Endeavor Health

2024

Community Health Needs Assessment

Swedish Hospital

Endeavor Health Swedish Hospital
2024 Community Health Needs Assessment

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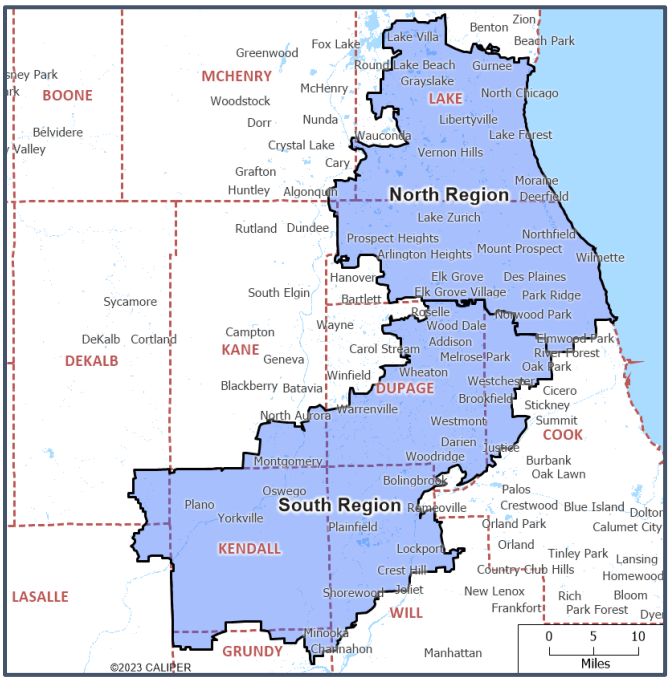
Overview: Community Health Needs Assessment

In 2024, Endeavor Health Swedish Hospital conducted a comprehensive Community Health Needs Assessment (CHNA) to identify and prioritize key health issues of the surrounding communities. Endeavor Health conducted this CHNA as part of a simultaneous, system-wide approach to our four CHNAs across the Endeavor Health service area. The insights gained through this assessment will guide the development of an implementation strategy to address priority concerns from 2025-2027.

About Endeavor Health

Endeavor HealthSM 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).

The Endeavor Health service area is composed of 171 ZIP codes across nearly 75 miles, with a total population of nearly 4.2 million.

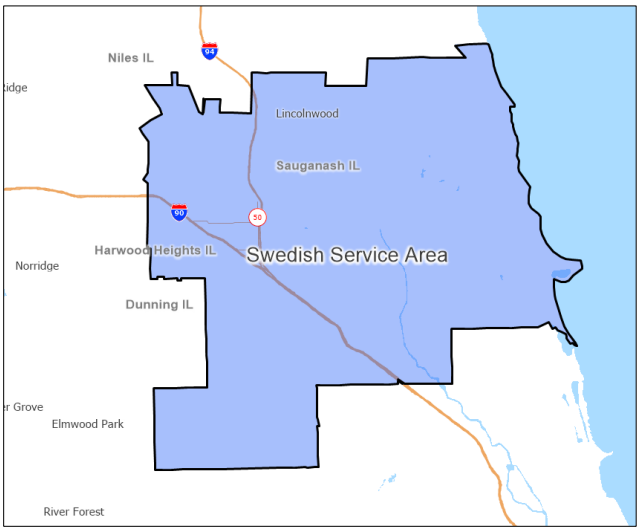


About Endeavor Health Swedish Hospital

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

Our Service Area

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



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

Source: Claritas Data from Environics Analytics ENVISION Tool

Service Area Demographics

Population by Age Group

The Swedish service area population is projected to decrease slightly over the next five years.

The highest utilizers of health care services are patients 65 and over, and this age group is expected to grow 11.7% over the next five years. The number of residents in age group 0-17 and 18-44 is expected to decrease 3.5% and 6.0% respectively, while age group 45-64 will increase 4.4%.

Age Group	2024 Population	% of Total	2029 Population	% of Total	% Change
0-17	129,688	18.6%	125,137	18.1%	-3.5%
18-44	301,154	43.3%	283,030	40.9%	-6.0%
45-64	167,766	24.1%	175,085	25.3%	4.4%
65 and over	97,616	14.0%	109,075	15.8%	11.7%
Total Swedish Service Area	**696,224**	**100.0%**	**692,327**	**100.0%**	**-0.6%**

Source: Claritas Data from Environics Analytics ENVISION Tool

Population by Gender

The male population in the Swedish service area is slightly higher than the female population and is projected to decline slightly along with the female population over the next five years.

Gender	2024 Population	% of Total	2029 Population	% of Total	% Change
Female	347,530	49.9%	345,638	49.9%	-0.5%
Male	348,694	50.1%	346,689	50.1%	-0.6%
Total Swedish Service Area	**696,224**	**100.0%**	**692,327**	**100.0%**	**-0.6%**

Source: Claritas Data from Environics Analytics ENVISION Tool

Population by Ethnicity/Race

The Swedish service area is primarily Non-Hispanic/Latino White (42%) but also has substantial Hispanic/Latino population (34%). The Hispanic/Latino population is projected to grow nearly 5% over the next five years, while Non-Hispanic/Latinos are projected to decrease 3% driven by Non-Hispanic/Latino White.

Ethnicity/Race	2024 Population	% of Total	2029 Population	% of Total	% Change
Hispanic/Latino	**239,561**	**34.4%**	**250,500**	**36.2%**	**4.6%**
White Alone	36,044	5.2%	37,207	5.4%	3.2%
Black/African American Alone	3,027	0.4%	3,124	0.5%	3.2%
American Indian/Alaskan Native Alone	9,205	1.3%	9,783	1.4%	6.3%
Asian Alone	1,091	0.2%	1,128	0.2%	3.4%
Native Hawaiian/Pacific Islander Alone	160	0.0%	160	0.0%	0.0%
Some Other Race Alone	124,203	17.8%	129,279	18.7%	4.1%
Two or More Races	65,831	9.5%	69,819	10.1%	6.1%
Non-Hispanic/Latino	**456,663**	**65.6%**	**441,827**	**63.8%**	**-3.2%**
White Alone	291,266	41.8%	276,646	40.0%	-5.0%
Black/African American Alone	63,540	9.1%	63,449	9.2%	-0.1%
American Indian/Alaskan Native Alone	1,047	0.2%	981	0.1%	-6.3%
Asian Alone	73,203	10.5%	71,464	10.3%	-2.4%
Native Hawaiian/Pacific Islander Alone	140	0.0%	118	0.0%	-15.7%
Some Other Race Alone	3,731	0.5%	3,554	0.5%	-4.7%
Two or More Races	23,736	3.4%	25,615	3.7%	7.9%
Total Swedish Service Area	**696,224**	**100.0%**	**692,327**	**100.0%**	**-0.6%**

Source: Claritas Data from Environics Analytics ENVISION Tool

25+ Population by Education Level

There is a small growth projected in nearly all education levels within the service area over the next five years. “Greater than Bachelor’s Degree” level is expected to slightly decline.

Education Level (Age 25+)	2024 Population	% of Total	2029 Population	% of Total	% Change
Less than High School	41,222	8.1%	41,322	8.0%	0.2%
Some High School	26,770	5.2%	27,120	5.3%	1.3%
High School Graduate	94,292	18.5%	95,497	18.6%	1.3%
Some College/Assoc. Degree	104,834	20.5%	106,281	20.7%	1.4%
Bachelor's Degree	147,100	28.8%	147,405	28.7%	0.2%
Greater than Bachelor's Degree	96,052	18.8%	95,842	18.7%	-0.2%
Total Swedish Service Area	**510,270**	**100.0%**	**513,467**	**100.0%**	**0.6%**

Source: Claritas Data from Environics Analytics ENVISION Tool

Unemployment

The unemployment rate in the Swedish service area is 0.6% less than Illinois and 0.5% above Endeavor Health service area. Unemployment rates are projected to grow about 1% by 2027 in the Swedish service area, Endeavor Health service area and Illinois.

Service Area	2022 Unemployment Rate	2027 Unemployment Rate	% Change
Swedish Service Area	**4.2%**	**5.5%**	**1.3%**
Endeavor Health Service Area	3.7%	4.6%	0.9%
Illinois	4.8%	5.9%	1.1%

Source: Claritas Data from Environics Analytics ENVISION Tool

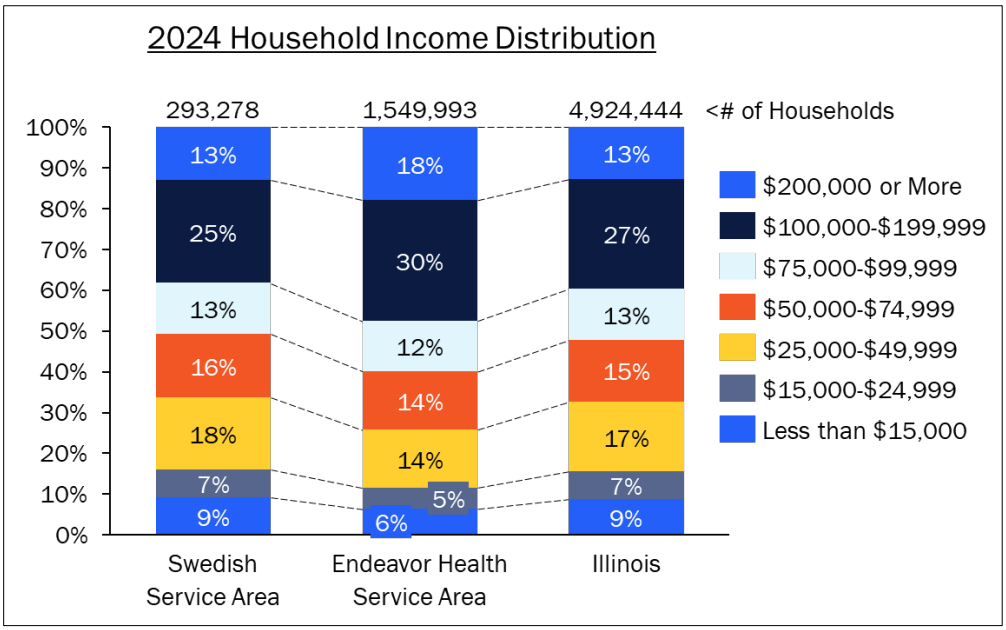
Households by Income Level

The number of households in upper income brackets ($100,000+ annual income) is projected to increase while all lower income brackets are projected to decrease. The average household income in the Swedish service area is $110,620 while the median household income is $76,189.

Household Income	2024 Households	% of Total	2029 Households	% of Total	% Change
Less than $15,000	27,347	9.3%	25,124	8.5%	-8.1%
$15,000 - $24,999	19,606	6.7%	18,195	6.2%	-7.2%
$25,000 - $49,999	52,219	17.8%	48,314	16.4%	-7.5%
$50,000 - $74,999	45,525	15.5%	43,557	14.8%	-4.3%
$75,000 - $99,999	36,675	12.5%	35,773	12.1%	-2.5%
$100,000 - $199,999	73,809	25.2%	77,961	26.5%	5.6%
$200,000 or more	38,097	13.0%	45,602	15.5%	19.7%
Total Swedish Service Area	**293,278**	**100.0%**	**294,526**	**100.0%**	**0.4%**

Source: Claritas Data from Environics Analytics ENVISION Tool

The chart below summarizes household income distribution of the Swedish service area, Endeavor Health service area and Illinois. Household income levels in the Swedish area are less than Illinois for households making $100,000 or more but are projected to increase and exceed Illinois over the next five years. Note that 34% of households in the Swedish service area have a household income of less than $50,000 – compared to 25% within the Endeavor Health service area and 33% within Illinois overall.

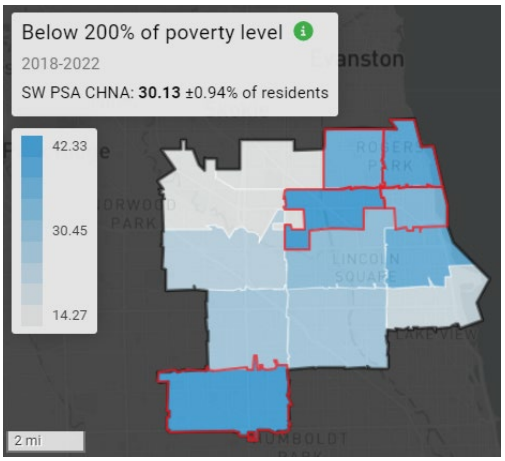


Source: Claritas Data from Environics Analytics ENVISION Tool

Poverty – Population 200% Below Poverty Level

Residents within the Swedish service area living below 200% of the poverty level are greater than the Endeavor Health service area as well as Illinois overall. Additionally, some ZIP codes in Swedish's service area have as high as 42.3% of residents living below 200% of the poverty level.

	SW Service Area	Endeavor Health Service Area	Illinois
% of Residents Below 200% of Poverty Level	30.3%	20.5%	26.2%



SW ZIP Codes with Largest Percentage of Residents Below 200% Poverty Line		
ZIP Code	City/Town	% of Residents Below 200% of Poverty Level
60639	Chicago, Belmont Cragin	42.3%
60659	Chicago, West Ridge	41.9%
60626	Chicago, Rogers Park	38.1%
60645	Chicago, West Ridge	36.9%
60640	Chicago, Uptown	32.5%

Source: American Community Survey 2017-2021

Insurance Status – Population Insurance Rates by Payor Type

The percentage of uninsured residents in the Swedish service area is higher than both the Endeavor Health service area and the Illinois average and ranges from 5.4% to 16.8%, an indicator of the disparities that exist within the communities we serve.

ZIP Code	City	Uninsured	Direct Purchase Health Insurance	Employment-Based Insurance	Medicare	Medicaid	Tricare/Military Insurance
60639	Chicago, Belmont Cragin	16.8%	6.6%	41.7%	14.5%	31.1%	0.3%
60625	Chicago, Lincoln Square	15.2%	10.0%	54.2%	10.0%	19.6%	0.3%
60641	Chicago, Portage Park	14.6%	9.6%	52.7%	12.0%	21.7%	0.3%
60659	Chicago, West Ridge	14.1%	8.6%	40.8%	14.1%	35.4%	0.1%
60645	Chicago, West Ridge	13.8%	11.1%	46.0%	14.5%	29.2%	0.4%
60626	Chicago, Rogers Park	13.5%	10.8%	53.5%	11.9%	20.8%	0.7%
60618	Chicago, North Center	10.5%	9.9%	64.9%	9.2%	13.4%	0.3%
60660	Chicago, Edgewater	9.9%	13.0%	58.6%	14.8%	17.1%	0.5%
60640	Chicago, Uptown	8.4%	12.9%	57.6%	13.5%	20.8%	0.5%
60630	Chicago, Gladstone Park	8.1%	12.5%	61.2%	16.6%	14.3%	0.5%
60712	Lincolnwood, IL	6.6%	21.4%	50.9%	29.6%	16.8%	0.5%
60613	Chicago, Lakeview	5.5%	12.4%	74.8%	9.3%	7.2%	0.3%
60646	Chicago, South Edgebrook	5.4%	15.9%	66.4%	18.9%	11.4%	0.2%

Uninsured Rates	
SW Service Area	11.7%
Endeavor Health Service Area	7.5%
Illinois	6.6%

Source: American Community Survey 2017-2021

Medicaid Rates	
SW Service Area	20.4%
Endeavor Health Service Area	14.5%
Illinois	20.2%

Source: American Community Survey 2017-2021

Language – Population with Limited English Proficiency

The percentage of residents with limited English proficiency in the Swedish service area is higher than both the Endeavor Health service area and the Illinois average and ranges from 2.8% to 18.4%, an indicator of the disparities that exist within the communities we serve.

