Endeavor Health℠

Northwest Community Hospital

2025-2027 Implementation Strategy

Based on 2024 Community Health Needs Assessment

About Endeavor Health and Northwest Community Hospital

Mission

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

Vision

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

Values

Act with Kindness
Earn Trust
Respect Everyone
Build Relationships
Pursue Excellence

This Implementation Strategy (IS) pertains to Northwest Community Hospital, which is part of Endeavor Health.

Please note that all Endeavor Health hospitals develop and release their own separate IS. This IS pertains to Northwest Community Hospital's 2024 Community Health Needs Assessment (CHNA) and is active from 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 Northwest Community Hospital

Endeavor Health Northwest Community Hospital (NCH) has served Chicago's northwest suburbs since 1959. NCH houses a Level III NICU, Level II Trauma Center and a dedicated pediatric emergency department. It is also a Joint Commission-certified Comprehensive Stroke Center. In addition, the John M. Boler Center for Rehabilitation at NCH provides a comprehensive, 33-bed acute inpatient rehab unit with all private rooms. The center offers award-winning, personalized care aimed at ensuring a safe and independent transition back to the community. The NCH campus is home to the Wellness Center, a premier health and fitness center and spa, as well as a full-service, retail pharmacy.

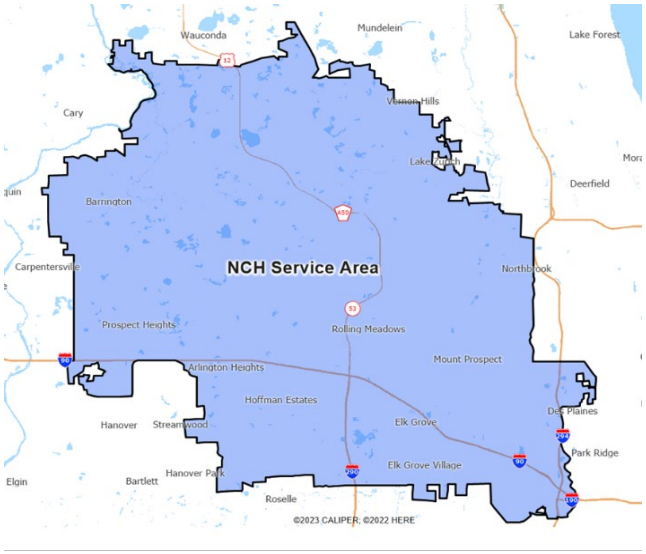
Implementation Strategy Purpose and Development

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

Community Definition

The NCH service area is composed of 33 ZIP codes, with a total population of nearly 660,000. NCH holds a vast geographical position, extending across multiple counties and encompassing a diverse range or socioeconomic profiles. The geographic footprint is illustrated in the following map along with a chart that lists the ZIP codes. This community definition was determined because most of NCH's patients originate from these areas.



NCH Service Area				
60004	60011	60056	60094	60192
60005	60016	60067	60095	60193
60006	60017	60070	60159	60194
60007	60018	60074	60168	60195
60008	60019	60078	60169	60196
60009	60038	60089	60173	
60010	60047	60090	60179	

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. NCH 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

