

Parkview Hospital, Inc.
Implementation Strategy Report 2017

Health Priorities: Obesity, Maternal/Child Health and Mental Health

I. Parkview Health's Mission and Vision

- a. Parkview Health Mission Statement: As a community owned, not-for-profit organization, Parkview Health is dedicated to improving your health and inspiring your well-being.
- b. Parkview Health Vision: We will achieve our mission by:
 - i. Tailoring a personalized health journey to achieve your unique goals
 - ii. Demonstrating world-class teamwork as we partner with you along that journey
 - iii. Providing the excellence, innovation and value you seek in terms of convenience, compassion, service, cost and quality.

Within the walls of Parkview Health facilities there is a strong emphasis on providing excellent Care, every patient, every day. Another integral part of the mission takes place outside our walls, in the community, and is accomplished through the community health improvement outreach programs which focus on improving access to healthcare and addressing identified community health needs especially serving vulnerable populations.

II. Community Served which includes description of the geographic areas and populations that will be addressed by the implementation strategy.

- a. Residents of Allen County, in northeast Ind., with an emphasis on underserved families will be served through community health improvement programs that address the top identified health priorities.

III. Implementation Strategy Process - Explanation of how the implementation strategy was developed including who advised or participated in the process. Also describe how the implementation strategy was adopted by the authorized body of the hospital.

- a. The Indiana Partnership for Healthy Communities, a partnership between the Indiana University Richard M. Fairbanks School of Public Health and the Polis Center at Indiana University Purdue University Indianapolis (IUPUI), provided a supplemental report that contained an analysis of our current health initiatives, additional evidence based practices and geographic map of community resources in northeast Indiana to assist in the creation of the implementation strategy report.

Based on the community health needs assessment (CHNA) results and the supplemental report, our internal team along with external partner organizations plan to continue to build on health initiatives that have been developed over the past three years, 2014 through 2016, to address obesity, maternal/child health (previously prenatal care), and mental health in Allen County. Obesity will be a system-wide health priority for all Parkview hospital entities from 2017 through 2019.

- b. The implementation strategy report based on the priorities selected through the most recent community health needs assessment process was reviewed, discussed and approved (adopted) by the community health improvement committee, a committee of the Parkview Hospital Board of Directors and the designated authorized governing body.

IV. Prioritized List of Significant Health Needs Identified in the CHNA - Describe the process and criteria used to identify priorities.

- a. The Hanlon Method referred to as the Basic Priority Rating System (BPRS) is recommended by the Healthy Communities Institute and the National Association of County and City Health Officials (NACCHO) for the purpose of prioritizing community health needs. This method takes into account the size and seriousness of the health issue and proven effectiveness of clinical interventions.
- b. Then staff applied the PEARL criteria of Propriety, Economics, Acceptability, Resources and Legality to local health issues in order to further prioritize identified needs. After this analysis, it was determined that obesity, maternal/child health and mental health will be addressed through community health improvement efforts.

Note: Additional information about the prioritization process is located in the 2016 CHNA report pages 32 through 43.

V. Significant Health Needs (Obesity, Maternal/Child Health and Mental Health) to be Addressed include:

- a. Actions taken to address obesity
- b. Anticipated impact of actions taken to address obesity
- c. Resources the hospital plans to commit to the initiative
- d. Planned collaboration between the hospital and other facilities and organizations

OVERVIEW OF THE OBESITY INITIATIVE (Part of V.)

Problem Statement: Obesity (having a body mass index greater than 30.0) affects all age groups and disproportionately affects people of different socioeconomic statuses and racial/ethnic groups. There are often many complications that can occur as a direct or indirect result of obesity.

Obesity rates in Indiana are higher than the national average, with rates in most of northeast Indiana above the state average. In Indiana, childhood obesity has been identified as a “staggering” problem with 30 percent of children ages 10 to 17 years of age overweight

Purpose: Parkview Hospital will serve as a community leader partnering with other key community organizations to promote a culture of healthy living and well-being.

Goal: The goal of this initiative is to reduce obesity and the chronic diseases that develop as a result in Allen County.

Actions: Parkview Hospital, Inc. will continue outreach programs established from 2014 through 2016 to address obesity primarily in low-income areas of Allen County. Actions to address the issue of obesity center around programs that engage children and families and include the following programs: 1) The Healthy Eating Active Living (HEAL) initiative; 2) Planting Healthy Seeds for 3rd and 4th graders; 3) Planting Healthy Seeds: Early Childhood Edition; 4) Planting Healthy Seeds: After-school Edition; 5) Taking Root well-being challenge program for 4th and 5th graders; 6) Simple Solutions for parents of low-income, pre-school children and; 6) The community nursing nutrition and diabetes education program and cardiovascular/diabetes screening program.

Anticipated Impact: Parkview is bolstering its efforts in areas deemed to be the highest impact for obesity prevention. Anticipated impact include the following: 1) Increase access to fresh, affordable and locally grown food; 2) Increase consumption of fresh produce; 3) Provide curriculum for elementary and middle school students and parents of pre-school children related to physical activity and nutrition; 4) Provide preventive health and skill-building classes for families and pregnant women; 5) Enhance and increase provider directed wellness resources including referrals to health management programs in the community.

Committed Resources to the Obesity Initiative: The hospital has committed over \$400,000 to programs related to reducing obesity during 2017. The hospital sets aside up to 10 percent of its net income on an annual basis as community health improvement funds in order to support community health-related outreach programs to address access to healthcare, and other identified health priorities.

