2023 Implementation Strategy

Parkview Hospital, Inc.

PARKVIEW HEALTH

Table of Contents

Introduction 1
- Purpose 1
- Mission and Vision 1

Parkview Hosptial 2
- Community Served 2

Summary of 2022 Community Health Needs Assesment 3
- Summary of Findings 3
- Approach 3

Prioritization Methodology 4
- Prioritization Process 4

Implementation Strategy Process 5

Community Health Implementation Plan 6
- Priority #1: Mental Health 6
- Priority #2: Obesity 9
- Priority #3: Maternal and Child Health 18

Significant Health Needs Not Addressed by the Implementation Strategy 22

References 23
- For More Information 24
- Board Approval 24

Introduction

Purpose

To grow and ensure the continued quality of Parkview Health's commitment to improving the health of our community, each of our licensed hospitals prepare a community health needs assessment (CHNA) and subsequent implementation strategy on a triennial basis. Using the knowledge gained from the 2022 CHNA results, this report will define Parkview Hospital's community health implementation strategy for the 2023 – 2025 assessment cycle as federally required by the Affordable Care Act. In doing so, this report will define:

- The community served
- The community's top health needs
- The CHNA/implementation strategy process
- How the hospital is addressing community needs
- Identified needs not being addressed

The contents of this report were formed in compliance with the requirements set forth by the Internal Revenue Service for tax-exempt health systems and hospitals.

Mission and Vision

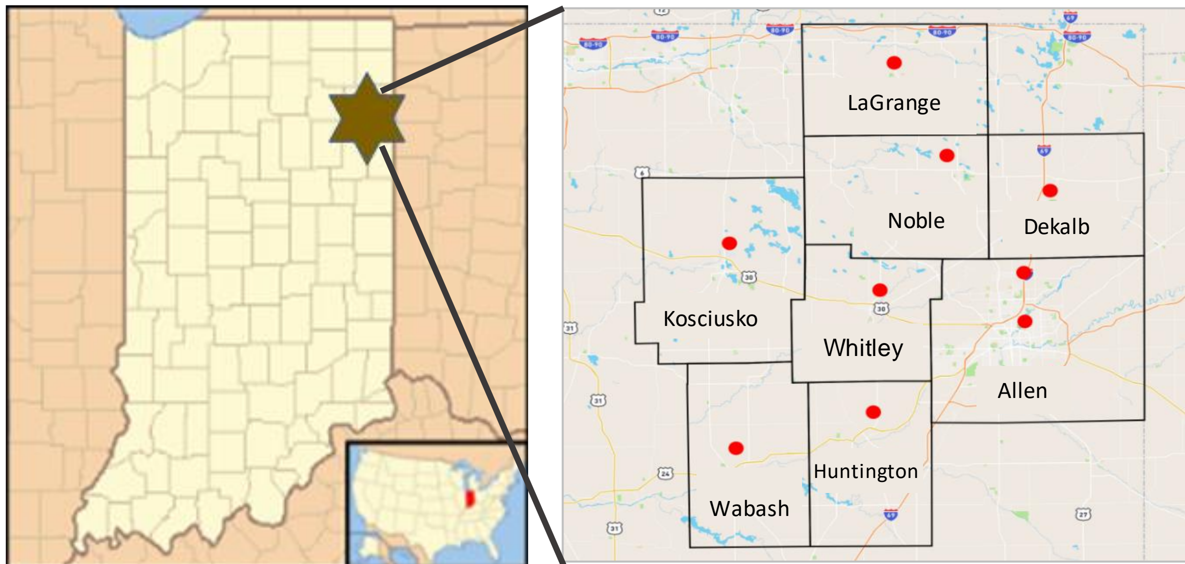
Parkview Health Mission & Vision
Parkview's mission is to improve the health of our community members and inspire them to take steps to improve their well-being. Parkview puts their patients at the center of everything they do, as an individual, as an employer and as our community.

Parkview Hospital

Parkview Hospital, inc. is a charitable, not-for-profit, community-owned hospital and consists of a 476-bed regional tertiary referral center (Parkview regional medical center), as well as a 216-bed community hospital (Parkview hospital Randallia) and an 89-bed behavioral health hospital (affiliate of Parkview behavioral health institute), located in Fort Wayne, Indiana. The service area includes northeast Indiana, northwest Ohio, and south-central Michigan.

