SILVER CROSS HOSPITAL

2027-2029
Community Health Implementation Plan

Based on the FY26 Community Health Needs Assessment (CHNA)

This Community Health Implementation Plan describes the strategies Silver Cross Hospital will use from 2027 through 2029 to address the four significant health needs prioritized through the 2025 Will County Community Health Needs Assessment. For each priority, the plan identifies intended actions, anticipated impact, outcome measures, hospital resources, and community collaborators.

Community Health Needs Assessment approved and publicly available December 2025: https://ncstoragemlsilvercross.blob.core.windows.net/public/2025-Will-County-Community-Health-Needs-Assessment-Report-2025.Silver%20Cross.pdf

Community Health Implementation Plan Approved by: Silver Cross Hospital Board of Directors on (DATE PENDING)

Community Health Implementation Plan publicly available (POSTING PENDING)

I. Introduction and Purpose

Silver Cross Hospital is a locally governed, not-for-profit health system rooted in Will County and surrounding communities. Founded in Joliet in 1895 as a 33-bed hospital, Silver Cross has grown into a 348-bed hospital in New Lenox while remaining committed to providing high-quality, compassionate, patient-centered care.

a. About Silver Cross

Silver Cross Hospital's commitment goes back to Thanksgiving Day in 1895 when the Will County Union of King's Daughters and Sons opened the doors to a 33-bed hospital in Joliet. They named it Silver Cross, after their emblem - the Maltese cross. They made a promise to provide quality healthcare with compassion for the citizens of Will County and surrounding communities. Over 130 years later, SCH remains true to that promise, treating patients the way you should be treated.

b. Mission

To improve the health of those we serve and advance wellness in our community.

c. Vision

Together, the Silver Cross Family strives to always be the region's most trusted, highest-quality, patient-centered health system. We are locally governed, rooted in the communities we serve, with a culture focused on delivering a clinically excellent and unrivaled experience.

d. Core Values

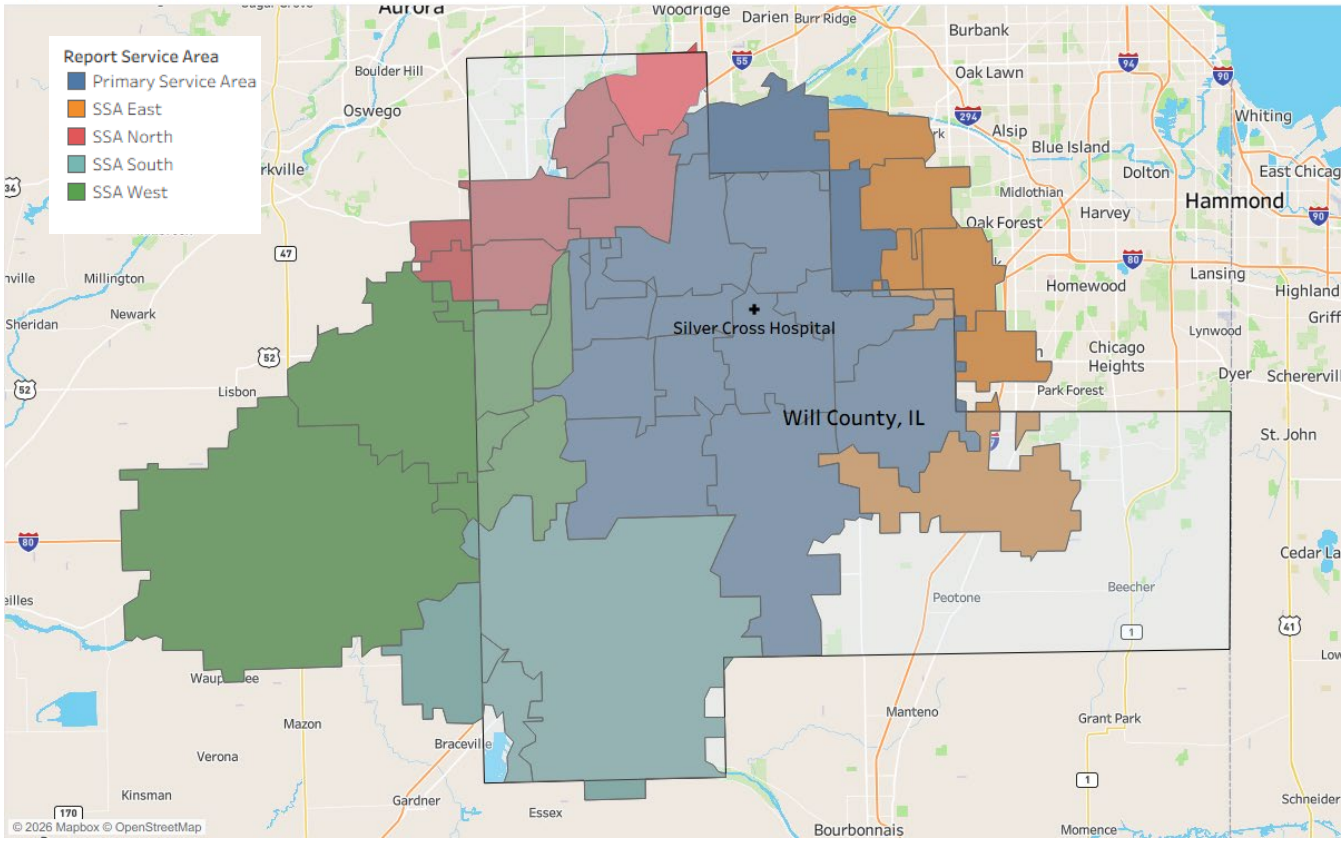
We, as members of Silver Cross Hospital team, are dedicated to meeting the needs of the people we serve by living our Core Values of:

