provide feedback on initial findings and priorities from the CHNA. Additionally, various organizations from the Community Leader group were active contributors to focus groups related to health care providers and social services, including immigrant and refugee-serving organizations.

Swedish Hospital's Participation in the Alliance for Health Equity

The Alliance for Health Equity (AHE) is a partnership between the Illinois Public Health Institute (IPHI), hospitals, health departments, and community organizations across Chicago and Cook County. This initiative is one of the largest collaborative hospital-community partnerships in the country with the current involvement of 30+ nonprofit and public hospitals, seven local health departments, and representatives of more than 100 community organizations serving on action teams. The Alliance for Health Equity is a collaboration of Chicago and Cook County-based hospitals that strives to promote a collective impact on health outcomes in the city of Chicago through an environment that fosters learning, sharing of resources, data and best practices. They are also the driving force to facilitate and execute the Community Health Needs Assessment (CHNA) for their hospital members. Swedish has been an active member of the Alliance for Health Equity since June of 2017 when the Health Impact Collaborative of Cook County and the Healthy Chicago Hospital Collaborative merged to form the Alliance for Health Equity. Several Swedish employees participate as active, engaged members of the following committees and workgroups:

- Steering Committee
- CHNA Committee
- Policy Committee
- Trauma-Informed Hospitals Collaborative
- Mental Health and Substance Use Disorders Committee
- Social and Structural Determinants of Health Committee
    - o Subcommittee: Food Security/Food Access Workgroup
    - o Subcommittee: Housing and Health Workgroup

Communities We Serve (Service Area)

Swedish's community, as defined for the purposes of the Community Health Needs Assessment, includes each of the residential ZIP Codes that comprise the hospital's Primary Service Area (PSA) and Secondary Service Area (SSA): 60613, 60618, 60625, 60626, 60630, 60640, 60641, 60645, 60646, 60659, 60660 and 60712, as shown in the map in Figure 1. 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 Swedish's patients originate from these areas.

The total population in Swedish's service area is 686,000. In the service area, 25% of the population identifies as Hispanic/Latinx and 75% Non-Hispanic. Fifty-three percent of the population identifies as white, 10% Asian, 8%

Black/African American, 3% identifies as two or more races, and less than 1% as Native American (Figure 2). The age distribution for the service area is shown in Figure 3.

Figure 1. Map of Swedish Hospital's CHNA service area

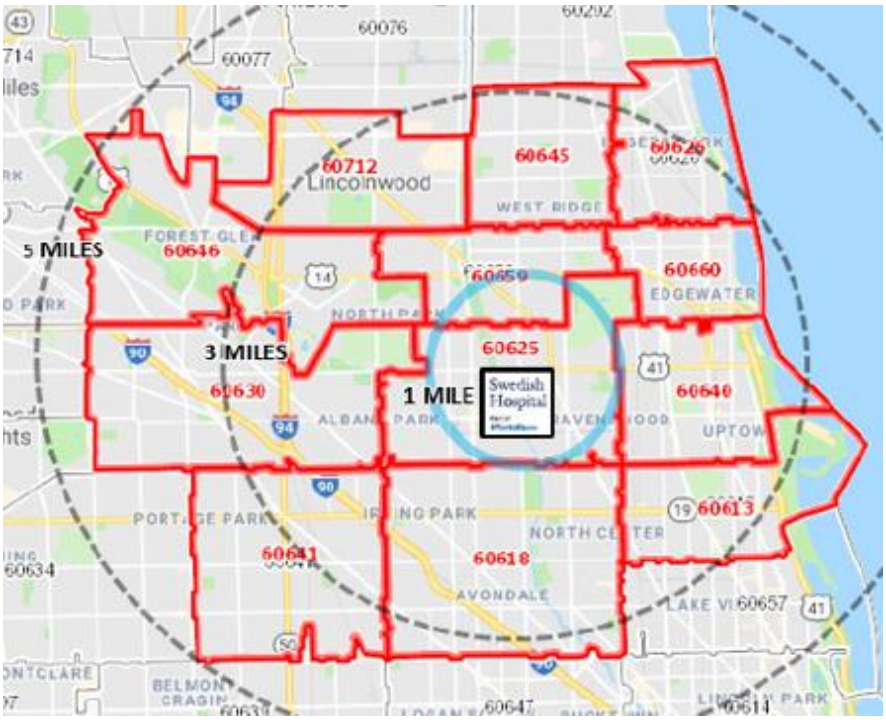
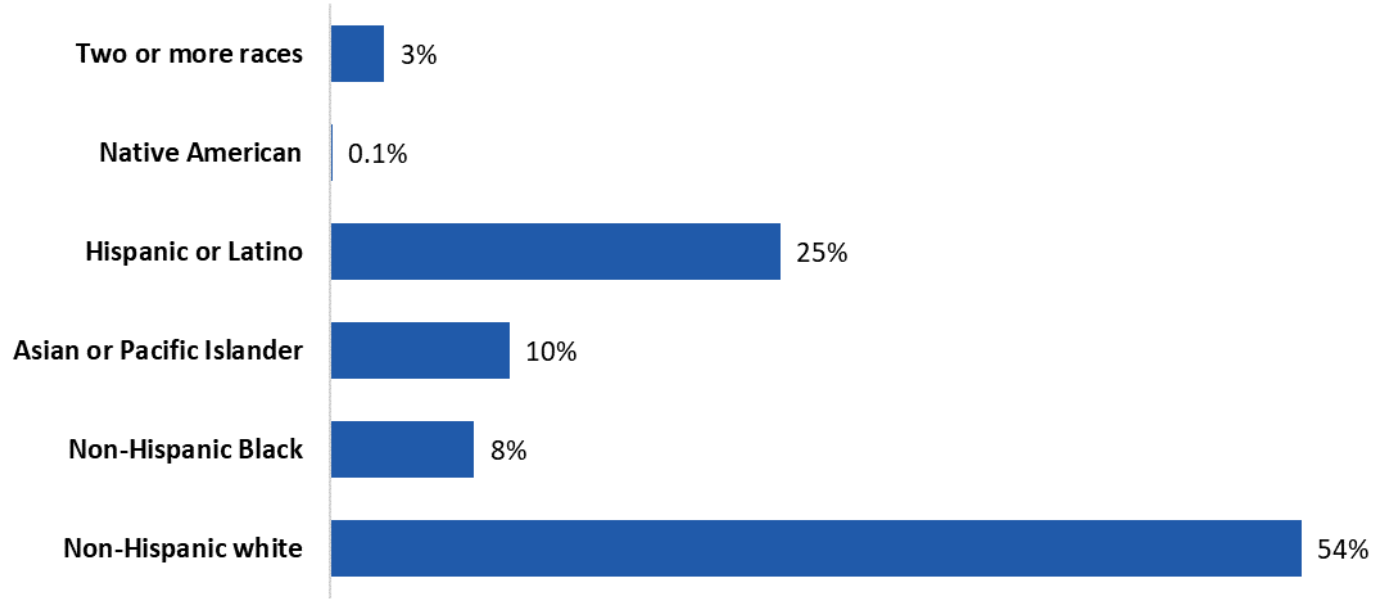
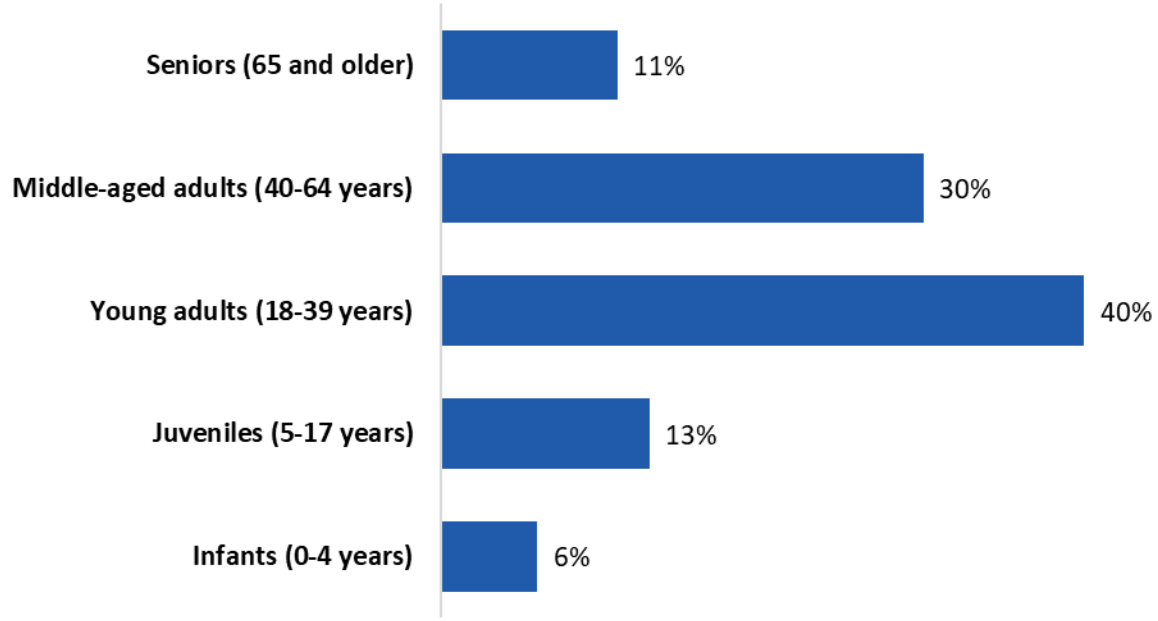


Figure 2. Race and ethnicity in Swedish Hospital's service area, 2016-2020



US Census, American Community Survey, 2016-2020

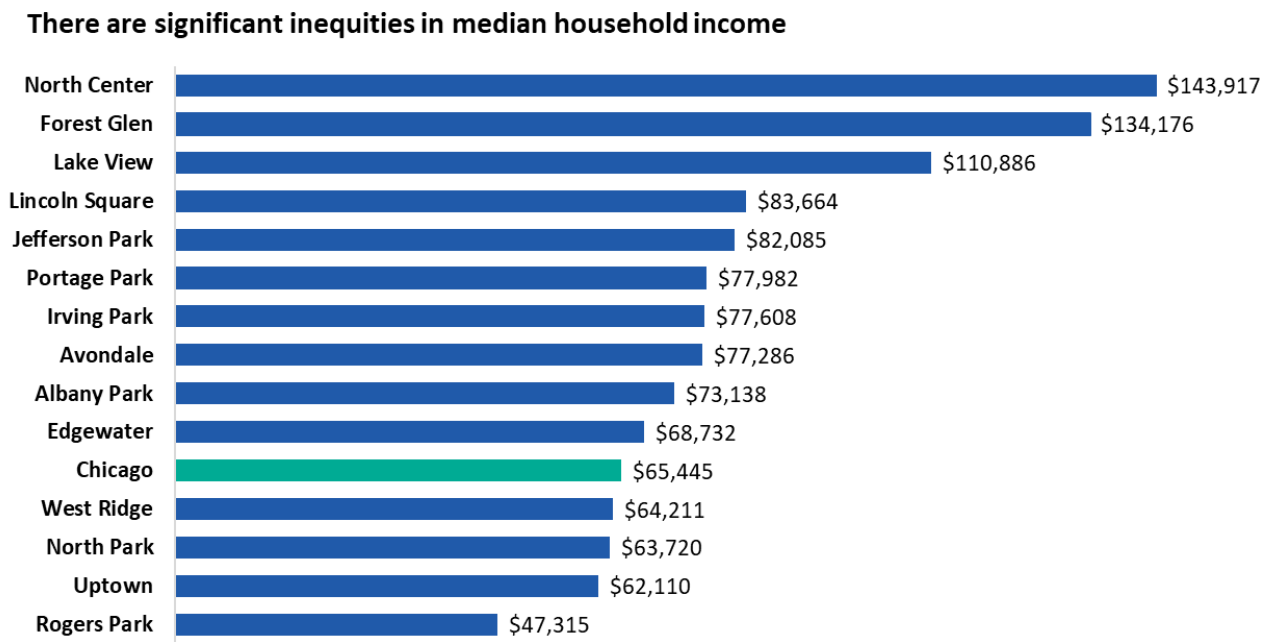
Figure 3. Age distribution, Swedish Hospital's service area, 2016-2020



US Census, American Community Survey, 2016-2020

There is substantial variation in median income within Swedish's service area (Figure 4). The median income in Rogers Park ($47,315) is nearly $100,000 less than the median income in North Center. In addition, poverty rates are highest in Rogers Park and Uptown.

Figure 4. Median household income in Swedish Hospital's service area



U.S. Census Bureau, American Community Survey, 2016-2020

Swedish Hospital serves a remarkably diverse population, and many of the community areas are home to large immigrant and refugee populations. Five of the 14 community areas within Swedish's service area have a limited English-speaking population of 10% or greater (Figure 5).

Figure 5. Percentage of population that is limited English-speaking in Swedish Hospital's service area

Limited English-Speaking Population	Percentage
Lake View	1%
North Center	1%
Forest Glen	4%
Lincoln Square	6%
Rogers Park	6%
Edgewater	7%
Uptown	7%
Chicago (citywide)	7%
Jefferson Park	8%
North Park	9%
Irving Park	10%
Portage Park	10%
Avondale	12%
West Ridge	12%
Albany Park	17%

U.S. Census Bureau, American Community Survey, 2016-2020

Summary of Collaborative Needs Assessment Results and Data Specific to Swedish Hospital's Service Area

Summary of Collaborative Health Equity Approach to CHNA

The Alliance for Health Equity's collaborative CHNA combined robust public health data, community input, existing research, existing plans, and existing assessments to document the health status of communities within Chicago and Suburban Cook County and to highlight systemic inequities that are negatively impacting health. The CHNA also provided insight into community-based assets and resources that would benefit from support and leverage during the implementation of health improvement strategies.

Swedish Hospital partnered with the Alliance for Health Equity (AHE), other hospitals, the Chicago Department of Public Health, Cook County Department of Public Health, and community organizations to complete this collaborative CHNA between March 2021 and March 2022, during a time that communities across our county, country, and globe have been experiencing profound impacts from the COVID-19 pandemic. The **health**, **economic**, and **social impacts of the pandemic** are strongly present in what we heard from community members and healthcare and public health workers over the course of the assessment.

Primary and secondary data from a diverse range of sources were utilized for robust data analysis and to identify community health needs in Chicago and Suburban Cook County. IPHI worked with the CHNA committee and steering committee to design and facilitate a collaborative, community-engaged assessment. As with the 2018-2019 collaborative CHNA, this 2022 CHNA process is adapted from the Mobilizing for Action through Planning and Partnerships (MAPP) framework, a community-engaged strategic planning framework that was developed by the National Association for

County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC). Both the Chicago and Cook County Departments of Public Health use the MAPP framework for community health assessment and planning. The MAPP framework promotes a system focus, emphasizing the importance of community engagement, partnership development, and the dynamic interplay of factors and forces within the public health system. AHE chose this inclusive, community-driven process to leverage and align with health department assessments and to actively engage stakeholders, including community members, in identifying and addressing strategic priorities to advance health equity.

Primary data for the CHNA was collected through three methods:

- *Community input surveys*
- *Community resident focus groups*
- *Social service provider focus groups*

Epidemiologists from the Cook County Department of Public Health (CCDPH) and Chicago Department of Public Health (CDPH) and Metopio are invaluable partners in identifying, compiling, and analyzing secondary data for the CHNA. IPHI and the Alliance for Health Equity steering committee worked with CDPH and CCDPH to refine a common set of indicators based on an adapted version of the County Health Rankings and Roadmaps Model. Secondary data used in the CHNA were compiled from a range of sources. Additional information can be found in Figures 6 and 7 (p. 11) of the full Alliance for Health Equity Countywide CHNA report.

In alignment with the purpose, vision, and values, the Alliance for Health Equity prioritizes engagement of community members and community-based organizations as a critical component of assessing and addressing community health needs.

Community partners have been involved in the assessment and ongoing implementation process in several ways both in providing community input and in decision making processes (page 9 of Countywide CHNA Report). The community-based organizations engaged in the Alliance for Health Equity represent a broad range of sectors such as workforce development, housing and homeless services, food access and food justice, community safety, planning and community development, immigrant rights, youth development, community organizing, faith communities, mental health services, substance use services, policy and advocacy, transportation, older adult services, health care services, higher education, and many more. All community partners work with or represent communities that are disproportionately affected by health inequities such as communities of color, immigrants, youth, older adults and caregivers, LGBTQ+, individuals experiencing homelessness or housing instability, individuals living with mental illness or substance use disorders, individuals with disabilities, veterans, and unemployed youth and adults.

Overview of Data Categories

Assessment findings were organized in six areas:

- overview of health inequities
- mental health and substance use disorders
- access to quality health care and community resources
- COVID-19
- social and structural determinants of health
- chronic conditions – risk factors, prevention, and management

The following section highlights primary and secondary data related specifically to Swedish's service area.

Primary Data: Community Input Survey and Focus Groups

Community input is the most important data input into the Alliance for Health Equity Community Health Needs Assessment. Particularly in the context of the current COVID-19 pandemic, first-hand information from communities most impacted by inequities is the most up-to-date data we have available about priority community health needs. Swedish Hospital (Swedish) worked closely with the AHE and community-based organizations that are members of Swedish's Community Leader Program to collect in-depth community input data through a community input survey and focus groups. **We collected 1108 surveys** and conducted 8 focus groups with residents from Swedish's service area.

Community Input Survey

The community input survey was a qualitative tool designed to understand community health needs and assets from community members, with a focus on hearing from community members most impacted by health inequities. The community input surveys, along with focus group data, informed the priority areas and strategies for community health improvement in Chicago and suburban Cook County. There were 1108 survey respondents from Swedish's service area. Figure 6 is a table of survey respondent demographics. Responses to key questions are included in Figures 6-9.

Figure 6. Demographics of community input survey respondents

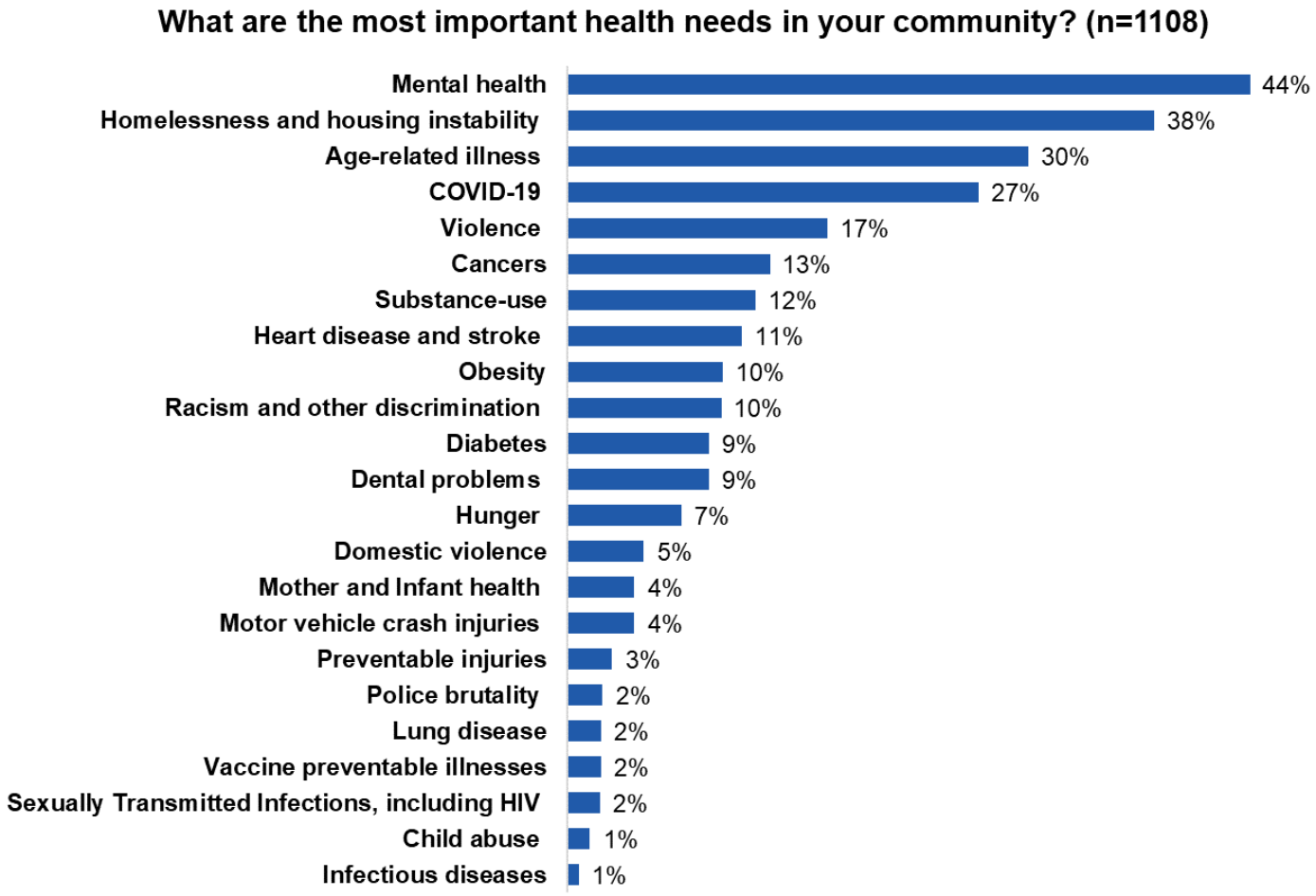
DEMOGRAPHICS -- CHICAGO SURVEY RESPONDENTS

Age of Respondents	Percent
Younger than 18	2.1
18 to 34	15.4
35 to 64	48.4
65 and older	34.2
Race/Ethnicity	**Percent**
White Only	58.9
African American/Black Only	14.7
Latinx/Hispanic Only	13.3
Asian Only	5.6
American Indian or Alaskan Native Only	0.2
Middle Eastern, Arab American, or Persian Only	0.5
Pacific Islander or Hawaiian Native Only	0.3
Other	0.4
Two or More Race/Ethnicities	6.2
Respondent Identified as LGBTQ+	**Percent**
No	88.7
Yes	11.3