Parkview hospital, inc. Is home to a verified level ii adult and pediatric trauma center in addition to the Samaritan medical flight and ground transport services, and a full-service, 24-hour emergency department. Specialty services include a heart institute, a certified comprehensive stroke center, women's & children's hospital, outpatient service center and cancer institute.

Figure 1. Counties with Parkview Hospitals



Community Served

The facilities of Parkview Hospital, Inc., consisting of the Parkview Regional Medical Center, Parkview Hospital Randallia and the Parkview Behavioral Health Institute, are located in Allen County. Allen County, or more specifically, Fort Wayne, Indiana, is the largest urban area within the health system's service area. According to the 2022 Parkview Hospital, Inc. CHNA, Allen County has a population of 375,520 (2020). In addition, the median income of Allen County residents is approximately $57,104, with 12.6% living below the federal poverty level (2020). Approximately 8% of Allen County residents do not have health insurance (2020).

Summary of 2022 Community Health Needs Assessment

Parkview Hospital's CHNA report provides an overview of the approach taken to identify and prioritize significant health needs in Allen County, as federally required by the Affordable Care Act. The Health Services and Informatics Research (HSIR) group at Parkview's Mirro Center for Research and Innovation designed and conducted both primary and secondary data collection and analysis activities. Data collection was focused on the eight counties in northeast Indiana that comprise Parkview's primary service area and where a Parkview hospital is located, including: Allen, DeKalb, Huntington, Kosciusko, LaGrange, Noble, Wabash and Whitley.

The purpose of the CHNA report is to offer a comprehensive understanding of the health and social needs of Allen County, to guide Parkview Hospital, Inc.'s strategic community health improvement plan for addressing the identified needs (*CDC - Assessment and Plans - Community Health Assessment - STLT Gateway*, 2019). Parkview Hospital, Inc. in Allen County will use the findings in this report to identify and develop efforts to improve the health and quality of life for residents in the counties we serve.

Approach

The HSIR group assessed the overall health needs of the Parkview Health region, as well as the needs of each individual county. Community health needs of interest were based on past CHNAs and secondary data from the Healthy Communities Institute (HCI) database. The HSIR team used surveys to gather input from individual community members and healthcare and social service providers (i.e., physicians, nurses, social workers) to understand local health concerns, needs, and service availability.

Summary of Findings

The findings from Parkview Hospital's 2022 CHNA are a result of the analysis of an extensive set of secondary data (over 200 indicators from national and state data sources) and primary data (2842 surveys) collected from community members and healthcare/social service providers. Below are the top ten health concerns and health service needs as ranked by the Hanlon method and survey data, respectively.

Allen County's Top Ten Health Concerns*	
• Obesity	• Cardiovascular disease (stroke, coronary heart disease)
• Mental health	• Substance use/abuse (drugs, alcohol, tobacco)
• Chronic obstructive pulmonary disease	• Cancer
• Asthma	• Diabetes
• Kidney disease	• Child abuse

* After Hanlon method applied to secondary and primary data; merged categories of concerns are in parentheses

Allen County's Top Ten Health Service Needs*	
• Mental health services	• Access to primary care providers
• Substance use disorder services	• Senior services
• Access to healthy food	• Gun safety
• Access to recreational spaces	• Health insurance
• Access to birth control	• Childcare

* As indicated by community and provider concerns expressed in survey data

Prioritization Methodology

To organize and rank order significant health needs across the Parkview Health eight-county region, primary data from community and provider surveys and secondary data were combined using a modified Hanlon score. Each health indicator corresponded to a health concern from the survey, thus health domains from the survey were used to cluster health indicators.

For each health indicator, scores for percentage of the population affected (size), percentage of community respondents endorsing the corresponding health concern (seriousness), percentage of provider respondents endorsing the corresponding health concern (seriousness), trend in health indicator (seriousness), and existence of evidence-based interventions (effectiveness of intervention) were assigned.

According to the Hanlon scores, the top health concerns were mental health, obesity, and chronic disease.

Prioritization Process

A prioritization session was convened on September 21, 2022, with 26 attendees. Attendees included providers, administrators, board members, and community health partners. Survey data collection methods were explained, and the 10 health concerns with the highest Hanlon scores were presented via slides. Once all 10 health concerns were presented, attendees discussed and amended the categories. Through this process, consensus emerged around the top four priorities. A large-group discussion ensued around these four health issues, and attendees were then asked to vote to rank the four health concerns in terms of their top priorities for Parkview Health. Twenty-three individuals (3 HSIR employees did not vote) participated in the voting.

