Endeavor Health℠

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

2025-2027 Implementation Strategy

Based on 2024 Community Health Needs Assessment





About Endeavor Health and NorthShore Hospitals

Mission

Help everyone in *our communities* *be their best.*

Vision

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

Values

Act with Kindness
Earn Trust
Respect Everyone
Build Relationships
Pursue Excellence

This Implementation Strategy (IS) pertains to NorthShore Hospitals, which is part of Endeavor Health. Please note that all Endeavor Health hospitals develop and release their own separate IS. This IS pertains to NorthShore Hospitals' 2024 Community Health Needs Assessment (CHNA) and is active for 2025-2027.

Endeavor Health's Mission

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

About Endeavor Health

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

About Endeavor Health NorthShore Hospitals

Endeavor Health NorthShore Hospitals (NorthShore), now representing Endeavor Health Evanston, Glenbrook, Highland Park and Skokie Hospitals, is an integrated healthcare delivery system headquartered in Evanston, Illinois. NorthShore is a Magnet recognized organization, the first in Illinois designated as a system to receive this prestigious honor that demonstrates nursing excellence. The system has a strong history of earning A's in the Leapfrog Hospital Safety Grades, recognizing the continuous commitment to patient safety. NorthShore also includes the NorthShore Hospitals Foundation, part of Endeavor Health, and is the primary teaching affiliate for the University of Chicago Pritzker School of Medicine.

Implementation Strategy Purpose and Development

Purpose of a Hospital's Implementation Strategy

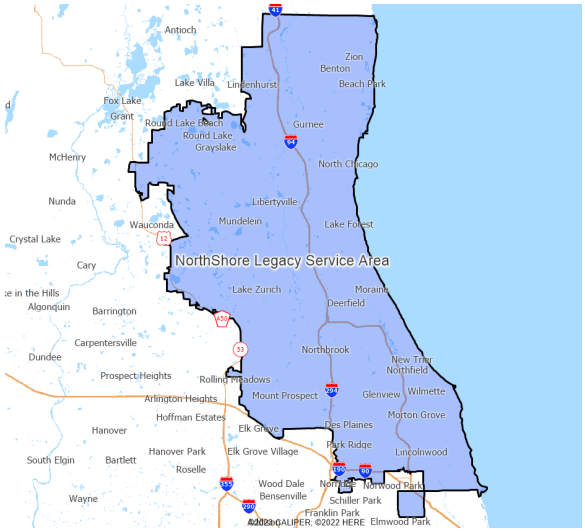
An Implementation Strategy (IS) outlines how a hospital plans to address community health needs and is intended to satisfy the requirements set forth by state law and the Internal Revenue Code Section 501(r)(3) regarding Community Health Needs Assessments (CHNA) and Implementation Strategy. The IS process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

Community Definition

The NorthShore service area is composed of 58 ZIP codes, with a total population of 1.7 million and includes 58 ZIP codes within Lake and Cook Counties in Illinois. This community definition was determined because most of NorthShore's patients originate from these areas.

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 and Chicago Communities: Arlington Heights, Buffalo Grove, Des Plaines, Evanston, Glencoe, Glenview, Golf, Kenilworth, Morton Grove, Mount Prospect, Niles, Northbrook/Techny, Prospect Heights, Skokie, Wheeling, Wilmette, Winnetka, Edgewater, Forest Glen, Irving Park, North Park, Norwood Park, Ravenswood, Rogers Park, Uptown, Lincolnwood, West Ridge



NorthShore Service Area						
60004	60031	60053	60073	60090	60625	60712
60005	60035	60056	60076	60091	60626	60714
60015	60037	60060	60077	60093	60631	60656
60016	60040	60061	60082	60096	60640	60068
60022	60043	60062	60083	60099	60641	
60025	60044	60064	60085	60201	60645	
60026	60045	60065	60087	60202	60646	
60029	60047	60069	60088	60203	60659	
60030	60048	60070	60089	60208	60660	