Educational Attainment	Percent
Less than High School	3.5
High School Diploma or Equivalent	5.6
Some College	14.7
College Graduate or Higher	76.2
Household includes Children (Aged <18 Years)	**Percent**
No	76.6
Yes	23.4
Household includes Individual with a Disability	**Percent**
No	82.5
Yes	17.5
Language of Survey	**Percent**
English	96.8
Spanish	3.2

Figure 7. Community input survey responses – Most important health needs in Swedish Hospital's service area

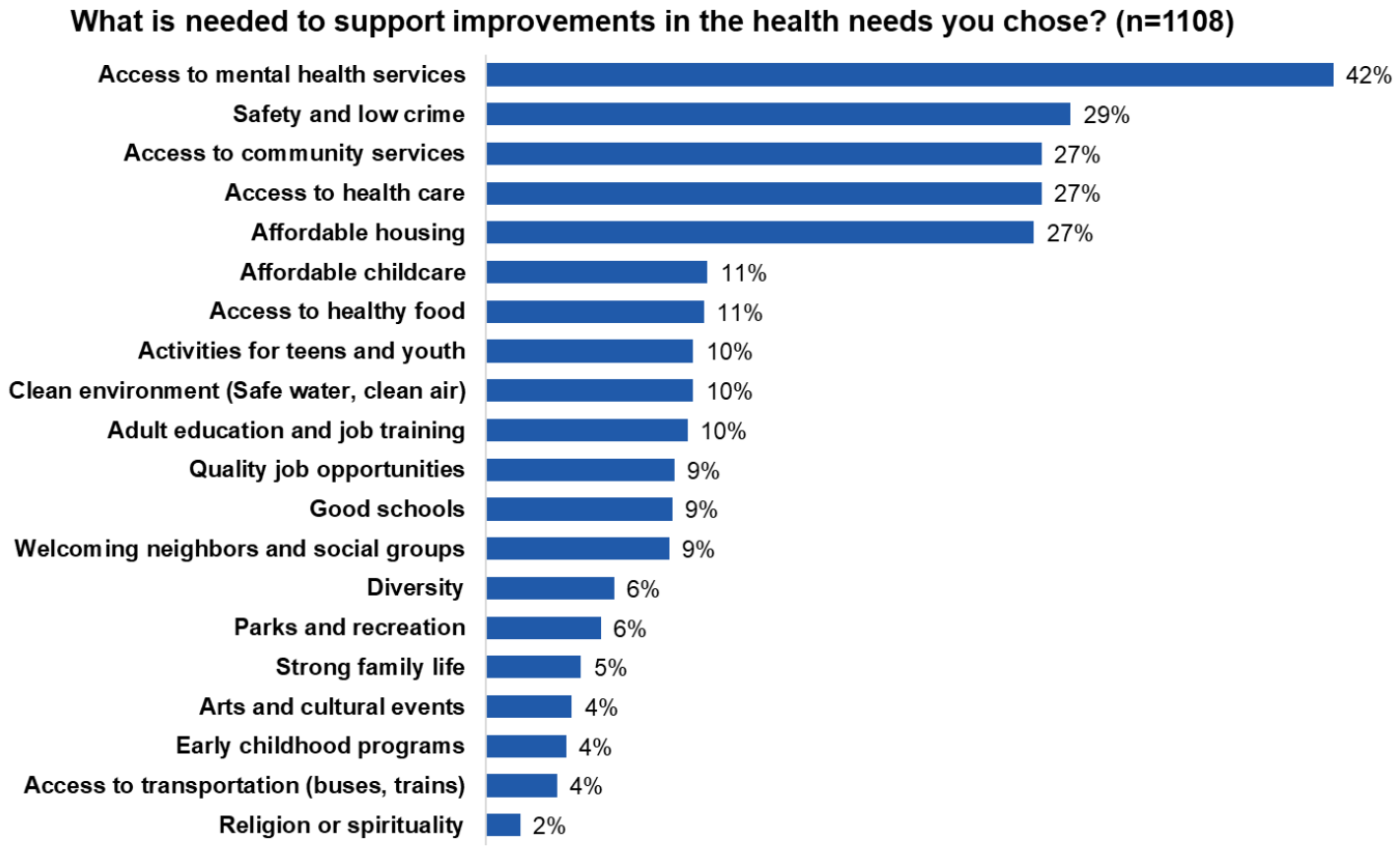
What are the most important health needs in your community? (n=1108)	Top responses selected by 15% or more of respondents
Mental health	44%
Homelessness and housing instability	38%
Age-related illness	30%
COVID-19	27%
Violence	17%



The top health needs identified in Swedish's service area are closely aligned with priority health needs identified for the county as whole. However, mental health was ranked second for the overall county and first within Swedish's service area.

Figure 8. Community input survey responses – What is needed to support improvements in health needs in Swedish Hospital's service area

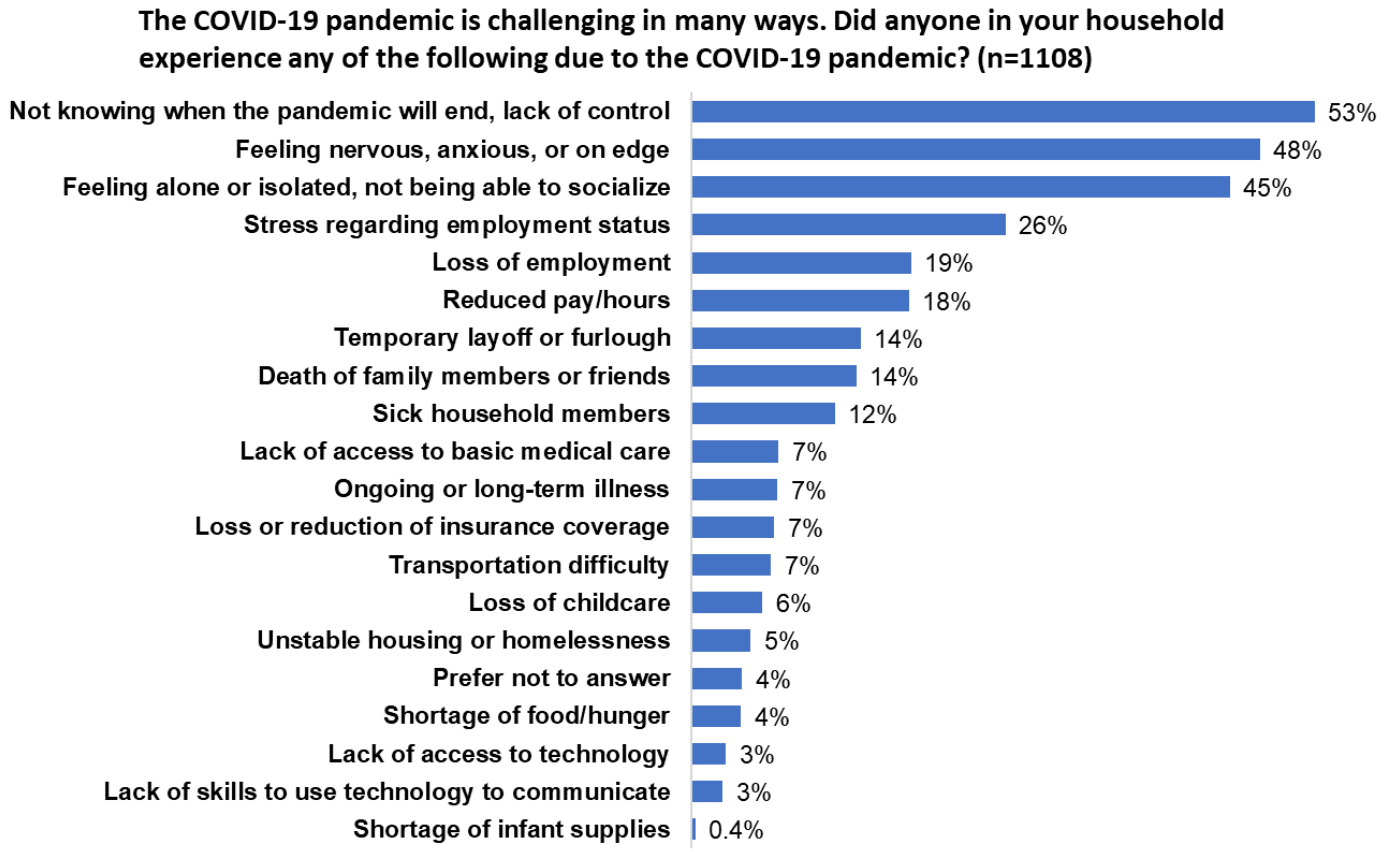
What is needed to support improvements in the health needs you chose? (n=1108)	Top responses selected by 20% or more of respondents
Access to mental health services	42%
Safety and low crime	29%
Access to community services	27%
Access to healthcare	27%
Affordable housing	27%



The supports needed to improve health needs within the service area are reflective of the top health needs identified. As a result, access to mental health services was identified as most needed improvement followed by access to healthcare, access to community services, safety and low crime, and affordable housing.

Figure 9. Community input survey responses – COVID-19 impacts in Swedish Hospital's service area

The COVID-19 pandemic is challenging in many ways. Did anyone in your household experience any of the following due to the COVID-19 pandemic (n=1108)	Top responses selected by 15% or more of respondents
Not knowing when the pandemic will end, lack of control	53%
Feeling nervous, anxious, or on edge	48%
Feeling alone or isolated, not being able to socialize with other people	45%
Stress regarding employment status	26%
Loss of employment	19%
Reduced pay/hours	18%



Focus Groups

Between August 2021 and February 2022, the Illinois Public Health Institute (IPHI) worked with Alliance for Health Equity partners to hold a total of 43 focus groups with priority populations such as veterans, individuals living with mental illness, communities of color, older adults, caregivers, teens and young adults, LGBTQ+ community members, adults and teens experiencing homelessness, families with children, faith communities, adults with disabilities, and children and adults living with chronic conditions such as diabetes and asthma. In total, eight focus groups were held with community members and service providers in Swedish's service area.

Community Resident Focus Groups:

- AHS Family Health Center
- Community Health Workers (CHWs) (citywide)
- Community members that identify as LGBTQIA+
- Immigrant and refugee-serving organizations
- NAMI Chicago (individuals with lived experience of mental illness)
- NAMI Chicago (family members and caregivers of individuals living with mental illness)
- Northwest Side Housing Center (youth)
- Northwest Side Housing Center (parents)

There were five major themes identified based on the focus group input collected from across the county:

- **Behavioral health** – stigma, substance use, trauma and crisis, social determinants of health and integrated care
- **Child and adolescent health** – childcare, education, COVID-19 impacts on child and adolescent health, programs, and services
- **Healthcare** – insurance and public benefits, local access to services, LGBTQIA+ affirming care, primary care access, and culturally and linguistically appropriate care
- **Social and structural determinants of health** – income, employment, education, opportunities for youth, housing and homelessness, and food systems; and
- **Chronic conditions** – socioeconomic causes, health behaviors, access and communication, obesity, asthma, hypertension, and diabetes.

An overall description of the themes is included in Figure 10.

In addition to the five overall themes, there were four cross-cutting topics identified that are pervasive and impact health across the spectrum of concerns:

- **Racism and discrimination**
- **COVID-19**
- **Safety and violence**
- **Community cohesion**

Figure 10. Descriptions of key themes discussed by focus group participants

Theme	Descriptions of top issues discussed	Examples quotes from Swedish Hospital's service area
Mental health and behavioral health	• Increased wholistic integrated care • Increased awareness and treatment of substance use disorders • Mental health crises – improved education about crises and how to address safely • Reducing stigma • Improving overall access to behavioral health treatment • COVID-19 has had profound impacts on mental health (mostly negative), children and adolescents have experienced a large burden of the negative impacts • Addressing the connections between mental health and other determinants of health	**"Awareness and education surrounding mental illness, so people can better help when it comes to deescalating a crisis"** Response from a NAMI Chicago focus group participant to a question about community health needs
Child and adolescent health	• More programs and services are needed for children and adolescents in communities particularly after the closure of services following COVID-19 • Affordable childcare is scarce • Inequities in education • COVID-19 impacts • Child and adolescent behavioral health needs are continuing to increase • Overall child and adolescent health is a priority across communities	**"Well, ever since the pandemic we have seen a lot of suicide at an international level across all ages"** Northwest Side Housing Center parent focus group participant

Healthcare	• Several factors influence access
	  ○ Ease of access to health clinics
	  ○ Insurance coverage and public benefits
	  ○ Immigration status
	  ○ Linguistically and culturally appropriate services
	  ○ Bureaucracy that requires extensive paperwork and approvals before accessing care
	• Discrimination, racism, and lack of empathy among healthcare professionals are impacting access and quality of care
	• Several additional healthcare needs discussed
	  ○ Behavioral health services
	  ○ Affordable specialty care
	  ○ Engagement in primary care
	  ○ Telehealth coverage
	  ○ Expanded use of CHWs and in-home health promoters/health services
	  ○ Building trust with communities
	  ○ Better communication about resources
	  ○ Transportation to appointments
		"Immigrants are taking expired medication they brought from home because they cannot access medical care" AHS Family Health Center focus group participant

Social and structural determinants of health	• Some of the most discussed needs included:
	  ○ Access to affordable and supportive housing
	  ○ Access to healthy foods, famers markets, and grocery stores
	  ○ Quality education
	  ○ Affordable childcare
	  ○ Economic opportunity and community investment
	  ○ Improved infrastructure
	  ○ Environmental health
		"**Rent prices are increasing. There are families who must share an apartment"** Northwest Side Housing Center focus group participant

Chronic conditions	• Obesity, diabetes, and hypertension were common chronic conditions mentioned by participants
	• Several health behaviors and social determinants are contributing to chronic disease
	  ○ Inactivity in youth and young adults
	  ○ Inadequate access to healthy foods
	  ○ Cost of medical care
	  ○ Smoking
	• COVID-19 infection is causing complications for those with chronic conditions
		"Chronic health issues communities are facing come from diet and access to healthy and affordable foods" Rush Community Health Worker focus group participant

Secondary Data

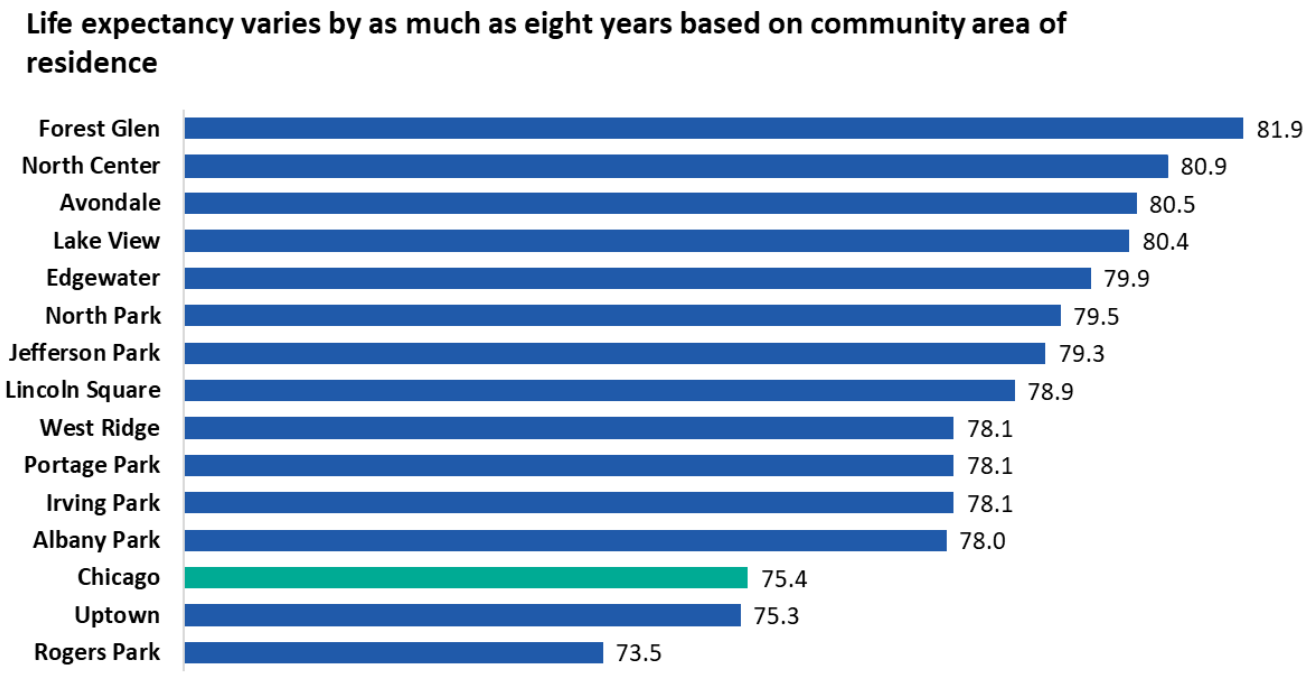
The key highlights below highlight data pertaining to life expectancy, health behaviors, chronic diseases, community safety, and mental health within the Swedish's service area. This data was collected and analyzed by Chicago Department of Public Health (CDPH) and compiled and presented by the Illinois Public Health Institute (IPHI).

Health Expectancy and Overall Health Status

Life Expectancy

Life expectancy is the average number of years an individual is expected to live. As seen in Figure 11, there are disparities in life expectancy within Swedish Hospital's service area. Life expectancy in Rogers Park (73.5) is more than eight years less than life expectancy in Forest Glen (81.9). For comparison, life expectancy in Chicago is 75.4 and life expectancy in the US overall is 78.8 years.

Figure 11. Life expectancy at birth within Swedish Hospital's service area in years

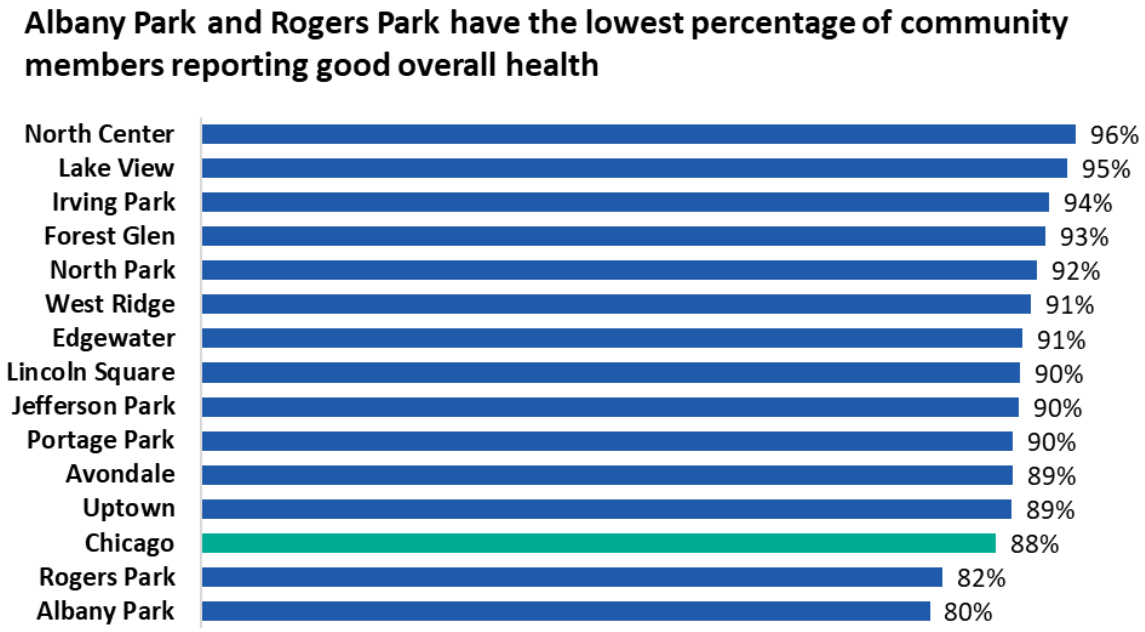


Chicago Department of Public Health, Chicago Health Atlas, 2016-2020

Health status

There are significant inequities in the percentage of people reporting excellent, very good, and good overall health status in Swedish's service area (Figure 12). Rogers Park and Albany Park have the lowest percentage of community members reporting good health.

Figure 12. Percentage of adults reporting excellent, very good, or good overall health status



Chicago Department of Public Health, Healthy Chicago Survey 2020-2021

Health Behaviors – Key Findings

There are five key health behaviors that are strongly correlated with chronic disease outcomes: smoking, physical activity, alcohol consumption, body weight, and sufficient daily sleep. Some communities in Chicago face significant barriers to engaging in preventative health behaviors such as access to safe exercise spaces, access to healthy affordable foods, and access to mental health and substance use disorder treatment. The status of health behaviors for communities in Swedish's service area are presented in Figures 13-17.