Attendees used Mentimeter, an anonymous, synchronous polling system, to score each health concern using four criteria (1) significance of the health problem (i.e., how many people are affected?); (2) severity of the health problem (i.e., how likely is it to limit length and quality of life?); (3) suitability for a strategic intervention (i.e., can Parkview address the problem?; and (4) SDOH (i.e., do social determinants of health drive health disparities in rates and outcomes?). For each health concern, participants were asked to score each criterion on a scale of 1 (very little) to 10 (very much).

The health concerns obesity and maternal/child health were selected as the top priorities. Mental health was determined to be the single shared priority across Parkview Health at the system-wide prioritization session held August 22, 2022.For more detail regarding prioritization methodology please see page 40 of Parkview Hospitals CHNA:

https://www.parkview.com/media/file/2022%20Allen%20County%20CHNA.pdf

Implementation Strategy Process

Based on the 2022 CHNA results, our prioritization sessions and collaboration with our internal and external partners, our health initiatives have transitioned to the following:

- 2019 Mental Health and Substance use disorder → 2022 Mental Health
- 2019 Cardiovascular/Diabetes → 2022 Obesity
- 2019 Maternal/Child Health → 2022 Maternal/Child Health

In addressing each prioritized health issue identified above, Parkview Hospital created the following implementation strategy to define how Parkview Hospital intends to address each identified health need. This process requires expertise from Community Health Improvement staff, program leads, community nurses and health workers, and partner organizations. Parkview Hospital's Community Health Improvement committee, a committee consisting of hospital board members, hospital leadership and community stakeholders, reviewed and adopted the implementation strategy on May 3, 2023.

Community Health Implementation Plan

Implementation strategies are illustrated below according to health priority.

Mental Health

Identified Health Need: Mental Health

Goal: By December 31, 2025, the SOS Team, Parkview/Park Center's mobile crisis team, will decrease unnecessary mental health crisis visits to Emergency Departments (ED) within the Parkview/ Park Center Health System service area by responding to individuals in crisis wherever they are located, de-escalating the situation, and connecting the person to ongoing wrap-around services to better support their mental health needs.

Objectives: Increase the percentage of patients maintained in the community as a result of a mobile crisis visit by 2% each year.

- Increase the number of crisis runs, crisis calls, and follow-up calls and visits completed by the SOS Team by 5% each year.
- Increase the average number of services each patient in crisis is referred/connected to.

Program	Indicator	Interventions	Anticipated Impact	Internal/External Partners
SOS Program	• Number of crisis runs • Number of crisis calls • Number of follow-up calls • Number of in-person follow-up visits/case management • Number and percentage of patients maintained in the community • Number and percentage of patients taken/referred to ED by HelpLine and SOS • Average number of services patients referred/connected	• Screen person in crisis for suicidal ideation • Complete Mental Health assessment • Connect to necessary resources and services • Provide/arrange transportation to appointments as needed • Complete Safety Plan • Assessment and education on Access to Lethal Means conducted and person in crisis assisted with keeping environment safe (e.g., medications locked up, gun locks distributed and put on) • Share Crisis/ HelpLine information with person in crisis • Follow-up with persons seen and provide case management as needed until person is connected to ongoing services	• Decreased number of ED visits by person in crisis • Connection to wrap-around services such as Intensive Outpatient Therapy (IOP), Individual therapy, Medication services, case management • Person in crisis utilizes Parkview HelpLine when necessary for support • Person in crisis follows safety plan when suicidal ideation is present • Medication compliance allowing person in crisis to maintain within the community safely	• Parkview HelpLine • Parkview Health referrals (e.g., departments, social workers, providers, clinics, etc.) • DCS for counties served • Sheriff Departments for counties served • City Police Departments within counties served • School Systems within counties served • Community Partner Organizations within counties served

Identified Health Need: Mental Health				
Goal: Reduce the number of individuals with substance use disorders (SUD) in individuals/families in Allen/Adams/Wells County who go without services.				
Objective: Decrease the health risks due to substance use disorder for mom and baby during pregnancy and the post-partum period.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
SAMHSA SUD/OUD Peer Recovery Coach Program	• Number of unduplicated clients who participate in a SUD treatment program • Client retention at six months • Proportion of clients maintaining abstinence at six months	• CD Navigators placed within criminal justice system. • Community education position • Outreach coordination • Prevention/Early intervention outreach at shelter • Peer recovery coaches	• Increased engagement to the SUD continuum of care • Increased access to higher levels of care, such as IOP	• DCS • Criminal Justice • Emergency Dept • Community Agencies • Homeless Shelters