ZIP Code	City	% of Residents with Limited English Proficiency
60639	Chicago, IL – Belmont Cragin	18.4%
60641	Chicago, IL – Portage Park	11.8%
60659	Chicago, IL – West Ridge	11.0%
60625	Chicago, IL – Lincoln Square	10.9%
60645	Chicago, IL – West Ridge	9.1%
60630	Chicago, IL – Gladstone Park	8.3%
60618	Chicago, IL – North Center	8.1%
60660	Chicago, IL – Edgewater	6.2%
60626	Chicago, IL – Rogers Park	5.7%
60640	Chicago, IL – Uptown	5.4%
60712	Lincolnwood, IL	4.8%
60646	Chicago, IL – South Edgebrook	4.0%
60613	Chicago, IL – Lakeview	2.8%

% of Residents with Limited English Proficiency	
SW Service Area	9.1%
Endeavor Health Service Area	5.6%
Illinois	3.9%

Source: American Community Survey 2017-2021

Top 5 Languages at Swedish
Spanish
Arabic
Korean
Vietnamese
Russian

Source: LanguageLine 2023 utilization, top languages requested for interpretation at Swedish Hospital

Existing Healthcare Facilities and Resources

Swedish Hospital and the broader Endeavor Health system 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, which is not a comprehensive list:

- Acute-Care Hospitals/Emergency Departments
  - Advocate Illinois Masonic
  - Advocate Lutheran General
  - Ascension Resurrection
  - Ascension St. Francis
  - Ascension St. Joseph
  - Community First Medical Center
  - Thorek
  - Weiss

- Federally Qualified Health Centers and Other Safety Net Providers
  - Asian Human Services Family Health Center
  - Erie Family Health
  - Hamdard Health Alliance
  - Howard Brown Health
  - Tapestry 360 Health
  - Midwest Refuah Health Center
  - American Indian Health Service of Chicago

- Immediate/Urgent Care Centers
  - Advocate Clinic at Walgreens
  - Advocate Medical Group Immediate Care
  - Alliance Immediate and Primary Care
  - Metro Urgent Care
  - Midwest Express Clinic
  - Northwestern Medicine Immediate Care
  - Physicians Immediate Care

- Behavioral Health Services/Facilities
  - Advocate Behavioral Health Services
  - Community Counseling Centers of Chicago (C4)
  - Compass Health
  - Howard Brown Health Counseling Center
  - The Kedzie Center
  - Lutheran Social Services of Illinois
  - Rincon Family Services
  - Rockwell Behavioral Health
  - Thresholds
  - Trilogy Behavioral Healthcare

- Turning Point

CHNA Goals and Objectives

The 2024 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 prioritizing these individuals may then be developed to address 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 and Insights

Primary and secondary data from a variety of sources were used for robust data analysis and to identify community health needs within the Swedish service area.

Primary data for the CHNA was collected through three methods:

- Community health surveys
- Key informant surveys
- Focus groups with under-resourced populations

Secondary data for the CHNA included:

- Demographic information
- Public health data

Primary Data Collection

Community Health Survey

Swedish Hospital developed a comprehensive online community health survey to accept input from people who represent the broad interests of the community served by the hospital. The survey, available in English and Spanish, 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 health concern for the community. Community members who live in the

hospital's service area were invited to participate in the online survey through social media, a system leader newsletter, and various emails to Swedish's donors, volunteers, employees and patients. The survey link, located on Endeavor Health's website (endeavorhealth.org/survey), was open March 25 – April 8, 2024 and 881 people in Swedish's service area responded. The tables below summarize survey respondent demographics and key insights. To view the full survey, please see appendix.

DEMOGRAPHICS – COMMUNITY HEALTH SURVEY	
Age	**Percent**
18-24	1.1%
25-34	8.2%
35-44	12.4%
45-54	11.9%
55-64	19.0%
65-74	28.9%
75+	14.6%
Prefer not to answer	3.9%
Gender	**Percent**
Female	65.4%
Male	29.9%
Prefer not to answer	2.2%
Another gender identity	1.0%
Non-binary	0.8%
Transgender	0.7%
Gender fluid	0.1%
Race/Ethnicity	**Percent**
White	68.9%
Asian	7.4%
Latino(a)/Hispanic	8.5%
African American/Black	2.5%
Middle Eastern/Arab American or Persian	0.9%
American Indian or Alaskan Native	0.2%
Pacific Islander or Hawaiian Native	0.1%
Prefer not to answer	5.8%
Two or more races/ethnicities	3.5%
Another race or ethnicity	2.2%
Education	**Percent**
Master's or Doctorate degree	40.0%
Bachelor's degree	31.2%
Some college, no degree	12.0%
High school graduate (includes equivalency)	5.8%
Associate's degree	5.0%
Prefer not to answer	2.4%
Other	1.1%

Vocational/trade school certificate	1.1%
Less than high school graduation	1.4%
Household Income	**Percent**
Less than $10,000	3.4%
$10,000 to $19,999	3.9%
$20,000 to $39,999	9.2%
$40,000 to $59,999	10.9%
$60,000 to $79,999	10.9%
$80,000 to $99,999	10.4%
$100,000 to $199,999	20.1%
Over $200,000	10.3%
Prefer not to answer	20.9%
Current Health Insurance Status	**Percent**
Private/commercial insurance	44.5%
Medicare	30.2%
Health insurance purchased from the ACA Marketplace	4.3%
Medicare and Medicaid (DUAL)	4.4%
Medicaid	4.4%
Uninsured	1.4%
Government/VA	0.6%
Other	6.8%
Prefer not to answer	3.4%
Dental Insurance	**Percent**
Yes	68.3%
No	29.3%
Prefer not to answer	2.4%
Sexual Orientation	**Percent**
Straight/Heterosexual	81.0%
Gay or lesbian	6.7%
Prefer not to answer	4.7%
Bisexual	4.3%
Another sexual orientation	1.2%
Asexual	1.0%
Pansexual	1.0%
Household includes individual with a physical, mental or intellectual disability	**Percent**
Yes	23.2%

No	71.4%
Prefer not to answer	5.4%

Key Insights – Community Health Survey

Top 12 Areas of Concern Ranked by Community Survey Participants	Area of Focus	Percent Ranking as a Major or Moderate Concern
Community Violence	Social Determinants of Health/Other Concerns	88%
Heart Disease, High Blood Pressure, Stroke	Chronic Diseases/Other Health Issues	86%
Mental Illness (incl depression, anxiety and others)	Behavioral Health	85%
Cancer	Chronic Diseases/Other Health Issues	84%
Financial Instability	Social Determinants of Health/Other Concerns	83%
Physical Activity (lack of exercise)	Modifiable Risk Behavior	83%
Dementia/Alzheimer's	Chronic Diseases/Other Health Issues	82%
Nutrition (choosing healthy foods)	Modifiable Risk Behavior	82%
Domestic Violence	Social Determinants of Health/Other Concerns	81%
Homelessness	Social Determinants of Health/Other Concerns	81%
Diabetes/Pre-Diabetes	Chronic Diseases/Other Health Issues	81%
Adequate/Affordable/Safe Housing	Social Determinants of Health/Other Concerns	80%

Key Informant Survey

An additional online survey was implemented as part of the CHNA process specifically to solicit input from key informants. Key informants are defined as 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.

On March 4, 2024, the hospital President sent an email to the key informants to explain the purpose of the survey and invite them to participate. A direct link to the survey, which remained open until March 18, 2024, was also included. A reminder email was sent on March 14, 2024 to encourage participation. The key informants were asked the same questions as the community, focused on access to care, behavioral health, chronic disease/health issues, modifiable risk factors/behaviors and Social Determinants of Health and other concerns. It also asked them to rank their "top health concern" for the community. A total of 26 surveys were completed at Swedish's invitation. The Key Informant Survey was modeled off of the Community Survey (located in appendix), with minimal variations.

Key Informant Survey		
Key Informant Type	**Organizations Invited to Participate**	**Number Invited**
Faith Based Leaders	The Chicago Center	1

Public Health Experts	Chicago Dept of Public Health, Howard Brown Health, Alliance for Health Equity, Partners in Health	13
Physicians	Swedish Hospital, Asian Human Services Family Health Center, Howard Brown Health, Muslim Community Center, The Kedzie Center	6
Other Health Providers	Swedish Hospital, Tapestry 360 Health	6
Community/ Business Leader/Elected Officials	Chicago Police Department, Edgebrook Sauganash Chamber of Commerce, Andersonville Chamber of Commerce, Chicago Public Schools, North Park University, Northeastern Illinois University, One Northside, Polish National Alliance, State Senator and Representatives, Local Aldermanic Offices	30
Health Administrator or Other Health Professional	Swedish Hospital, Erie Family Health, Hamdard Health, Midwest Refuah Health Center, American Indian Health Center	9
Social Service Agencies	The Friendship Center, HANA Center, STOP-It, Resilience, Rohingya Culture Center, Lutheran Social Services of Illinois, Between Friends, Neighborhood Boys and Girls Club, ICNA Relief, Family Matters, Community Counseling Centers of Chicago, Thresholds, Apna Ghar, Common Pantry, Girl Forward, North River Commission, Hanul Family Alliance, Heartland Alliance International, South East Asia Center, World Relief	23
Total		88

Through this process, input was gathered from individuals whose organizations work with low-income populations, minority populations or other medically underserved populations (including the disabled, the elderly, the homeless, Medicaid/Medicare beneficiaries, the mentally ill, pregnant teens, substance abusers, undocumented individuals, veterans and uninsured/underinsured residents).

Demographics of Key Informant Survey Participants		
Profession	**Count**	**Percent**
Community/Business Leader/Elected Official	2	7.7%
Social Service Representative	6	23.1%
Health Administrator or Other Health Professional	9	34.6%
Other Health Provider	2	7.7%
Public Health Expert	1	3.8%
Physician	3	11.5%
Faith Based Leader	1	3.8%
Other	2	7.7%
Year of Professional Experience	**Count**	**Percent**
1-5 years	8	30.8%
6-10 years	5	19.2%

11-15 years	6	23.1%
16+ years	5	19.2%
Grand Total	26	100%
Work with Vulnerable Populations	**Count**	**Percent**
Yes	25	96.2%
No	1	3.8%
Grand Total	26	100%
Age	**Count**	**Percent**
25-34	0	0%
35-44	9	34.6%
45-54	9	34.6%
55-64	4	15.4%
65-74	1	3.8%
Prefer not to answer	3	11.5%
Grand Total	26	100%
Race/ Ethnicity	**Count**	**Percent**
White	11	42.3%
Latino(a)/Hispanic	4	15.4%
Asian	3	11.5%
Middle Eastern/Arab American/Persian	1	3.8%
Another race or ethnicity	1	3.8%
Two or more races/ethnicities	3	11.5%
Prefer not to answer	3	11.5%
Grand Total	26	100%

Key Insights – Key Informant Health Survey

Top 12* Areas of Concern Ranked by Key Informant Survey Participants	Area of Focus	Percent Ranking as a Major or Moderate Concern
Mental Illness	Behavioral Health	100%
Adequate/Affordable/Safe Housing	Social Determinants of Health/Other Concerns	100%

Nutrition (choosing healthy food)	Modifiable Risk Behavior	93%
Physical Activity (lack of exercise)	Modifiable Risk Behavior	92%
Diabetes/Pre-Diabetes	Chronic Diseases/Other Health Issues	92%
Older Adults Ability to Age in Place (stay in home)	Social Determinants of Health/Other Concerns	92%
Cancer	Chronic Diseases/Other Health Issues	89%
Adequate Employment Opportunities	Social Determinants of Health/Other Concerns	88%
Community Violence	Social Determinants of Health/Other Concerns	88%
Heart Disease/High Blood Pressure/Stroke	Chronic Diseases/Other Health Issues	88%
Alcohol Use	Behavioral Health	85%
Obesity-Adults	Chronic Diseases/Other Health Issues	85%
Smoking/Tobacco (includes vaping)	Modifiable Risk Behavior	85%
Child Abuse	Social Determinants of Health/Other Concerns	85%
Domestic Violence	Social Determinants of Health/Other Concerns	85%
Food Insecurity (ability to access healthy foods)	Social Determinants of Health/Other Concerns	85%
Homelessness	Social Determinants of Health/Other Concerns	85%

*includes more than top 12 due to several priorities tied at 85%

Focus Groups

Swedish Hospital recognized the importance of gathering opinions and feedback from under-resourced populations in the community who have some of the greatest healthcare needs. Independent moderators were identified to conduct two focus groups, one with Spanish- speaking under-resourced community members and one with English-speaking under-resourced community members. These focus groups were held at The Friendship Center and Centro Romero in Chicago, located within the hospital's primary service area. Potential participants were given a short screening questionnaire to verify they lived in the hospital's service area and to ensure that participants selected would vary in age, gender, insurance status, income and educational levels, to the extent possible. The focus groups followed a guideline which mirrored questions included in the community and key informant surveys (Community Survey included in appendix) 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.