Figure 13. Percentage of adults that have easy access to fruits and vegetables in Swedish Hospital's service area

Easy access to fruit and vegetables	Percent
Albany Park	79%
Avondale	64%
Chicago	88%
Edgewater	85%
Forest Glen	83%
Irving Park	68%
Jefferson Park	65%
Lake View	83%
Lincoln Square	87%
North Center	81%
North Park	81%
Portage Park	75%
Rogers Park	68%
Uptown	77%
West Ridge	72%

Chicago Department of Public Health, Healthy Chicago Survey (2020-2021)

Figure 14. Percentage of adult smokers in Swedish Hospital's service area

Smoking	Percent
Albany Park	10%
Avondale	10%
Chicago	12%
Edgewater	12%
Irving Park	10%
Jefferson Park	20%
Lake View	6%
Lincoln Square	4%
North Center	11%
Portage Park	12%
Rogers Park	12%
Uptown	9%
West Ridge	8%
Forest Glen	Not available
North Park	Not available

Chicago Department of Public Health, Healthy Chicago Survey (2020-2021)

Figure 15. Percentage of adults who report binge drinking (men having 5 or more drinks on one occasion, women having 4 or more drinks on one occasion) in the past month in Swedish Hospital's service area

Binge Drinking	Percent
Albany Park	25%
Avondale	43%
Chicago	35%
Edgewater	32%
Forest Glen	32%
Irving Park	31%
Jefferson Park	33%
Lake View	53%
Lincoln Square	41%
North Center	59%
North Park	18%
Portage Park	34%
Rogers Park	35%
Uptown	40%
West Ridge	30%

Chicago Department of Public Health, Healthy Chicago Survey (2020-2021)

Figure 16. Percentage of adults who reported a height and weight that yield a body mass index of 30 or greater in Swedish Hospital's service area

Obesity	Percent
Albany Park	26%
Avondale	24%
Chicago	33%
Edgewater	27%
Forest Glen	33%
Irving Park	27%
Jefferson Park	31%
Lake View	18%
Lincoln Square	28%
North Center	23%
North Park	20%
Portage Park	35%
Rogers Park	36%
Uptown	20%
West Ridge	27%

Chicago Department of Public Health, Healthy Chicago Survey (2020-2021)

Figure 17. Percentage of adults who reported that they did not participate in any physical activities or exercises in the past month

Physical activity	Percent
Albany Park	27%
Avondale	27%
Chicago	25%
Edgewater	21%
Forest Glen	19%
Irving Park	24%
Jefferson Park	23%
Lake View	9%
Lincoln Square	18%
North Center	14%
North Park	25%
Portage Park	24%
Rogers Park	26%
Uptown	23%
West Ridge	29%

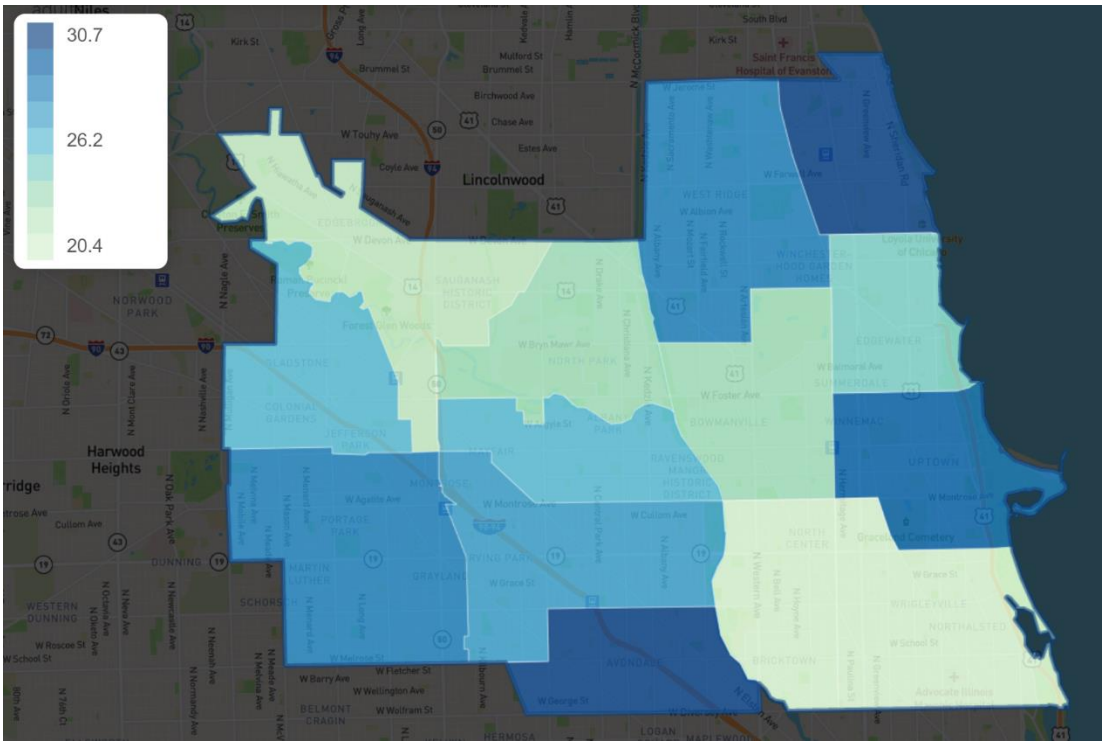
Chicago Department of Public Health, Healthy Chicago Survey (2020-2021)

Chronic Conditions – Key Findings

A chronic condition is an ongoing physical or mental health condition that lasts a year or more, requires ongoing medical attention, and/or limits activities of daily living. Worldwide and in the United States chronic diseases are the leading cause of disability and death. Chronic conditions such as heart disease, stroke, cancer, diabetes, arthritis, asthma, mental illness, and HIV/AIDS create a significant health and economic cost for individuals and communities. Prevention and management of chronic conditions can significantly reduce the burden of these diseases on individuals and society.

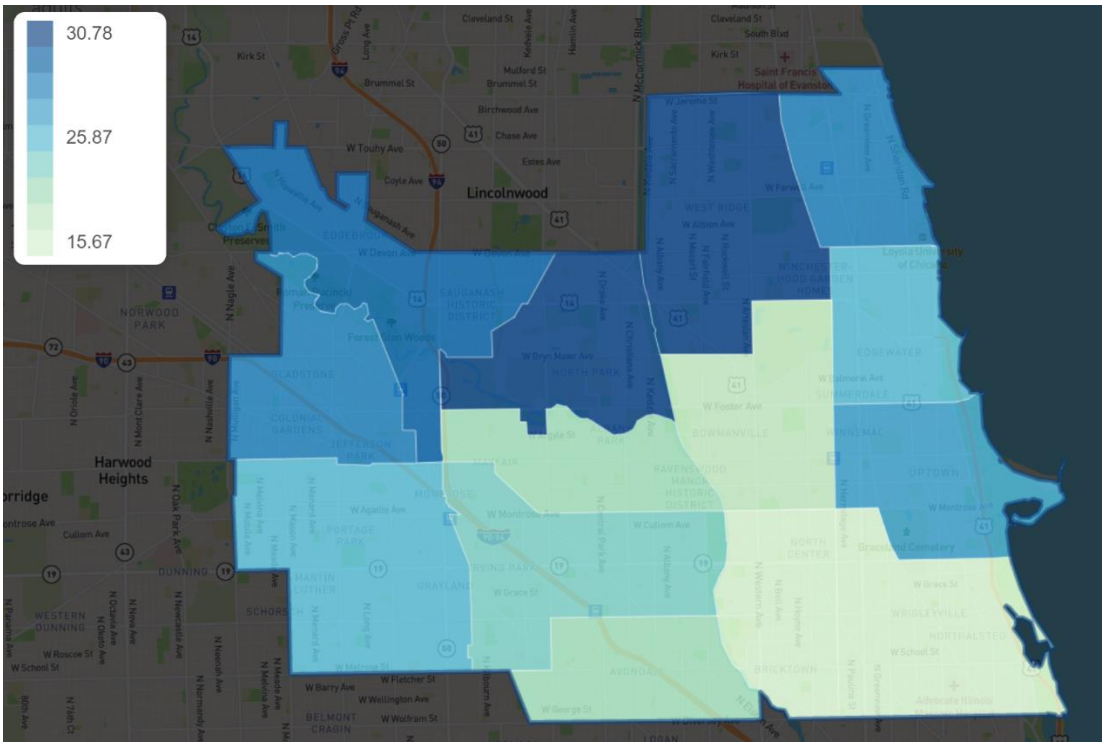
Obesity and hypertension are often interconnected risk factors for cardiovascular disease, the leading cause of death in the U.S. Within Swedish's service area, more than a quarter of community members are reported to be obese. Similarly, approximately a quarter of adults within the service area are reported to have hypertension. There is significant variation between community areas in obesity and hypertension rates (Figures 18-19).

Figure 18. Map of obesity rates within Swedish Hospital's service area (percentage)



Behavioral Risk Factor Surveillance System (BRFSS) (State and US data), Diabetes Atlas (County level data), PLACES, 2019

Figure 19. Map of hypertension rates within Swedish Hospital's service area (percentage)

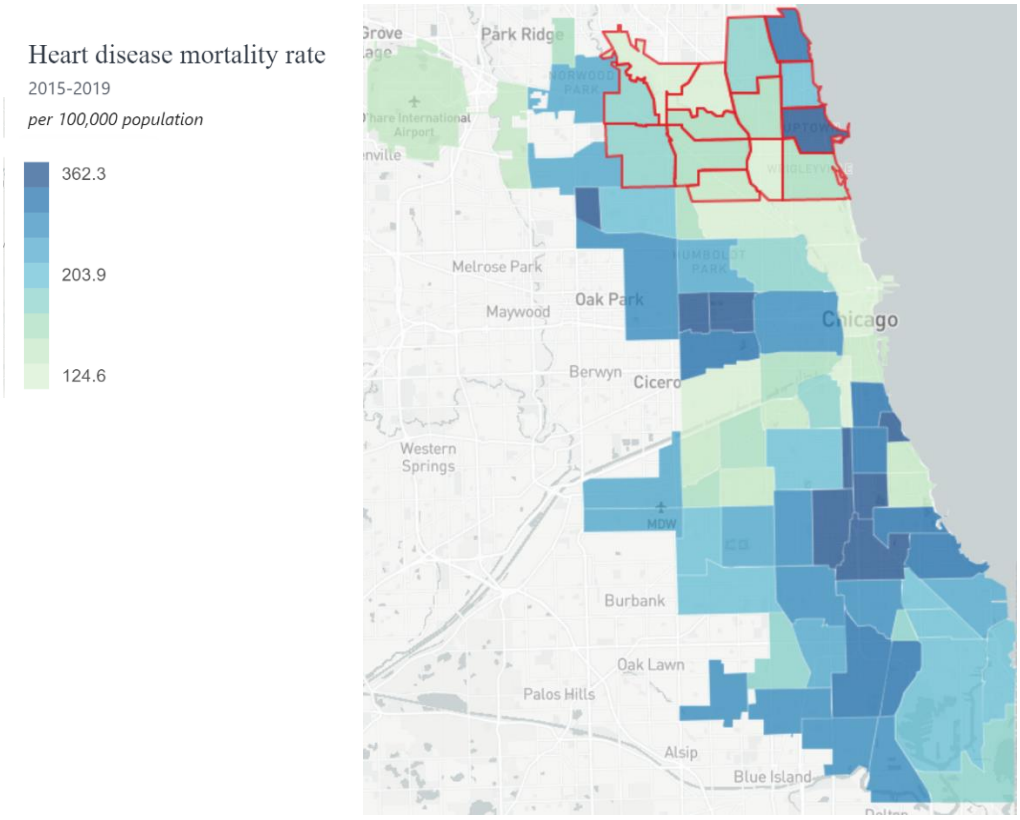


Behavioral Risk Factor Surveillance System (BRFSS) (State and US data), Diabetes Atlas (County level data), PLACES, 2019

Mortality

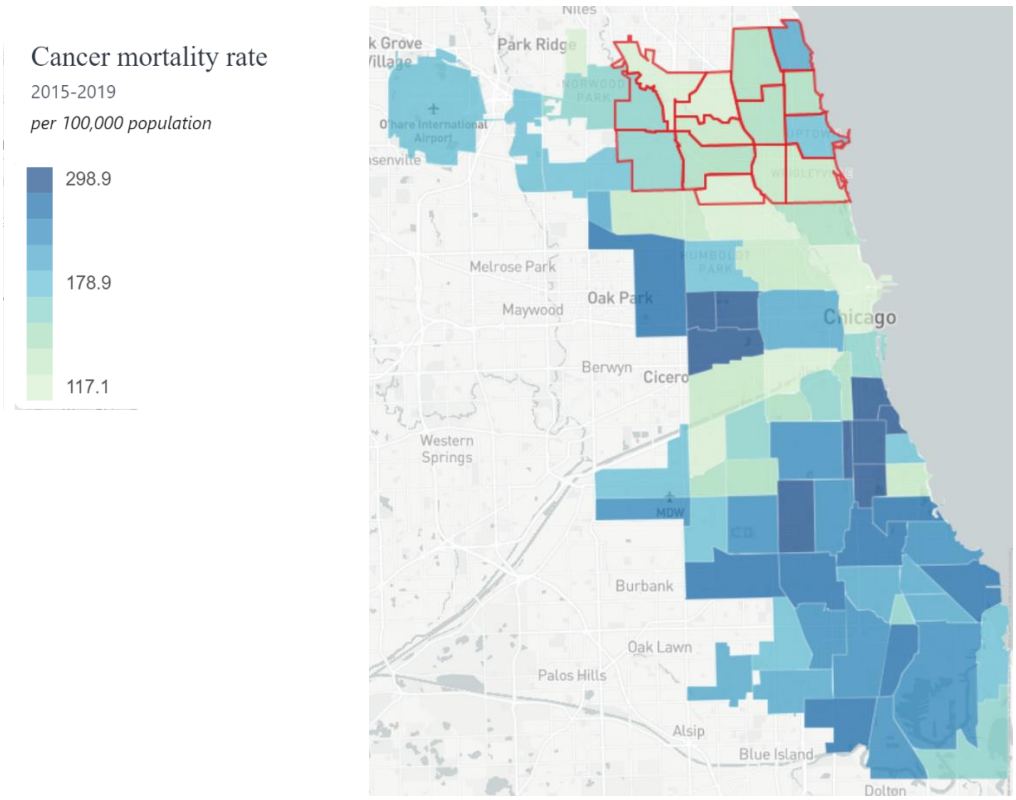
Centers for Disease Control and Prevention (2021) data indicate that heart disease, cancer, and diabetes are the leading causes of death in the U.S. and are the leading drivers of the nation's 3.8 trillion in annual healthcare costs. The geographic distribution of chronic disease mortality rates for heart disease, cancer, and diabetes are presented in Figures 20-22. (Here we present mortality maps showing all communities in the City of Chicago to show the communities served by Swedish in context with the City overall.)

Figure 20. Age-adjusted heart disease mortality rates per 100,000 population, Chicago, Illinois



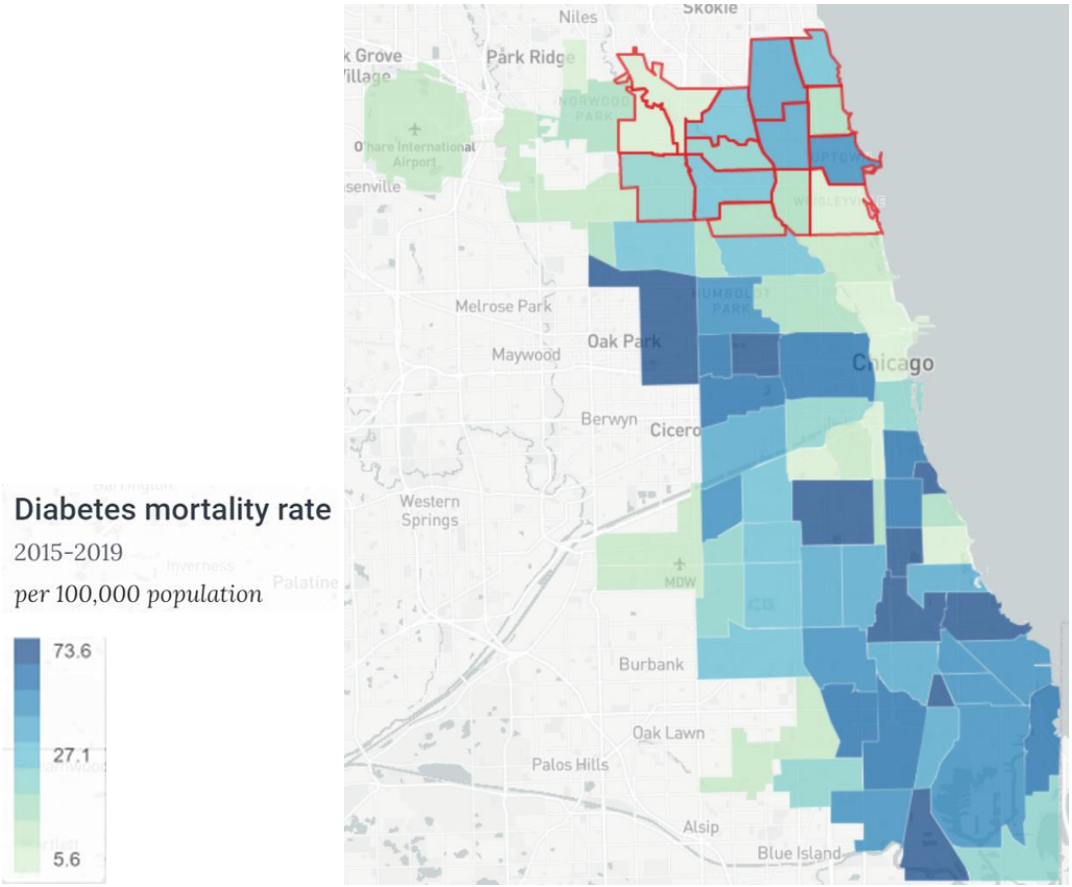
Illinois Department of Public Health, Death Certificate Files 2015-2019

Figure 21. Age-adjusted cancer mortality rates per 100,000 population, Chicago, Illinois



Illinois Department of Public Health, Death Certificate Files 2015-2019

Figure 22. Age-adjusted diabetes mortality rate per 100,000 population, Chicago, Illinois



Illinois Department of Public Health, Death Certificate Files 2015-2019

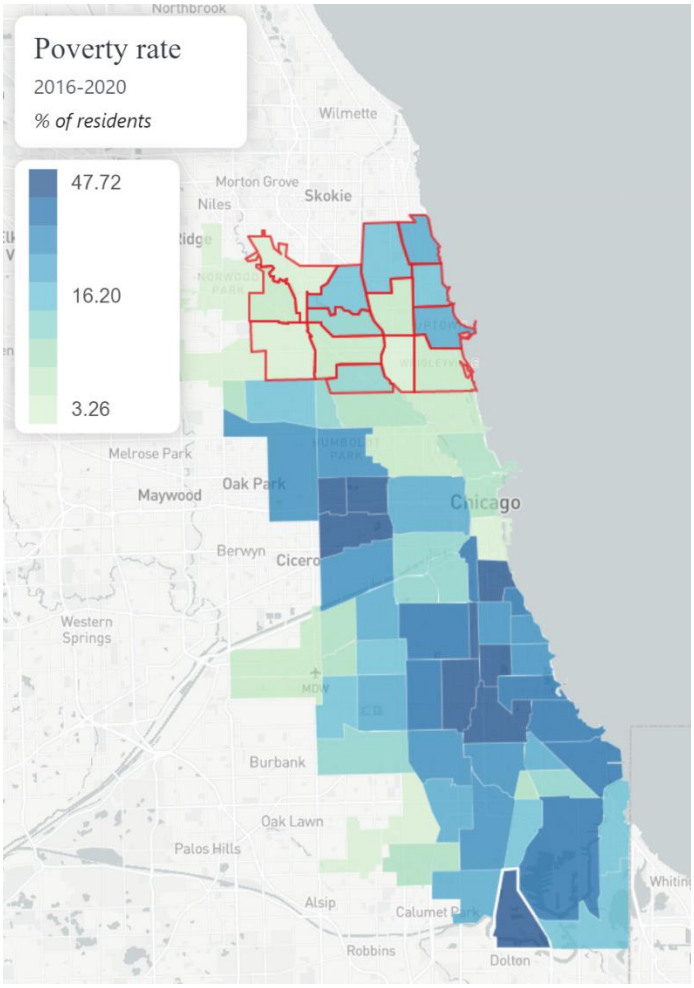
Social and Structural Determinants of Health

Social determinants of health such as poverty, limited access to healthy foods, exposure to violence, limited access to healthcare, and housing conditions are both underlying root causes of chronic disease and are barriers to the management of chronic disease.