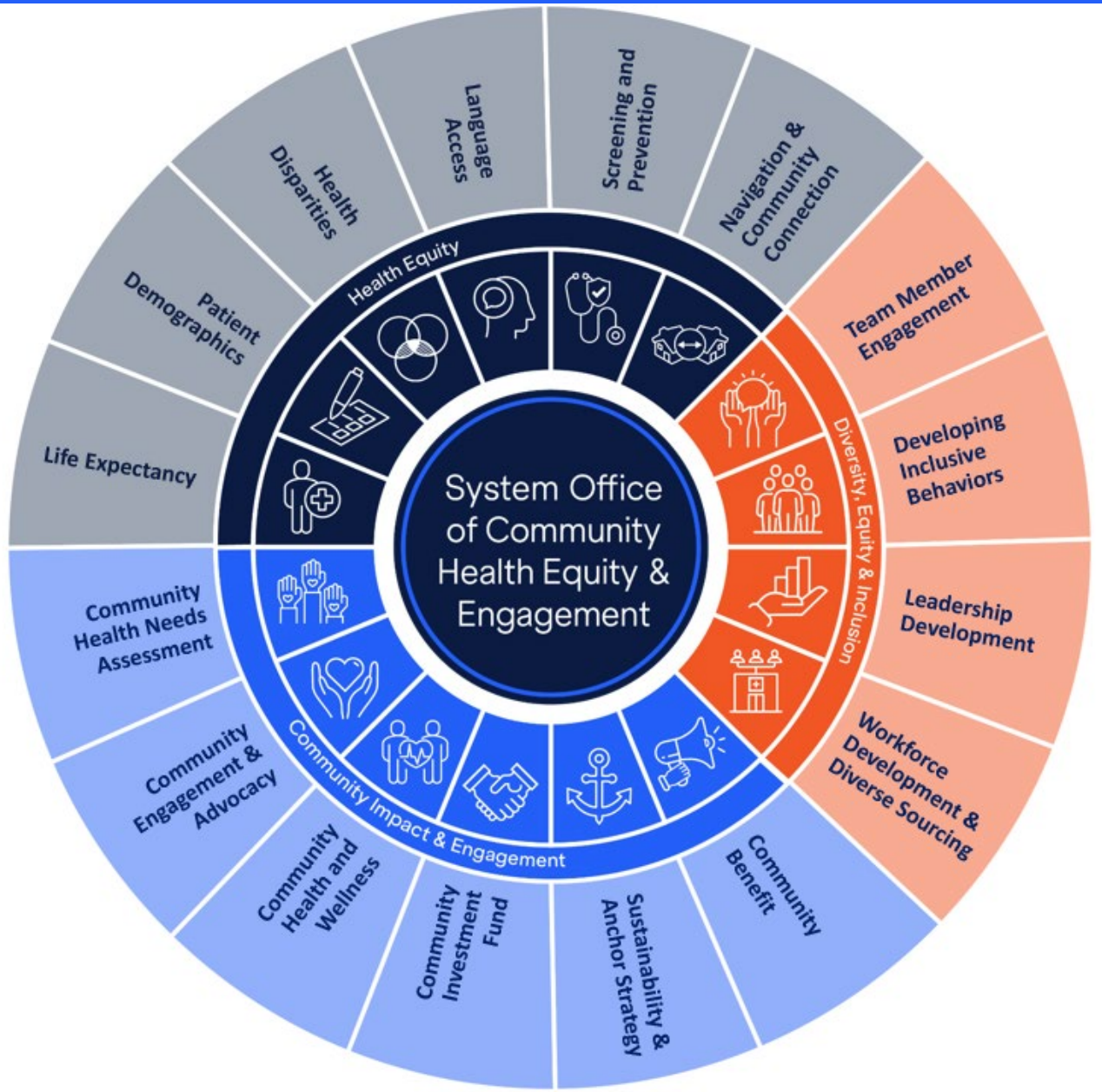
A Multidisciplinary Approach

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 NCH.

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			
	In-person and virtual behavioral health assessments for community members via Behavioral Health Assessment and Referral Center.	# of assessments completed 2025 Goal: 500			
	Patients referred by primary care physicians that receive behavioral health referrals and resources via Behavioral Health Navigation.	# of patients supported 2025 Goal: 2,500			

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			
Access to Physical Activity	Low-cost 60-day guided customized exercise program for individuals referred by physicians (MedFit Program).	# of enrollments 2025 Goal: 700			
Screenings and Prevention	Number of persons receiving workplace health and wellness preventative screenings to identify obesity and chronic disease risk factors.	# of screenings 2025 Goal: 700			
Access to Treatment	Offer physician-supervised medical weight loss program for adults.	# patients supported 2025 Goal: 1,000			

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% NCH: 78%			
	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% NCH: 80%			
	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% NCH: 3.9%			
	A comprehensive program which includes rehab exercising and education to improve heart health and reduce cardiovascular risk (Cardiac Rehab Program).	# of patients enrolled in the program 2025 Goal: 600 % of patients enrolled that complete at least 12 classes 2025 Goal: 85%			
Education and Support	Support group for stroke survivors to promote emotional healing and community-based risk factor assessments and education to identify and prevent strokes.	# of encounters 2025 Goal: 350			

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
Screenings and Early Detection	Utilize FIT Tests (fecal immunochemical test) for Endeavor Health Medical Group (MG) patients who have been recommended a colonoscopy screening and declined.	% of positive FIT Tests that have a colonoscopy scheduled within 90 days of receiving results 2025 Goals: System and NCH: 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% NCH: 76%			
	Lung cancer screenings for early detection and treatment.	# of patients screened 2025 Goal: 1,700			
	Provide free mammograms for uninsured women over 40.	# of women receiving mammograms 2025 Goal: 200			
Survivorship and Support	Provide financial assistance for cancer patients struggling to pay their rent, utilities and other living expenses.	$ of support provided 2025 Goal: $70,000			

Key
Systemwide Strategy
Local Entity Strategy

Priority Need: Access to Care

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

Strategy	Initiatives/Programs	Metrics and Goals	2025 Progress	2026 Progress	2027 Progress
Access to Healthcare and Community Resources	Deploy a team of Community Health Workers (CHW's) to provide patient support which may include finding medical homes, scheduling appointments and screenings, addressing social determinants of health and referrals to other community resources.	# of patients supported 2025 Goals: System: Establish baseline NCH: 425			
	Community nurses provide health education, screenings, assistance with chronic disease management and referrals to medical homes and other community resources.	# of client visits. 2025 Goal: 5,000			
	Atherton Heart Failure Clinic supports individuals with congestive heart failure regardless of ability to pay.	# of patient visits. 2025 Goal: 2,300			
	NCH Foundation subsidizes OB visits for under-resourced women at Greater Family Health, a local Federally Qualified Health Center (FQHC).	# of patient visits. 2025 Goal: 2,750			

Key
Systemwide Metric
Local Entity Metric

Key Collaborative Partnerships

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.