Demographics of Community Focus Group Participants		
	English Focus Group	Spanish Focus Group
# of Participants	9	12
Age		
0-17	0%	0%
18-24	0%	33%
25-34	0%	33%
35-44	0%	8%
45-54	11%	17%
55-64	22%	8%
65-74	56%	0%
75+	11%	0%
Grand Total	100%	100%
Gender		
Female	67%	50%
Male	33%	50%
Grand Total	100%	100%

Race		
White	44%	0%
Latino(a)/Hispanic	22%	100%
Black/African American	33%	0%
Grand Total	100%	100%
Primary Language Spoken in the Home		
Spanish	0%	100%
English	100%	0%
Grand Total	100%	100%
Annual Household Income		
$0-$15,000	33%	100%
$15,001-$30,000	44%	0%
$30,001-$45,000	0%	0%
$45,001-$60,000	11%	0%
$60,000 or more	11%	0%
Grand Total	100%	100%
Current Health Insurance Status		
Medicaid	11%	0%
Uninsured	11%	100%
Medicare	78%	0%
Grand Total	100%	100%
Highest Level of Education		
Never attended school or Kindergarten only	0%	0%
Grades 1-8 (elementary)	0%	8%
Grades 9-11 (some high school)	0%	17%
Grade 12 or GED (high school graduate)	22%	25%
Some College (1-3 yrs.) or Technical School	22%	42%
Bachelor's Degree (college graduate)	33%	8%
Postgraduate Degree (Master's, Doctorate)	22%	0%
Grand Total	100%	100%

Key Insights – Focus Groups

Top 12* Areas of Concern Ranked by Focus Group Participants (English Group)	Area of Focus	Percent Ranking as a Major or Moderate Concern
Mental Illness	Behavioral Health	100%
Suicide	Behavioral Health	100%
Alcohol Use	Behavioral Health	100%
Diabetes/Pre-Diabetes	Chronic Diseases/Other Health Issues	100%
Heart Disease/High Blood Pressure/Stroke	Chronic Diseases/Other Health Issues	100%
HIV/AIDS/Sexually Transmitted Diseases	Chronic Diseases/Other Health Issues	100%
Obesity-Adults	Chronic Diseases/Other Health Issues	100%
Obesity-Children	Chronic Diseases/Other Health Issues	100%
Oral Health (Dentist)	Chronic Diseases/Other Health Issues	100%
Physical Activity (lack of exercise)	Modifiable Risk Behavior	100%
Nutrition (choosing healthy food)	Modifiable Risk Behavior	100%
Adequate/Affordable/Safe Housing	Social Determinants of Health/Other Concerns	100%
Adequate Employment Opportunities	Social Determinants of Health/Other Concerns	100%
Child Abuse	Social Determinants of Health/Other Concerns	100%
Community Violence	Social Determinants of Health/Other Concerns	100%
Domestic Violence	Social Determinants of Health/Other Concerns	100%
Elder Abuse	Social Determinants of Health/Other Concerns	100%
Homelessness	Social Determinants of Health/Other Concerns	100%
Older Adults Ability to Age in Place (stay in home)	Social Determinants of Health/Other Concerns	100%
Racism/Other Discrimination	Social Determinants of Health/Other Concerns	100%
Teen Births	Social Determinants of Health/Other Concerns	100%

*includes more than top 12 due to numerous priorities ranked at 100%

Top 12* Areas of Concern Ranked by Focus Group Participants (Spanish Group)	Area of Focus	Percent Ranking as a Major or Moderate Concern
Mental Illness	Behavioral Health	100%
Prescription Drug Misuse	Behavioral Health	100%
Obesity-Adults	Chronic Diseases/Other Health Issues	100%
Obesity-Children	Chronic Diseases/Other Health Issues	100%
Nutrition (choosing healthy foods)	Modifiable Risk Behavior	100%
Smoking/Tobacco (includes vaping)	Modifiable Risk Behavior	100%
Adequate/Affordable/Safe Housing	Social Determinants of Health/Other Concerns	100%
Adequate Employment Opportunities	Social Determinants of Health/Other Concerns	100%
Child Abuse	Social Determinants of Health/Other Concerns	100%
Community Violence	Social Determinants of Health/Other Concerns	100%
Domestic Violence	Social Determinants of Health/Other Concerns	100%
Elder Abuse	Social Determinants of Health/Other Concerns	100%
Food Insecurity (ability to access healthy food)	Social Determinants of Health/Other Concerns	100%
Homelessness	Social Determinants of Health/Other Concerns	100%
Infant/Child Health	Social Determinants of Health/Other Concerns	100%
Older Adults Ability to Age in Place (stay in home)	Social Determinants of Health/Other Concerns	100%
Racism/Other Discrimination	Social Determinants of Health/Other Concerns	100%

*includes more than top 12 due to numerous priorities ranked at 100%

Secondary Data Collection

Demographics

The Endeavor Health strategy team used Claritas data from the Environics analytics ENVISION tool to gather demographic information for the hospital's service area. Demographic information was shared previously in the "Our Service Area" section of this report.

Public Health Data

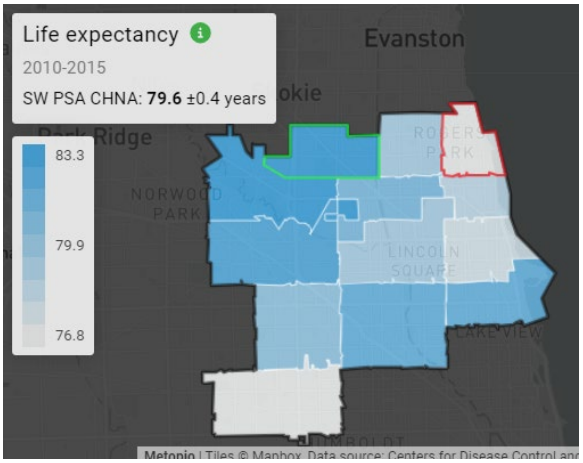
The Endeavor Health Clinical Analytics Team used the Metopio platform to pull and analyze public health data. Metopio features pre-loaded, curated data from public and proprietary sources, built-in analytics and powerful visualizations that enable healthcare organizations to identify and reduce disparities. Each highlight below indicates the data source within Metopio that it was drawn from. Additional data is available within the appendix.

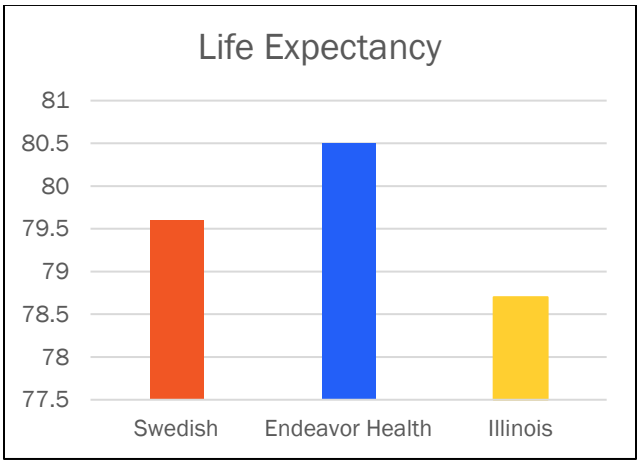
Our Clinical Analytics team pulled from Metopio all data available related to the Key Life Expectancy Drivers (Cancer, Diabetes, Hypertension, Infant Mortality, Mental Health and Violence). In addition, emphasis was placed on collecting data that pertained to Key

Priorities which were identified from the previous CHNA (Access to Care, Behavioral Health, Cancer, Chronic Disease and Diabetes), and which often directly align with the Key Life Expectancy Drivers. The key highlights below reference data pertaining to life expectancy, health behaviors, chronic diseases, mental health and social determinants of health (SDOH) within the Swedish service area. In order to draw attention to disparities within our service area, we drill down and display the top 5-6 ZIP codes with the most concerning rates for each health indicator. At the end of this section we include additional health indicators where the Swedish service area is performing worse than the state average.

Life Expectancy

Life expectancy is the average number of years an individual is expected to live. Within the Swedish service area, there is a 6.5 year gap in life expectancy, with the highest life expectancy at 83.3 for 60712-Lincolnwood and lowest life expectancy at 76.8 for 60626-Rogers Park.





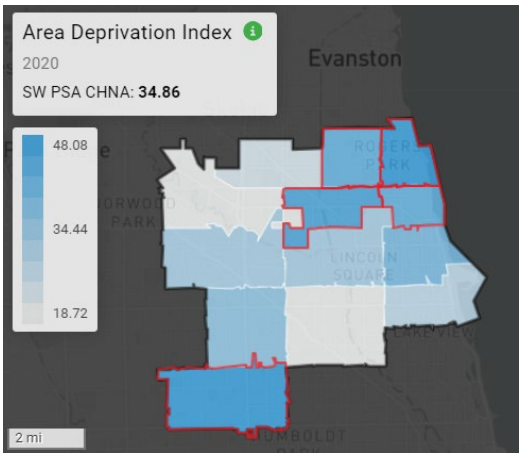
Source: USALEEP 2010-2015

Area Deprivation Index

Area Deprivation Index (ADI) is a composite score using indicators from the domains of income, education, employment, and housing quality. Higher values indicate higher levels of socioeconomic disadvantage.

While the Swedish service area average scores better than both the Endeavor Health service area average and Illinois, when zooming in to the ZIP code level it is possible to see that some communities have significantly higher ADI scores, which means higher levels of socioeconomic disadvantage.

	SW Service Area	Endeavor Health Service Area	Illinois
Area Deprivation Index	34.9	35.4	50.9



SW Zip Codes with the Highest ADI		
Zip Code	City/Town	ADI
60626	Chicago, IL – Rogers Park	48.8
60639	Chicago, IL – Belmont Cragin	46.5
60659	Chicago, IL – West Ridge	44.9
60660	Chicago, IL - Edgewater	43.2
60645	Chicago, IL – West Ridge	41.2

Source: Neighborhood Atlas- University of Wisconsin - School of Medicine and Public Health. Data as of 2020.

Self-Reported Overall Health Status

Within the Swedish service area, the percentage of residents reporting “fair” or “poor” overall health is slightly higher (15.3%) compared to the Endeavor Health service area (13.2%) or Illinois overall (14.6%). The ZIP code with the highest percentage of residents reporting “fair” or “poor” overall health was 60639-Belmont Cragin, at 23.4%.

ZIP Code	City	% of Residents Reporting "Fair" or "Poor" Health
60639	Belmont Cragin	23.4%
60659	West Ridge	18.7%
60645	West Ridge	17.5%
60641	Portage Park	16.4%
60626	Rogers Park	16.1%
60640	Uptown	13.6%
60660	Edgewater	13.6%
60618	North Center	13.5%
60630	Gladstone Park	13.4%
60625	Lincoln Square	13.3%
60712	Lincolnwood	12.8%
60646	South Edgebrook	12.1%
60613	Lakeview	7.8%

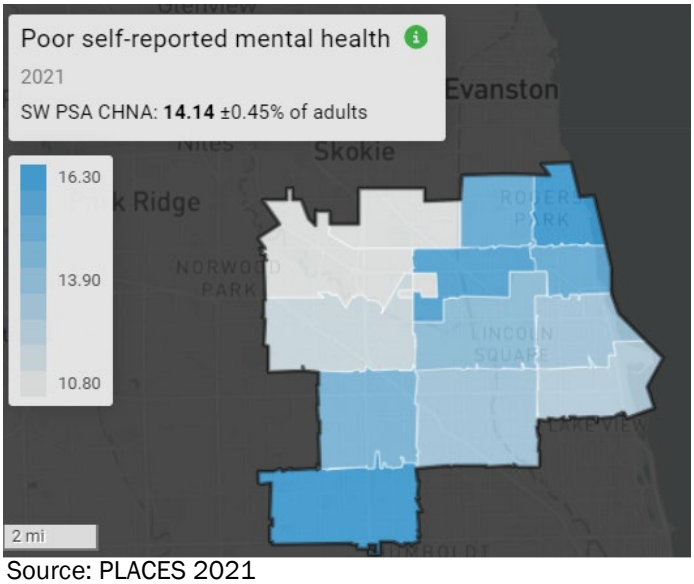
Source: PLACES 2019

% of Residents Reporting “Fair” or “Poor” Health	
SW Service Area	15.3%
Endeavor Health Service Area	13.2%
Illinois	14.6%

Self-Reported Mental Health Status

The percentage of residents with poor self-reported mental health was similar to the Illinois average and slightly higher than the Endeavor Health service area. The areas with the highest percentages of poor self-reported mental health included 60639-Belmont Cragin and 60626-Rogers Park, which were both at 16%.

	SW Service Area	Endeavor Health Service Area	Illinois
% of Residents with Poor Self-Reported Mental Health	14.1%	13.3%	14.4%



Source: PLACES 2021

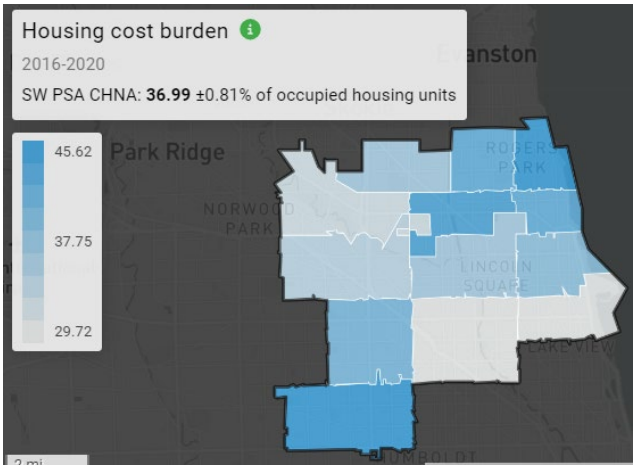
SW ZIP Codes with the Highest Percentage of Residents with Poor Self-Reported Mental Health		
ZIP Code	City/Town	% of Residents with Poor Self-Reported Mental Health
60639	Chicago, IL – Belmont Cragin	16.3%
60626	Chicago, IL – Rogers Park	16.0%
60659	Chicago, IL – West Ridge	15.0%
60645	Chicago, IL – West Ridge	14.5%
60660	Chicago, IL - Edgewater	14.3%

Social Determinants of Health (SDOH)

Housing Cost Burden

If a household spends more than 30% of its income on housing, this is referred to as a housing cost burden. Within the Swedish service area, 37% of households have a housing cost burden, which is higher than both the Endeavor Health service area and Illinois. In some communities near Swedish (60639-Belmont Cragin), nearly 47% of residents are spending more than 30% of their income on housing.

	SW Service Area	Endeavor Health Service Area	Illinois
% of Households Spending More Than 30% of Income on Housing	37.0%	30.6%	30.3%



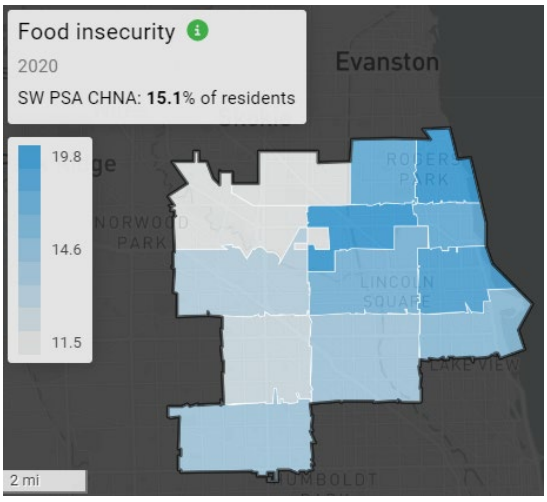
Source: American Community Survey 2017-2021

SW ZIP Codes with Largest Percentage of Households Spending More than 30% of Income on Housing		
ZIP Code	City/Town	% of Households Spending More than 30% of Income on Housing
60639	Chicago, IL – Belmont Cragin	46.7%
60626	Chicago, IL – Rogers Park	42.2%
60659	Chicago, IL – West Ridge	41.9%
60660	Chicago, IL – Edgewater	38.2%
60640	Chicago, IL - Uptown	37.3%

Food Insecurity

Food insecurity is the household level economic and social condition of limited or uncertain access to adequate food. Within the Swedish service area, 15.1% of residents report experiencing food insecurity, which is higher than both the Endeavor Health service area and Illinois. In some communities near Swedish (60626-Rogers Park), the percentage is as high as 19.8%.

	SW Service Area	Endeavor Health Service Area	Illinois
% of Residents Experiencing Food Insecurity	15.1%	11.1%	9.5%



Source: American Community Survey 2017-2021

SW ZIP Codes with Largest Percentage of Residents Experiencing Food Insecurity		
ZIP Code	City/Town	% of Residents Experiencing Food Insecurity
60626	Chicago, IL – Rogers Park	19.8%
60659	Chicago, IL – Rogers Park	19.2%
60640	Chicago, IL - Uptown	18.8%
60660	Chicago, IL - Edgewater	17.2%
60645	Chicago, IL – West Ridge	16.8%

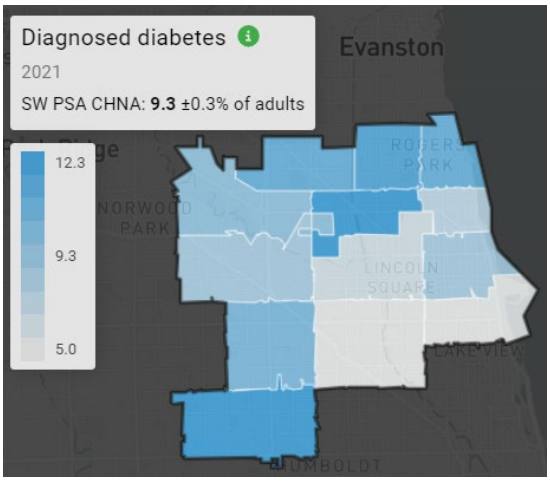
Chronic Diseases

A chronic disease is an ongoing condition that lasts a year or more, requires ongoing medical attention, and/or limits the activities of daily living. Worldwide and in the United States, chronic conditions are the leading cause of disability and death. Chronic diseases create a significant health and economic cost for individuals and communities. Prevention and management of chronic diseases can significantly reduce the burden of these diseases on individuals and society.