Safety — do no harm
Inclusiveness — work collaboratively and transparently
Leadership — take initiative, demonstrate professionalism and be accountable
Virtue — demonstrate integrity and ethical behaviors
Excellence — achieve distinction for high reliability in quality and service
Respect — honor the feelings, traditions, and rights of others.

II. Community Definition

Silver Cross Hospital defines its community as Will County and the surrounding geographic area represented by the ZIP codes from which approximately 65 percent of inpatient admissions originated during calendar year 2025. This patient-origin methodology focuses the Implementation Plan on the population and geographic area most directly served by the hospital.

Silver Cross Service Area
(Will County Overlay)



Service Area	Zip and PO Name
Primary Service Area	60403 - CREST HILL
Primary Service Area	60421 - ELWOOD
Primary Service Area	60423 - FRANKFORT
Primary Service Area	60432 - JOLIET
Primary Service Area	60433 - JOLIET
Primary Service Area	60435 - JOLIET
Primary Service Area	60436 - JOLIET
Primary Service Area	60439 - LEMONT
Primary Service Area	60441 - LOCKPORT
Primary Service Area	60442 - MANHATTAN
Primary Service Area	60448 - MOKENA
Primary Service Area	60451 - NEW LENOX
Primary Service Area	60467 - ORLAND PARK
Primary Service Area	60491 - HOMER GLEN

Service Area	Zip and PO Name
Secondary Service Area - East	60443 - MATTESON
Secondary Service Area - East	60449 - MONEE
Secondary Service Area - East	60462 - ORLAND PARK
Secondary Service Area - East	60464 - PALOS PARK
Secondary Service Area - East	60477 - TINLEY PARK
Secondary Service Area - East	60487 - TINLEY PARK
Secondary Service Area - North	60440 - BOLINGBROOK
Secondary Service Area - North	60446 - ROMEOVILLE
Secondary Service Area - North	60490 - BOLINGBROOK
Secondary Service Area - North	60544 - PLAINFIELD
Secondary Service Area - North	60586 - PLAINFIELD