Source: Claritas Data from Environics Analytics ENVISION Tool

CHNA Implementation Strategy 2024 Development and Ongoing Review

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

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

Priority Needs Identified by the CHNA

Priority Needs and Foundational Commitments

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

Behavioral Health

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

Community Health and Wellness

(includes nutrition, physical activity, healthy body weight and food security)

Chronic Diseases

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

Cancer

(includes smoking/ tobacco cessation)

Access to Care

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

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

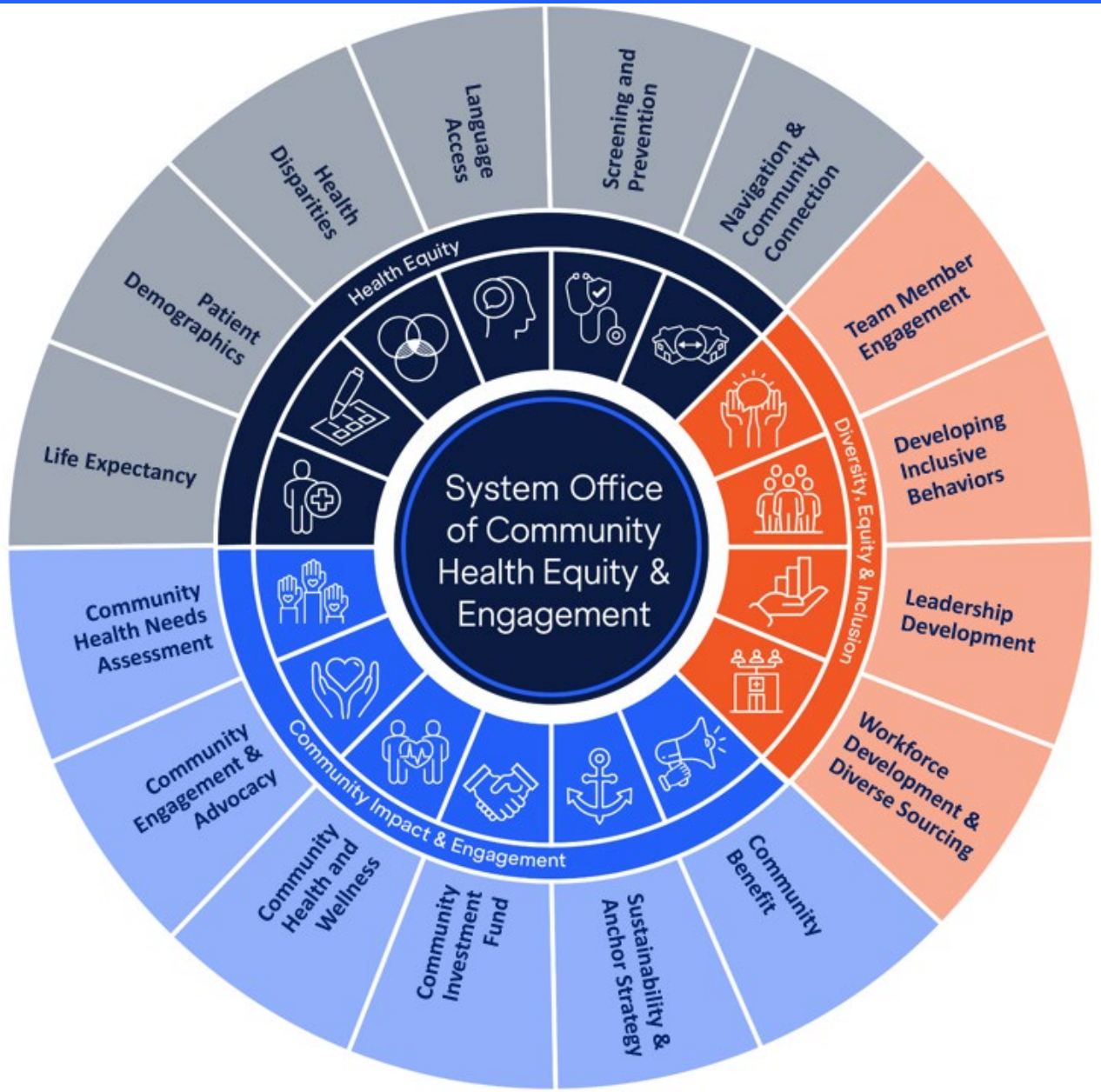
A Multidisciplinary Approach

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

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

Social Determinants of Health (SDOH)

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



Community Impact & Engagement

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

Community Engagement
We convene and connect people for collective impact.