Diabetes

Within the Swedish service area, the percentage of residents with diabetes is 9.3%, which is similar to both the Endeavor Health service area and the state average. In some communities near Swedish (60639-Belmont Cragin, 60659-West Ridge), the percentage is closer to 12%, which is higher than the state and system averages.

	SW Service Area	Endeavor Health Service Area	Illinois
% of Residents with Diabetes	9.3%	8.8%	9.8%



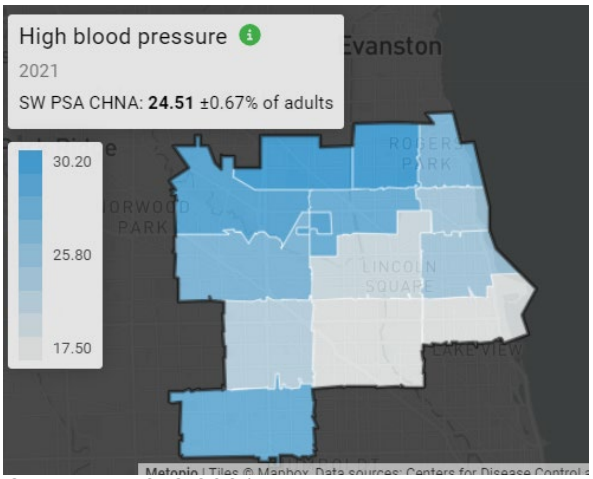
Source: PLACES 2021

SW ZIP Codes with Highest Prevalence of Diabetes		
ZIP Code	City	% of Residents with Diabetes
60639	Chicago, IL – Belmont Cragin	12.3%
60659	Chicago, IL – West Ridge	11.9%
60645	Chicago, IL – West Ridge	11.2%
60712	Lincolnwood, IL	10.6%
60626	Chicago, IL – Rogers Park	9.6%

High Blood Pressure

Within the Swedish service area, 24.5% of residents are reported to have high blood pressure, which is slightly below both the Endeavor Health service area and Illinois. In some communities near Swedish (60712-Lincolnwood), the percentage is 30.2%, slightly above the state average of 29%.

	SW Service Area	Endeavor Health Service Area	Illinois
% of Residents with High Blood Pressure	24.5%	26.5%	29.0%



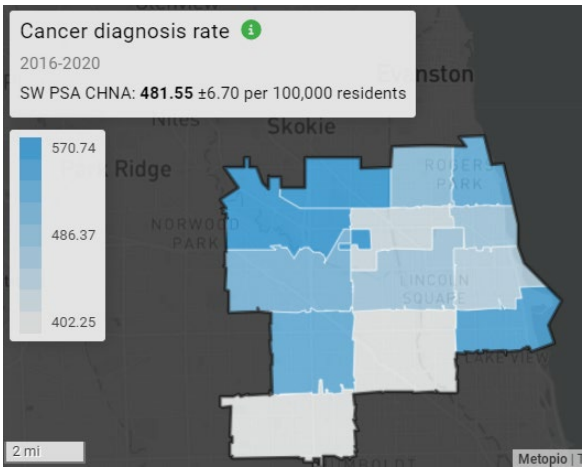
Source: PLACES 2021

SW ZIP Codes with Highest Prevalence of High Blood Pressure		
ZIP Code	City	% of Residents with High Blood Pressure
60712	Lincolnwood, IL	30.2%
60645	Chicago, IL – West Ridge	28.9%
60646	Chicago, IL – South Edgebrook	28.6%
60659	Chicago, IL – West Ridge	28.0%
60639	Chicago, IL – Belmont Cragin	26.3%

Cancer Diagnosis

Within the Swedish service area, the cancer diagnosis rate per 100,000 residents is 481.6, which is below both the Endeavor Health service area and the state average. In some communities near Swedish (60712-Lincolnwood), the cancer diagnosis rate is at the state average.

	SW Service Area	Endeavor Health Service Area	Illinois
Cancer diagnosis rate per 100,000 residents	481.6	556.5	570.7



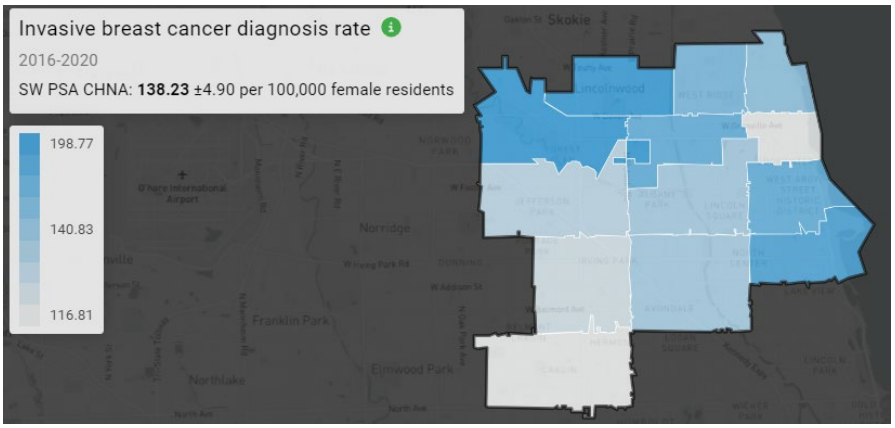
Source: Illinois State Cancer Registry: 2016-2020

SW ZIP Codes with the Highest Cancer Diagnosis Rates		
ZIP Code	City/Town	Cancer Diagnosis Rate per 100,000
60712	Lincolnwood, IL	570.7
60646	Chicago, IL – South Edgebrook	554.8
60613	Chicago, IL – Lakeview	538.9
60626	Chicago, IL – Rogers Park	532.5
60641	Chicago, IL – Portage Park	507.0

Invasive Breast Cancer Diagnosis

Within the Swedish service area, the invasive breast cancer diagnosis rate per 100,000 residents is 138.2, which is lower than both the Endeavor Health service area and the state average. In some communities near Swedish (60712-Lincolnwood), the invasive breast cancer diagnosis rate is 198.8, which is higher than both the Endeavor Health service area and the state average.

	SW Service Area	Endeavor Health Service Area	Illinois
Invasive Breast Cancer diagnosis rate per 100,000 residents	138.2	168.5	161.1



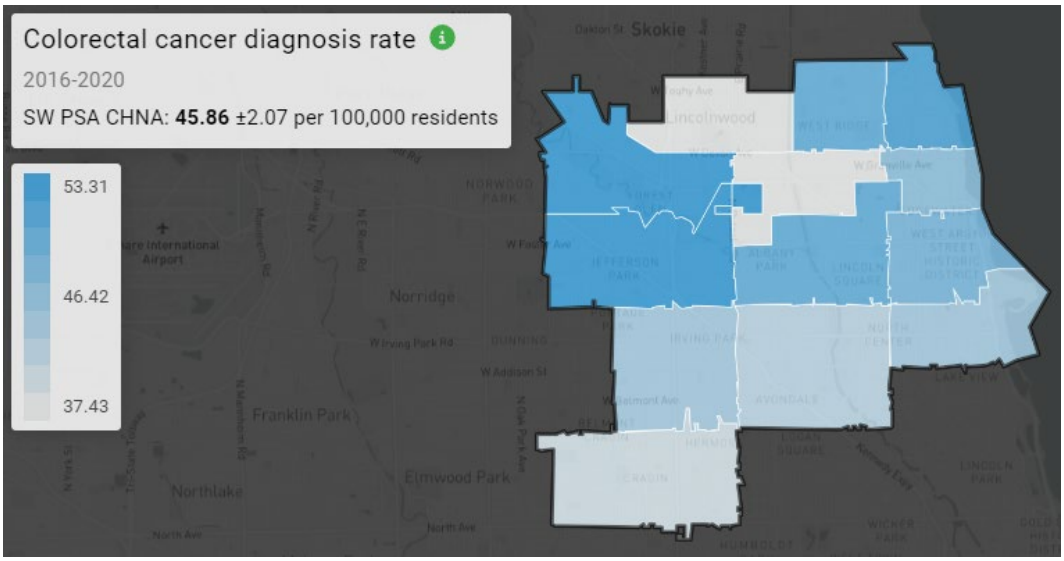
Source: Illinois State Cancer Registry: 2016-2020

SW ZIP Codes with Highest Invasive Breast Cancer Diagnosis Rates		
ZIP Code	City/Town	Invasive Breast Cancer Diagnosis Rate per 100,000
60712	Lincolnwood, IL	198.8
60646	Chicago, IL – South Edgebrook	163.9
60613	Chicago, IL - Lakeview	157.1
60640	Chicago, IL - Uptown	149.3
60659	Chicago, IL – West Ridge	147.0

Colon Cancer Diagnosis

Within the Swedish service area, the colon cancer diagnosis rate per 100,000 residents is 45.9, which is slightly lower than both the Endeavor Health service area and the state average. In some communities near Swedish (60646-Edgebrook, 60630-Gladstone Park, 60626-Rogers Park), the colon cancer diagnosis rate is above 52.5, which is higher than both the Endeavor Health service area and the state average.

	SW Service Area	Endeavor Health Service Area	Illinois
Colon Cancer diagnosis rate per 100,000 residents	45.9	44.6	47.4



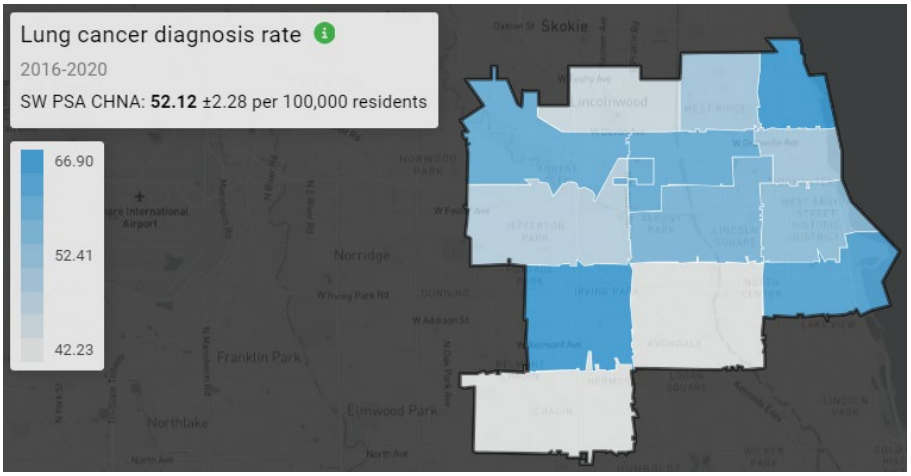
Source: Illinois State Cancer Registry: 2016-2020

SW ZIP Codes with Highest Colon Cancer Diagnosis Rates		
ZIP Code	City/Town	Colon Cancer Diagnosis Rate per 100,000
60646	Chicago, IL – South Edgebrook	53.3
60630	Chicago, IL – Gladstone Park	53.3
60626	Chicago, IL – Rogers Park	52.8
60645	Chicago, IL – West Ridge	49.0
60625	Chicago, IL – Lincoln Square	46.9

Lung Cancer Diagnosis

Within the Swedish service area, the lung cancer diagnosis rate per 100,000 residents is 52.1, which is below both the Endeavor Health service area and the state average. In some communities near Swedish (60641-Portage Park), the lung cancer diagnosis rate is 66.9, which is higher than the Endeavor Health service area but lower than the state average.

	SW Service Area	Endeavor Health Service Area	Illinois
Lung Cancer diagnosis rate per 100,000 residents	52.1	59.2	73.3



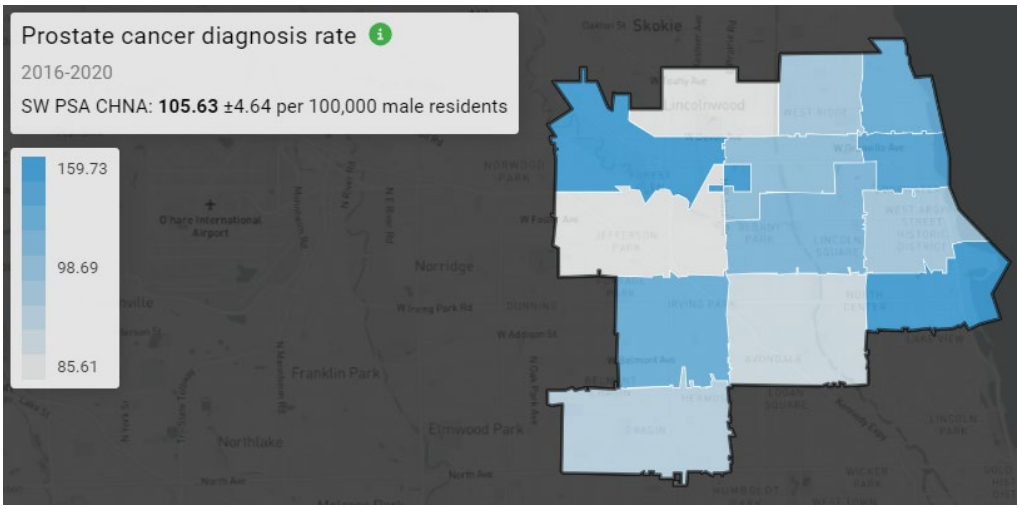
Source: Illinois State Cancer Registry: 2016-2020

SW ZIP Codes with Highest Lung Cancer Diagnosis Rates		
ZIP Code	City/Town	Lung Cancer Diagnosis Rate per 100,000
60641	Chicago, IL – Portage Park	66.9
60626	Chicago, IL – Rogers Park	59.4
60613	Chicago, IL - Lakeview	58.1
60646	Chicago, IL – South Edgebrook	56.5
60659	Chicago, IL – West Ridge	54.8

Prostate Cancer Diagnosis

Within the Swedish service area, the prostate cancer diagnosis rate per 100,000 residents is 105.6, which is lower than both the Endeavor Health service area and the state average. In some communities near Swedish (60613-Lakeview, 60646-Edgebrook) the prostate cancer diagnosis rate is above 150, which is higher than both the Endeavor Health service area and the state average.

	SW Service Area	Endeavor Health Service Area	Illinois
Prostate Cancer diagnosis rate per 100,000 residents	105.6	135.9	139.5



Source: Illinois State Cancer Registry: 2016-2020

SW ZIP Codes with Highest Prostate Cancer Diagnosis Rates		
ZIP Code	City/Town	Prostate Cancer Diagnosis Rate per 100,000
60613	Chicago, IL - Lakeview	159.7
60646	Chicago, IL – South Edgebrook	152.0
60660	Chicago, IL - Edgewater	125.7
60626	Chicago, IL – Rogers Park	114.9
60641	Chicago, IL – Portage Park	108.4

Additional Indicators Worse Than Illinois Average

In addition to the above data sets, additional health indicators where the Swedish service area performed worse than the Illinois average are summarized below. Note, this is not a comprehensive list.