Identified Health Need: Mental Health				
Goal: Reduce the number of pre-term births resulting from substance use in Allen County.				
Objectives: Decrease the health risks due to substance use disorder for mom and baby during pregnancy and the post-partum period. • Link 100% of program participants with appropriate services.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
Maternal Substance Use Disorder Navigator program for pregnant women with substance use disorder	• Number of total referrals • Number of engaged individuals • Number of participants linked to mental health treatment • Number of participants referred to recovery supportive services	• Coordination of local medication assistance treatment programs and psychosocial resources • Coordination of communication related to patient, physician and local recovery services • Navigation of patients through the appropriate level of care	• Improved health outcomes for both mom and baby • Increased knowledge • Behavioral change • Decreased prevalence of maternal overdoses	• PPG OBGYN practices • Parkview Women's & Children's Hospital

<table>
<tr><td colspan="5">Identified Health Need: Mental Health</td></tr>
<tr><td colspan="5">Goal: To improve access to health care services and care coordination each year by supporting clients at local shelters needing assistance with care navigation and other healthcare needs.</td></tr>
<tr><td colspan="5">Objective: Assist clients with mental health care navigation to have the tools and resources to better self-regulate in 100% of clients seeking our help.</td></tr>
<tr><th>Program</th><th>Indicator</th><th>Interventions</th><th>Anticipated Impact</th><th>Internal/External Partners</th></tr>
<tr><td>Homeless Outreach</td><td>• Total numbers served at shelters
• Number Of 911 calls related to mental health needs
• Number of ER visits related to mental health needs
• Number connected to behavioral health services (mental health navigation)
• Number connected to medical home
• Percentage with health insurance
• Number of pharmacy runs</td><td>• Provide nursing care/ medical education to clients and staff
• Connect to behavioral health services when appropriate
• Support clients who need assistance with care navigation for:
- Medical home
- Behavioral Health Services
- Health insurance
- Medication assistance
- Medication pick-up at pharmacies
- Medication preauthorization with providers Follow up appointments Compliance with care
- Discharge instructions
- Connect to community resources</td><td>• Increase connection to behavioral health services when appropriate
• Increased knowledge
• Behavior Change</td><td>• Parkview Behavioral Health
• Park Center
• Local Emergency Rooms
• Alliance Health
• Rescue Mission
• Salvation Army
• Charis House
• St Joseph’s Missions ER Women Shelter
• Community Resources</td></tr>
</table>

Obesity

Identified Health Need: Obesity				
Goal: By December 31, 2025, Taking Root will help reduce childhood obesity in Allen County among program participants.				
Objectives: Improve biometrics and well-being behaviors of program participants (3rd, 4th & 5th graders). • Increase average positive behavior score by 0.50 points / all participating students. • Decrease average mile run time change by 15 seconds / all participating students (creating baseline in 2023). • Increase average body mass index by 0.75 kg/m^2 / all participating students. • Increase average VO2 change by 1.25 mL/kg/min / all participating students.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
Taking Root Health Challenge Program (school-based)	• Aerobic Capacity • Body mass index • Mile Run Test • Behavior score change • Number of program participants	• Healthy lifestyle habit education • Aerobic challenges • Motivational support provided by health champions	• Behavior change • Increased knowledge	• Fort Wayne Community Schools • School staff/faculty and health champions

Identified Health Need: Obesity				
Goal: Promote access and importance of fresh produce through farmers markets (8-16 weeks per year), nutrition and growing education classes (minimum of 36 per year), and facilitation of food insecurity programs (>400 participants over 3 years).				
Objective: Increase understanding of nutrition's role in health, fresh produce consumption, and knowledge of how to grow fresh foods at home by residents in surrounding zip codes.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
Parkview Community Greenhouse and Learning Kitchen	• Number of participants • Percentage of participants from 05/06 zip codes • Percentage of produce sold per farmers market • Number of classes provided per year • Number of participants that learned recommendation of fruits and vegetable.	• HEAL partner engagement classes • Veggie Rx education • Seasonal HEAL farm markets • Yearly nutrition and agriculture classes • Directly engage those living and working in the 05/06 via marketing & outreach strategies and feedback sessions	• Increased knowledge • Behavior change • Improved access to fresh produce • Increased confidence in growing food at home. • Advanced local food systems.	• The HEAL program (St. Joe Foundation & Health Visions) • Purdue Extensions • Veggie Rx program • Other community partner organizations

Identified Health Need: Obesity

Goal: Youth and family community nutrition programs will aid in the reduction of childhood obesity while also improving dietary behaviors among program participants by December 31, 2025.