Community Benefit
We demonstrate community impact.

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

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

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

Health Equity

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

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

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

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

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

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

Diversity, Equity & Inclusion

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

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

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

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

Systemwide Foundational Goals Embedded In All Priority Areas

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

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

Key
Systemwide Metric
Local Entity Metric

Priority Need: Behavioral Health
(includes mental health, substance use and access to treatment)

Strategy	Initiatives/Programs	Metrics and Goals	2025 Progress	2026 Progress	2027 Progress
Screenings and Access to Care	Provide standardized behavioral health inpatient placement for individuals in crisis via the ED Crisis Teams and Care Management Center.	# of individuals successfully placed for inpatient stay within Endeavor Health or other Illinois behavioral health treatment facilities 2025 Goal: 8,000			
	Offer free, confidential 24/7 telephone support to individuals needing behavioral health support and referrals (1-847-HEALING).	# of individuals who receive support and referrals via 24/7 telephone support lines 2025 Goal: 60,000			
	Provide school-based mental health assessments, medication management and psychotherapy for students (ex. Bridges Program).	# of students # of visits # of new assessments 2025 Goal: Establish baselines			
	Provide psychiatric services in person and virtually via Evanston Hospital's Community Health Center (CHC) for community members living within the CHC boundary area (ex. CHC, Phoenix Program).	# of patients # of visits # of new assessments 2025 Goal: Establish baselines			

Key
Systemwide Metric
Local Entity Metric

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

Strategy	Initiatives/Programs	Metrics and Goals	2025 Progress	2026 Progress	2027 Progress
Education and Outreach	Offer free wellness webinars focused on health education and living a healthy lifestyle.	# of participants % of survey respondents who learned something new 2025 Goal: Establish baselines			
	Provide digital health literacy education (including Endeavor MyChart portal) to community members via Simbulance outreach team.	# of participants 2025 Goal: Establish baseline			
	Offer education to providers on inclusive language to address the topic of obesity with patients.	# of participants 2025 Goal: Establish baseline			
	Provide outpatient nutrition counseling by a registered dietitian.	# of visits 2025 Goal: 700			

Key
Systemwide Metric
Local Entity Metric

Priority Need: Chronic Diseases
(includes heart disease/high blood pressure/stroke and diabetes)

Strategy	Initiatives/Programs	Metrics and Goals	2025 Progress	2026 Progress	2027 Progress
Support and Intervention	Support controlled hypertension (HTN) levels among Endeavor Health Medical Group (MG) patients.	% of adult MG patients with a HTN diagnosis with controlled HTN level (Controlled = BP<140/90) 2025 Goals: System: 78% NS: 76%			
	Support controlled levels of diabetes/A1C among MG patients.	% of adult MG patients with Type I or Type II diabetes with controlled diabetes/A1C levels (Controlled = A1C <8) 2025 Goals: System: 76% NS: 74%			
	Use the Lens of Equity Tool to identify populations and develop targeted interventions around chronic disease management.	% reduction in the disparity gap for MG target population. 2025: Target Population-African American HTN -Disparity Gap for Hypertension. 2025 Goals: System: 3.9% NS: 5.7%			
Education and Outreach	Provide health education and screenings at community events (Evanston Hospital Community Health Center staff).	# of events 2025 Goal: 6			
	Provide diabetes and nutrition education for community members and healthcare professionals.	# of outreach engagements 2025 Goal: 20			

Key
Systemwide Metric
Local Entity Metric

Priority Need: Cancer
(includes smoking/tobacco cessation)