Indicator	Ranking as Compared to all Illinois ZIP Codes
Visited doctor for routine checkup (% of adults)	Lowest 5%
No heat (% of occupied housing units)	Highest 10%
Taking medicine for high blood pressure (% of adults with high blood pressure)	Lowest 10%
Binge drinking (% of adults)	Top quartile (75-90%)
Cervical cancer diagnosis rate (Per 100,000 female residents)	Top quartile (75-90%)
Nervous system cancer diagnosis rate (Per 100,000 residents)	Top quartile (75-90%)
Cholesterol screening (% of adults)	Lowest quartile (10-25%)
Colorectal cancer screening (% of adults)	Lowest quartile (10-25%)

Prioritization Process and Results

In April 2024, Swedish Hospital hosted its semi-annual Community Leader meeting to review and discuss preliminary data. The group consisted of key stakeholders representing healthcare, social services and other public interests. After presenting preliminary data and engaging in discussion, attendees were asked fill out an index card indicating what they feel is the top community concern and any resources or recommendations about how to make an impact in that area of concern. Top responses included access to affordable care for all and navigation support to resources from both hospital and community social services. Also emphasized was a need for mental health access and a focus on health prevention and education. These responses mirrored many of the findings from the other primary data sources.

In May and June 2024, Swedish Hospital convened an internal multidisciplinary committee that met multiple times to review the results of the CHNA, to affirm and prioritize needs and identify the most qualified people to develop implementation plans to address each priority need. Representatives from the following departments served on the multidisciplinary committee: Behavioral Health, Case Management, Community Health, Community Impact & Engagement, Emergency Department, Foundation, Health Equity, Medical Group, Nursing, Nutrition Services, Patient Access Services, Patient Experience, Pastoral Care, Quality, Strategy/Planning, Transformation, and Women's Health. In addition, a member of the Community Health and Mission Committee of the Swedish Board of Directors participated in the committee.

The committee members were provided with an overview of the community health needs assessment process, community demographics and a summary and comparison document (see appendix), which was used as a tool to review the primary and secondary data collected. The primary data included findings from focus groups, a community survey and a key informant survey. Secondary data included additional demographic and public health data for the service area sourced by the Endeavor Health Strategy and Clinical Analytics teams. The most common themes and comments from the narrative portion of the surveys and focus groups were also highlighted in the document.

The committee was given time to review the summary and comparison document and was asked to rank or prioritize the issues from one to five, with five being the greatest concern. The committee then reviewed the cumulative rankings and 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 Swedish during the recent year

The following chart lists the concerns that ranked in the top 50% of the cumulative rankings.

Areas of Concern	Multidisciplinary Committee Cumulative Ranking
Mental Illness	4.78
Access to Mental Health Care	4.58
Housing (adequate, affordable, safe)	4.23
Access to Substance Abuse Treatment	4.13
Access to Prescription Medication	4.00
Diabetes/Pre-Diabetes	4.00
Nutrition	4.00
Community Violence	4.00
Access to Specialty Care	3.96
Obesity-Adults	3.96
Domestic Violence	3.95
Obesity-Children	3.91
Heart Disease/High Blood Pressure/Stroke	3.87
Adequate Employment Opportunities	3.87
Food Insecurity	3.87
Homelessness	3.87
Access to Preventative Screenings	3.71
Suicide	3.71
Alcohol Use	3.65
Access to Prenatal Care	3.63
Access to Oral Health Care	3.61
Older Adults Aging In Place	3.57
Cancer	3.55
Access to Primary Care	3.50

Once the priority areas were identified, the multidisciplinary committee recommended key individuals to develop implementation strategies and tactics for each of the areas, either via issue-specific committees or via other small-group meetings with key stakeholders. Each priority included a combination of system and entity-level initiatives. The key stakeholders for each priority area also developed metrics to measure the success of the strategies which will be monitored and updated annually.

While this CHNA is quite comprehensive, Swedish Hospital 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. In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community.

2024 Key Priority Health Needs

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 Swedish Hospital would focus the majority of its efforts on developing and/or supporting strategies and initiatives that address the following priority areas (in no particular order), with health equity and SDOH woven throughout:

1. **Behavioral Health (includes mental health, substance abuse and access to care)**
2. **Community Health and Wellness (includes nutrition, physical activity, healthy body weight and food security)**
3. **Chronic Diseases (includes heart disease/high blood pressure/stroke and diabetes)**
4. **Cancer (includes smoking/tobacco cessation)**
5. **Access to Care (includes primary, specialty, screenings, diagnostics and prescription medication)**

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 Implementation Strategies will describe programs Swedish is undertaking over the coming years to address the prioritized health needs within the surrounding communities.

Previous CHNA Key Priority Areas and Impact

Swedish focused on three priority health issues as a result of the previous 2022 CHNA:

1. Access to Health and Social Services
2. Mental and Behavioral Health
3. Chronic Health Conditions and Wellness

The hospital made significant progress in addressing the communities' greatest needs. For a detailed description of the strategies developed and outcomes, see the appendix.

Conclusion

Swedish Hospital values the CHNA process as an opportunity to engage with the community. We undertake this collaborative, collective impact approach to address the underlying root causes of health disparities and to support greater community health and wellbeing in the communities we serve.

This CHNA was reviewed and approved by the Swedish Hospital Board of Directors on November 6, 2024.

The CHNA was posted on the Endeavor Health website (endeavorhealth.org/CHNA) in December, 2024 as well as the Swedish Hospital website (swedishcovenant.org/CHNA). It was also shared broadly with internal and external stakeholders, including employees, volunteers, physicians, elected officials and members of the community. Swedish Hospital will also maintain at its facilities hard copies of the CHNA report that may be viewed by any who request it.

Feedback on the CHNA or its related Implementation Strategy can be provided through an online form.

Appendix

Demographic and Public Health Data
Community Survey
Multidisciplinary Summary Document
Previous CHNA Impact

Appendix

Zip Code	City/Town	ADI
60626	Chicago, IL	48.08
60639	Chicago, IL	46.45
60659	Chicago, IL	44.85
60660	Chicago, IL	43.24
60645	Chicago, IL	41.16
60640	Chicago, IL	36.19
60641	Chicago, IL	34.78
60630	Chicago, IL	32.36
60625	Chicago, IL	30.14
60613	Chicago, IL	24.20
60712	Lincolnwood, IL	22.67
60618	Chicago, IL	21.92
60646	Chicago, IL	18.72

Endeavor Health℠

Source: Neighborhood Atlas- University of Wisconsin - School of Medicine and Public Health. Data as of 2020.

Zip Code	City/Town	% of Residents Below 200% of Poverty Line
60639	Chicago, IL	42.3%
60659	Chicago, IL	41.9%
60626	Chicago, IL	38.1%
60645	Chicago, IL	36.9%
60640	Chicago, IL	32.5%
60660	Chicago, IL	32.0%
60625	Chicago, IL	30.8%
60641	Chicago, IL	28.5%
60618	Chicago, IL	22.3%
60630	Chicago, IL	21.8%
60613	Chicago, IL	17.4%
60712	Lincolnwood, IL	15.5%
60646	Chicago, IL	14.3%

Endeavor Health℠

Source: American Community Survey 2017-2021

Zip Code	City/Town	% of Households Spending More Than 30% of Income on Housing
60639	Chicago, IL	46.7%
60626	Chicago, IL	42.2%
60659	Chicago, IL	41.9%
60660	Chicago, IL	38.2%
60640	Chicago, IL	37.3%
60645	Chicago, IL	37.3%
60712	Lincolnwood, IL	37.2%
60641	Chicago, IL	35.9%
60625	Chicago, IL	35.0%
60630	Chicago, IL	31.9%
60618	Chicago, IL	31.6%
60646	Chicago, IL	31.0%
60613	Chicago, IL	30.4%

Endeavor Health℠

Source: American Community Survey 2017-2021

Zip Code	City/Town	% of Residents Experiencing Food Insecurity
60626	Chicago, IL	19.8%
60659	Chicago, IL	19.2%
60640	Chicago, IL	18.8%
60660	Chicago, IL	17.2%
60645	Chicago, IL	16.8%
60625	Chicago, IL	15.3%
60613	Chicago, IL	14.6%
60639	Chicago, IL	14.0%
60618	Chicago, IL	12.8%
60630	Chicago, IL	12.5%
60641	Chicago, IL	12.4%
60646	Chicago, IL	11.8%
60712	Lincolnwood, IL	11.5%

Source: American Community Survey 2017-2021

Zip Code	City/Town	Life Expectancy
60712	Lincolnwood, IL	83.3
60646	Chicago, IL	82.8
60630	Chicago, IL	81.2
60613	Chicago, IL	80.8
60618	Chicago, IL	80.3
60659	Chicago, IL	80.1
60641	Chicago, IL	79.9
60625	Chicago, IL	79.8
60645	Chicago, IL	79.6
60660	Chicago, IL	79.1
60640	Chicago, IL	77.9
60639	Chicago, IL	77.8
60626	Chicago, IL	76.8

Endeavor Health℠

Source: USALEEP 2010-2015

Zip Code	City/Town	% of Residents with High Blood Pressure
60712	Lincolnwood, IL	30.2%
60645	Chicago, IL	28.9%
60646	Chicago, IL	28.6%
60659	Chicago, IL	28.0%
60639	Chicago, IL	26.3%
60626	Chicago, IL	26.0%
60630	Chicago, IL	26.0%
60640	Chicago, IL	25.4%
60660	Chicago, IL	24.7%
60641	Chicago, IL	24.2%
60625	Chicago, IL	21.4%
60618	Chicago, IL	21.2%
60613	Chicago, IL	17.5%

Endeavor Health℠

Source: PLACES 2021

Zip Code	City/Town	% of Residents with Diabetes
60639	Chicago, IL	12.3%
60659	Chicago, IL	11.9%
60645	Chicago, IL	11.2%
60712	Lincolnwood, IL	10.6%
60626	Chicago, IL	9.6%
60641	Chicago, IL	9.4%
60646	Chicago, IL	9.3%
60640	Chicago, IL	9.1%
60630	Chicago, IL	9.0%
60660	Chicago, IL	8.9%
60625	Chicago, IL	8.1%
60618	Chicago, IL	7.9%
60613	Chicago, IL	5.0%

Source: PLACES 2021

Zip Code	City/Town	% of Residents with Poor Mental Health
60639	Chicago, IL	16.3%
60626	Chicago, IL	16.0%
60659	Chicago, IL	15.0%
60645	Chicago, IL	14.5%
60660	Chicago, IL	14.3%
60641	Chicago, IL	14.2%
60625	Chicago, IL	13.8%
60618	Chicago, IL	13.7%
60640	Chicago, IL	13.6%
60613	Chicago, IL	13.0%
60630	Chicago, IL	12.9%
60646	Chicago, IL	11.4%
60712	Lincolnwood, IL	10.8%

Source: PLACES 2021

Zip Code	City/Town	Cancer Diagnosis Rate
60712	Lincolnwood, IL	570.74
60646	Chicago, IL	554.79
60613	Chicago, IL	538.92
60626	Chicago, IL	532.47
60641	Chicago, IL	506.96
60630	Chicago, IL	494.88
60645	Chicago, IL	483.08
60660	Chicago, IL	481.15
60625	Chicago, IL	478.60
60640	Chicago, IL	477.58
60659	Chicago, IL	467.14
60618	Chicago, IL	445.44
60639	Chicago, IL	402.25

Endeavor Health℠

Source: Illinois State Cancer Registry 2016-2020

Zip Code	City/Town	Colon Cancer Diagnosis Rate
60646	Chicago, IL	53.31
60630	Chicago, IL	53.26
60626	Chicago, IL	52.81
60645	Chicago, IL	48.98
60625	Chicago, IL	46.87
60640	Chicago, IL	46.82
60660	Chicago, IL	46.27
60613	Chicago, IL	46.17
60641	Chicago, IL	42.58
60618	Chicago, IL	42.43
60639	Chicago, IL	42.28
60712	Lincolnwood, IL	39.05
60659	Chicago, IL	37.43

Source: Illinois State Cancer Registry 2016-2020

Zip Code	City/Town	Lung Cancer Diagnosis Rate
60641	Chicago, IL	66.90
60626	Chicago, IL	59.36
60613	Chicago, IL	58.08
60646	Chicago, IL	56.47
60659	Chicago, IL	54.78
60625	Chicago, IL	53.70
60640	Chicago, IL	53.27
60645	Chicago, IL	50.25
60660	Chicago, IL	49.15
60630	Chicago, IL	48.99
60712	Lincolnwood, IL	48.08
60639	Chicago, IL	43.14
60618	Chicago, IL	42.23

Source: Illinois State Cancer Registry 2016-2020

Zip Code	City/Town	Invasive Breast Cancer Diagnosis Rate
60712	Lincolnwood, IL	198.77
60646	Chicago, IL	163.92
60613	Chicago, IL	157.13
60640	Chicago, IL	149.26
60659	Chicago, IL	147.01
60645	Chicago, IL	143.47
60626	Chicago, IL	143.21
60618	Chicago, IL	135.83
60625	Chicago, IL	133.94
60630	Chicago, IL	132.83
60641	Chicago, IL	129.67
60660	Chicago, IL	119.77
60639	Chicago, IL	116.81

Endeavor Health℠

Source: Illinois State Cancer Registry 2016-2020

Zip Code	City/Town	Prostate Cancer Diagnosis Rate
60613	Chicago, IL	159.73
60646	Chicago, IL	151.95
60660	Chicago, IL	125.69
60626	Chicago, IL	114.94
60641	Chicago, IL	108.35
60625	Chicago, IL	100.21
60659	Chicago, IL	97.97
60640	Chicago, IL	97.90
60645	Chicago, IL	95.89
60639	Chicago, IL	92.32
60618	Chicago, IL	88.91
60630	Chicago, IL	86.79
60712	Lincolnwood, IL	85.61

Source: Illinois State Cancer Registry 2016-2020

Community Health Survey 2024

Thank you for participating in Endeavor Health's Community Health survey. Endeavor Health includes the following hospitals: Edward, Elmhurst, Evanston, Glenbrook, Highland Park, Linden Oaks, Northwest Community, Skokie and Swedish. The survey results, along with other data, will help us identify our community's greatest health needs and guide our outreach efforts and how to best use our resources. **Your responses are anonymous and will be kept confidential.** This survey consists of 22 questions and will take approximately 8-10 minutes to complete.

SURVEY INSTRUCTIONS-PLEASE READ

When answering these questions please think of health and our community very broadly. In addition to your own health, consider the health of your family, friends, neighbors and the entire community. Our community includes individuals of many different races and ethnicities and who are from many different socio-economic classes (affluent, middle class and low-income). **PLEASE CONSIDER EVERYONE WHEN ANSWERING THESE QUESTIONS**.