Objectives: Improve knowledge, skills, and well-being behaviors of participants (children ages 3-18 and their families).

- Increase knowledge of the five food groups and how to create a balanced plate.
- Increase knowledge of kitchen safety.
- Increase healthy habits, specifically fruit and vegetable consumption.
- Gain multiple food exposures; therefore, increasing the likelihood that they will try a variety of foods.
- Gain confidence in preparing a nourishing meal or snack.
- Increase independence, problem solving skills, and critical thinking skills while using creativity skills.
- Strengthen skills related to teamwork, communication, and time management.
- Increase motivation to cook/prepare food for self.
- Improved health literacy through comprehension of nutrition education received.
- Cooking confidence/self-efficacy.
- Develop culinary skills.

Program	Indicator	Interventions	Anticipated Impact	Internal/External Partners
Youth and Family Community Nutrition Programs	• Lifestyle and behavioral surveys • Number of program participants • Knowledge-based surveys • Satisfaction surveys	• Healthy lifestyle habit education • Nutrition education • Hands-on cooking demonstrations/classes • Basic knife and kitchen skills • Life skills education	• Behavior change • Increased knowledge • Increased kitchen and life skills • Gain multiple food exposures • Increased confidence	• Childcare providers • Local non-profit, youth-serving organizations (Fort Wayne Parks & Rec, Big Brothers, Big Sisters, etc.) • Area Schools • After-school and summer programs • LC Nature Park • Center for Healthy Living • Parkview Community Greenhouse & Learning Kitchen

Identified Health Need: Obesity				
Goal: By December 31, 2025, decrease obesity and the effects of chronic disease among children ages 5-17 and their families who participate in the program.				
Objectives: Improve obesogenic risk scores and well-being behaviors of participants (children ages 5-17 and their families). • 50% of referred participants show no change or decrease their body fat percentage and their body mass index. • Increase positive behavior score by 0.75 points for 50% of referred participants. • 50% of referred participants have at least a 5% increase in their score between pre and post assessments. • 50% of referred participants decrease screen time. • 50% of referred participants increase their moderate to vigorous physical activity. • 50% of referred participants increase their fruit and vegetable intake. • 70% family retention rate.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
FitKids360 (a stage two pediatric obesity treatment program)	• Family nutrition and physical activity screening tool • Family (children only) biometric values • Retention rate • Lifestyle and behavioral surveys • Psychosocial functioning survey	• Physician referral • Assessment • Goal setting sessions • Education sessions • Physical activities • Follow-up sessions	• Behavior change • Increased knowledge	• PPG specialty clinics, primary care clinics, and pediatric clinics • External primary care and pediatric clinics • HealthNet of West Michigan • Other community organizations

Identified Health Need: Obesity				
Goal: Administer a Produce prescription program engaging Physicians to offer lifesaving produce to their medically underserved population with chronic disease, so as to reduce the financial barrier to healthy eating.				
Objectives: Increase access to and intake of fresh produce. • Embed knowledge of diet, disease, and utilization of fresh produce to participants.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
Veggie RX (a nutrition prescription program)	• Number of participants • Breakdown of participants by zip codes • Percentage retention rate of program participants. • Number of classes provided per year • Percentage utilization of vouchers • Increase consumption of fresh fruits and vegetables • Improved and sustained food security • Number of provider referrals (internal vs external) • Participant self-reported health change	• Physician referral • RD consultation • Nutrition Education led by registered dietitian • Voucher distribution • Surveys and follow-up	• Behavior change • Increased knowledge • Increased consumption of fresh fruit and vegetables • Skill building for future diet improvements • Improved access to community resources	• PPG offices • External provider offices • FW Farmer’s Market • Plowshares • Parkview Community Greenhouse & Learning Kitchen • HEAL Farm Markets