Community Resource Center (CRC) –NCH owns and financially supports this center, and the not-for-profit organization, Partners for Our Communities (POC), coordinates the services of the organizations housed in the CRC. POC 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 13 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 200,000 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

Mobile Dental Clinic –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 has a long-standing relationship with the University of Illinois College Of Dentistry (UIC COD) and recently partnered with Midwestern College of Dental Medicine-Illinois. Fourth-year dental student interns from both schools have monthly rotations and also provide dental care for MDC patients. Palatine, Elk Grove, and Wheeling Townships have been partners since the inception of the clinic, and they have continuously qualified the patients and provided financial support. Schaumburg Township joined as a partner in 2012. This Township collaboration has been successful for 21 years.

Senior Services - NCH's dedicated Senior Services Specialist works closely with the Arlington Heights and Palatine Senior Centers to address the unique healthcare needs of older adults in the community. Health education lectures, screenings and programs such as Ask the Nurse, Parkinson's Exercise Class, Diabetes Support Group, Walkers Club and Healthy Cooking Demos are held at the hospital and the local senior centers on a regular basis.

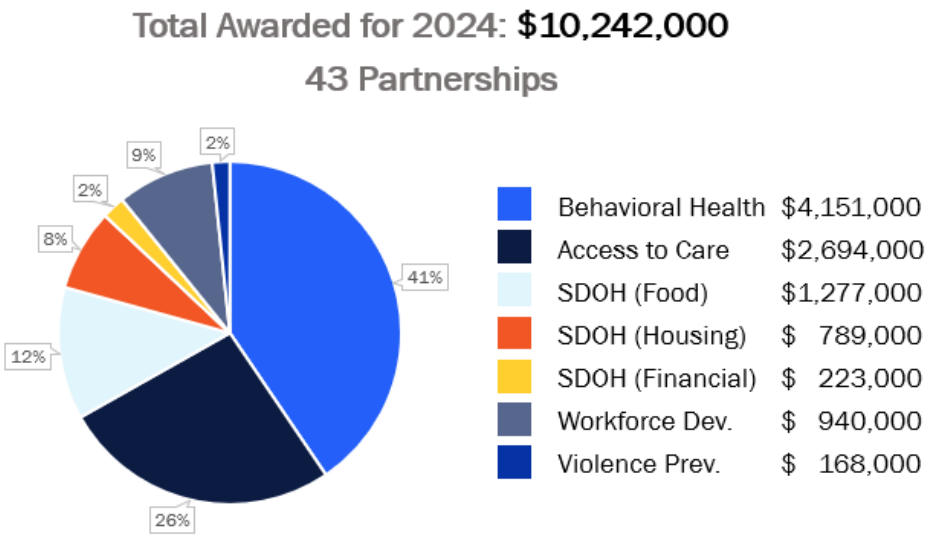
Domestic Violence - NCH partners with WINGS (Women in Need Growing Stronger), a local domestic violence organization, to provide a hospital-based domestic violence response program. WINGS at NCH provides support services, including individual counseling, domestic violence education, resources and referral information for victims of domestic violence. The partnership also provides continuing education for the hospitals physicians and staff.

Community Investment Fund

Endeavor Health Community Investment Fund

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

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



Current CIF Partners Serving Northwest Community Hospital Service Area

Kenneth Young Center

POC Partners for Our Communities
Empower people and change lives

Protecting Children • Strengthening Families • Transforming Communities
Shelter, Inc.

Information Gaps and Other Needs

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.

Other Significant Health Needs

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. NCH 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)	NCH works closely with Journey's the Road Home, a local not-for-profit organization that has extensive experience and expertise with homelessness and is located in the hospitals service area. NCH provides Journeys with an annual financial contribution. NCH Social Workers have direct linkages with organizations that address affordable housing.
Older Adults Aging In Place	NCH recognizes that its service area is comprised of many older adults and wants to work collaboratively with other organizations to address their unique health and wellness needs. NCH has a dedicated Senior Services Specialist and is a member of the "Community Wrap Around Committee" facilitated by Catholic Charities, which is dedicated to supporting older adults.
Racism/Other Discrimination	NCH has a Diversity, Equity and Inclusion (DEI) Steering Committee focused on ensuring equitable policies and practices for employees, patients, visitors and community members. There is also an internal DEI Council comprised of NCH employees that focus on internal employee-focused priorities. In addition, Endeavor Health has a system-wide Health Equity Team that is focused on broader issues.
Community Violence	NCH partners and provides financial support to a number of not-for-profit organizations that address community violence including: The Children's Advocacy Center, Northwest Center Against Sexual Assault, Women In Need Growing Stronger. In addition, Endeavor Health is a member of the Northwell Collaborative Gun Violence Prevention Learning Collaborative for Health Systems and Hospitals.

Implementation Strategy Approval and Publication

This Implementation Strategy was reviewed and approved by the Northwest Community Hospital's Board of Directors on October 28, 2024. NCH 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 NCH 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 is 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.