Service Area	Zip and PO Name
Secondary Service Area - South	60408 - BRAIDWOOD
Secondary Service Area - South	60416 - COAL CITY
Secondary Service Area - South	60481 - WILMINGTON
Secondary Service Area - West	60404 - SHOREWOOD
Secondary Service Area - West	60410 - CHANNAHON
Secondary Service Area - West	60431 - JOLIET
Secondary Service Area - West	60447 - MINOOKA
Secondary Service Area - West	60450 - MORRIS

III. Community Health Needs Assessment

Guided by its mission to improve the health of those it serves and advance community wellness, Silver Cross Hospital strives to be the region's most trusted health system by delivering clinical excellence, an exceptional patient experience, and programs that respond to the evolving health needs of the community.

As part of this mission, Silver Cross Hospital collaborated with the Will County MAPP (Mobilizing for Action through Planning and Partnerships) Collaborative to complete the 2025 Community Health Needs Assessment (CHNA). The Collaborative gathered qualitative information through surveys, interviews, and focus groups involving public health representatives, community leaders and organizations, healthcare providers, residents, and other public-serving entities. It also reviewed data from public sources and compared local results with state and national benchmarks to assess the relative severity of each health need. The quantitative and qualitative findings were then combined to identify Will County's significant community health needs.

This collaborative process supported Silver Cross Hospital's compliance with Section 501(r)(3) of the Internal Revenue Code, as established by the Patient Protection and Affordable Care Act. This provision requires each tax-exempt hospital facility to conduct a community health needs assessment at least once every three years and adopt an implementation strategy to address the significant health needs identified through that assessment.

The findings of the Will County Community Health Needs Assessment are available to the community at https://ncstoragemlsilvercross.blob.core.windows.net/public/2025-Will-County-Community-Health-Needs-Assessment-Report-2025.Silver%20Cross.pdf

IV. The Identified Community Health Needs

The Silver Cross Hospital Health Equity Steering Committee, a team of senior leadership members representing several departments of the organization, including clinical administration, medical operations, nursing, business intelligence and community relations reviewed the findings of the CHNA. Based on the analyses of both the quantitative and qualitative data of the CHNA, they prioritized Will County's significant community health needs into four main needs:

1. Chronic Conditions Management and Physical Inactivity

- Chronic conditions management
- Rising physical inactivity
- Escalating health needs of aging community

2. Maternal and Child Health Issues

- Maternal and child health
- Pregnancy and postpartum domestic violence

3. Healthy Food Access and Intake

- Access to Food and Nutrition
- Declining healthy food intake

4. Gap in Behavioral Health and Social Isolation

- Gap in behavioral health/ substance abuse services
- Risk of aging community social isolation

V. Implementation Plan Purpose and Development

The Health Equity Steering Committee developed this Implementation Plan to align Silver Cross Hospital's strategic initiatives, programs, and resources with measurable goals for addressing the community health needs identified in the CHNA.

The Implementation Plan outlines how Silver Cross Hospital plans to address the prioritized community health needs and is intended to satisfy the requirements set forth by state law and the Internal Revenue Code Section 501(r)(3) regarding Community Health Needs Assessments (CHNA) and Implementation Strategy addressing identified needs.

The Health Equity Steering Committee will review this Implementation Plan annually to assess progress against the identified outcome measures, determine whether strategies remain responsive to community needs, and recommend revisions when results, resources, or community conditions warrant a change.

For each of the identified and prioritized community health needs identified, this plan includes the following:

- **Strategies:** The actions Silver Cross intends to take to address the prioritized health need.
- **Anticipated Impact:** The anticipated impact of these actions.
- **Outcome Measures:** The measures used to evaluate such impact.
- **Hospital Resources Contributed:** Identification of programs and resources Silver Cross plans to commit to addressing health needs.
- **Community Organization Collaborators/Partners:** Description of any planned collaboration between Silver Cross and other organizations in addressing health needs.

Silver Cross Hospital will monitor implementation progress using the outcome measures established for each strategy. The Health Equity Steering Committee will review results annually, document progress and implementation barriers, and recommend adjustments to strategies, resources, or partnerships when needed. Findings will be incorporated into the hospital's community benefit reporting and future community health planning.