Poverty

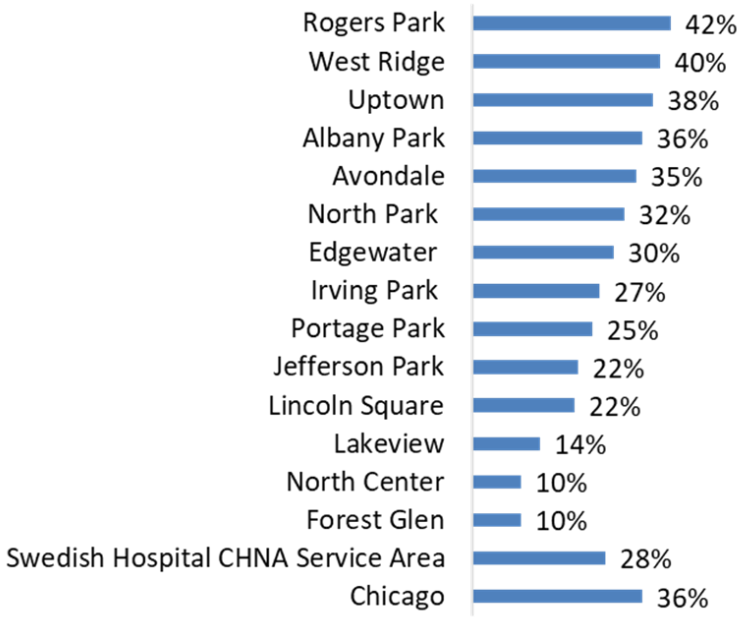
Healthy People 2020 highlights that communities with high rates of poverty are at increased risk for mental illness, chronic disease, higher mortality, and lower life expectancy. Within Swedish's service area 22% of non-Hispanic Black and 22% of Native American families live below the federal poverty level compared to 14% of Hispanic/Latino and 9% of white community members. A map of the geographic distribution of poverty within the service area is shown in Figure 23. Rogers Park and West Ridge have the highest percentages of households living in deep poverty (below the 200% federal poverty level) compared to a 28% deep poverty rate for the service area overall (Figure 24).

Figure 23. Map of population living below the 100% federal poverty level, Chicago, Illinois



U.S. Census Bureau, American Community Survey, 2016-2020

Figure 24. Percentage of population living below the 200% poverty level in Swedish Hospital's service area

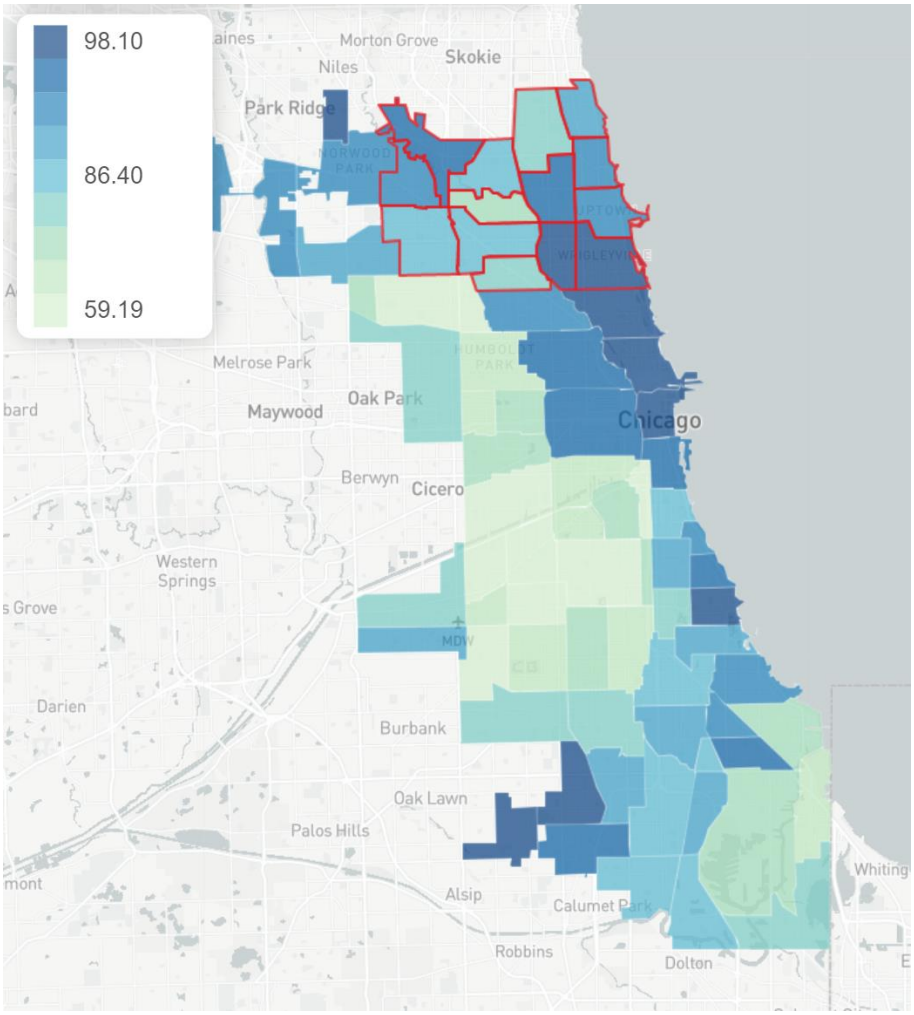


U.S. Census Bureau, American Community Survey, 2016-2020

Education

Education is an important determinant of health because poverty, unemployment, and underemployment are highest among those with lower levels of educational attainment. The high school graduation rate within Swedish's service area is 89% which is comparable to the high school graduation rate for Chicago overall (86%). The percentage of the population aged 25 or older with a high school diploma is presented in Figure 25.

Figure 25. Map of the percentage of adults aged 25 or older with a high school diploma or equivalent, Chicago, Illinois

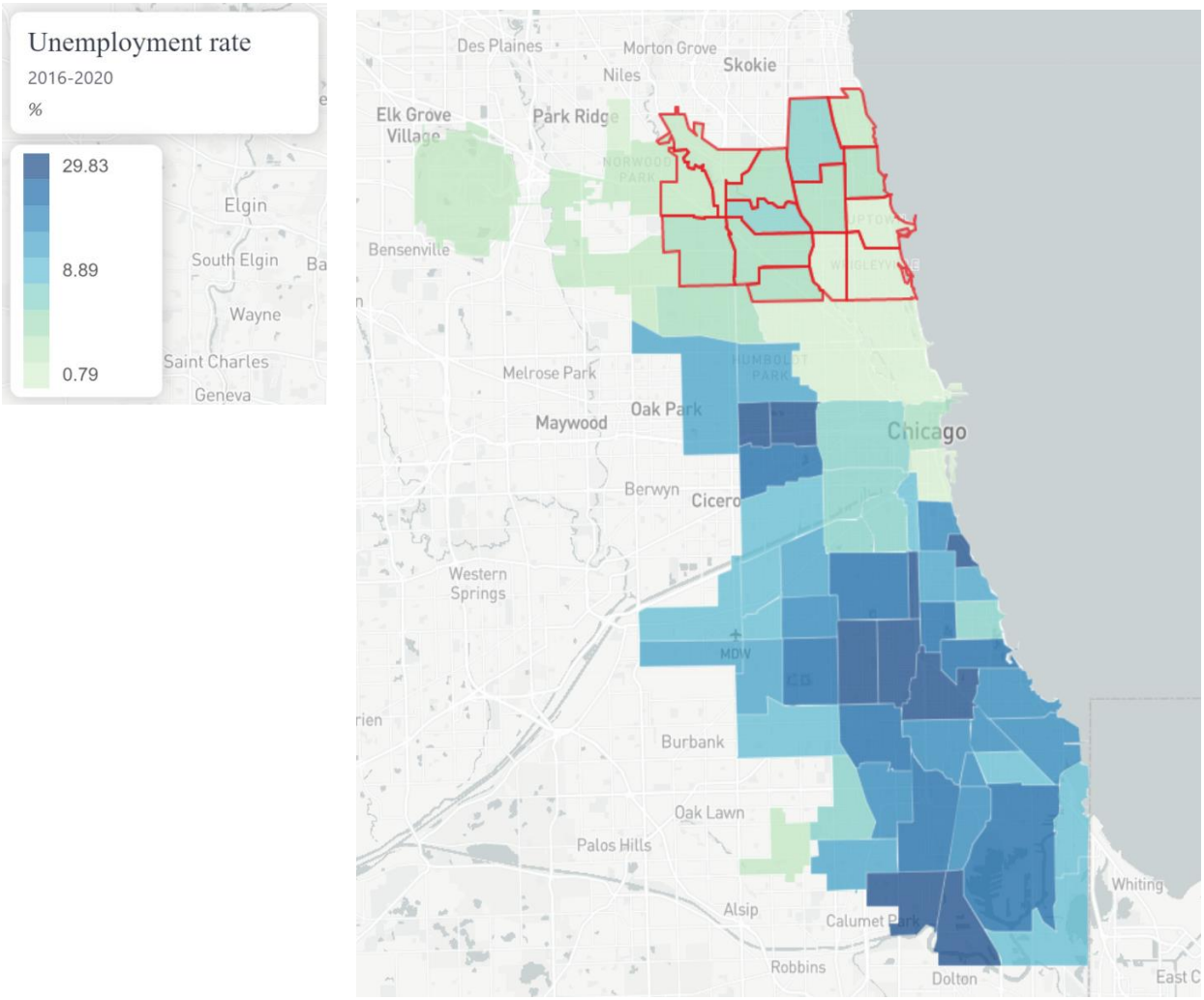


U.S. Census Bureau, American Community Survey, 2016-2020

Unemployment

Unemployment and underemployment can create financial instability, which influences access to health care services, insurance, healthy foods, stable quality housing, and other basic needs. The unemployment rate within Swedish's service area is low (5%) compared to the city overall (8%). However, racial, and ethnic disparities are prevalent with non-Hispanic Blacks and Native Americans having higher than average unemployment rates within the service area. In addition to racial and ethnic differences, there are geographic inequities in unemployment as well (Figure 26).

Figure 26. Map of unemployment rates, Chicago, Illinois

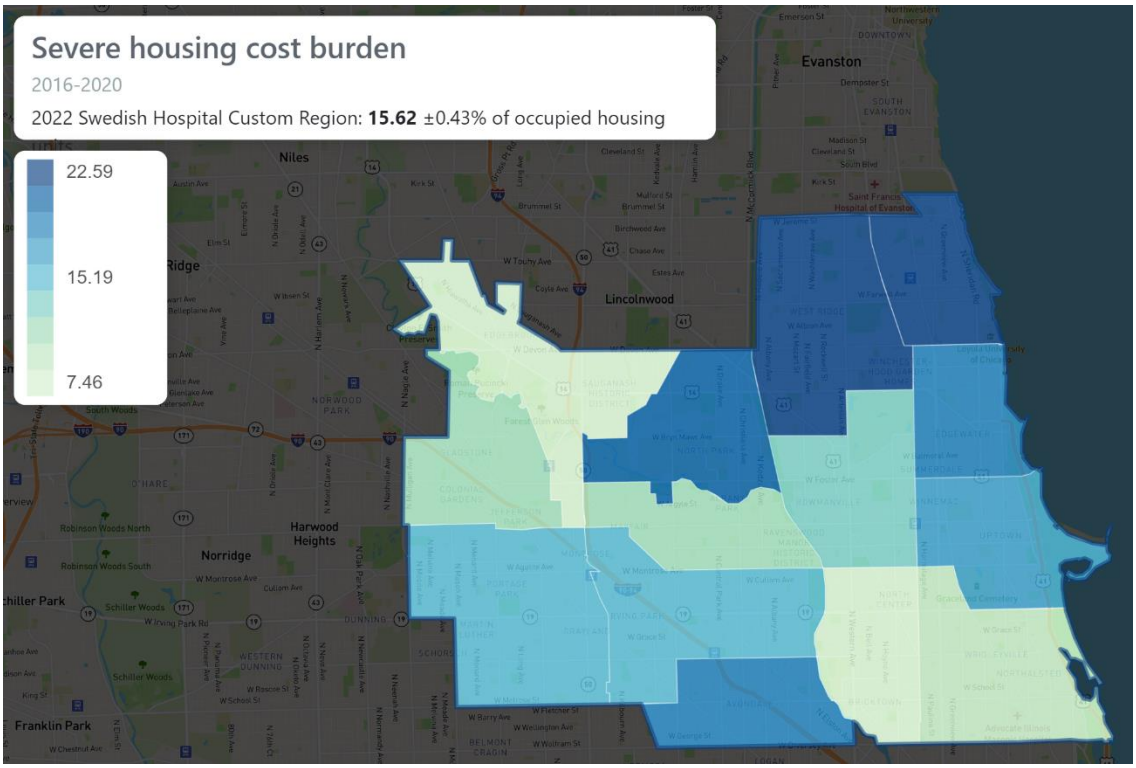


U.S. Census Bureau, American Community Survey, 2016-2020

Housing

Housing can serve as an opportunity for many people in this country, offering a pathway to better health, education, and businesses. However, for some people, housing (or the lack of it) provides a significant path to health inequities that have been sustained for decades due to systemic racism. Seventeen percent of the population within Swedish's service area is severe housing cost burdened, spending more than 50% of their income on housing costs. Rogers Park and West Ridge have the highest rates of severe housing cost burdened population (Figure 27).

Figure 27. Percentage of population experiencing severe housing cost burden in Swedish Hospital's service area

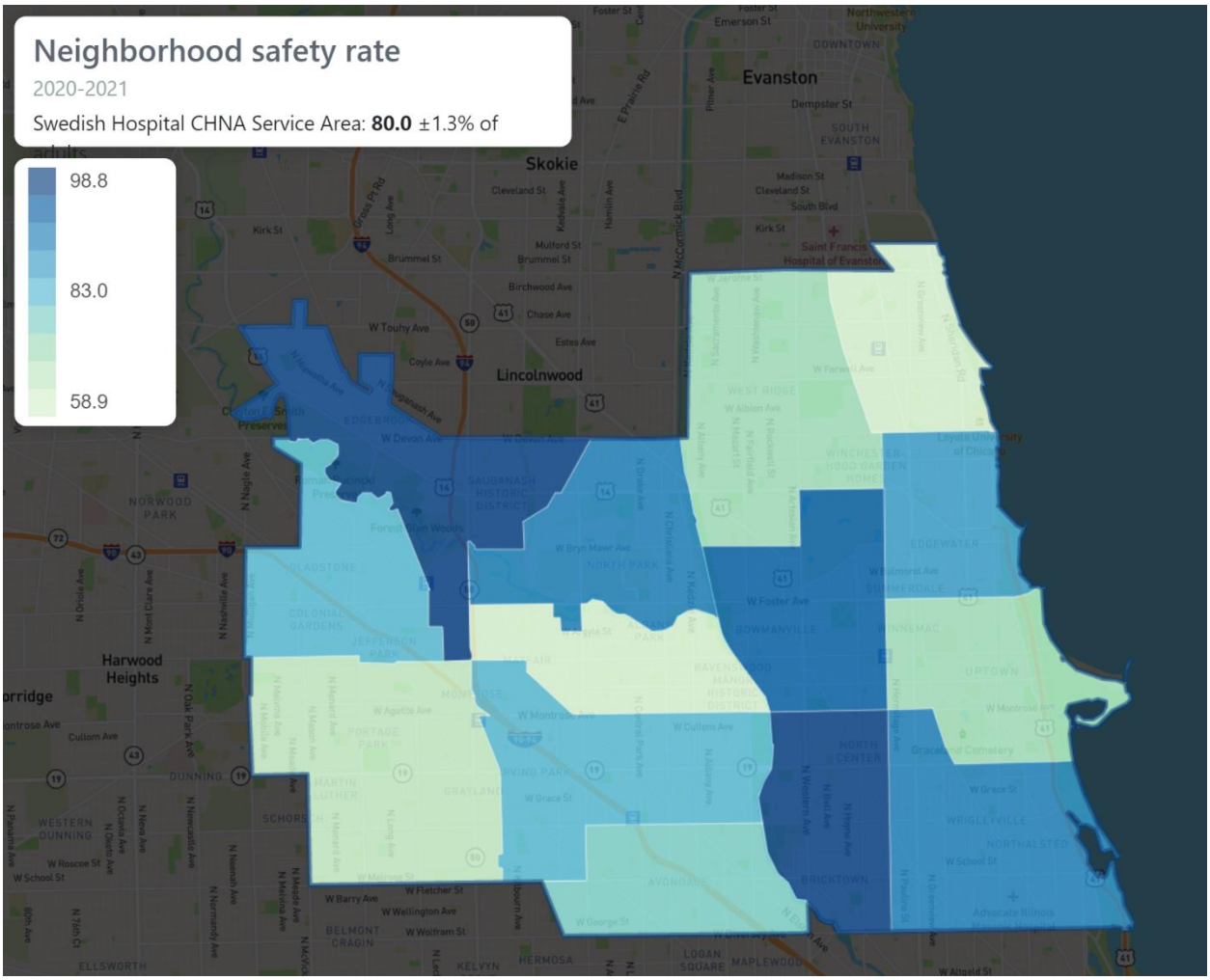


U.S. Census Bureau, American Community Survey, 2016-2020

Community safety and violence

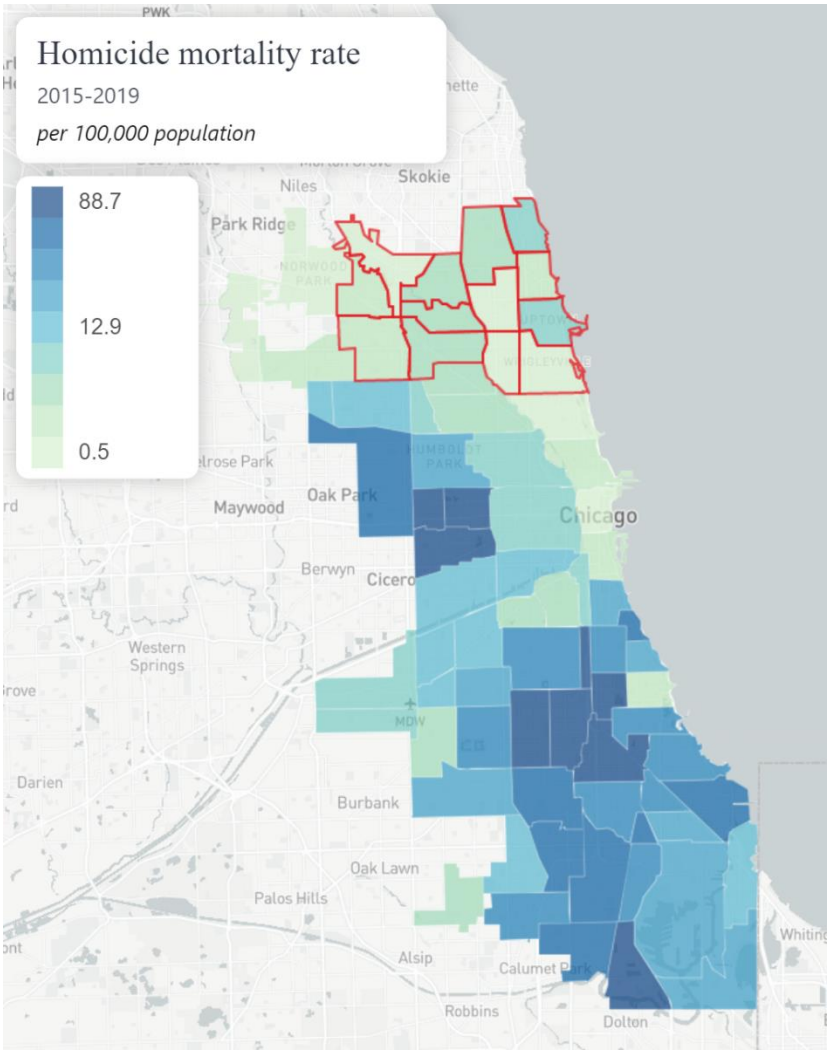
The root causes of community violence are multifaceted but include issues such as the concentration of poverty, education inequities, poor access to health services, mass incarceration, differential policing strategies, and generational trauma. Research has established that exposure to violence has significant impacts on physical and mental well-being. In addition, exposure to violence in childhood has been linked to trauma, toxic stress, and an increased risk of poor health outcomes across the lifespan. Violence also has a negative impact on the socioeconomic conditions within communities that contribute to the widening of disparities. The percent of adults who report that they feel safe in their neighborhood "all of the time" or "most of the time" within Swedish's service area is 80% which is high compared to the city overall (63%) (Figure 28). In addition, the homicide mortality rates within the service area are lower than those found in other regions of the city (Figure 29). However, there are significant disparities between community areas (Figure 28). Populations in the Rogers Park, West Ridge, and Avondale community areas report feeling significantly less safe in their communities compared to the service area overall.