Section A: Access to Healthcare

1. Do you feel all community members have adequate **access to** the following healthcare services**?**

   Routine medical care (primary care)? Yes No Unsure

   Specialty care (cancer specialists, cardiologists, orthopedics, GI physicians, etc.)? Yes No Unsure

   Prenatal care? Yes No Unsure

   Mental health care (depression, anxiety, PTSD, suicide, etc.)? Yes No Unsure

   Substance use treatment (alcohol, prescription misuse, and other drugs)? Yes No Unsure

   Preventive screenings (mammograms, colonoscopies, lung screenings, etc.)? Yes No Unsure

   Immunizations? Yes No Unsure

   Oral health care (dentist)? Yes No Unsure

   Vision? Yes No Unsure

   Audiology (hearing)? Yes No Unsure

   Prescription medication? Yes No Unsure

2. How significant are the following barriers in accessing health care?

   Hours of Operation (availability of evening/weekend appointments): Major Barrier Moderate Barrier Minor Barrier No barrier Unsure

   Availability of physicians (appointment availability, accepting new patients): Major Barrier Moderate Barrier Minor Barrier No barrier Unsure

   Insurance restrictions: Major Barrier Moderate Barrier Minor Barrier No barrier Unsure

   Lack of insurance: Major Barrier Moderate Barrier Minor Barrier No barrier Unsure

   Transportation: Major Barrier Moderate Barrier Minor Barrier No barrier Unsure

   Language: Major Barrier Moderate Barrier Minor Barrier No barrier Unsure

   Limited financial resources: Major Barrier Moderate Barrier Minor Barrier No barrier Unsure

Section B: Behavioral Health

In this section we will assess our concerns about behavioral health issues (mental health and substance use) in our community. When ranking your answer, **please consider the seriousness or magnitude of the issue, not whether people have access to care for it.**

3. Please provide your level of concern for the following behavioral health issues.

   Mental Illness (this includes depression, anxiety, and more complex mental health issues): Major Concern Moderate Concern Minor Concern No Concern Unsure

   Suicide: Major Concern Moderate Concern Minor Concern No Concern Unsure

   Alcohol Use: Major Concern Moderate Concern Minor Concern No Concern Unsure

   Prescription Drug Misuse: Major Concern Moderate Concern Minor Concern No Concern Unsure

   Marijuana Misuse: Major Concern Moderate Concern Minor Concern No Concern Unsure

   Other Drug Use (cocaine, heroin, etc.): Major Concern Moderate Concern Minor Concern No Concern Unsure

4. If you have any other behavioral health concern not addressed above please list here.
   Open Answer (optional)

Section C: Chronic Diseases and Health Issues

In this section we will assess our concerns about different chronic diseases/health issues in our community. When ranking your answer, **please consider the seriousness or magnitude of the issue, not whether people have access to care for these concerns.**

5. Please rank your level of concern for each of the following chronic diseases/health issues.

   Arthritis/Osteoporosis/Back Conditions: Major Concern Moderate Concern Minor Concern No Concern Unsure

Cancer: Major Concern Moderate Concern Minor Concern No Concern Unsure

Chronic Kidney Disease: Major Concern Moderate Concern Minor Concern No Concern Unsure

Dementia/Alzheimer's: Major Concern Moderate Concern Minor Concern No Concern Unsure

Diabetes/Pre-Diabetes: Major Concern Moderate Concern Minor Concern No Concern Unsure

Hearing Loss: Major Concern Moderate Concern Minor Concern No Concern Unsure

Heart Disease/High Blood Pressure/Stroke: Major Concern Moderate Concern Minor Concern No Concern Unsure

HIV/AIDS-Sexually Transmitted Disease: Major Concern Moderate Concern Minor Concern No Concern Unsure

Infant Mortality: Major Concern Moderate Concern Minor Concern No Concern Unsure

Obesity in adults: Major Concern Moderate Concern Minor Concern No Concern Unsure

Obesity in children: Major Concern Moderate Concern Minor Concern No Concern Unsure

Oral Health (Dental): Major Concern Moderate Concern Minor Concern No Concern Unsure

Respiratory Illness (Asthma/COPD/breathing): Major Concern Moderate Concern Minor Concern No Concern Unsure

Vision: Major Concern Moderate Concern Minor Concern No Concern Unsure

Section D: Modifiable Risk Behaviors

Premature deaths in the U.S. can be linked back to lifestyle, behaviors and choices people make that affect their health. These are not hereditary. Please read each of the following and rank your concern for our community.

6. Please rank your level of concern for each of the following modifiable risk behaviors.

   Physical activity (lack of exercise): Major Concern Moderate Concern Minor Concern No Concern Unsure

   Nutrition (**choosing** healthy foods): Major Concern Moderate Concern Minor Concern No Concern Unsure

   Smoking/Tobacco (includes vaping, all forms of tobacco): Major Concern Moderate Concern Minor Concern No Concern Unsure

Section E: Other Concerns/Social Determinants of Health

There are many non-medical factors that influence health outcomes. These are often referred to as Social Determinants of Health (SDOH).

7. Please rank your level of concern for each of the following Social Determinants of Health (SDOH) and other community issues:

   Adequate/affordable/safe housing: Major Concern Moderate Concern Minor Concern No Concern

Unsure

Adequate employment opportunities: Major Concern Moderate Concern Minor Concern No Concern Unsure

Child abuse: Major Concern Moderate Concern Minor Concern No Concern Unsure Concern

Community violence: Major Concern Moderate Concern Minor Concern No Concern Unsure

Domestic violence: Major Concern Moderate Concern Minor Concern No Concern Unsure

Elder abuse: Major Concern Moderate Concern Minor Concern No Concern Unsure

Food insecurity (ability to access healthy food): Major Concern Moderate Concern Minor Concern No Concern Unsure

Homelessness: Major Concern Moderate Concern Minor Concern No Concern Unsure

Infant/child health: Major Concern Moderate Concern Minor Concern No Concern Unsure

Older adult's ability to age in place (stay in their homes): Major Concern Moderate Concern Minor Concern No Concern Unsure

Racism or other discrimination: Major Concern Moderate Concern Minor Concern No Concern Unsure

Teen births: Major Concern Moderate Concern Minor Concern No Concern Unsure

Section F: Most Significant Health Concern

8. Please list what you feel is our community's most significant health concern. Your answer could be focused on access to care, a specific health concern, a modifiable risk factor or a social concern.
   Open Answer (optional)

Section G: Individual Health Status

Throughout this survey we have asked you to answer questions based on your perception of your community's health. For the following questions please answer based on **your own** health experience.

9. How would you rate the current status of your **physical** health?
   Excellent
   Good
   Fair
   Poor
   Prefer not to answer

10. How would you rate the current status of your **mental** health?
    Excellent
    Good
    Fair
    Poor
    Prefer not to answer

11. How confident do you feel understanding information about health education and prevention?
    Very confident
    Somewhat confident
    Not so confident
    Not at all confident
    Prefer not to answer

12. Do you have a doctor or clinic where you go for regular care?
    Yes
    No
    Prefer not to answer

13. Please tell us your current health insurance status
    Private/commercial insurance
    Health insurance purchased from the ACA Marketplace
    Medicare
    Medicaid
    Medicare and Medicaid (DUAL)
    Government/VA
    Uninsured
    Other
    Prefer not to answer

14. Do you have dental insurance?
    Yes
    No
    Prefer not to answer

Section H: Demographics

Our community is very diverse, and this section will help us have a better understanding of who has participated in the survey.

Please answer the following questions:

15. Enter the five-digit zip code where you live*. Open Answer*

16. Which of these best describes your current gender identity?
    Male
    Female
    Non-binary
    Transgender
    Gender fluid
    Prefer not to answer
    Another gender identify *Open Answer*

17. Which of these best describes your sexual orientation**?**
    Straight/Heterosexual
    Gay or lesbian
    Bisexual
    Asexual
    Pansexual
    Prefer not to answer
    Another sexual orientation *Open Answer*

18. What is your highest level of education?
    Less than high school graduation
    High school graduate (includes equivalency)
    Some college, no degree
    Associate's degree
    Bachelor's degree
    Master's or Doctorate degree
    Vocational/trade school certificate
    Prefer not to answer
    Other *Open Answer*

19. What is your age?
    0-17
    18-24
    25-34
    35-44
    45-54
    55-64
    65-74
    75+
    Prefer not to answer

20. Which race/ethnicity best describes you?
    African American/Black
    American Indian or Alaskan Native
    Asian
    Latino (a)/Hispanic
    Middle Eastern/Arab American or Persian
    Pacific Islander or Hawaiian Native
    White
    Two or more races/ethnicities
    Prefer not to answer
    Another race or ethnicity *Open Answer*

21. What is your annual household income?
    Less than $10,000
    $10,000-$19,999
    $20,000-$39,999
    $40,000-$59,000
    $60,000-$79,000
    $80,000-$99,999
    $100,000-$199,999
    Over $200,000
    Prefer not to answer

22. Does anyone in your household live with a physical, mental or intellectual disability?
    Yes
    No
    Prefer not to answer

2024 Community Health Needs Assessment
Swedish Summary/Comparison Document

Endeavor Health	Focus Group The Friendship Center (English)	Focus Group Centro Romero (Spanish)	Survey Key Informant 26 respondents	Survey Broad Community	Secondary Data Metopio/Claritas	Ranking 1-5 (5 Is The Greatest Need)
SECTION A: ADEQUATE ACCESS TO HEALTHCARE SERVICES (Response options: Yes, No, Unsure)						
Primary Care	No-89%	No-75%	No-69%	No-47%		
Specialty Care	No-100%	No-83%	No-96%	No-57%		
Prenatal Care	No-78%	No-83%	No-50%	No-38%		
Mental Health Care	No-100%	No-25%	No-100%	No-60%		
Substance Abuse Treatment	No-100%	No-83%	No-88%	No-52%		
Preventative Screenings	No-100%	No-83%	No-85%	No-45%		
Immunizations	No-100%	No-50%	No-35%	No-26%		
Oral Health Care/Dentist	No-89%	No-92%	No-85%	No-55%		
Vision Services	No-89%	No-83%	No-73%	No-50%		
Audiology/Hearing Services	No-100%	No-92%	No-81%	No-51%		
Prescription Medication	No-78%	No-0%	No-77%	No-46%		
Barriers to Healthcare (Response options: Major Barrier, Moderate Barrier, Minor Barrier, No Barrier, Unsure)						
	Major Barrier / Moderate Barrier	Major Barrier / Moderate Barrier	Major Barrier / Moderate Barrier	Major Barrier / Moderate Barrier		
Hours of operation	56% / 44%	% / 100%	15% / 38%	23% / 37%		
Availability of physicians	67% / 22%	% / 92%	54% / 31%	48% / 30%		
Insurance restrictions	67% / 33%	67% / 33%	62% / 23%	56% / 22%		
Lack of insurance	89% / 11%	100% / %	65% / 19%	60% / 13%	Uninsured rate > EH and IL	
Transportation	56% / 33%	% / 83%	27% / 58%	22% / 34%		
Language	44% / 56%	42% / 58%	35% / 46%	15% / 29%	Limited Eng Prof > EH and IL	
Limited financial resources	89% / 11%	100% / %	62% / 35%	56% / 20%	Below 200% of Poverty Level > EH and IL; 34% have HH Income < $50K	

Notes on Access to Care: Abbreviations: UI=Uninsured MD= Medicare MC=Medicaid POC=People of Color SDOH=Social Determinants of Health CHW=Community Health Workers BMH=Behavioral Mental Health	Technology is a big barrier, especially for seniors when so much hc process is now online-education would be helpful. Transportation safety is sometimes an issue. CHW-making positive impact to help ppl understand and access programs; more funding needed.	UI immigrants have troubles with access. Language is a huge barrier-lack information on how to access. Fear of getting ill due to cost; Kids are sick but they don't want to take them due to lack of insurance/cost; transportation also big challenge.	Availability/cost for routine MH services-therapy/counseling; Lack of behavioral health care access felt most by uninsured, refugees, minorities, and homeless. Inadequate interpretation for BMH care, incl Trauma informed, youth focused or any medical encounter requiring use of an interpreter.					

SECTION B: BEHAVIORAL HEALTH (Response options: Major Concern, Moderate Concern, Minor Concern, No Concern, Unsure)										
	Major Concern	**Moderate Concern**	**Major Concern**	**Moderate Concern**	**Major Concern**	**Moderate Concern**	**Major Concern**	**Moderate Concern**		
Mental Illness	**78%**	**22%**	**100%**	**0%**	**85%**	**15%**	**60%**	**25%**	Self-reported poor MH > EH and = to IL; with 4 zips > than IL	
Suicide	**44%**	**56%**	**17%**	**50%**	**31%**	**46%**	**41%**	**30%**		
Alcohol Use	**56%**	**44%**	**0%**	**75%**	**50%**	**35%**	**36%**	**34%**	Binge drinking = IL, < EH	
Prescription Drug Misuse	**44%**	**33%**	**100%**	**0%**	**31%**	**46%**	**37%**	**30%**		
Marijuana Misuse	**33%**	**33%**	**0%**	**0%**	**27%**	**31%**	**17%**	**22%**		
Other Drug Use	**33%**	**33%**	**0%**	**0%**	**27%**	**54%**	**41%**	**27%**		
Notes on Behavioral Health:	Lack of social connection big issue tied to mental health. Dementia and ALZ connected to mental health and shame/fear to access social services, or lack of services; can't always tell when ppl are struggling w/mental health.		Need more help within community for people with depression. Need programs for homeless who use drugs or have mental health issues. Easy to develop substance use issues/hard to find resources for help.		Postpartum depression. Adolescent treatment and support. Teens self-medicating with marijuana to cope with stress-as substitute for medications with side effects that treat BMH.		Lack of access to mental health services and providers; societal issues are impacting mental health-need support and resources; substance use and addiction is a need; also concerns about mental health resources available for youth/adolescents.			

SECTION C: CHRONIC DISEASES AND OTHER HEALTH ISSUES (Response options: Major Concern, Moderate Concern, Minor Concern, No Concern, Unsure)										
	Major Concern	Moderate Concern	Major Concern	Moderate Concern	Major Concern	Moderate Concern	Major Concern	Moderate Concern		
Arthritis/Osteoporosis/ Back Conditions	89%	0%	0%	83%	15%	42%	29%	41%		
Cancer	67%	22%	0%	0%	35%	54%	55%	29%	Cancer diagnosis < than EH & IL; 1 zip > EH	
Chronic Kidney Disease	33%	44%	0%	0%	27%	46%	34%	36%		
Dementia/Alzheimer's	78%	11%	0%	0%	46%	31%	52%	30%		
Diabetes/Pre-Diabetes	89%	11%	0%	0%	65%	27%	50%	31%	Diabetes > than EH, 4 zips > than EH & IL	
Hearing Loss	33%	56%	0%	0%	8%	31%	21%	40%		
Heart Disease/High Blood Pressure/Stroke	100%	0%	0%	0%	65%	23%	59%	27%	Overall HBP < than EH & IL; 4 zips > than EH	
HIV/AIDS/Sexually Transmitted Diseases	22%	78%	8%	0%	4%	50%	20%	36%		
Infant Mortality	33%	56%	0%	8%	27%	38%	29%	28%		
Obesity-Adults	78%	22%	0%	100%	54%	31%	47%	30%		
Obesity-Children	89%	11%	100%	0%	54%	27%	48%	27%		
Oral Health (Dentist)	78%	22%	0%	0%	38%	38%	30%	39%		
Respiratory Illness (Asthma)	56%	33%	0%	0%	42%	38%	37%	39%		
Vision	33%	56%	0%	0%	12%	50%	26%	39%		
Notes on Chronic Disease:	Mobility issues; lack of accessible public transit for people w/ disabilities or mobility challenges. Chronic pain and pain management. Concern around viruses like COVID, TB,measles.		Women care such as a gynecologist. Junk food is easy to access - problem with obesity and no help.							