VI. Community Needs Not Addressed

Silver Cross Hospital provides a wide range of needed healthcare services and community benefits through adherence to its mission, using its resources and capabilities and working collaboratively with a vast array of community partners. By focusing on our strengths and allocating our resources appropriately, we can achieve a greater impact in the community we serve.

There are no significant health needs that are not being addressed in Will County as identified by the CHNA.

VII. Community Health Implementation Plan by Need:

1. Chronic Conditions Management and Physical Inactivity

Rationale: The CHNA found that adults in the community experience higher rates of chronic conditions, including diabetes and cancer, than state benchmarks, along with rising physical inactivity compared with prior years, particularly among older adults. In response, the Health Equity Steering Committee identified the need to strengthen chronic disease self-management support and expand accessible opportunities for physical activity to help residents better manage chronic conditions and improve overall health.

Strategies to address this community need include:

	Strategies	Anticipated Impact	**Outcome Measures**	Hospital Resources Contributed	Community Organization Collaborators/Partners
1.	Utilize technology to contact patients to proactively manage access and compliance with follow-up to close chronic care gaps.	Increased awareness and improved self-management of chronic conditions among participants.	Number of participants annually, trending quarterly.	SCH Staff Finances to deploy agency partner resources	• Phamily
2.	Provide health lectures/education throughout the year.	Increased awareness of chronic conditions management; better management of chronic conditions among participants.	Number of sessions educational sessions held annually.	SCH Staff class coordinators, clinical speakers, venues and educational materials	• Will County Fire Dept • Will County Bar Association (Wellness Fair) • City of Joliet
3.	Provide fitness/exercise sessions within community, including nursing communities, to increase physical activity.	Increased movement for community members at sessions and routines to be able to continue outside of the sessions.	Number of fitness/exercise sessions held annually.	Physical instructor and venues	• National Hook-Up of Black Women • City of Joliet • Nursing Homes
4.	Provide Heart Failure management services and grow clinic visits to CHF clinic.	Awareness and anticoagulant adherence; better patient outcomes.	Heart Failure Clinic participation trending.	SCH CHF clinic staff and resources	
5.	Continue to offer health screenings at discounted self-pay prices.	Increase access to screenings for lung cancer and heart disease for patients with any or no insurance.	Screenings available and utilized.	SCH Staff and sites	

6.	Continue community patient liaison program to provide resources/access to care for uninsured and underinsured patients in the community**.**	Increase access to care for uninsured/underinsured patients to seek proactive care and to help manage chronic conditions.	Number of patients referred to Will County resources.	SCH Staff	• Will County Community Health Center • Will Grundy Medical Center

2. Maternal and Child Health Issues

Rationale: Hospital and community leaders identified insufficient access to prenatal care as a significant concern because delayed or inadequate prenatal care can increase the risk of low birth weight and other adverse outcomes, particularly for pregnant patients who do not have an established obstetric provider. In response, the Health Equity Steering Committee identified the need to strengthen connections to prenatal and obstetric care to support earlier intervention, improve continuity of care, and promote healthier outcomes for parents and infants.

Strategies to address this community need include:

	Strategies	Anticipated Impact	**Outcome Measures**	Hospital Resources Contributed	Community Organization Collaborators/Partners
1.	Screen postpartum patients for complications and mental health (part of the Illinois Perinatal Quality Collaborative (ILPQC) on Equity) in ED and OB units.	Identify postpartum patients at risk for complications and mental health and escalate cases to social work/psych consultants.	Percentage of postpartum ED patients that were screened.	SCH Staff	• Illinois Perinatal Quality Collaborative (ILPQC) on Equity and Safe Sleep for Infants (ESSI)
2.	Screen prenatal and postpartum patients for domestic violence/intimate partner violence in ED.	Identify prenatal and postpartum patients at risk for domestic violence/intimate partner violence and escalate cases to social work consultants.	Percentage of prenatal and postpartum ED patients that were screened.	SCH Staff	
3.	Screen and identify patients at risk of not having safe sleep options.	Identify patients in need of pack and plays and provide them for infants free of cost to patients.	Number of pack and plays provided trending.	SCH Staff	• Illinois Perinatal Quality Collaborative (ILPQC) on Equity and Safe Sleep for Infants (ESSI) • Rush Perinatal Center • United Way Program (Pack and Plays)