Figure 28. Percentage of adults that report feeling safe in their neighborhood "all of the time" or "most of the time" in Swedish Hospital's service area



Healthy Chicago Survey, Chicago Department of Public Health, 2020-2021

Figure 29. Age-adjusted homicide mortality rate per 100,000 population, Chicago, Illinois

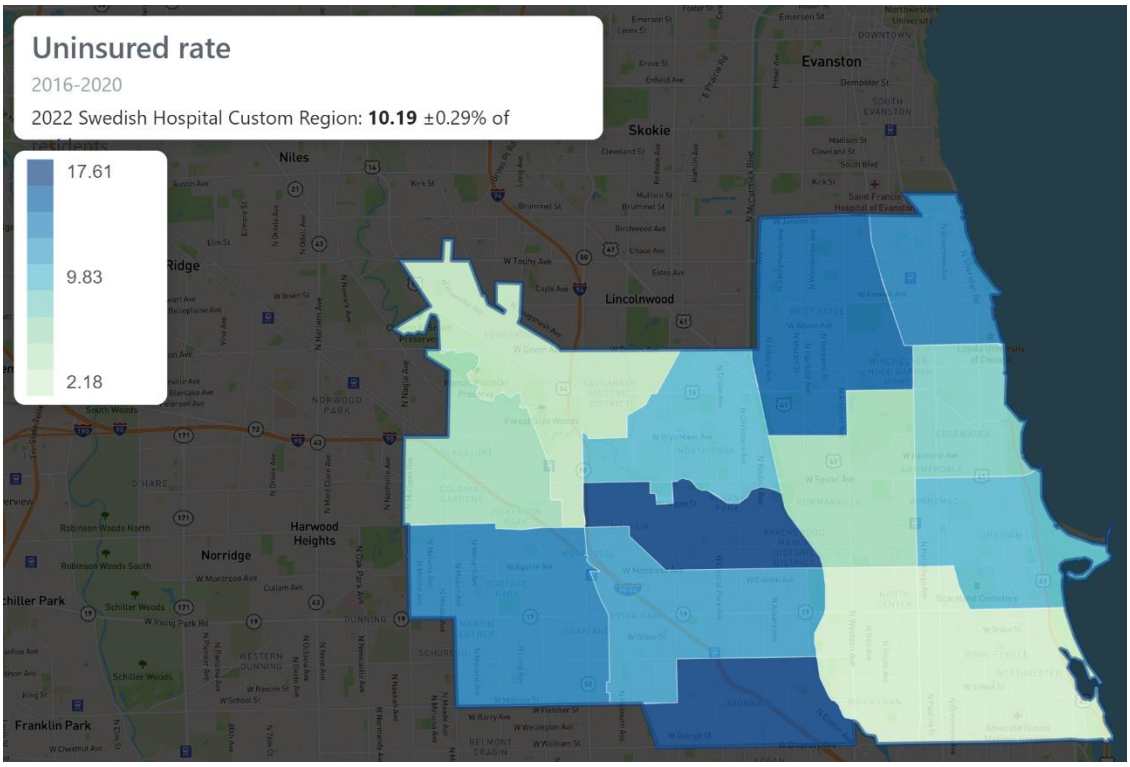


Illinois Department of Public Health, Death Certificate Files 2015-2019

Access to Healthcare

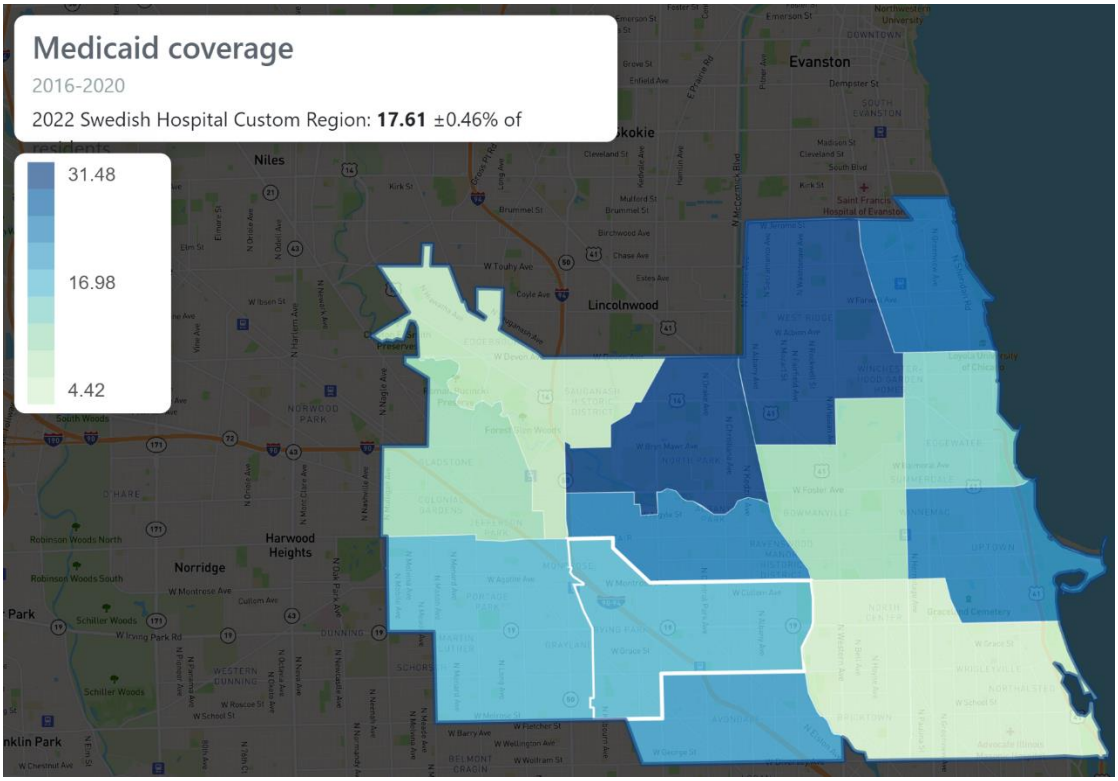
There are several complex factors that influence access to health care including proximity; affordability; availability, convenience, accommodation, and reliability; quality and acceptability; openness and approachability; and cultural responsiveness and appropriateness. Insurance coverage is associated with improved access to health services and better health monitoring. Within Swedish's service area, approximately 10% of the population is uninsured with Albany Park having the highest percentage of uninsured population (18%) followed by Avondale (16%) and West Ridge (14%). Eighteen percent of the population in the service area has Medicaid coverage with West Ridge (32%) and North Park (27%) having the highest rates followed by Rogers Park (25%), Albany Park (24%), Uptown (24%), and Avondale (20%) (Figures 30-31).

Figure 30. Percentage of uninsured adults in Swedish Hospital's service area



U.S. Census Bureau, American Community Survey, 2016-2020

Figure 31. Percentage of population with Medicaid coverage in Swedish Hospital's service area

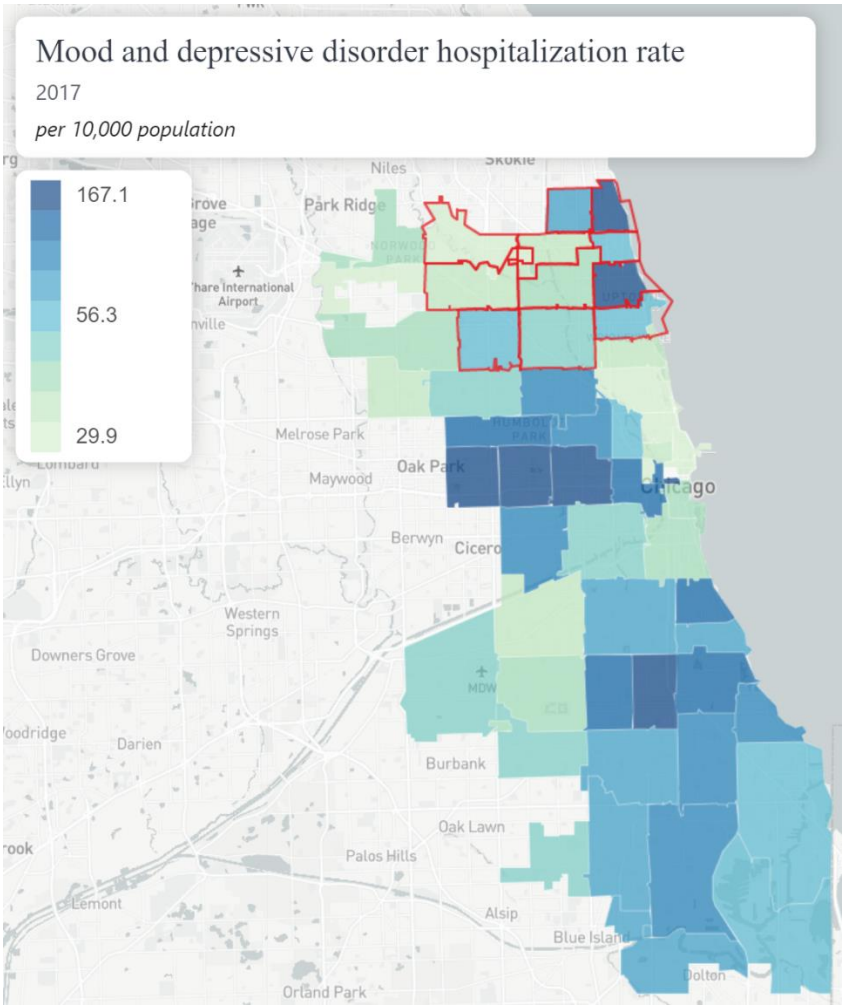


U.S. Census Bureau, American Community Survey, 2016-2020

Mental health and substance use disorders

The World Health Organization states that mental health is an integral and essential component of overall health and wellbeing. Mental health continues to be a top priority for communities in Chicago including those within Swedish's service area. In 2019, 19% of the population in Swedish's service area reported experiencing depression which is comparable to the rates for the city overall. In addition, based on trends from the Healthy Chicago Survey, rates of people experiencing serious psychological distress have been increasing over time. Within the service area, the hospitalization rates for mood and depressive disorder were highest in Rogers Park and Uptown (Figure 32).

Figure 32. Hospitalization rate per 10,000 for mood and depressive disorder, Chicago, Illinois
Chicago Department of Public Health, COMPdata, 2017

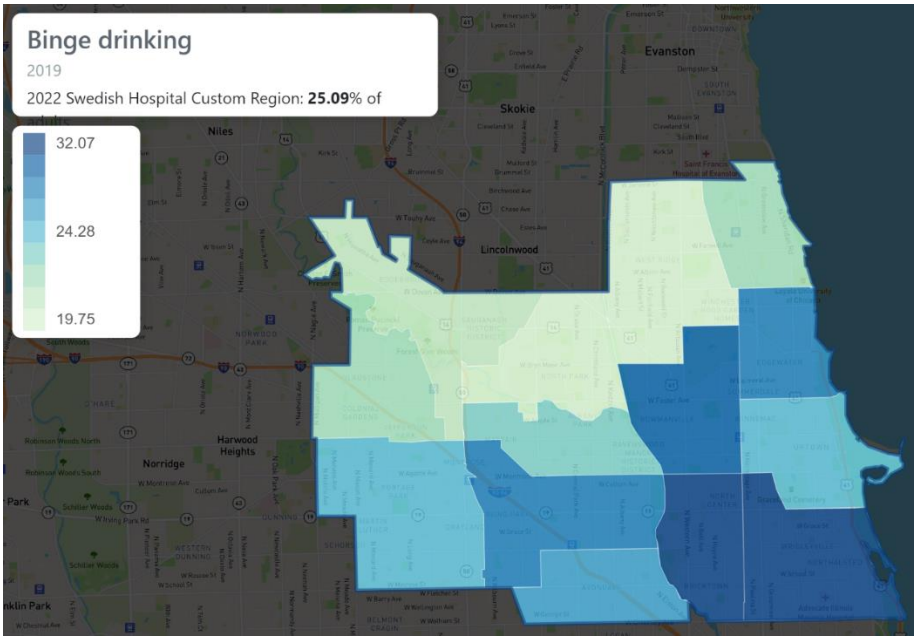


Chicago Department of Public Health, COMPdata, 2017

Substance use disorders

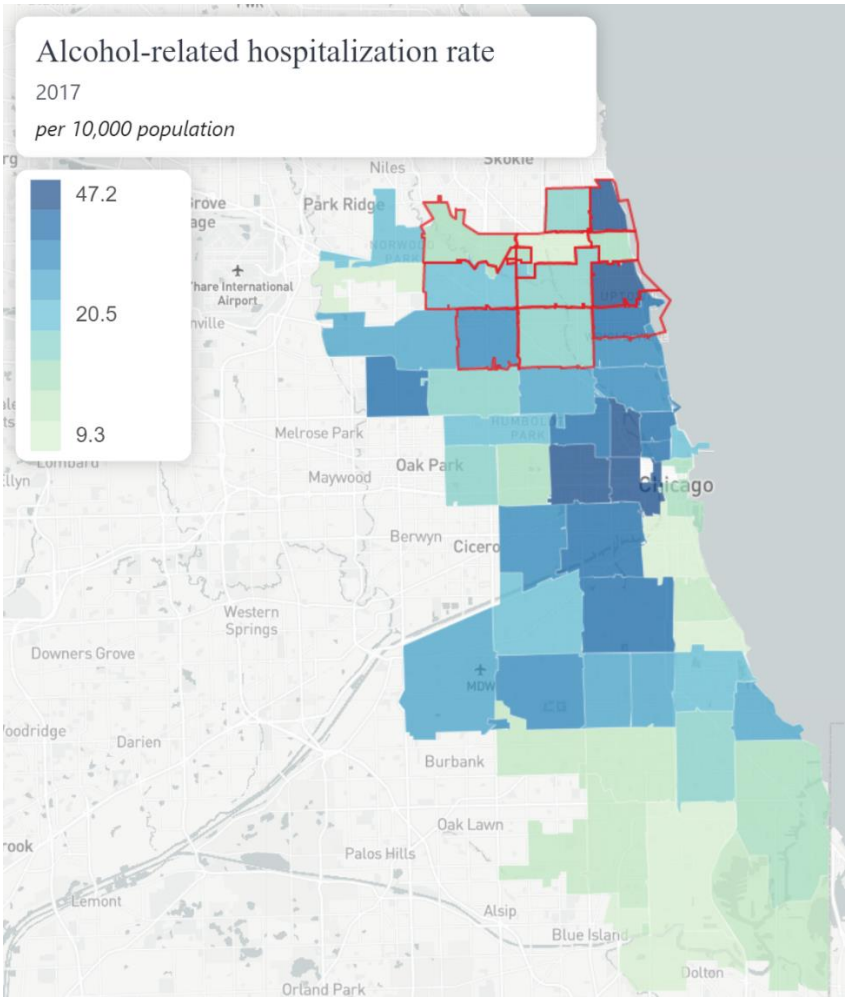
According to the American Psychiatric Association, a substance use disorder is a complex condition in which there is uncontrolled use of a substance despite harmful consequences and day-to-day functioning becomes impaired. Mental Health America estimates that substance abuse affects 25 million Americans directly and an additional 40 million Americans – such as families of drug users or those killed by intoxicated drivers – are impacted indirectly. Within Swedish's service area 25% of adults reported binge drinking in 2019 (Figure 33) and alcohol-related hospitalization rates were highest in Rogers Park and Uptown (Figure 34).

Figure 33. Percentage of adults that reported binge drinking in Swedish Hospital's service area



Chicago Department of Public Health, Chicago Health Atlas, 2019

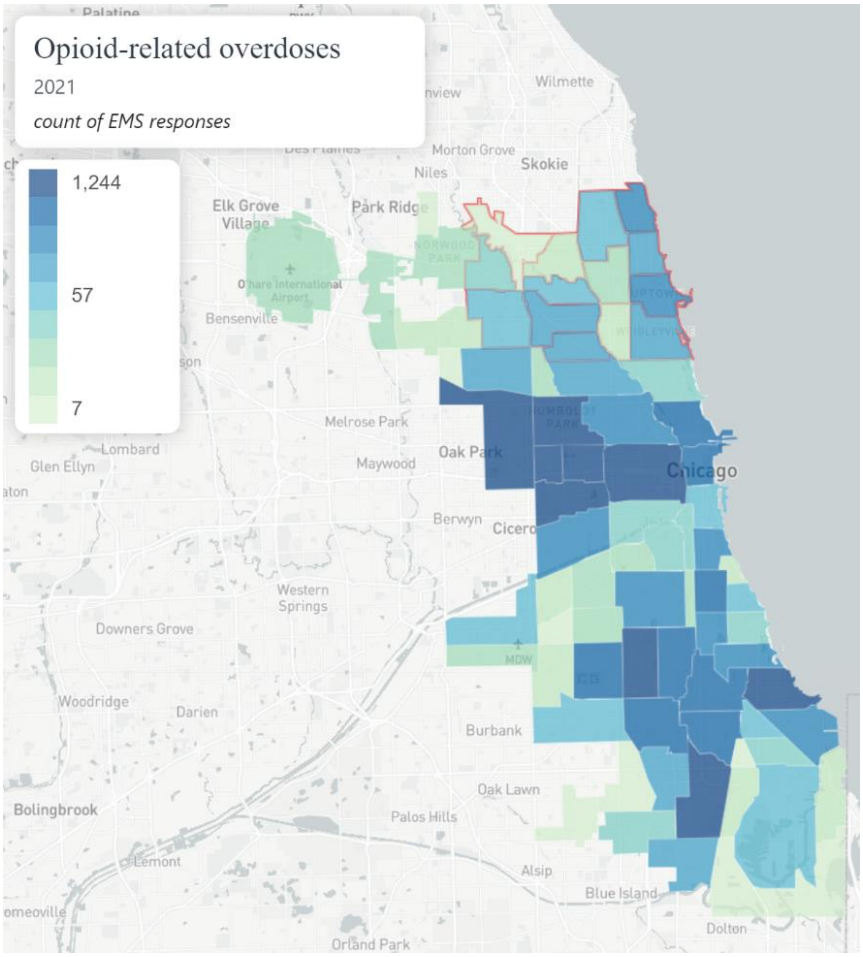
Figure 34. Alcohol-related hospitalization rate per 10,000 population, Chicago, Illinois



Chicago Department of Public Health, COMPdata, 2017

Over the past several years, drug overdoses have steadily increased. In 2020 during the COVID-19 pandemic, the rates of drug overdose deaths hit a historic high in the United States. In addition, there are significant inequities in mortality with non-Hispanic Black people being hit the hardest by drug overdose deaths. Within the Swedish service area, Rogers Park and Uptown have the highest count of EMS calls for opioid overdoses (Figure 35).

Figure 35. Count of EMS responses for opioid overdoses, Chicago, Illinois



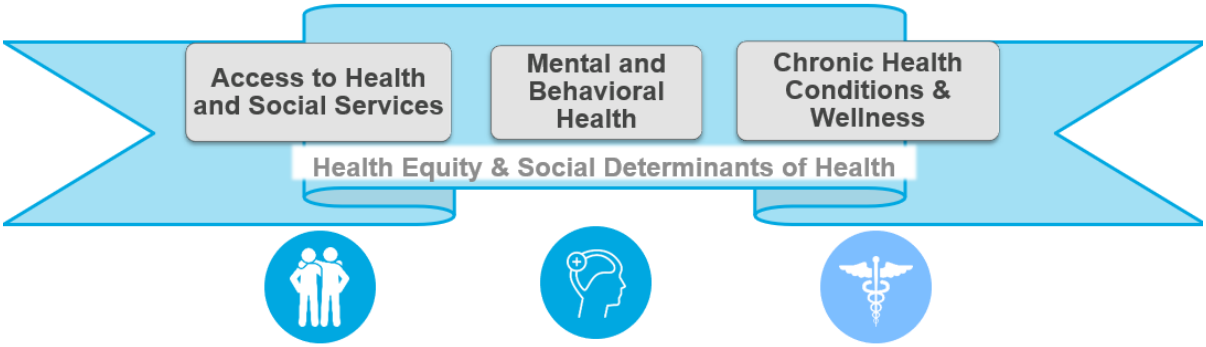
Chicago Department of Public Health, Chicago Health Atlas, 2021

Priority health needs for FY22-24

Based on assessment and analysis of the primary and secondary data compiled for the Swedish Hospital Service Area, Swedish plans to focus on the following needs, **with health equity and social determinants of health woven throughout**:

1. **Access to Health and Social Services**
2. **Mental and Behavioral Health**
3. **Chronic Health Conditions and Wellness**

Figure 36. Swedish Hospital Priority Health Needs



Based on relationships with community partners, clinical expertise, strategic priorities and an ongoing commitment to community engagement, Swedish believes it is best equipped to make an impact in the above priority needs, including focused attention within communities of greatest need. The corresponding Community Health Implementation Plan will describe programs Swedish is undertaking over the coming years to address the prioritized health needs within our community.

Needs identified in previous 2019 CHNA and key supporting activities

Swedish focused on three priority health issues as a result of the previous 2019 CHNA:

1. Addressing Social and Structural Determinants of Health
    a. Violence, Trauma and Community Safety
    b. Conditions that Support Healthy Eating and Active Living
    c. Housing and Neighborhood Environment
2. Addressing Chronic Conditions: Risk Factors, Prevention and Management
    a. Diabetes
    b. Heart Disease and Hypertension
    c. Obesity
    d. Cancer
3. Improving Mental Health
    a. Enhancing Access to Resources and Services

It should be noted that the COVID pandemic impacted Swedish's ability to address each of these areas to their fullest extent. Below is a summary of objectives and key implementation programs and activities from 2019-2022.