Strategy	Initiatives/Programs	Metrics and Goals	2025 Progress	2026 Progress	2027 Progress
Screening and Early Detection	Utilize FIT Tests (fecal immunochemical test) for Endeavor Health Medical Group (MG) patients who have been recommended a colonoscopy screening and declined.	% of positive FIT Tests that have a colonoscopy scheduled within 90 days of receiving results 2025 Goals: System and NS: Establish baselines			
	Use Lens of Equity Tool to identify populations and develop targeted interventions around cancer screenings.	% cancer screening rate among MG target population 2025 Goals: Focus on breast cancer screenings for patients who live in lowest quartile for median family income. System: 81% NS: 81.5%			
Education and Support	Offer smoking cessation program to Kellogg oncology patients who use tobacco.	# of patients referred to smoking cessation program # of patients receiving follow up consultation 2025 Goal: Establish baselines			
	Offer oncology support groups for patients, family members and caregivers.	# of participants 2025 Goal: Establish baseline			
Education and Outreach	Provide community based cancer prevention, awareness and screening programs (ex. presentations, health fairs).	# of educational programs hosted by Endeavor and/or community partners 2025 Goal: Establish baseline			

Key
Systemwide Metric
Local Entity Metric

Priority Need: Access to Care

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

Strategy	Initiatives/Programs	Metrics and Goals	2025 Progress	2026 Progress	2027 Progress
Access to Healthcare and Community Resources	Deploy a team of Community Health Workers (CHW) to provide patient support which may include finding medical homes, scheduling appointments and screenings, addressing social determinants of health and referrals to other community resources.	# of patients supported 2025 Goal: System and NS: Establish baseline			
	Provide primary and specialty care to adults who lack private medical insurance via Evanston Hospital's Community Health Center.	# of patients 2025 Goal: 3,700			
	Provide oral healthcare services for medically underserved adult patients via the Dental Center at Evanston Hospital.	# of patients visits 2025 Goal: 3,000			
	Provide healthcare services, education and support to Evanston Township High School students via onsite Health Center.	# of students served 2025 Goal: 800			

Key
Systemwide Metric
Local Entity Metric

Key Collaborative Partnerships

Active Partnerships

NorthShore is committed to active and ongoing collaboration with local organizations addressing a variety of health and social needs. The hospital offers an array of community health and outreach programs designed to serve the needs of its diverse community, addressing health equity and various social determinants of health.

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.

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.

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.

Mental Health First Aid (MHFA) – NorthShore collaborated with Josselyn Center to provide community responder training and instructor training to local community organizations. The trainings expanded the number of MHFA instructor resources to teach community members how to identify and respond to mental health emergencies.

Erie HealthReach Waukegan Health Center – Erie HealthReach Waukegan partners with NorthShore to move their small hospital delivery team to Highland Park for high-risk pregnancy care. This partnership ensures community-focused, high-quality and affordable care with 24/7 access to OB/GYN physicians.