3. Healthy Food Access and Intake

Rationale: Community members reported limited access to affordable, nutritious food, and CHNA data showed that food insecurity in the community exceeds the state benchmark. In response, hospital leadership identified the need to expand access to healthy food by providing short-term assistance to patients at risk and strengthening community food resources through coordinated partnerships.

Strategies to address this community need include:

	Strategies	Anticipated Impact	**Outcome Measures**	Hospital Resources Contributed	Community Organization Collaborators/Partners
1.	Screen admitted patients and ED patients for food insecurity.	Identify patients at risk for food insecurity and provide food referral resources.	Percentage of patients screened for food insecurity trending.	SCH Staff	• Northern Illinois Food Bank • Senior Services of Will County
2.	Create a centralized source of food referrals on SCH website.	Increased support for patients to access local food banks and resources offering healthy food options.	Activity on/use of SCH website for food resources.	SCH Staff SCH Website	• My Pantry Express/ Northern Illinois Food Bank referrals. • NHBW – Emergency Food Bank
3.	Screen OB and NICU patients for WIC eligibility.	Refer 100% of eligible OB and NICU patients to WIC before discharge to ensure access to food.	Percentage of OB and NICU patients screened for food insecurity and WIC eligibility.	SCH Staff	• WIC
4.	Sponsor or deliver healthy cooking or nutrition classes and fruit and vegetable gardens with community partners.	Learned skills or increased education on healthy cooking and nutrition.	Number of classes per year.	SCH Staff Class Venues	• Joliet Boys and Girls Club • Harvey Brooks Foundation • National Hook-Up of Black Women

4. Gaps in Behavioral Health and Social Isolation

Rationale: Community members identified gaps in mental health and substance use services, including difficulty finding appropriate care, increased demand since the pandemic, and delayed treatment when caregivers and others do not recognize emerging mental health concerns. CHNA data also showed a higher average number of mentally unhealthy days, as well as higher rates of opioid-involved accidental poisoning deaths and drug overdose deaths, compared with state benchmarks. In response, hospital and community leaders identified the need to improve access to mental and behavioral health services, strengthen early recognition, and support timely connections to appropriate care throughout Will County.

Strategies to address this community need include:

	Strategies	Anticipated Impact	**Outcome Measures**	Hospital Resources Contributed	Community Organization Collaborators/Partners
1.	Create education for the community on sight of care options for behavioral health visits.	Increased knowledge or options for behavioral health visits, reducing waits at SCH ED and increased capacity for behavioral health patients.	Number of behavioral health patients in SCH ED, Silver Oaks seen and transferred.	SCH Staff Risk and Marketing Departments	• Silver Oaks
2.	Partner with community organizations, including the provision of grant funding, to improve mental health of youth and families.	Increase confidence, self-awareness and purpose of community youth and adults.	Number of events co-sponsored in community.	SCH Staff	• Silver Cross Healthy Community Commission • Joliet Aid Mentorship Program for Teen Girls • National Hook-Up of Black Women • Thriveworks • Mindful Living Centers • NAMI Will-Grundy • Will County Community Health Center
3.	Screen 65+ inpatients for risk of social isolation and share community resources available.	Identify inpatients 65+ at risk for social isolation and share resources available to improve their mental health.	Number of patients 65+ screened and referred.	SCH Staff	• Paramedicine program Joliet/Lockport
4.	Address community substance abuse need.	Reduce overdoses in community.	Number of substance abuse admissions trending.	SCH Staff SCH DOPP Program	• Extensional Counseling Society • Will County Health Department