Identified Health Need: Obesity				
Goal: Dispense healthy groceries through monthly boxes (groceries worth $25 that are culturally tailored, with nutrition education materials, and local resources) for 3 months to 50 families with children 0-5 that identify as food insecure. • Dispense medically tailored groceries through monthly boxes (groceries worth $25 that are culturally tailored, with nutrition education materials, and local resources) for 3 months to 50 seniors 50+ per year that identify as food insecure.				
Objective: Increase nutrition quality and other healthy habits in young family and senior participants.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
Fresh Food Farmacy	• Percentage of participants that identify as food insecure post program • Number of servings of vegetables consumed in the last 24 hours • Number of servings of fruits consumed in the last 24 hours • Percentage of participants that utilized resources provided in boxes • Number of fresh boxes delivered per month	• Grocery boxes • Deliver lessons through handouts • Survey participants pre and post program • Provide additional community resources in boxes.	• Through improved health strategies, increase development, growth, cognition, immunity, and behavior in children 0 to 5 years of age. • Improved health, quality of life, and access to healthy food for seniors 50 and older.	• Safety Pin • Parkview Home Health Care & Hospice • Parkview Seniors Club • Internal/ external providers

Identified Health Need: Obesity				
Goal: Promote access of produce through HEAL farmers markets and importance of healthy eating through a train the trainer model for nutrition education to be delivered to community members (goal of 1,000 per year) through grants awarded to local organizations from partner organization.				
Objective: Increase access and consumption of fresh produce in underserved areas of Allen County.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
Healthy Eating Active Living (HEAL) initiative	• Amount of fresh fruit and vegetable consumption • Number of participants who accessed HEAL Farm Markets • Number of SNAP, WIC and senior vouchers collected and matched • Number of participants of Our Healing Kitchen food preparation classes	• HEAL Farm Markets will accept and double SNAP, WIC and senior vouchers • HEAL Farm Markets will accept VeggieRx • Our Healing Kitchen is offered using a train-the-trainer and peer-to-peer approaches • Growth of sales at our markets • Serve as location and producer for one of the markets	• Behavior change • Increased knowledge • Increased access to fresh produce • Significant community awareness and engagement	• St Joseph Community Health Foundation • Parkview Community Greenhouse • Area churches • Community organizations • Local farmers • Purdue Extension • HealthVisions

Identified Health Need: Obesity				
Goal: Offer urgent access to healthy foods boxes for 100 patients per year who identify as food insecure. Identify internal and external resources tailored to their needs by our FAST team to help ensure patients become food secure (50%).				
Objective: Increase access and consumption of healthy foods and resources in our most vulnerable populations of Allen County.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
Food Assistance Support Team (FAST)	• Number of participants who obtained access to urgent healthy food box • Percentage of participants who became food secure/sustain food security • Percentage of participants we were able to enroll into federal nutrition assistance programs such as SNAP, WIC and senior vouchers. • Number of provider screenings for food insecurity.	• Provide tailored assessment of participant needs. • Address urgent, short-term, and/or long- term needs. • Connect to a community health worker. • Medical nutrition therapy referral to patients with identified need for that service. • Nutrition education provided by dietitian in a variety of different modalities.	• Behavior change • Increased knowledge • Increased access to fresh produce and healthy foods • Significant community awareness and engagement	• St Joseph Community Health Foundation • Parkview Community Greenhouse & Learning Kitchen • Area churches • Community organizations • HealthVisions • Fort Wayne Housing Authority

Identified Health Need: Obesity				
Goal: Offer Simple Solutions, an 8-week interactive curriculum (train the trainer model) focused on embedding healthy lifestyles into at-risk families with children from 0 – 5 years of age, as well as pregnant at-risk women.				
Objective: Increase good nutrition, physical activity, and other healthy habits in young family participants and pregnant women.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
Simple Solutions for Healthy Living	• Increase number of fresh meals prepared weekly • Increase number of meals shared together weekly • Increase percentage of families turning off TV & electronics during mealtime • Increase percentage of families reporting increase in preparing balanced meals • Percentage of decrease in overall screen time • Percentage of increase of those engaging in active play • Percentage of increase in hours of sleep. • Percentage of increase in daily fruit and vegetable consumption. • Increased number of planned meals and snacks • Percentage of decrease in consumption of sugary beverages.	• Train the trainers, i.e., agency home visitors • Family goal setting sessions • Deliver lessons through various media tools of both written/read, and visual. • Survey participants throughout the process • Program evaluation and assessment	• Through improved health strategies, increase development, growth, cognition, immunity, and behavior in children 0 to 5 years of age and their families. • Reduce future risk of childhood obesity • Improve rates of healthy full-term pregnancy and normal birth weight babies.	• SCAN • Lutheran Social Services of Indiana • Network for Safe Families • Parkview Health-Women & Children's Community Outreach: Safety PIN • Early Childhood Alliance • Parkview Health-Community Health Workers • Indiana Department of Health • Healthier Moms & Babies