SECTION D: MODIFIABLE RISK BEHAVIORS (Response options: Major Concern, Moderate Concern, Minor Concern, No Concern, Unsure)										
	Major Concern	Moderate Concern	Major Concern	Moderate Concern	Major Concern	Moderate Concern	Major Concern	Moderate Concern		
Physical Activity (lack of exercise)	67%	33%	0%	0%	54%	38%	43%	40%		
Nutrition (choosing healthy food)	56%	44%	100%	0%	81%	12%	47%	35%		
Smoking/Tobacco (includes vaping)	78%	11%	100%	0%	50%	35%	42%	28%		
Notes on Modifiable Risk Behaviors:	Concern around drug and substance use among homeless. Concern around sexual promiscuity/STDs/lack of sexual health especially in senior buildings. Smoking among seniors.		Living where rent is more affordable, but commute to work is burden on mental and overall health. Lack of sleep, sometimes needing to take energy drinks to boost energy, not good for health.							

SECTION E: OTHER CONCERNS/SOCIAL DETERMINANTS OF HEALTH (Response options: Major Concern, Moderate Concern, Minor Concern, No Concern, Unsure)										
	Major Concern	Moderate Concern	Major Concern	Moderate Concern	Major Concern	Moderate Concern	Major Concern	Moderate Concern		
Adequate/Affordable/ Safe Housing	89%	11%	100%	0%	65%	35%	56%	24%	% of Households spending >30% income on housing – higher than EH and IL	
Adequate Employment Opportunities	89%	11%	100%	0%	46%	42%	46%	31%	Unemployment rate > EH but < than IL	
Child Abuse	78%	22%	8%	92%	35%	50%	49%	24%		
Community Violence	78%	22%	100%	0%	65%	23%	67%	21%		
Domestic Violence	78%	22%	0%	100%	62%	23%	55%	26%		
Elder Abuse	89%	11%	100%	0%	19%	46%	42%	32%		
Food Insecurity (ability to access healthy food)	67%	22%	100%	0%	62%	23%	48%	30%	Food insecurity > EH and IL	

SECTION E: OTHER CONCERNS/SOCIAL DETERMINANTS OF HEALTH (CONTINUED) (Response options: Major Concern, Moderate Concern, Minor Concern, No Concern, Unsure)										
Homelessness	**89%**	**11%**	**100%**	**0%**	**73%**	**12%**	**56%**	**25%**		
Infant/Child Health	**56%**	**33%**	**100%**	**0%**	**35%**	**46%**	**41%**	**31%**		
Older Adults Ability to Age in Place (Stay in home)	**89%**	**11%**	**0%**	**100%**	**27%**	**65%**	**48%**	**31%**	65+ group projected to grow 11.7% over next 5 years	
Racism/Other Discrimination	**89%**	**11%**	**100%**	**0%**	**65%**	**19%**	**50%**	**25%**		
Teen Births	**56%**	**44%**	**0%**	**17%**	**8%**	**46%**	**20%**	**31%**		
Notes on Other Concerns:	Lead exposure and "forever chemicals" City cleanliness as a public and mental health issue. Loss of good docs to other cities. Seeking multigenerational engagement for mental health young/old More opportunities for social cohesion, community leadership. Access to parks/green space also highlighted. Financial instability is also a significant concern, along with social isolation or loneliness.		Some of our people have been through major traumas growing up and never got help (taboo, cost, navigation). As a result more substance use. Lead exposure also mentioned. Financial instability is also a significant concern, along with social isolation/loneliness.		Intolerance in community re: racism and violence.					
Most Significant Health Concern	**1. Accessible and affordable HC for all 2. Navigation 3. Affordable housing**		**1. Affordable housing/rent assistance 2. Education on navigation and access for underresourced and new immigrants 3. Mental health support**		**1. Preventative and primary care awareness and navigation 2. Access to comprehensive, culturally sensitive care for un and underinsured 3. Affordable housing**		**1. Accessible and affordable healthcare, including access for uninsured/underinsured as well as timely appts to doctors and specialists 2. Mental health support and access 3. Community safety**			**(Committee Members: List Your Top Concern Here)**

Participant Demographics/Information

	Focus Group The Friendship Center (English) 9 of Participants	Focus Group Centro Romero (Spanish) 12 of Participants	Survey Key Informant 26 Participants	Survey Broad Community 869 English Participants 12 Spanish Participants
	Age 0% 18-24 0% 25-34 0% 35-44 11% 45-54 22% 55-64 56% 65-74 11% 75+ **Gender:** 33% Male 67% Female **Race:** 44% White 22% Hispanic/Latino 33% Black/African American **Primary language spoken in home:** 100% English **Insurance Status:** 11% Uninsured 11% Medicaid 78% Medicare **Annual Household Income:** 33% $0-$15,000 44% $15,001-$30,000 0% $30,001-$45,000 11% $45,001-$60,000 11% $60,000 or more	**Age** 33% 18-24 33% 25-34 8% 35-44 17% 45-54 8% 55-64 0% 65-74 **Gender:** 50% Male 50% Female **Race:** 100% Hispanic/Latino **Primary language spoken in home:** 100% Spanish **Insurance Status:** 100% Uninsured **Annual Household Income:** 100% $0-$15,000 **Highest Level of Education:** 0% Never attended school, Kindergarten only 8% Grades 1-8 (Elementary) 17% Grades 9-11 (Some HS) 25% Grades 12 or GED (HS Grad) 42% College 1-3 years (or Tech School)	**Age** 0% 18-24 0% 25-34 35% 35-44 35% 45-54 15% 55-64 4% 65-74 **Race/Ethnicity** 42% White 12% Asian/Pacific Islander 15% Latino/Hispanic 4% Middle Eastern/Arab American/Persian 4% Another race 12% Two or more races 12% Prefer not to answer % American Indian or Alaskan Native % Black/African American **Profile/Position:** 8% Community/Bus Leaders 35% Health Administrator/other health professional 12% Physician 8% Other Health Provider 23% Social Service Rep 4% Public Health Expert 4% Faith Based Leader 8% Other	**Age** 1% 18-24 8% 25-34 12% 35-44 12% 45-54 19% 55-64 29% 65-74 15% 75+ 4% prefer not to answer **Gender:** 65% Female 30% Male 1% Trans 1% Non-binary 1% Another gender 2% prefer not to answer **Race/Ethnicity:** 69% White 9% Latino/Hispanic 7% Asian/Pacific Islander 3% African American/Black 1% Middle Eastern/Arab American/Persian .2% American Indian or Alaskan Native .1% Pacific Islander/Hawaiian Native 6% prefer not to answer 4% 2 or more 2% another race/ethnicity

	Highest Level of Education: **% Never attended school, Kindergarten only** **% Grades 1-8 (Elementary)** **% Grades 9-11 (Some HS)** **22% Grades 12 or GED (HS Grad)** **22% College 1-3 years (or Tech School)** **33% Bachelor's Degree (College Grad)** **22% Postgraduate Degree (Masters, Doctors)**	**8% Bachelor's Degree (College Grad)** **0% Postgraduate Degree (Masters, Doctors)**	**How long in current position:** **8% less than one year** **31% 1-5 years** **19% 6-10 years** **23% 11-15 years** **19% 16 years or more** **96% that work with vulnerable, populations (low-income, immigrants, elderly or individuals with disabilities)**	**Insurance Status:** **45% Private/commercial** **30% Medicare** **4% Medicaid** **7% Other** **3% prefer not to answer** **4% DUAL Medicare/Medicaid** **4% ACA Marketplace** **.6% Government** **1% Uninsured** **Sexual Orientation:** **81% Straight/Heterosexual** **7% Gay or lesbian** **5% prefer not to answer** **4% Bisexual** **1% Pansexual** **1% Asexual** **1% Another sexual orientation** **Annual Household Income:** **3% Less than $10,000** **4% $10,000- $19,999** **9% $20,000-$39,999** **11% $40,000-$59,999** **11% $60,000-$79,999** **10% $80,000-$99,000** **20% $100,000-$199,999** **10% Over $200,000** **21% prefer not to answer** **Highest Level of Education:** **% Never attended school, Kindergarten only** **% Grades 1-8 (Elementary)** **1% Grades 9-11 (Some HS)** **6% Grades 12 or GED (HS Grad)** **12% College 1-3 years (or Tech School)** **31% Bachelor's Degree (College**

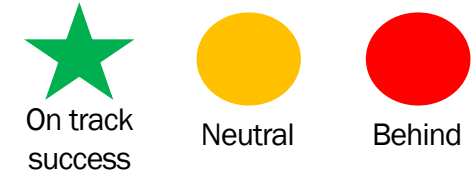
				Grad) 40% Postgraduate Degree (Masters, Doctors) 5% Associates 2% prefer not to answer 1% Vocational/trade school 1% other <u>Other:</u> 71% Self-reported physical health status excellent or good 78% Self-reported mental health Status excellent or good 96% Understanding of health education/prevention rated very confident or somewhat confident 93% that has have a primary care provider 68% that has dental insurance 23% have disabled person in household
PLEASE LEAVE ANY COMMENTS/SUGGESTIONS YOU HAVE ABOUT THE CHNA PRIORITIZATION PROCESS				

Previous CHNA Impact

Swedish Hospital

Priority: Access to Health and Social Services

Strategy #1: Expand efforts to identify and respond to social determinants of health (SDOH).



Initiative	Progress/Highlights	Overall Outcome
Implement and expand SDOH screening referral tool within some inpatient and outpatient settings to navigate screened individuals to resources/services.*	**2022 (stub year):** Began pilot using standardized questions in EPIC for food insecurity screening; 10% screening positive for one or more SDOH need-256 internal/external referrals made; 61 patients connected to Swedish community health programs **2023:** Food insecurity screening continued January-October, with rollout of multi-domain SDOH screening tool in October; total of 13,261 screenings with 11% screening positive for one or more SDOH need; 2,207 internal/external referrals made; 114 patients connected to Swedish community health programs **2024 (to date):** Inpatient SDOH screening live, SDOH committee seated, preparing to implement North Carolina SDOH screening tool across inpatient and outpatient settings	★
Build community-facing page for consumers to search for services and resources.	**2022 (stub year):** Awaiting Findhelp contracting approval **2023:** Findhelp implementation ongoing; public facing page not yet live **2024 (to date):** Priority focus on integrating Findhelp with EPIC for patient navigation; community-facing page delayed.	●
Provide funding through NorthShore's Community Investment Fund (CIF) to help local organizations build capacity and increase impact.*	**2022 (stub year):** Developed and launched Community Investment Fund **2023:** Supported and engaged with CIF partnerships to address access to care, including but not limited to hiring benefits coordinator and supporting 270+% increase in food rescue via The Friendship Center and supporting the purchase of a new building with expanded capacity to serve community social and wellbeing needs via Rohingya Culture Center **2024 (to date):** Supported new and continuing CIF partnerships, including 13,699 lives touched Jan-Mar and 2.5 jobs supported/created via The Friendship Center and opening of family health practice through Midwest Refuah	★

* denotes initiative with health equity integration

Priority: Access to Health and Social Services

Strategy #2: Expand efforts to support benefits enrollment for under-resourced community members.


On track success


Neutral


Behind

Initiative	Progress/Highlights	Overall Outcome
Initiate process to enroll patients who screen positive for food insecurity in various programs (LINK, SNAP, WIC)*	**2022 (stub year):** Initiate enrollment process for public programs tied to food insecurity; 34 individuals referred to programs (does not confirm enrollment) **2023:** 233 patients referred to programs (does not confirm enrollment) **2024 (to date):** 145 patients referred to programs (Jan-Apr) – does not confirm enrollment	
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.*	**2022 (stub year):** Explore ways to expand benefits enrollment assistance beyond inpatient support offered by Great Lakes **2023:** Continued need for greater outpatient/community enrollment support **2024 (to date):** Exploring other opportunities for benefits enrollment assistance for Healthcare Transformation patients and beyond	

* denotes initiative with health equity integration

Priority: Access to Health and Social Services

Strategy #3: Increase access to specialty care and diabetes education via Healthcare Transformation Program.

On track success | Neutral | Behind

Initiative	Progress/Highlights	Overall Outcome
Continue to partner with local FQHCs to provide specialty medical care services.*	**2022 (stub year):** Initiated specialty care services at FQHCs via Healthcare Transformation Program (HCT); 173 new and follow up visits completed, including 43 new uninsured patients served **2023:** Provided 1,563 new office visits and 2,134 follow up visits, including 376 new uninsured patients served **2024 (to date):** Continuing to provide specialty care services via FQHC partnership and HCT Program, increasing uninsured patients along with increasing new patient appointments; expanding to include American Indian Health Center	
Access to 1-1 diabetes education with local FQHCs.*	**2022 (stub year):** Initiating 1-1 diabetes support via HCT Program; 27 patients received 1-1 diabetes education **2023:** Continued to provide access to 1-1 diabetes education; 367 patients received 1-1 diabetes education support **2024 (to date):** Continuing 1-1 diabetes education, expanding program to include American Indian Health Center	

* denotes initiative with health equity integration

Priority: Access to Health and Social Services

Strategy #4: Strengthen Swedish Hospital's capacity to respond to survivors of sexual and intimate partner violence via Pathways Program.


On track success


Neutral


Behind

Initiative	Progress/Highlights	Overall Outcome
Continue to provide extensive de-escalation, neurobiology of trauma, domestic violence, human trafficking and sexual assault training to medical providers, and staff.	**2022 (stub year):** Provided 8 trainings to 103 team members to educate about trauma, domestic violence, human trafficking and sexual assault. Additional, public safety team provided 4 trainings to 69 team members about de-escalation (Oct-Dec 2022) **2023:** Provided 23 trainings to 520 team members to educate about trauma, domestic violence, human trafficking and sexual assault. Additional, public safety team provided 13 trainings to 117 team members about de-escalation; hosted an all-day symposium on brain injury and intimate partner violence; hosted a SANE (Sexual Assault Nurse Examiner) simulation lab, supported by a federal SANE grant (14 total SANE nurses at Swedish currently) **2024 (to date):** Provided 16 trainings to 151 team members to educate about trauma, domestic violence, human trafficking and sexual assault. Additional, public safety team provided 3 trainings to 26 team members about de-escalation (Jan-Apr 2024); Pathways awarded $600K from IDHS to create trauma informed clinic for survivors - funding will support hiring of clinical care staff and on-site advocate (program expected to launch Fall 2024)	
Provide crisis intervention to people impacted by sexual and intimate partner violence.*	**2022 (stub year):** Responded to 26 crisis intervention requests (Oct-Dec 2022) **2023:** Responded to 130 crisis intervention requests **2024 (to date):** Responded to 63 crisis intervention requests (Jan-Apr 2024)	
Provide counseling and case management to people impacted by sexual and intimate partner violence.*	**2022 (stub year):** 35 individuals received counseling and case management support (Oct-Dec 2022) **2023:** 126 individuals received counseling and case management support; hired trauma counselor **2024 (to date):** 57 individuals received counseling and case management support (Jan-Apr 2024); team is fully staffed, providing crisis intervention, advocacy, case management and trauma therapy services	

* denotes initiative with health equity integration

Priority: Access to Health and Social Services

Strategy #5: Develop Community Health strategy addressing health and racial disparities through community partnership and program development.