1a: Addressing Social and Structural Determinants of Health: Violence, Trauma and Community Safety

Objective	Programs/activities which have supported objective
Create a culture of safety and awareness where individuals impacted by violence and abuse	• More than 275 patients served annually who have been impacted by sexual assault, domestic violence, or human trafficking.

encounter skilled, trauma-informed and compassionate care.	• Displayed multi-lingual signage with tear-off cards in public washrooms to discreetly provide resources to access help. More than 500 info cards taken annually. • Sponsored hospital-wide, awareness-raising events on domestic violence, human trafficking, and sexual assault, including a "Start by Believing" event in April and purple ribbon tying event during DV Awareness Month. • Provided extensive de-escalation, trauma, domestic violence, human trafficking and sexual assault training to medical providers, and staff. On average, more than 40 trainings held annually with more than 500 people trained each year. • Provided trauma-informed medical, dental, and mental health services to trauma survivors referred by our domestic violence and human trafficking partner agencies. • Hired a new bi-lingual Pathways Advocate/Counselor to further develop outpatient counseling practice. • Launched a Vanish the Ink program to provide free tattoo removal to human trafficking survivors.
Broaden partnership and engagement within the community around topics of domestic violence, sexual assault and human trafficking to elevate awareness and education.	• Contributed to enhanced law enforcement response to domestic violence, human trafficking, and sexual assault through ongoing engagement, multi-disciplinary teams, and task force/committee representation with law enforcement partners, including the Cook County Human Trafficking Task Force Steering Committee and Cook County Sexual Assault Multi-Disciplinary Team Case Review, Steering Committee and Advisory Group. The Pathways Program Director is the Domestic Violence Chair of the Chicago Police Department District #20 Advisory Committee. • Engaged in robust partnerships with local domestic violence, sexual assault, and human trafficking agencies as well as organizations that provide longer-term services in the areas of mental health, housing and employment. Supported partners during pandemic including serving as a peer support group and providing vaccines to sexual assault advocates to ensure a swift return to in-person sexual assault response. • Convened a quarterly work group of community partners and internal champions to coordinate and strengthen our responses to domestic violence, human trafficking, and sexual assault. New partners during this through the Office of Victims of Crime grant included Sarah's Circle, the YWCA of Evanston, the Hana Center and the Jane Addams Resource Center.
Serve as thought leader and mentor to health professionals and institutions in an effort to build broad health care capacity and awareness around topics of violence, sexual assault and human trafficking.	• The Pathways program continues to lead innovative approaches to addressing health care capacity around violence, SA and HT, and is looked to as a leader regionally and beyond. NorthShore University HealthSystem is in the process of implementing a similar model within their legacy hospitals.

1b: Addressing Social and Structural Determinants of Health: Conditions that Support Healthy Eating and Active Living

Objective	Programs/activities which have supported objective
Develop and implement one or more pilot programs to better identify food insecurity and increase food access for vulnerable inpatient and/or outpatient populations	• Swedish Hospital's Food Connections Program was launched, with a focus on four areas: 1) Raising awareness of food insecurity as a health issue among Swedish staff, 2) Implementing the Hunger Vital Sign™ food insecurity screening questions, 3) Food access interventions including Food Package at Discharge Program, Veggies for Health 8 week nutrition class, and the Cupboard Swedish's onsite no-questions-asked pantry and 4) Building relationships with community partners including Lakeview Pantry, Common Pantry, the Friendship Center and more.
Educate the community about the importance of healthy eating and	• Swedish hosted or participated in dozens of community events to promote healthy lifestyles. One key initiative included bike safety tips and free helmet

physical activity via free special events and programs	giveaways/fittings in partnership with Chicago's SAFE Ambassador Program at area farmer's markets and community resource events. • GLC, Swedish's medical fitness facility, is a key partner in fitness and wellness programming. In addition to signature programs like Fundamental Fitness, they offer an array of programs, including free programs throughout the year such as National Senior Health and Fitness Day. • During the first few months of COVID, GLC provided free online fitness classes for several months to anyone in the community.
Explore external funding opportunities to enhance offerings related to this priority area at Swedish Hospital	• The Swedish Hospital Foundation has supported this priority area via ongoing financial support of the Food Connections Program.
Research best practices for innovative ways Swedish Hospital may enhance programs to support healthy eating, food access and physical activity	• Swedish continues to explore best practices and ways to enhance programs, in collaboration with GLC, community partners and other stakeholders. While COVID has limited the resources and time available, we will continue focusing on these important aspects of wellness.

1c: Addressing Social and Structural Determinants of Health: Housing and the Neighborhood Environment

Objective	**Programs/activities which have supported objective**
Raise awareness among healthcare team about homelessness being a risk factor to health	• Swedish remains committed to identifying, housing, and providing support services to homeless individuals in our area. Ongoing updates about the program are sent to all employees to keep them informed and encourage their ongoing engagement. • Swedish currently partners with Lutheran Social Services of Illinois (LSSI), to reduce hospital visits and improve the well-being of the homeless by providing permanent housing and support services.
Share housing options and resources with healthcare team	• The ED Director of Nursing and staff continue to remain engaged in the process of identifying homeless patients who need assistance with food, shelter, and clothing.
Secure funding for supportive housing, and develop agreements with local agencies who provide supportive housing, as well as explore future opportunities for collaboration	• Swedish Hospital Foundation provides funding to support housing program, through partnership with LSSI. • Swedish invests time mentoring relationships with LSSI and other outside agencies, including meetings with the Alliance for Health Equity Housing Committee.
Identify frequent users of Swedish Hospital's Emergency Department who are homeless or do not have stable housing	• The ED team is very sensitive to housing needs of patients and how much it relates to their health. Information is shared with the ED Director of Nursing. Though patients are reluctant to assistance with housing, repeat visits allow staff to gain the trust of this population by providing small items to meet their needs like jackets, personal hygiene items and food.
Connect individuals with housing partners and appropriate wraparound services from community partners	• Swedish ED physicians and medical staff provide extensive case management services to connect individuals with appropriate medical services within Swedish Medical Group and beyond. • In addition to LSSI, Swedish maintains ongoing relationships with Heartland Alliance and other community-based organizations to connect patients in need with appropriate support services.

2a: Addressing Chronic Conditions: Risk Factors, Prevention and Management - DIABETES

Objective	**Programs/activities which have supported objective**

Provide free support groups and education sessions for ongoing diabetes lifestyle management	• Ongoing efforts to provide comprehensive diabetes education, resources and support via the ADA accredited self-management program • 1-1 support provided via physician referral • Uninsured or underinsured community members were encouraged to attend free monthly offerings via the Nutrition and Diabetes Center. Participants share experiences and learn tips about healthy living. • Due to COVID, some support groups and Get Educated sessions were offered virtually.
Embed/streamline process for monitoring and managing diabetic patients and providing appropriate referrals to diabetes resources, including the Nutrition and Diabetes Center (NDC)	• New Nutrition Department role, Nutrition Care Coordinator, connects with diabetic patients during acute admission and assists in nutrition transitions of care. • Outpatient referrals in Epic are being updated to point patients more directly to the NDC for education. • Working to embed process for increasing screening and monitoring rates of diabetic patients within new EPIC system. • Presentation at All-Providers meeting in FY21 to raise awareness and educate physicians about = range of services available in the NDC.
Deliver programs to promote community education and awareness of diabetes	• Limited due to COVID, increased outreach and education provided to community in FY22 via Smoothie Bike interaction and other educational resources
Explore ways to enhance access to certified diabetes educators via community partnerships and collaborations	• Funding received from American Hospital Association and BCBSIL to support diabetes education for low-income racially diverse patients and community members through May 2021. Health disparity grant provided free individual diabetes education to uninsured/underinsured ethnic minorities in the Swedish Hospital community. Multilingual fliers were created for partnering organizations to assist in referring patients into this free service. • Funding received from G.A. Ackermann Memorial Fund to provide providing nutrition and diabetes education to uninsured or underinsured patients and community members in FY22. Through this grant, physical fitness classes, food access resources and transportation assistance are included.
Research best practices for innovative ways Swedish Hospital may enhance diabetes outreach, education and/or support	• As part of the Transformation Program and Northside Health Care Collaborative, a Certified Diabetes Care and Education Specialist from Swedish will soon provide services in Federally Qualified Health Centers (FQHCs). • Department continually explores ways to provide additional community-facing education and programming to improve nutrition-related health literacy in our service area.

2b: Addressing Chronic Conditions: Risk Factors, Prevention and Management – HEART DISEASE & HYPERTENSION

Objective	**Programs/activities which have supported objective**
Provide community outreach, education and screening related to heart disease and stroke risk factors, warning signs and how to respond in an emergency	• Due to COVID, the ability to provide education and outreach in this area has been significantly limited. • Bystander CPR/AED community training was offered on a very limited basis due to COVID. • Free educational programs hosted both on and off campus to raise awareness about risks and prevention of heart disease and stroke, presented by expert physicians or other clinicians.
Engage with Swedish Transitional Care Team, Wellness Coaches and Rehab Team to provide support and education during and after discharge	• Due to COVID, the ability to provide education and outreach in this area has been significantly limited. • Robust, certified cardiac and pulmonary rehab programs continue, utilizing a team approach with nurses, exercise physiologists, nutritionists and cardiologists develop personalized plans for each patient. • Those transitioning out of cardiac rehab have an opportunity to continue on with various fitness/nutrition programs facilitated by Cardiac Rehab staff and GLC

	staff, including the Medical Fitness Program (Cardiac Rehab Phase 3) and Fundamental Fitness.
Research best practices for innovative ways Swedish Hospital may enhance programs to address risk factors, prevention and management of heart disease and hypertension	• In FY20, the hospital established a COVID Rehabilitation pilot program within the cardiac rehab department, supported by a donation from the hospital's Foundation. In FY21, the program supported 460 visits with more than $55,000 in funding.

2c: Addressing Chronic Conditions: Risk Factors, Prevention and Management – OBESITY

Objective	Programs/activities which have supported objective
Provide robust programs and services via Galter LifeCenter (GLC) which support individuals who aim to prevent or manage obesity	• To help support community members in their mental and physical well-being, GLC offered more than 100 free virtual fitness classes at the onset of the COVID pandemic. • Fundamental Fitness and Eat, Move, Lose supported individuals on a weight loss journey and to embark on a new fitness/lifestyle program. • The hospital continued to support the community gardening movement by hosting an edible community garden on campus for both employees and general community members, in partnership with Peterson Garden Project.
Provide limited number of GLC membership scholarships to community members in need	• Approximately 80 members annually received GLC scholarships, which provided discounted membership for individuals experiencing both financial and medical need, via an application process. Scholarship Members received a $51 discount ($86-$35) on the full membership, which totaled more than $48,000 in discounts provided by GLC annually.
Engage community in annual large-scale wellness/healthy lifestyle event, featuring leadership from GLC and Swedish Hospital along with other community partners	• This large on-campus event was postponed due to COVID and social distancing requirements. Due to lack of resources, we were not able to offer an alternative option.
Train and mentor future exercise science specialists via ongoing collaborations with local universities	• GLC hosted interns from North Park University's Exercise Science program, UIC and others. Interns assisted with our hybrid class platform, member challenges, and our Fundamental Fitness and Eat/Move/Lose programs.

2d: Addressing Chronic Conditions: Risk Factors, Prevention and Management - CANCER

Objective	Programs/activities which have supported objective
Provide free and reduced cost screening and diagnostic breast health services to those in need via charity care and grant-funded programs.	• Robust, ongoing partnerships and grant support via The National Breast Cancer Foundation, Susan G. Komen Chicagoland and A Silver Lining to support breast cancer detection, treatment, and survivorship. • More than 1,100 no-charge cancer detection services provided annually to more than 850 uninsured or underinsured low-income women, many of whom are new immigrants facing numerous barriers and challenges. • Robust support for breast cancer survivors through the Integrated Cancer Care Program (ICCP), including support groups, integrative therapies (massage, acupuncture, etc.), fitness programming, nutrition counseling, and other services, free of charge.

Enhance cancer treatment by complementing standard care with psychosocial and other supports via the Integrated Cancer Care Program.	• Key partnership with GLC to connect cancer survivors with integrative therapies/services that support healing and overall health, including massage therapy, acupuncture fitness groups and meditation/relaxation classes. Swedish provided cancer survivors with access to the offerings at no charge to the patient. • Swedish Hospital Foundation provided more than $56,000 in funding to support cancer survivorship in FY21.
Raise awareness among healthcare providers and community members regarding age-appropriate screenings and vaccinations (ex. colorectal, breast, prostate, lung, HPV vaccinations) via outreach and education events.	• Skin cancer screenings provided 1-2 times annually • Smoking Cessation Programs (8-week comprehensive session) provided 2-4 times annually • Annual Korean Health Fair hosted at Swedish in partnership with HANA Center. Services include lab work, mammography, cervical cancer screening, and primary/specialty care (significant discounts provided). The Annual Korean Health Fair resumed in 2022 after being postponed due to COVID.

3: Improving Mental Health – Enhancing Access to Resources and Services

Objective	**Programs/activities which have supported objective**
Continue and enhance robust partnership with Lutheran Social Services of Illinois, via inpatient acute access and outpatient access on-campus (Project Impact, Welcoming Center and Mobile Crisis Team)	• Swedish Hospital continues to have a strong and robust partnership with Lutheran Social Services (LSSI), within the ED (Project IMPACT), through LSSI's outpatient setting (The Welcoming Center) on the hospital's campus and through the LSSI Mobile Crisis Team. • One enhancement to the hospital's ongoing LSSI partnership includes access within the Swedish Emergency Department for patients who are need of medical stabilization for substance or alcohol abuse. • Successful partnership with LSSI's Welcoming Center allows individuals access to appropriate levels of care for non-emergent treatments, helping to reduce inappropriate use of the ED. • LSSI's Mobile Crisis Team deploys Crisis Counselors to help an individual who is experiencing a behavioral health crisis. Crisis Counselors will help de-escalate a client, assess for follow-up treatment, and help create a crisis plan. Available 24/7 for children, adolescents, and adults experiencing a crisis on the North/Northwest side of Chicago.
Evaluate pilot program within Swedish Medical Group (SMG), featuring behavioral health integration within primary care setting to provide more comprehensive health to SMG patients.	• Established an integrated, team-based approach to create improved access to behavioral health providers, within the primary care setting. Clinical psychologist, co-located among four, physically and operationally connected practices that included sixteen primary care providers. The collaborative team developed processes for referrals, warm handoffs, electronic health record integration and more. • Thus far from pilot, significantly improved access to behavioral health services and resources, elevated levels of provider and patient buy-in, and high provider and patient satisfaction ratings. Program has created a more streamlined approach to ensure patients are successfully connected to behavioral health services.
Educate the community about mental health and access to resources via free special events and programs, along with ongoing communication between Swedish Hospital and community organizations, including local social service agencies	• Free weekly new moms' group is offered to support new mothers in community (transitioned to virtual) • Online assessment tools offer depression and anxiety assessment. • Free counseling services provided to uninsured or underinsured women through Swedish Hospital Foundation's Women's Care Fund. More than $20,000 in counseling sessions provided in FY21. • Free programs offered in partnership with local schools and other groups to address COVID, anxiety and isolation.
Enhance child and adolescent behavioral mental health offerings available to the community via LSSI robust on-campus partnership,	• Child and Adolescent mental health services are accessible via the Welcoming Center and LSSI's Mobile Crisis Team, to create more streamlined care and access for patients who may present in our Emergency Department initially.

expanding options beyond merely admitting vs. discharging a patient	
Raise community awareness regarding resources available via GLC which support mental health	• GLC offered mindfulness-based meditation practices (mental exercises shown to have numerous benefits for mental and physical health and wellbeing, strengthening the mind's ability to respond wisely rather than react habitually to thoughts, emotions, physiological experiences and more.
Research best practices for innovative ways Swedish Hospital may enhance programs to support enhancing access to mental health resources and services	• Due to COVID, progress on this was delayed. LSSI, Swedish Hospital and Erie are discussing ways to collaborate on the creation of a mental health and medical services directory to insure appropriate, streamlined access for community members in need. • Exploring a pilot project in collaboration with the City of Chicago to address behavioral mental health via CFD/CPD Diversion. Pre-COVID, LSSI was chosen by the city to be the provider on the north side. Currently awaiting further connection and alignment on process and flow.

Conclusion

Swedish Hospital values the community health needs assessment process as an opportunity to engage with community leaders and organizations and with our colleagues from other healthcare institutions across the County through the Alliance for Health Equity. In partnership with communities, the Chicago Department of Public Health, the Illinois Public Health Institute, and the Alliance for Health Equity, we have 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. We undertake this collaborative, collective impact approach to community health needs assessment and implementation in order to address the underlying root causes of health disparities and to support greater community health and well-being in the communities we serve. Swedish Hospital makes the Community Health Needs Assessment available at SwedishCovenant.org/community-benefit. It is also shared broadly with internal and external stakeholders, including employees, volunteers, physicians, elected officials and members of our community, including the Community Leader Engagement Program.

Please send feedback on this Community Health Needs Assessment to the following address:
Swedish Hospital
Attn: Community Relations
5145 N. California Ave.
Chicago, IL 60625

Alternatively, you may fill out our online form to provide feedback about the CHNA or its related Implementation Strategy.

This plan has been reviewed and approved by the Board of Directors of Swedish Hospital in 2022.

To access the full collaborative Community Health Needs Assessment for Chicago and Suburban Cook Counties, please visit: https://allhealthequity.org/projects/2022-chna-report/

Swedish Hospital

Part of NorthShore

2023–2024 Implementation Strategy Plan

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 Plan (ISP) pertains to Swedish Hospital, which is part of NorthShore – Edward-Elmhurst Health.

Please note that NorthShore Hospitals, Edward-Elmhurst Health and Northwest Community Healthcare develop and release their own separate ISPs.

NorthShore – Edward-Elmhurst Health's Mission

The core mission of NorthShore – Edward Elmhurst is to "help everyone in our communities be their best."

About NorthShore – Edward-Elmhurst Health

NorthShore – Edward-Elmhurst Health is a fully integrated healthcare delivery system committed to providing access to quality, vibrant, community-connected care, serving an area of more than 4.2 million residents across six northeast Illinois counties. Our more than 25,000 team members and more than 6,000 physicians aim to deliver transformative patient experiences and expert care close to home across more than 300 ambulatory locations and eight acute care hospitals – Edward (Naperville), Elmhurst, Evanston, Glenbrook (Glenview), Highland Park, Northwest Community (Arlington Heights) Skokie and Swedish (Chicago) – all recognized as Magnet hospitals for nursing excellence. Located in Naperville, Linden Oaks Behavioral Health, provides for the mental health needs of area residents.

NorthShore – Edward-Elmhurst Health desires to continue providing clinical programs and services to meet community health needs, while also pursuing continuous improvement in existing and future programs to improve the overall health of individuals in the communities it serves.

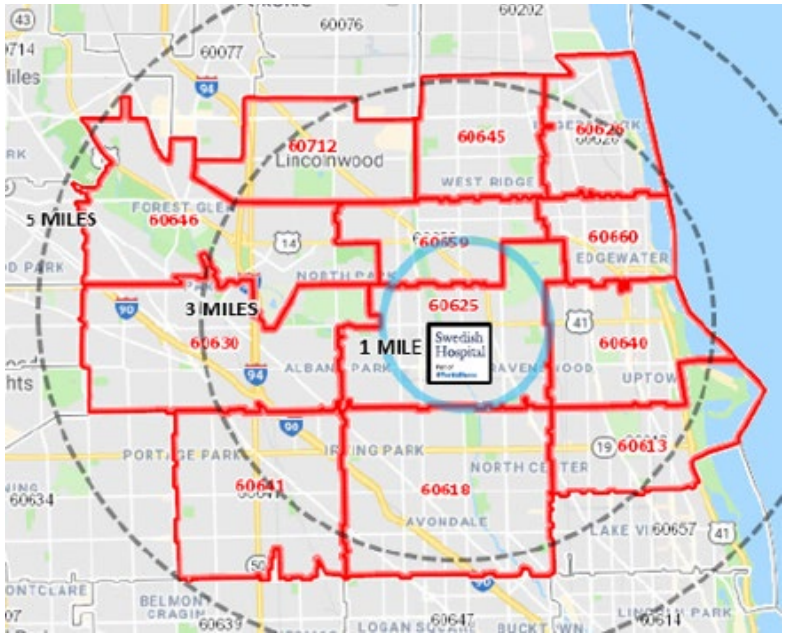
About Swedish Hospital

Swedish Hospital serves the culturally-diverse residents of Chicago's north and northwest side communities, with a full-service hospital campus located in Lincoln Square at the intersection of Foster and California Avenues. Swedish Hospital provides a full range of comprehensive health and wellness services including an acute care hospital, primary care and specialists in the medical group, strong community outreach programs and Chicago's only certified medical fitness center, Galter LifeCenter.

Purpose of a Hospital's Implementation Strategy

An Implementation Strategy Plan (ISP) 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 ISP 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.

The CHNA was developed in partnership with the Alliance for Health Equity (AHE), a collaborative of over 30 hospitals, 7 health departments, and 100 community partners throughout Chicago and Cook County. It also included direct input from local community members. Swedish Hospital partners with members of AHE and other key community partners within our service area to leverage existing resources and develop strategies which contribute to improving the most pressing health needs of our communities. This implementation plan describes programs Swedish Hospital is undertaking over the coming years to address the prioritized health needs within our community.



Community Definition

Swedish's community, as defined for the purposes of the Community Health Needs Assessment, includes each of the residential ZIP Codes that comprise the hospital's Primary Service Area (PSA) and Secondary Service Area (SSA): 60613, 60618, 60625, 60626, 60630, 60640, 60641, 60645, 60646, 60659, 60660 and 60712. 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 Swedish's patients originate from these areas.

The total population in Swedish's service area is 686,000. In the service area, 25% of the population identifies as Hispanic/Latinx and 75% Non-Hispanic. Fifty-three percent of the population identifies as white, 10% Asian, 8% Black/African American, 3% identifies as two or more races, and less than 1% as Native American.