Maternal and Child Health

Identified Health Need: Maternal & Child Health				
Goal: By December 31, 2025, improve access to healthy foods among at-risk pregnant women in Allen County by providing support and food resources to 100% of pregnant patients served by Community Health Workers with identified food insecurity.				
Objectives: Identify patients seen by community health workers who are food insecure. • Connect patients with resources to alleviate food insecurity.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
Community Health Workers – Food Insecurity	• Number of patients screened for food insecurity by OB nurse navigators • Number of patients screened by CHWs • Number of patients provided with support and food resources	• Screen patients • Refer to appropriate community resources • Develop and utilize standard work processes	• Improved pregnancy outcomes • Improved nutrition • Increased trust in the healthcare system	• Parkview Outreach Dieticians • OB Nurse Navigators • Community Harvest Food Bank • Local food pantries • WIC • Local churches/charities

Identified Health Need: Maternal & Child Health				
Goal: By December 31, 2025, improve access to prenatal care within underserved communities in Allen County by providing support and transportation resources to 100% of pregnant patients served by Community Health Workers with identified transportation barriers.				
Objectives: Identify patients who have transportation barriers. • Connect patients with resources to alleviate barriers.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
Community Health Workers - Transportation	• Number of patients screened for transportation barriers by OB nurse navigators • Number of patients screened by CHWs • Number of patients provided support and transportation resources	• Screen patients for transportation barriers • Refer to appropriate community resources • Develop and utilized standard work processes	• Fewer no show visits • Improved pregnancy outcomes • Increased patient self-efficacy	• OB Nurse Navigators • CHWs • Community Nursing • Citilink • Medicaid Taxi • Local churches/charities

Identified Health Need: Maternal & Child Health				
Goal: By December 31, 2025, reduce the risk of vehicular death and injury among Allen County infants by enhancing parental knowledge and confidence as demonstrated by at least 80% of parents provided with education by CHW reporting that they are confident in safely transporting their infant.				
Objective: Increase caregiver knowledge and confidence about car seat safety.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
Car Seat Safety Program (CHW)	• Number of caregivers educated • Percentage of caregivers reporting that their confidence level after receiving education is rated at "confident" or "very confident"	• Educate and certify staff • Identify appropriate individuals • Provide car seat safety education • Assess caregiver understanding • Follow up to confirm ongoing confidence	• Increased caregiver self-efficacy • Decreased vehicular deaths and injuries • Increased caregiver trust in the healthcare system	• Community non-profits and agencies • Community nursing • Parkview nurse navigators

Identified Health Need: Maternal Child Health				
Goal: By December 31, 2025, identify and disseminate information about trends impacting infant mortality in Allen County.				
Objective: Implement a Fetal Infant Mortality Review Team				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
Allen County Fetal Infant Mortality Review (FIMR)	• Number of case review team meetings held • Number of cases reviewed • Number of maternal/family interviews offered • Number of trends identified	• Case identification & abstraction • Case reviews • Identify trends and make recommendations • Disseminate information • Community action projects	• Increased community engagement • Increased understanding of factors affecting maternal and infant health • Data-driven community action projects • Decreased infant mortality	• Non-profits • Insurance companies • Schools • Mental health organizations • Hospitals • Physician practices • Home visiting agencies • Pregnancy resource centers

Identified Health Need: Maternal/Child Health

Goal: Reduce the number of infant deaths (<1 year of age) in Allen County due to unsafe sleep each year.

Objectives: Increase knowledge and behavior change related to safe sleep practices in 100% of program participants.