On track success


Neutral

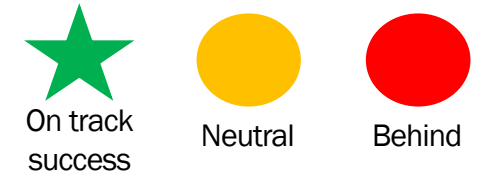

Behind

Initiative	Progress/Highlights	Overall Outcome
Continue and expand partnership with Community Area leads to identify and respond to each community's unique needs.*	**2022 (stub year):** As Regional Lead for North/Central Zone of Healthy Chicago Equity Zones (HCEZ), a collaboration with Chicago Department of Public Health, initiated community partnerships and program development in the 10 Community Areas for the North/Central Zone **2023:** Continued collaboration and program development with 50 partners among the North/Central Zone **2024 (to date):** Navigating staffing adjustments at both CDPH and Swedish, continuing partnership with 13 Community Area leads	
Launch Community Wellness Center as hub for educational programming, support groups and wellness offerings, including collaboration with area organizations.*	**2022 (stub year):** Launched Community Wellness Center (CWC) with 32 community program offerings **2023:** Transitioned CWC to new on-campus space at Galter Life Center; continued programming with a total of 114 community program offerings and 918 attendees **2024 (to date):** Continued programming at CWC, with a total of 37 community program offerings and 457 attendees (Jan-Apr 2024)	

* denotes initiative with health equity integration

Priority: Mental & Behavioral Health

Strategy #1: Deepen partnerships with community organizations addressing mental health.



Initiative	Progress/Highlights	Overall Outcome
Continue and enhance robust partnership with Lutheran Social Services of Illinois (LSSI), via inpatient acute access and outpatient access on-campus (Project Impact, Welcoming Center and Mobile Crisis Team)	**2022 (stub year):** Continued partnership and integration with LSSI via inpatient and outpatient options **2023:** Continued partnership and integration with LSSI via inpatient and outpatient options **2024 (to date):** Continuing partnership and integration with LSSI via inpatient and outpatient options; continuing to promote awareness of expanded Welcoming Center options to support those in need of outpatient behavioral health support on evenings and weekends	★
Explore partnerships or programming with area nonprofits addressing mental health stigma and treatment.	**2022 (stub year):** Partnered with organizations including North River Commission (Health & Safety Committee) and Erasing the Distance (stigma awareness and outreach) **2023:** Collaborated with area nonprofits on 42 programs, 13 new partnerships and 12 partner education sessions **2024 (to date):** Continued collaboration with area nonprofits on partnerships and programming	★
Provide funding through NorthShore's Community Investment Fund (CIF) to help local organizations build capacity and increase impact.*	**2022 (stub year):** Developed and launched Community Investment Fund **2023:** Supported and engaged with CIF partnerships to address mental health, including but not limited to 5 "A Night Out" family events serving 160 clients and financial ambassador outreach in 20+ Latino community spaces via Between Friends, 450+ client visits and DBT training via Howard Brown Health and 2 counselors serving Budlong Elementary School via LSSI **2024 (to date):** Supported new and continuing CIF partnerships, including 26-week specialized behavioral staff training for Howard Brown Health, expanded evening/weekend hours for outpatient behavioral health via LSSI's Welcoming Center, psycho-social therapy groups at Mather High School via Heartland Alliance International and 2 jobs supporting mentoring and community violence interruption via ONE Northside	★

* denotes initiative with health equity integration

Priority: Mental & Behavioral Health

Strategy #2: Continue and enhance behavioral, mental health and substance abuse services.

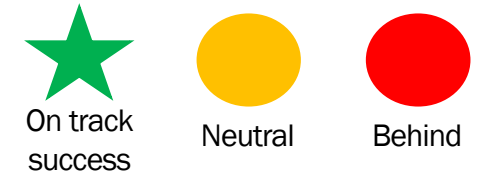
On track success | Neutral | Behind

Initiative	Progress/Highlights	Overall Outcome
Increase access to behavioral health services through integration within primary care setting; additionally, explore pilot and grant funding to extend integration to pediatrics.	**2022 (stub year):** Psychologist co-located in primary care emphasizing short-term therapy and providing increased access for patients **2023:** 146 new patients served by co-located psychologist in primary care; unable to pursue pediatric integration at this time **2024 (to date):** Psychologist joined Endeavor Collaborative Care Management team to explore expanding work at Swedish, likely to include hiring LCSW to provide therapy and some case mgmt.	★
Explore grant funding for LCSW training, therapy, psychoeducation to reduce stigma and expanded individual services.*	**2022 (stub year):** Applied for and awarded a one-year $100,000 grant from Cigna Foundation to hire LCSW to provide psychoeducation in the community and expand individual services beginning 2023 **2023:** Supported hiring of bilingual (English/Spanish) LCSW to serve as a Community Health Social Worker to provide psychoeducation in the community as well as individual services (LCSW position via Cigna grant in 2023); did not receive another Cigna grant to support LCSW position in 2024, seeking other funding to continue **2024 (to date):** Received funding from Swedish Foundation to support LCSW Community Health Social Worker; applied for Cook County Grant ($1 Mil) focused on Equitable Behavioral Health (would include training for two LSWs and two additional LCSW positions); applied for Cigna Youth Mental Health Grant ($140K) (would fund LCSW hire); applied for US DOJ ($2 Mil) - Community-based Violence Intervention Program	★
Pilot suboxone opioid addiction clinic within Emergency Department and explore expansion through funding.*	**2022 (stub year):** Developed pilot model for suboxone opioid addiction clinic **2023:** Launched suboxone opioid addiction clinic within Swedish Emergency Dept (1 day/wk) **2024 (to date):** Exploring expanded funding to support suboxone opioid addiction clinic	●
Initiate Family Connects screening and build connections to various post-partum depression support resources. *	**2022 (stub year):** Initiated partnership with CDPH on Family Connects program **2023:** 164 families served by Family Connects program **2024 (to date):** 208 families served by Family Connects program	★

* denotes initiative with health equity integration

Priority: Mental & Behavioral Health

Strategy #3: Explore opportunities to educate the community about mental health via programs and partnerships.

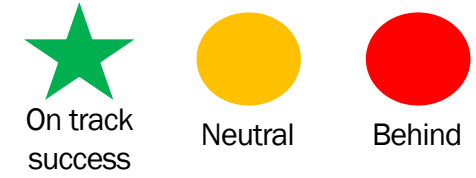


Initiative	Progress/Highlights	Overall Outcome
Explore programs or partnerships with area schools and other local organizations to provide education and/or training.	**2022 (stub year):** Provided educational sessions around mental health, anxiety and other topics to community groups including Muslim Community Center **2023:** Provided educational sessions including stress management support and other mental health topics to schools and community groups; completed 12 community events at 7 schools with more than 80 attendees **2024 (to date):** Community Health Social Worker serving as consultant for Coalition for Immigrant Mental Health's "Reimagining Mental Health Supports for Migrants" initiative (in partnership with University of Chicago, Feinberg School of Medicine and Lurie Children's Hospital). Providing training, reflective supervision and support to frontline shelter staff about basic emotional support for migrants.	★
Explore marketing strategies (including social media or via other channels) to raise awareness and destigmatize mental health for youth and adults.	**2022 (stub year):** Featured in Healthy Driven TV spots and online content "Boosting Your Mental Health"; Community Checkup video series included some mental health features **2023:** Collaborated with organizations including North River Commission (Health & Safety Committee) and Erasing the Distance (stigma awareness and outreach); Promoted monthly parent and teen mental health webinar series with Linden Oaks staff **2024 (to date):** Continued collaboration with area nonprofits on partnerships and programming and promotion of monthly parent/teen mental health Linden Oaks webinar series	★
Continue weekly free New Moms Group (NMG), open to all community members.	**2022 (stub year):** Continued offering weekly new moms group free for all community members, led by behavioral health staff with guest speakers on various topics; offered both in-person and virtually **2023:** Continued offering weekly new moms group free for all community members; 129 total attendees; offered both in-person and virtually **2024 (to date):** Continuing weekly new moms group free for all community members; offered both in-person and virtually	★

* denotes initiative with health equity integration

Priority: Chronic Health Conditions and Wellness

Strategy #1: Address high blood pressure, diabetes and preventative cancer screenings through targeted interventions and outreach.



Initiative	Progress/Highlights	Overall Outcome
Increase efforts around education for patients and providers and improve available data to help inform improvements efforts, inclusive of all patients.*	**2022 (stub year):** Established process to navigate patients to Women's Health Center who have no record of mammogram history or mammogram order on record; 72% of female medical group patients age 50-75 received screening mammogram within the prior 27 months; 52% of medical group patients age 50-75 received colon cancer screening within recommended time frame; 72% of medical group patients with hypertension had blood pressure controlled <140/90; 77% of medical group patients with diabetes had A1c is controlled <9% **2023:** Implemented annual colorectal cancer screening FIT test mailing to patients overdue for FIT or Colonoscopy; Implemented automatic reminder messages to patients overdue for breast cancer screening; 76% of female medical group patients age 50-75 received screening mammogram within the prior 27 months; 58% of medical group patients age 50-75 received colon cancer screening within recommended time frame; 74% of medical group patients with hypertension had blood pressure controlled <140/90; 72% of medical group patients with diabetes had A1c is controlled <9% **2024 (to date):** Continuing efforts to engage medical group patients overdue for cancer screenings; continuing efforts to support patients managing high blood pressure or diabetes	
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.*	**2022 (stub year):** Community Breast Health Program info incorporated into flier for community resources, used by Community and HCEZ teams **2023:** 866 grant funded breast health imaging services provided via Community Breast Health Program **2024 (to date):** Continuing education and promotion of preventative cancer screenings and prevention including services available via Community Breast Health Program grant	

* denotes initiative with health equity integration

Priority: Chronic Health Conditions and Wellness

Strategy #2: Enhance partnerships with local community organizations to better address chronic health conditions.


On track success


Neutral

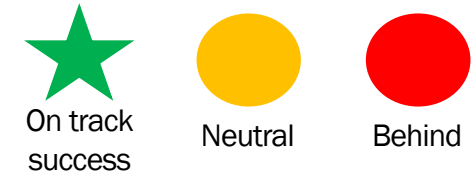

Behind

Initiative	Progress/Highlights	Overall Outcome
Deepen collaboration within local FQHCs via Healthcare Transformation Program to care for underresourced patients managing chronic health conditions.*	**2022 (stub year):** Established partnerships with local FQHCs via Healthcare Transformation Program to provide specialty care for underresourced patients managing A1c and hypertension **2023:** 871 completed appointments for patients managing A1c via Healthcare Transformation Program; 568 completed appointments for patients managing hypertension via Healthcare Transformation Program **2024 (to date):** Hired new Senior Manager, Clinical Operations, Community CARE to oversee Healthcare Transformation Program; Expanding offering to American Indian Center as a referral partner	
Provide funding through NorthShore's Community Investment Fund (CIF) to help local organizations build capacity and increase impact.*	**2022 (stub year):** Developed and launched Community Investment Fund **2023:** Supported and engaged with CIF partnerships to address chronic conditions, including but not limited to supporting the purchase of a new building with expanded capacity to serve community social and wellbeing needs via Rohingya Culture Center **2024 (to date):** Supported new and continuing CIF partnerships, including opening of family health practice through Midwest Refuah	

* denotes initiative with health equity integration

Priority: Chronic Health Conditions and Wellness

Strategy #3: Expand education and outreach to community and patients to promote nutrition, healthy lifestyle choices and wellbeing.

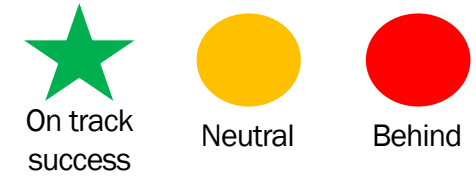


Initiative	Progress/Highlights	Overall Outcome
Expand Food Connections Program, including 1) expanding Veggies for Health program beyond those with food insecurity, to address chronic diseases and 2) launching "Food Prescriptions" pilot program for those with food insecurity + chronic disease, in partnership with area food pantry.*	**2022 (stub year):** Developed plans for expanded Food Connections offerings **2023:** 18 Veggies for Health participants; 5 "Food Prescriptions" pilot participants **2024 (to date):** 23 Veggies for Health participants (Jan-Apr 2024); Unable to proceed with "Food Prescriptions" pilot program at this time due to staffing and other challenges	
Explore ways to grow Nutrition & Diabetes Center via physician referral relationships, partnership with community organizations, CORD and other community awareness campaigns.*	**2022 (stub year):** Developed plans for building relationships with providers, partnering with community organizations and leveraging opportunities with Community Outreach Registered Dietitian (CORD) **2023:** 460 Nutrition & Diabetes Center encounters **2024 (to date):** Continuing services via Nutrition & Diabetes Center	
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.*	**2022 (stub year):** Provided community education including cooking demonstrations and practical nutrition tips via Community Outreach Registered Dietitian (CORD) and other presenters, with sessions taking place at Community Wellness Center as well as at partner community organizations **2023:** Provided community education programming for more than 2,500 individuals on hospital campus or in community; Presented Community CARE grand rounds session to educate hospital employees about programs and offerings available to community members **2024 (to date):** Continuing community education programming on hospital campus and in community	
Provide smoking cessation program, including discounted fees for under resourced individuals and explore new funding and referral opportunities.*	**2022 (stub year):** Continued offering Smoking Cessation 8-week program via hybrid model, including discounts for individuals unable to pay the full program fee **2023:** Offered 5 smoking cessation programs (each program has 8 weekly sessions) to a total of 34 individuals (in-person and virtual option) **2024 (to date):** Continuing to offer Smoking Cessation 8-week program via hybrid model	

* denotes initiative with health equity integration

Priority: Chronic Health Conditions and Wellness

Strategy #4: Enhance Galter Life Center (GLC) offerings to support health and wellbeing.



Initiative	Progress/Highlights	Overall Outcome
Explore funding and referral opportunities for various GLC wellness and integrative medicine programs.*	**2022 (stub year):** Explored new referral opportunities **2023:** 118 referrals into GLC wellness and integrative medicine programs **2024 (to date):** 22 non-EPIC referrals (Jan-Apr 2024)	★
Increase number of scholarship memberships for community members based on medical and financial need.*	**2022 (stub year):** Supported scholarship memberships based on medical and financial need **2023:** 117 members served by need-based scholarships **2024 (to date):** 114 members served by need-based scholarships; expansion of scholarship program underway due to member gift	★
Support Integrated Cancer Care Program (ICCP) via GLC services and explore expansion opportunities.	**2022 (stub year):** Promote and support ICCP program opportunities, funded by Swedish Hospital Foundation **2023:** 762 services provided to ICCP participants **2024 (to date):** 355 services provided to ICCP participants	★
Explore ways to enhance participation in community outreach, including point of care screening events.*	**2022 (stub year):** Not started **2023:** Discussion with stakeholders about types of screening events and equipment needed **2024 (to date):** Developing systemwide Blood Pressure Screening toolkit to support outreach events	●
Explore EPIC integration with GLC, to provide efficient, streamlined referrals from inpatient and outpatient settings to GLC wellness programs.	**2022 (stub year):** Explored process for EPIC integration to streamline GLC wellness program referrals **2023:** Navigated EPIC integration implementation process and successfully implemented in Dec 2023 **2024 (to date):** Promoting and supporting EPIC referrals to GLC wellness programs; raising awareness among referring providers; 69 EPIC referrals (Jan-Apr 2024)	★

* denotes initiative with health equity integration