How the CHNA Implementation Strategy was Developed

The ISP was developed after the comprehensive Community Health Needs Assessment (CHNA) was completed. Please refer to the complete CHNA for the full report. Strategies and action plans were developed based on a consensus among a steering committee comprised of Swedish Hospital leaders after input from each of the respective disciplines. The organization intends to undertake the following strategies to meet the identified community health needs. It is important to note that our health equity and social determinants of health (SDOH) work is fundamental and integrated throughout our priority needs' strategies on the following pages.

This ISP will be reviewed annually during the two-year lifespan of the 2022 CHNA and updated as needed to ensure viability and impact. The impact will be communicated regularly to reporting agencies and our community.

Access to Health & Social Services

- Expand efforts to identify and respond to social determinants of health (SDOH).
- Expand efforts to support benefits enrollment for under-resourced community members.
- Increase access to specialty care and diabetes education via Healthcare Transformation Program.
- Strengthen Swedish Hospital's capacity to respond response to survivors of sexual and intimate partner violence via Pathways Program.
- Develop Community Health strategy addressing health and racial disparities through community partnership and program development.

Mental & Behavioral Health

- Deepen partnerships with community organizations addressing mental health.
- Continue and enhance behavioral, mental health and substance abuse services.
- Explore opportunities to educate the community about mental health via programs and partnerships.

Chronic Health Conditions & Wellness

- Address high blood pressure, diabetes and preventative cancer screenings through targeted interventions and outreach.
- Enhance partnerships with local community organizations to better address chronic health conditions.
- Expand education and outreach to community and patients to promote nutrition, healthy lifestyle choices and wellbeing.
- Enhance Galter LifeCenter offerings to support health and wellbeing.

Health Equity and Social Determinants of Health Foundational to Our Approach

We are addressing disparities in health and well-being, advancing access and improving patient outcomes across all the communities we serve. This work is fundamental and integrated throughout our priority needs on the following pages of our ISP.

As an organization, we have key commitments around measurement, learning and action which are critical to our ongoing health equity work. By improving our data collection efforts on areas such as Race, Ethnicity and Language (REAL), we are able to get a more complete picture of our patient and community demographics, allowing us to improve the way we meet our community's needs and deliver care, all in a welcoming and affirming environment. Enhancing screening opportunities for Social Determinants of Health (SDOH) allows us to better understand challenges and barriers that our community members face, so we can navigate them to critical resources and services they may need. Finally, partnering with community organizations through our Community Investment Fund allows us to further address priority health needs in a powerful, collaborative way.

Health equity commitments include:

Measurement: We are working to accurately capture race, ethnicity, language and other preferences and to ensure that all of our patients' perspectives are captured in our measurement systems.	• Reduce % of all patients who have had a face to face encounter at NorthShore who we document as "Other, Declined or Unknown" • Educate and engage front line staff on REAL and/or Sexual Orientation and Gender Identity (SOGI) data collection improvement efforts
Learning: We are investing in leading practices and new ways to listen to our patients and community members, incorporating feedback to understand and impact social determinants of health.	• Develop a consistent and reliable process to collect, visualize, and intervene on Social Determinants of Health (SDOH) data • Educate and engage team members on SDOH screening efforts
Action: We are investing in and partnering with like-minded community organizations to close the gap on health disparities.	• Enhance partnerships and provide funding through NorthShore's Community Investment Fund (CIF) to help local organizations build capacity and increase impact, with at least 80% of annual CIF awardee partners addressing CHNA priority needs • Expand Healthy Chicago Equity Zones, Healthcare Transformation, Food Connections and others to deepen community partnerships within under-resourced communities

Swedish Steering Committee Members

Dr. Shameem Abbasy, VP Quality and Clinical Transformation, Swedish Hospital

Maria Balata, Director, Pathways Program

Amy Beck, Personal Training Manager, Galter LifeCenter

Charles Brandon, Director, Healthcare Transformation

Christine Bucheit, Manager, Quality Care & Transformation

Courtney Carlson, Exercise Physiologist, Cardiology

Dawn Carlson, Community Relations Coordinator

Jenise Celestin, Director, Community Relations

Linda Granato, Manager, Non-invasive Cardiology

Francie Habash, Program Director, Galter LifeCenter

Dr. Katherine Hanson, Psychology Division Lead, Swedish Medical Group

Marcia Jimenez, Director, Intergovernmental Affairs

Nadia Jimenez, Director, Community Health & COVID Response

Kate Lawler, Senior Director, Community Health Transformation

Kim Leslie, Director of Nursing – Emergency Department

Aji Lukose, Senior Director of Nursing – Psychiatry, Rehab, Med-Surg, Nursing Office

Elizabeth Miniscalco, Director of Nursing – Cancer Treatment

Ashlee Roffe, Director, Nutrition Services

Darcie Trier, Senior Director, Quality, Safety and Patient Experience

Ashley Tsuruda, Director of Development, Foundation and Corporate Relations

Priority Need: Access to Health & Social Services

Strategy	Initiatives/Programs	Reportable Metrics to Demonstrate Impact	Collaborations
Expand efforts to identify and respond to social determinants of health (SDOH).	Implement and expand SDOH screening and awareness within some inpatient and outpatient settings to navigate patients to resources/services.*	# screenings, # of screenings identifying at least one need, # of referrals, # of referrals to Swedish Community Health programs	Transformation Program, HCEZ/Community Wellness Center, Food Connections, Pathways, Family Connects
	Build community-facing page for consumers to search for services and resources.	# pageviews	
	Provide funding through NorthShore's Community Investment Fund (CIF) to help local organizations build capacity and increase impact.*	$'s invested in local awardee partners addressing CHNA priority needs	
Expand efforts to support benefits enrollment for under-resourced community members.	Initiate process to enroll patients who screen positive for food insecurity in various programs (LINK, SNAP, WIC, food pantries)*	# individuals connected to benefits	Food Connections, HCEZ/Community Wellness Center, area food pantries
	Build and expand Benefit Specialists program throughout Swedish Hospital and Community Wellness Center to offer navigation and support for underrepresented and/or under-resourced individuals.*	# individuals connected to benefits	
Increase access to specialty care and diabetes education via Healthcare Transformation Program.	Continue to partner with local FQHCs to provide specialty medical care services.*	# completed new and follow-up office visits (include breakdown of uninsured), $ care provided	Transformation Program, Erie Family Health, Tapestry 360 Health, Howard Brown Health, Hamdard Health Alliance, Asian Human Services Family Health Center
	Access to 1-1 diabetes education with local FQHCs.*	# of patients who receive 1-1 diabetes education, improvement in A1c	
Strengthen Swedish Hospital's capacity to respond response to survivors of sexual and intimate partner violence via Pathways Program.	Continue to provide extensive de-escalation, neurobiology of trauma, domestic violence, human trafficking and sexual assault training to medical providers, and staff.	# team members trained, # sessions hosted, # training hours	Apna Ghar, Between Friends, Centro Romero, KAN-WIN, The Network, Salvation Army Stop-it Program, Resilience, Lutheran Social Services of IL, Chicago Police Dept. District #20, Cook County State's Attorney's Office, DePaul University, local elected officials, local FQHCs, community centers and cultural organizations
	Provide crisis intervention to people impacted by sexual and intimate partner violence.*	# of people who receive crisis intervention	
	Provide counseling and case management to people impacted by sexual and intimate partner violence.*	# of people who receive counseling and case management	
Develop Community Health strategy addressing health and racial disparities through community partnership and program development.	Continue and expand partnership with Community Area leads to identify and respond to each community's unique needs.*	# of partners within network	Lead Program Partners: CDPH, Greater Auburn Gresham, Northwest Center, SWOP, West Side United, ICNA Relief, Rohyingya Culture Center, Tapestry 360 Health, Family Matters, Lutheran Social Services of Illinois, Common Pantry, EverThrive, Thresholds, Apna Ghar
	Launch Community Wellness Center as hub for educational programming, support groups and wellness offerings, including collaboration with area organizations.*	# of class offerings, # of sessions, # of participants, # of support groups, # of support sessions, # of participants	

* Denotes initiative with health equity integration

Priority Need: Mental and Behavioral Health

Strategy	Initiatives/Programs	Reportable Metrics to Demonstrate Impact	Collaborations
Deepen partnerships with community organizations addressing mental health.	Continue and enhance robust partnership with Lutheran Social Services of Illinois, via inpatient acute access and outpatient access on-campus (Project Impact, Welcoming Center and Mobile Crisis Team)	# of patients served by Project Impact annually, # patients navigated to Welcoming Center	Lutheran Social Services of IL, NorthShore Office of Community Health Equity and Engagement
	Explore partnerships or programming with area nonprofits addressing mental health stigma and treatment.	# programs, # partnerships, # people served, $ provided to organizations addressing mental health	
	Provide funding through NorthShore's Community Investment Fund (CIF) to help local organizations build capacity and increase impact.*	$'s invested in local awardee partners addressing CHNA priority needs	
Continue and enhance behavioral, mental health and substance abuse services.	Increase access to behavioral health services through integration within primary care setting; additionally, explore pilot and grant funding to extend integration to pediatrics.	# of patients served	City of Chicago, Chicago Department of Public Health, Swedish Medical Group, Community Wellness Center
	Explore opportunities to increase available services, including LCSW training, psychoeducation to reduce stigma and expanded individual services.*	$ awarded, grants pursued	
	Pilot suboxone opioid addiction clinic within Emergency Department and explore expansion through funding.*	# of patients served	
	Initiate Family Connects screening and build connections to various post-partum depression support resources.*	# of patients served	
Explore opportunities to educate the community about mental health via programs and partnerships.	Explore programs or partnerships with area schools and other local organizations to provide education and/or training.	# programs, # schools, # students/teachers trained	North River Commission, The Kedzie Center, Lawrence Hall
	Explore marketing strategies (including social media or via other channels) to raise awareness and destigmatize mental health for youth and adults.	# people reached	
	Continue weekly free New Moms Group, open to all community members.	# attendees, # sessions	

* Denotes initiative with health equity integration

Priority Need: Chronic Health Conditions & Wellness

Strategy	Initiatives/Programs	Reportable Metrics to Demonstrate Impact	Collaborations
Address high blood pressure, diabetes and preventative cancer screenings through targeted interventions and outreach.	Increase efforts around education for patients and providers and improve available data to help inform improvements efforts, inclusive of all patients.*	Quality improvement metrics, improved clinical processes to reduce outcome disparities (IVS Scorecard), diabetes A1C levels and hypertension management among SMG patients	Erie Family Health, Tapestry 360 Health, Asian Human Services Family Health Center, Hamdard Health Alliance, Howard Brown Health, National Breast Cancer Foundation, Susan G. Komen, A Silver Lining Foundation
	Continue to educate community about preventative cancer screenings, prevention and early detection, including Community Breast Health Program grant opportunities for breast health services for uninsured/ underinsured.*	Cancer screening rates, # of patients served by CBHP	
Enhance partnerships with local community organizations to better address chronic health conditions.	Deepen collaboration within local FQHCs via Transformation Program to care for underresourced patients managing chronic health conditions.*	# completed appts, A1c, Hypertension (IVS scorecard)	Erie Family Health, Tapestry 360 Health, Asian Human Services Family Health Center, Hamdard Health Alliance, Howard Brown Health
	Provide funding through NorthShore's Community Investment Fund (CIF) to help local organizations build capacity and increase impact.*	$'s invested in local awardee partners addressing CHNA priority needs	
Expand education and outreach to community and patients to promote nutrition, healthy lifestyle choices and wellbeing.	Expand Food Connections Program, including the launch of a "Food Prescriptions" pilot program for those with food insecurity + chronic disease, in partnership with area food pantry.*	# patients/community members receiving food prescription	Nutrition Services, Community Wellness Center, Galter LifeCenter
	Explore ways to grow Nutrition & Diabetes Center via physician referral relationships, partnership with community organizations, CORD, expansion of Veggies for Health program beyond those with food insecurity, to address chronic diseases and and other community awareness campaigns.*	# Veggies for Health participants in chronic disease group, # completed appointments	
	Expand community education programming about the importance of healthy eating and physical activity via free special events and programs, including partnership with Swedish's Healthy Chicago Equity Zones to outreach into local underserved communities.*	# programs, # outreach events, # attendees at outreach events	
	Provide smoking cessation program, including discounted fees for underresourced individuals and explore new funding and referral opportunities.*	# programs, # participants	
Enhance Galter LifeCenter offerings to support health and wellbeing.	Explore funding and referral opportunities for various GLC wellness and integrative medicine programs.*	# referrals to programs	Galter LifeCenter, local community organizations
	Increase number of scholarship memberships for community members based on medical and financial need.*	# members served by scholarships	
	Support Integrated Cancer Care Program (ICCP) via GLC services and explore expansion opportunities.	# ICCP participants, # services provided	
	Explore ways to enhance participation in community outreach, including point of care screening events.*	# of individuals served, # of programs	
	Explore EPIC integration with GLC, to provide efficient, streamlined referrals from inpatient and outpatient settings to GLC wellness programs.	# of referrals to programs	

* Denotes initiative with health equity integration

Significant Health Needs Not Addressed

IRS regulations require that the CHNA Implementation Strategy include a brief explanation of why a hospital facility does not intend to address any significant health needs identified through the CHNA.

Many of these needs are incorporated into other priority areas or are a part of existing hospital programs or services.

Identified Need	Reason for Not Addressing / How Need is Tied to Priorities and Health Equity
Age-Related Illness	While not detailed as a priority need in this ISP, this is incorporated into Chronic Health Conditions and Wellness.
Child and Adolescent Health	While not detailed as a priority need in this ISP, this is incorporated into Mental & Behavioral Health and other priority areas through SDOH screenings and other programs. The hospital is also committed to working with other organizations where possible to support these efforts and elevate awareness of these issues.
COVID-19	While not detailed as a priority need in this ISP, Swedish Hospital has a robust focus on COVID-19. This need is incorporated into Access to Health & Social Services and the active partnership between Swedish's Healthy Chicago Equity Zones team and the City of Chicago.
Homelessness and Housing Instability	While not detailed as a priority need in this ISP, this is incorporated into Access to Health & Social Services via SDOH screening enhancements and is also addressed via the hospital's Housing Connections program. The hospital is also committed to working with other organizations where possible to support these efforts and elevate awareness of these issues.
Violence	While not detailed as a priority need in this ISP, this is incorporated into Access to Health & Social Services priority via Swedish Hospital's Pathways Program.
Obesity	While not detailed as a priority need in this ISP, this is incorporated into Chronic Health Conditions and Wellbeing and Health Equity. It is also being addressed through existing work with the Nutrition & Diabetes Center.
Food Insecurity	While not detailed as a priority need in this ISP, Swedish Hospital has a robust focus on Food Insecurity via the Food Connections program. This need is incorporated into both the Access to Health & Social Services priority as well as Chronic Health Conditions & Wellness and is part of our SDOH screening enhancements.

Conclusion

This Implementation Strategy has been reviewed and approved by Swedish Hospital's Board of Directors on November 2, 2022.

Swedish Hospital values the community health needs assessment process as an opportunity to engage with community leaders and organizations through the Community Leader Engagement Program and Community Ambassador Program and with our colleagues from other healthcare institutions across the County through the Alliance for Health Equity. In partnership with communities, the Chicago Department of Public Health, the Illinois Public Health Institute, and the Alliance for Health Equity, we have 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. We undertake this collaborative collective impact approach to community health needs assessment and implementation in order to address the underlying root causes of health disparities and to support greater community health and well-being in the communities we serve. Swedish Hospital makes the Community Health Needs Assessment and Implementation Strategy available at SwedishCovenant.org/community-benefit. It is also shared broadly with internal and external stakeholders, including employees, volunteers, physicians, elected officials and members of our community, including the Community Leader Engagement Program.

Please send feedback on this Implementation Strategy or the corresponding Community Health Needs Assessment to the following address:

Swedish Hospital
Attn: Community Relations
5145 N. California Ave.
Chicago, IL 60625

Alternatively, you may fill out our online form to provide feedback about the CHNA or Implementation Strategy.

To access the full collaborative Community Health Needs Assessment for Chicago and Suburban Cook Counties, please visit https://allhealthequity.org/projects/2022-chna-report/.

Edward-Elmhurst Health Community Health Needs Assessment and Implementation

Healthy Driven®

Edward-Elmhurst HEALTH

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.

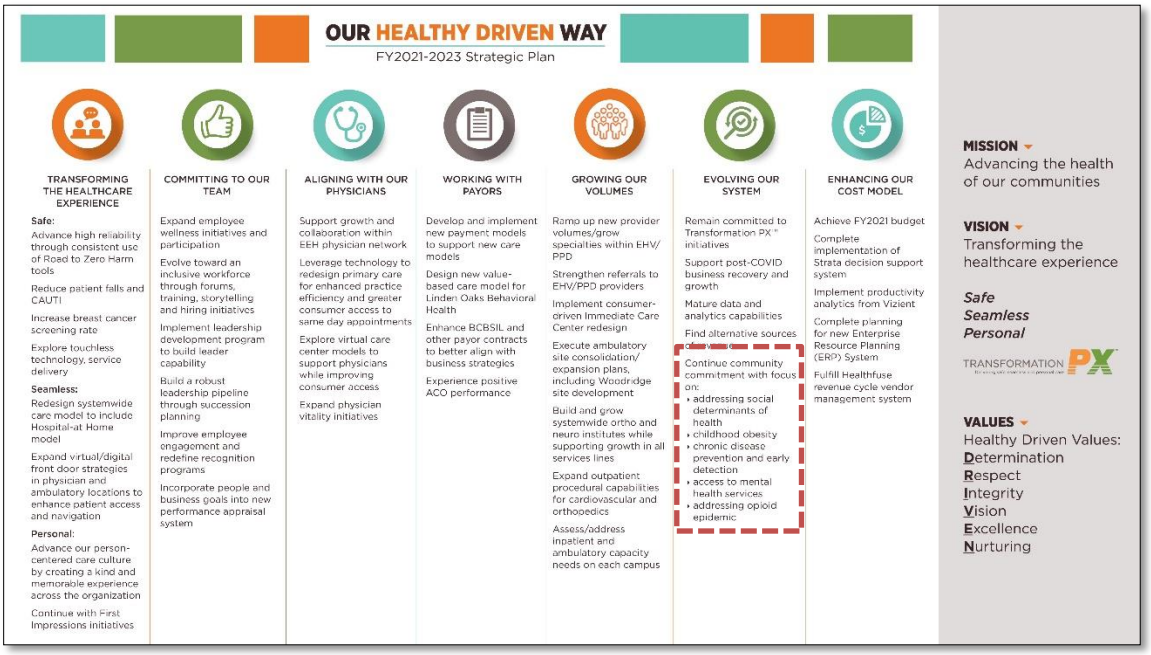
Linden Oaks

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.