- 100% of program participants can assemble and disassemble their Pack 'n Play™ at delivery
- 100% of program participants self-report during their two-week follow-up call they are placing infant on back to sleep

Program	Indicator	Interventions	Anticipated Impact	Internal/External Partners
Safe Sleep Education and Pack 'n Play™ distribution program	• Infant mortality resulting from unsafe sleep per 1,000 live births • Number of program participants • Number of referrals to safe sleep classes • Number of one-on-one education sessions • Number of interpreters utilized for education • Number of PNP and sheets distributed • Number of Safe Sleep Kits (Safe sleep sacks, and book) • Number of 8th graders completed Infant Safety classes	• Safe sleep education offered at no cost • Distribution of Safe Sleep kit - (including Pack 'n Play™) to families without a crib or PNP. • Referrals to safe sleep classes • Cultural support and interpretation • Infant Safety classes for 8th graders in FWCS	• Increased knowledge • Behavior change • Reduced infant death	• Community Health Worker (Safety PIN) • Community Nursing • PPG OB/GYN Nurse Navigators • Parkview Family Birthing Centers and NICU • A Baby's Closet • A Hope Center • A Mother's Hope • WIC • Courtyard • FWCS • Healthier Moms and Babies • Women's & Children's Nurse Navigators • SCAN/Healthy Families • Community partners

Identified Health Need: Maternal/Child Health				
Goal: Increase the number of new mothers who engage in breastfeeding year to year by providing assistance and education to vulnerable mothers through support groups in the targeted zip codes.				
Objective: Increase knowledge of breastfeeding health benefits, mechanics, and support resources in 100% of program participants.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
Community breastfeeding classes and support	• Number of women reporting an increase in knowledge • Number of breastfeeding initiations • Number of duration milestones achieved	• Instruction on breastfeeding health benefits, mechanics, and resources for on-going support • Follow-up phone calls • Follow-up virtual visits or home visits • Virtual and in-person support groups	• Increased knowledge • Improved health outcomes for mom and baby	• Community Health Worker (Safety PIN) program • Healthier Moms and Babies • PPG offices • Family Birthing Center • A Baby's Closet • Courtyard • SCAN/Healthy Families • A Mother's Hope

Significant Health Needs Not Addressed by the Implementation Strategy

Health needs identified and why Parkview Hospital does not intend to address these as part of the implementation strategy:

- **Cardiovascular disease (stroke, coronary heart disease)** –This need isn't being directly addressed with community health funding. However, community health programming related to obesity does address this need indirectly.

- **Substance use/abuse (drugs, alcohol, tobacco)** – This need isn't being directly addressed with community health funding. However, community health programming related to mental health does address this need indirectly.

- **Cancer** – While Parkview Hospital did not select cancer as a top health priority, Parkview Hospital, Inc.'s community health improvement program does provide funding support to Cancer Services of Northeast Indiana's client advocate program.

- **Diabetes** – While Parkview Hospital did not select diabetes as a top priority, it is our intent to help prevent and reduce the prevalence of this chronic condition by addressing obesity through nutrition education, increased access to healthy foods, active living programs and education on other healthy lifestyle habits.

  Chronic obstructive pulmonary disease – While Parkview Hospital did not select chronic obstructive pulmonary disease (COPD) as a top priority, it is our intent to help prevent and reduce the prevalence of this chronic condition by addressing obesity through nutrition education, increased access to healthy foods, active living programs and education on other healthy lifestyle habits. Additionally, the hospital is addressing COPD prevalence through smoking prevention and cessation programs. These programs provide free smoking cessation support to the community. Parkview Hospital also partners with Tobacco Free Allen County (TFAC), through serving as the fiscal agent for this organization.

- **Asthma** – While asthma was not selected as a top health priority, Parkview Hospital's community nursing program administers an asthma program that provides an intervention that moves patients beyond emergency rescue care toward a more proactive approach. The program includes education, information, and strategies for follow-up care that are both inexpensive and effective.

- **Kidney disease** – This need is better supported through external community agencies such as the local chapter of the National Kidney Foundation. This group focuses on prevention education and serves as a resource to those affected by kidney disease and their families.

References

1. *CDC - Assessment and Plans—Community Health Assessment—STLT Gateway*. (2019, April 6). https://www.cdc.gov/publichealthgateway/cha/plan.html

For More Information

Parkview would like to extend gratitude towards its community partners for their collaboration with the 2022 CHNA and 2023 Implementation strategy process that addresses the health needs of Allen County. For additional information about Parkview Hospital's 2022 CHNA or 2023 Implementation Plan, please email us at Community.Health@parkview.com.

Board Approval

Approved by the Community Health Improvement Committee
of the Parkview Hospital, Inc. Board of Directors
03 May 2023