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

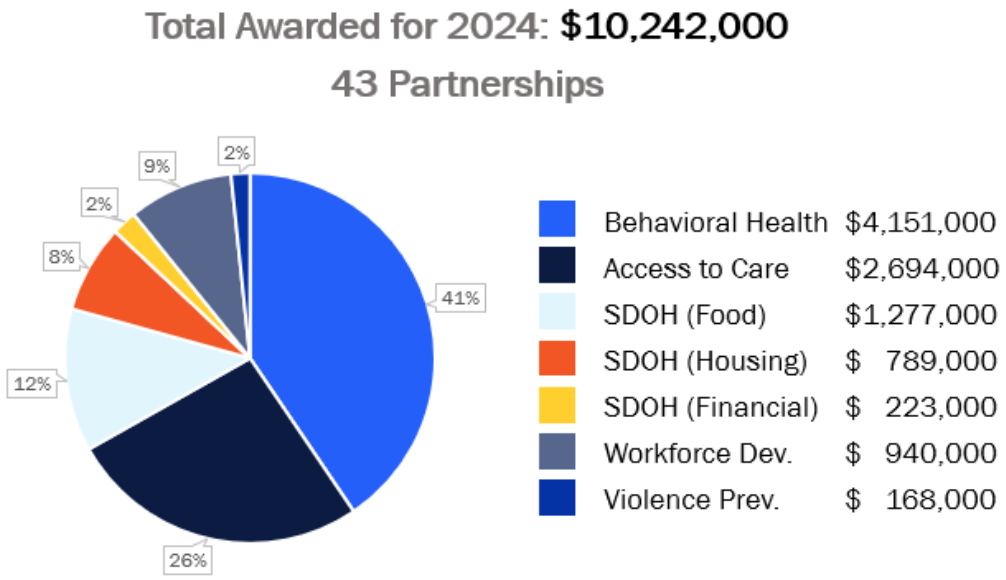
Community Advisory Committees – Each NorthShore hospital has a Community Advisory Committee (CAC) to ensure accountability to the communities they serve. These committees advise individual hospital administration on services and initiatives from a community perspective and identify community resources to 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

Endeavor Health Community Investment Fund

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

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



Current CIF Partners within NorthShore Community

ASPIRE
Community Workforce
Development Program

Lake County

ASPIRE
Community Workforce
Development Program

Information Gaps and Other Needs

Information Gaps

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

Other Significant Health Needs

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

Issue or Concern	Reason
Homelessness and Housing (adequate, affordable, safe)	In an effort to address affordable housing issues, NorthShore is a member of the Evanston Anchor Institutions Project. Additionally, NorthShore is currently providing funding through its Community Investment Fund to Connections for the Homeless and Lutheran Social Services of Illinois. Both of these organization have extensive experience and expertise with homelessness and are located within the hospitals' service area.
Transportation	Transportation has been identified as a regional issue impacting economic development, as well as access to care. To mitigate the challenges, NorthShore provides financial support to social service organizations, senior living facilities, townships and local villages to subsidize ride share as part of their existing resources. Additionally, parking, taxi or Lyft vouchers are provided for patients identified with transportation needs.
Dementia/Alzheimer's	NorthShore recognizes that the magnitude of this health condition requires action and collaboration on numerous levels to have measurable outcomes. Besides the clinical and health impacts, Dementia/Alzheimer's also provides caregiver, financial, transportation and aging in place challenges. Therefore, NorthShore Research Institute actively engages in research and clinical trials for Dementia & Alzheimer's to benefit patients as well as the community at large impacted by this degenerative disease.
Community Violence	Endeavor is a member of the Northwell Collaborative Gun Violence Prevention Learning Collaborative. At a health system level, NorthShore's Government Advocacy Department engages with elected officials on violence prevention issues. NorthShore also provides funding through its Community Investment Fund to organizations such as TASC (treatment alternatives to street crime) and ONE Northside to address root causes of violence in the community. Within the hospitals, NorthShore has trained Sexual Assault Nurse Examiners (SANE) to provide comprehensive care to sexual assault victims entering through the emergency departments, as well as an LCSW to provide resources to help victims. Additionally, NorthShore employs a Pathways Program coordinator who provides crucial support for patients experiencing domestic violence, human trafficking, and sexual assault.
Adults Aging in Place	NorthShore recognizes that the magnitude of this identified health need requires action and collaboration on numerous levels to have measurable outcomes. NorthShore provides financial support to social service organizations, senior living facilities, townships and local villages to subsidize ride share as part of their existing resources.

Implementation Strategy Approval and Publication

This Implementation Strategy has been reviewed and approved by NorthShore's Board of Directors on October 24, 2024.
NorthShore has taken an in-depth look at the needs and assets in the communities we serve, and we are committed to addressing those needs through implementation strategies in partnership with communities most impacted by health inequities. These strategies are in addition to millions of dollars of Charity Care and Medicaid/Medicare unreimbursed costs that NorthShore provides. We recognize that as a health system we cannot improve our community's health and wellbeing without the support of valued partners and community support.

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

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