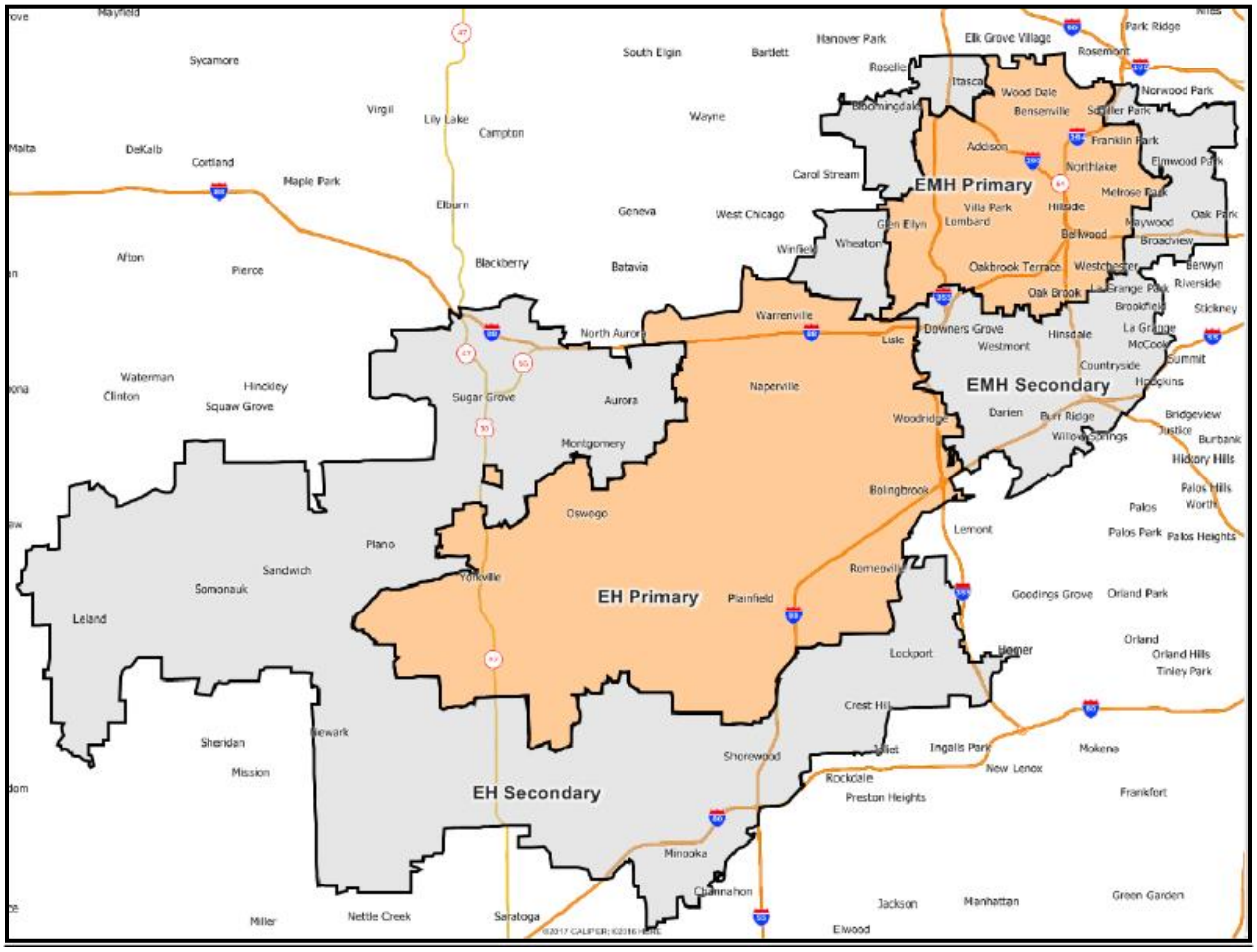


EEH community benefit planning, implementation and reporting is supported by the EEH System Community Benefit Steering Committee. The Committee is tasked to assess community need, establish priorities and supporting initiatives, and monitor outcomes to ensure initiatives are consistent with its mission 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

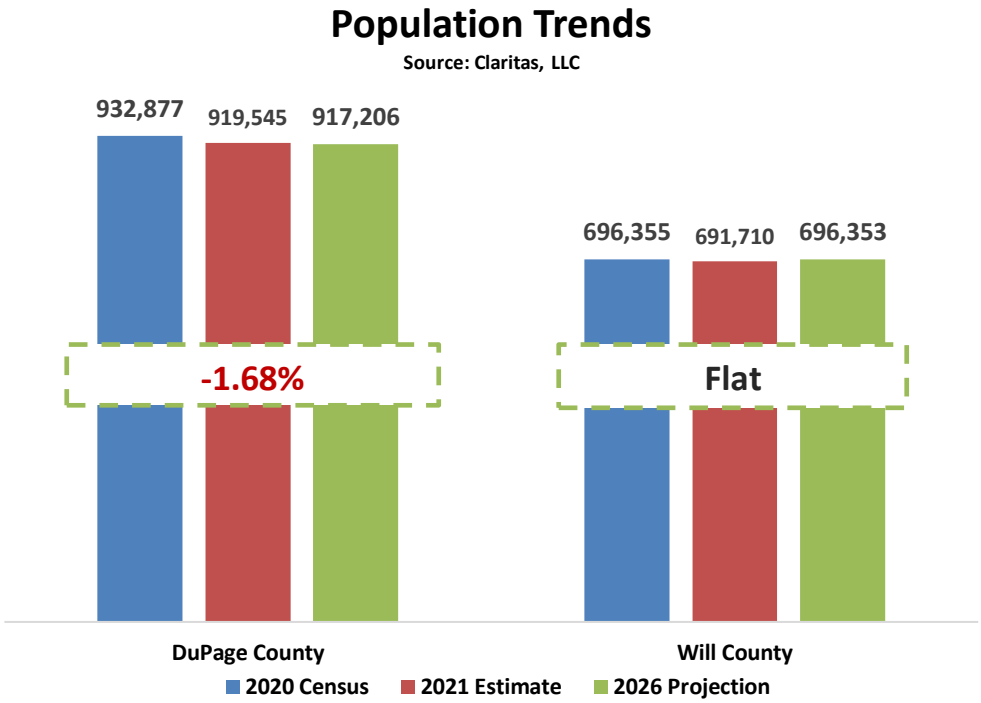
Elmhurst Hospital

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%.

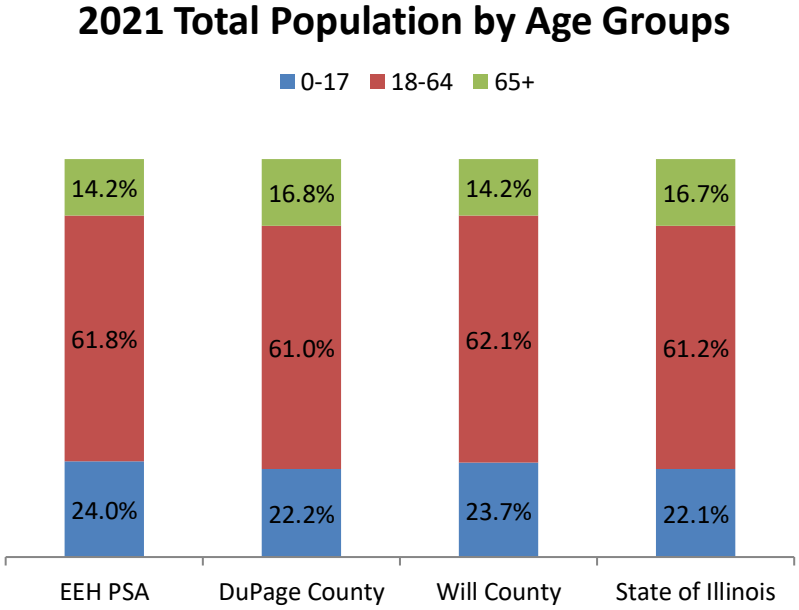
County	FY2021 Inpatient Discharges	Percent of Total	Cumulative Percent
DuPage	19,492	47.1%	47.1%
Will	9,303	22.5%	69.6%
Cook	8,135	19.7%	89.3%
Kane	1,543	3.7%	93.0%
Kendall	1,228	3.0%	96.0%
DeKalb	291	0.7%	96.7%
Grundy	250	0.6%	97.3%
All Others	1,114	2.7%	100.0%

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.

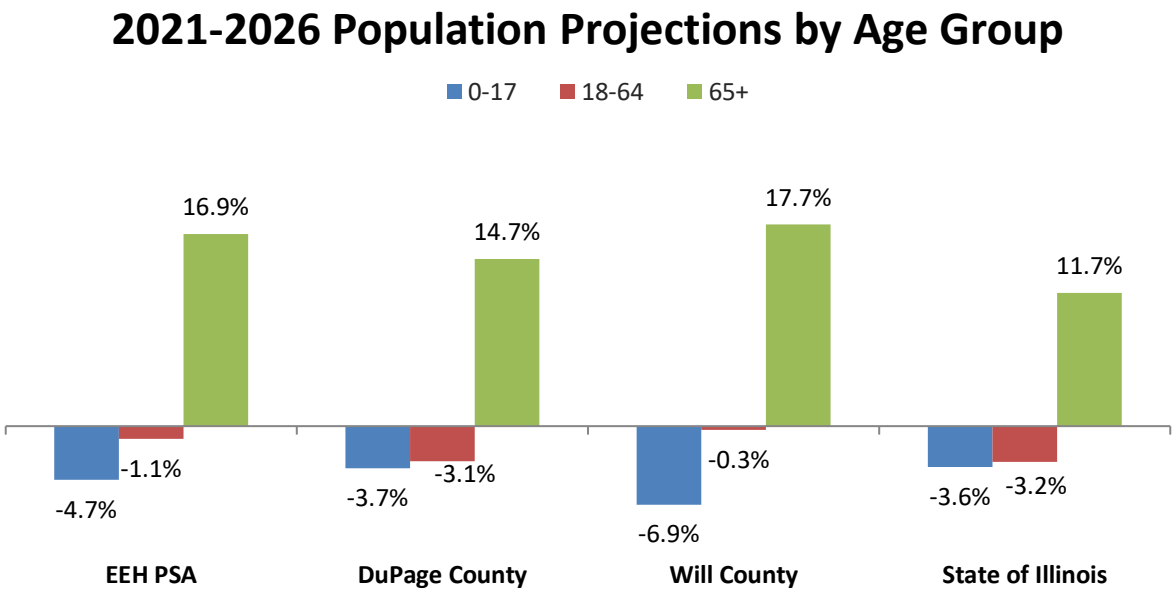


Age Trends

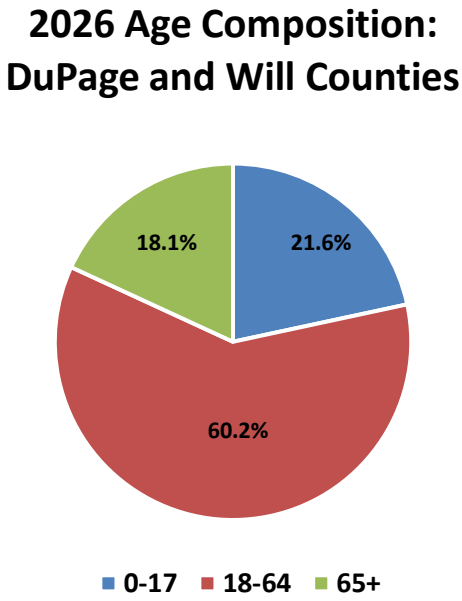
The graph below illustrates the 2021 estimated population by age group for EEH PSA, DuPage and Will counties, and the state of Illinois. When considering median age, EEH PSA and Will County are nearly the same (38.3 and 38.6 years respectively) as the state of Illinois (38.9 years) while DuPage County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



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

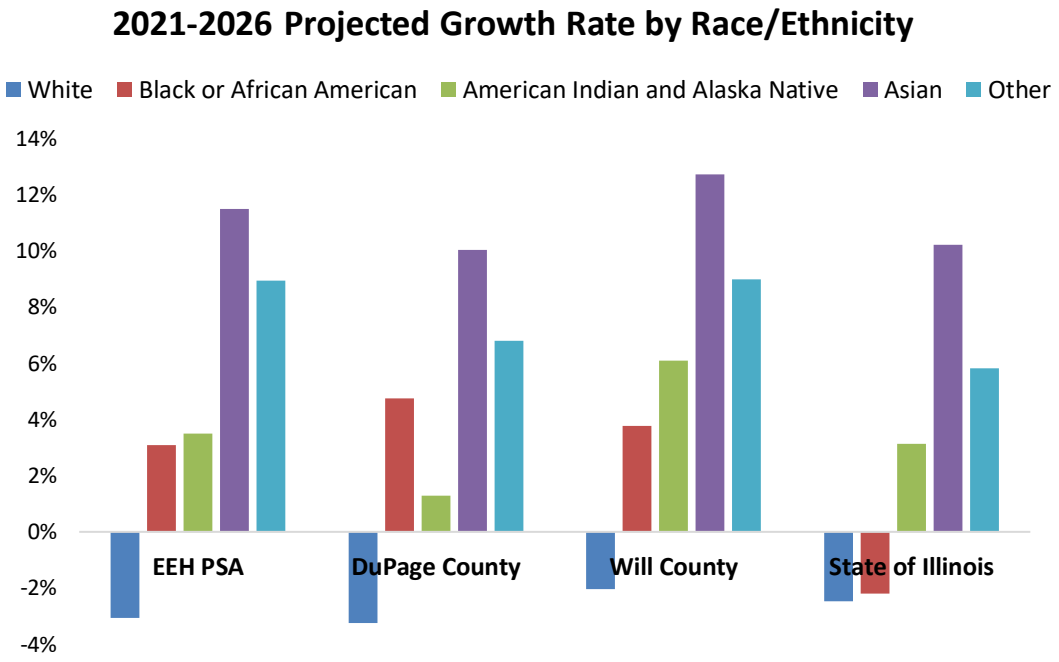


By 2026, it is projected that 18% of DuPage and Will County residents will be 65 years or older, compared to approximately 16% in 2021.

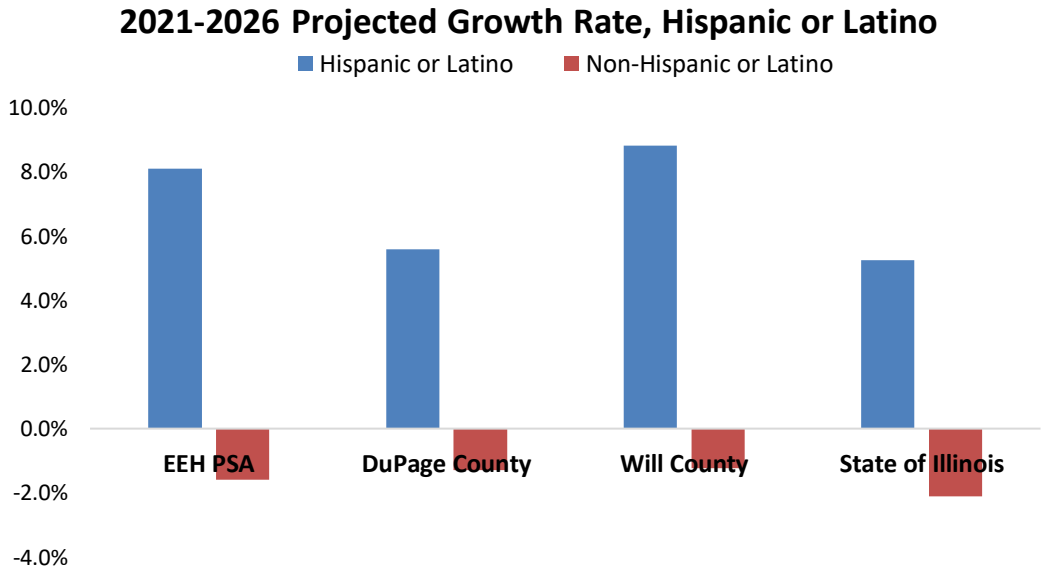


Race and Ethnicity Trends

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.

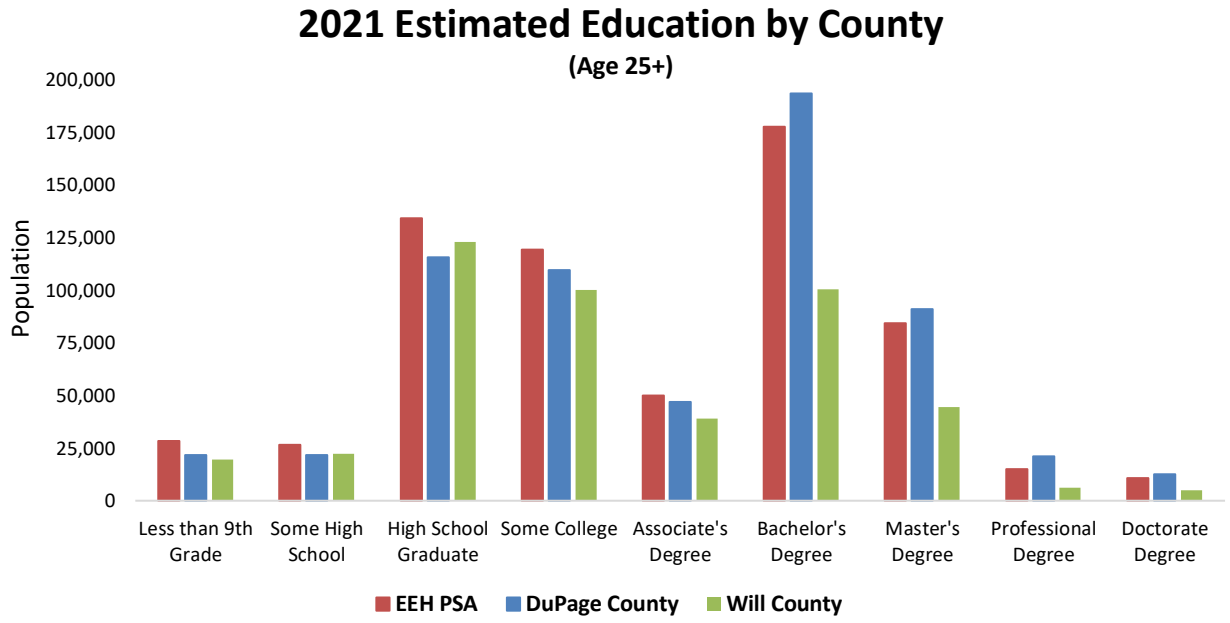


Imbedded within these trends is disproportionate growth in the Hispanic or Latino population. The graphic below indicates that this population will grow over 8% in EEH's region, compared to statewide growth of 5%.

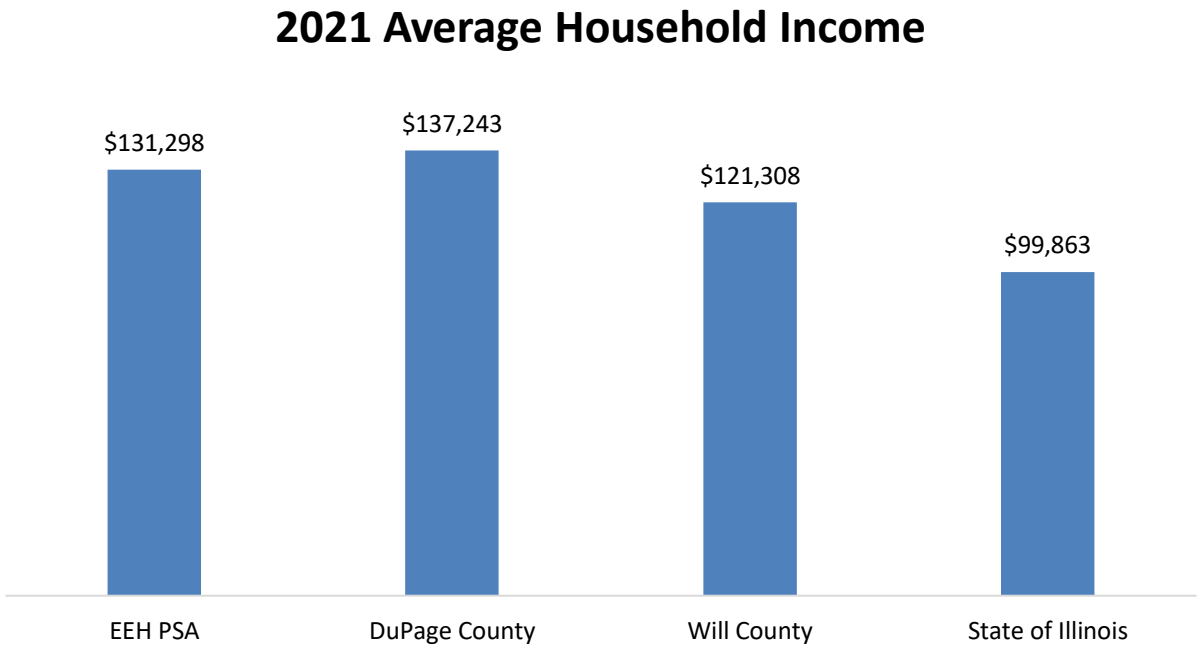


Socioeconomic Status

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

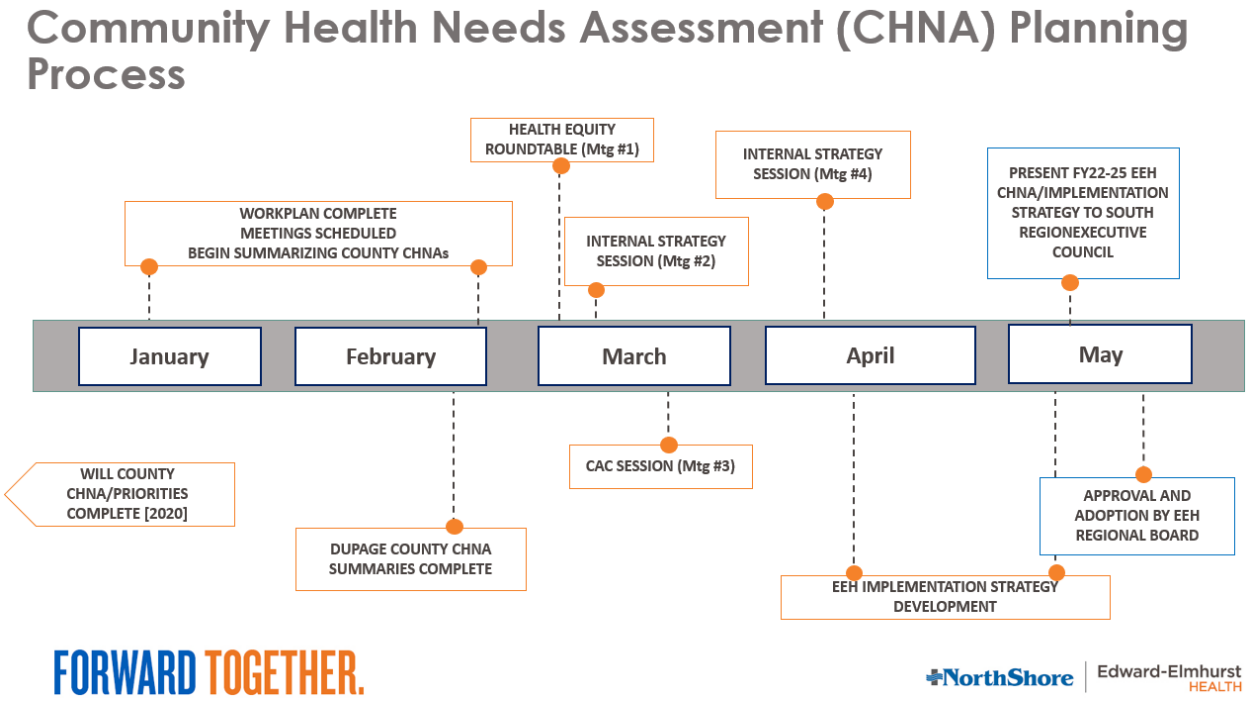
The MAPP process framework involves examining qualitative and quantitative analysis and performance against industry benchmarks and health outcome trends. From this process, areas of opportunity to improve health status were identified by each county, as summarized below. The areas of overlap between 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.