HEAL Initiative

Actions: Through a collaboration with St. Joseph Community Health Foundation (SJCHF), Parkview is committed to the continuation and further evolution of the HEAL initiative from 2017 through 2019. The HEAL initiative engages in three primary activities providing support of the following: 1) Seasonal gardens at various community organizations; 2) Processes that allow for acceptance and doubling of WIC produce vouchers and SNAP purchases at local produce and Farmers’ Markets and; 3) Our HEALing Kitchen cooking classes with curriculums for training the trainer and class participants.

Anticipated Impact: The anticipated impact of HEAL is to increase the sustainable access to and regular intake of fresh, local healthy foods by low income individuals in designated food desert areas of Allen County and link opportunities for healthy eating and active living leading to better overall health and well-being of residents in our community.

Committed Resources: For 2017 -- \$75,000 and additional in-kind staff

Planned Collaboration: HEAL partners include Growth in Agriculture Through Education (not-for-profit urban gardening organization), Slataper Farm urban garden, McCormick Place (low-income housing complex), Fort Wayne Housing Authority, Fort Wayne Boys and Girls Club, the Parkview Fitness Center, Southside Farmers’ Market, transitional

housing facilities, Purdue Extension of Allen County, local farmers, Food Council of Northeast Indiana, Indiana WIC program, SNAP food stamp program, area churches, youth groups and other not-for-profit organizations that assist underserved populations.

Community-based Nutrition/Diabetes Education Program

Actions: A registered dietitian provides educational and screening programs to underserved individuals with pre-diabetes, diabetes or other nutrition-related disease such as obesity, heart disease and hypertension. Activities are in the form of accessible educational classes, one-on-one consultations, blood glucose checks, cooking/nutrition classes, exercise classes and evidence-based educational materials.

Anticipated Impact: This program will increase awareness of pre-diabetes and diabetes, individual risk factors as well as improve access to programs and resources. This will assist clients in maximizing good health and to manage their diabetes or pre-diabetes with confidence. Early identification of pre-diabetes and educational support for those with diabetes to reduce the complications associated with Type 2 diabetes.

Committed Resources: For 2017 -- \$83,849

Planned Collaboration: The community nursing diabetes education program partners include the YMCA of Greater Fort Wayne, Fort Wayne Community Schools (FWCS), Fort Wayne Parks and Recreation Department, Indiana Three Rivers Association of Diabetes Educators, the Northeast Indiana Academy of Nutrition and Dietetics, Matthew 25 Health Clinic, The Rescue Mission (homeless shelter), Neighborhood Health Clinic, Center for Nonviolence, Health Visions, Stop Child Abuse and Neglect (SCAN), Early Childhood Alliance, Vincent Village, Fort Wayne Medical Education Program and the Community Harvest Food Bank. Other collaborations include multiple grocery stores and churches within the community.

Planting Healthy Seeds

Actions: This program is a school-based healthy eating/active living eighteen lesson curriculum designed for 3rd and 4th graders. This Indiana State Department of Education approved curriculum is used as a tool for teachers to instruct students on healthy living habits. Planting Healthy Seeds helps to instill healthy eating and active living habits and ties into this education the local mascot of the Fort Wayne TinCaps Baseball team, Johnny Appleseed.

Anticipated Impact: Students participating in Planting Healthy Seeds curriculum will demonstrate increased knowledge of healthy habits determined through pre- and post-tests. Long-term outcomes include positive behavior change among children and adults, reduction in childhood and adult obesity and reduction in the rates of chronic disease associated with obesity.

Committed Resources: For 2017 -- \$28,185

Planned Collaboration: Planting Healthy Seeds partners with two area school districts, local private schools, the Indiana State Department of Education and the Fort Wayne TinCaps.

Planting Healthy Seeds: Early Childhood Edition

Actions: This program was created for childcare providers focusing on the early childhood audience, ages 0 to 5 years, and their parents. A toolkit was developed for preschools and childcare sites and focuses on nutrition, physical activity and wellness plans. In collaboration with local early childhood education provider, this program provides linkage to professional development and well-being educational materials. Participating preschools and childcare sites receive the toolkit along with three professional development sessions for staff and implementation assistance through an early childhood educator site coach.

Anticipated Impact: Increase the proportion of participating sites that complete the following: 1) Improve their Let's Move Child Care quiz score; 2) Fully implement at least one best practice in nutrition and physical activity; 3) Document policies and procedures to adopt best practices; 4) Offer fruits and vegetables at every meal; 5) Offer recommended physical activity minutes per day for all age groups served. Long-term impact will encompass an increase in knowledge, behavior change, and a decrease in obesity rates and the occurrence of chronic diseases associated with obesity.

Committed Resources: For 2017 - \$13,145

Planned Collaboration: Planting Healthy Seeds: Early Childhood Edition partners with Early Childhood Alliance, other preschools and childcare providers, the Indiana Department of Education and the Fort Wayne TinCaps.

Planting Healthy Seeds: After-School Edition

Actions: This program is an adaptation of the original Planting Healthy Seeds curriculum focused on healthy lifestyle habits messaging that can be adapted to various age-groups. This program provides after-school programs with a linkage to well-being educational materials.

Anticipated Impact: The anticipated impact of the program is an increase in knowledge and positive behavior change related to nutrition and physical activity among northeast Indiana children and adults resulting in a reduction in childhood and adult obesity and the in rates of chronic disease associated with obesity.

Committed Resources: For 2017 - \$3,664

Planned Collaboration: The after-school edition of Planting Healthy Seeds partners with the Fort Wayne Parks and Recreation Department, Indiana Department of Education, after-school youth centers and the Fort Wayne TinCaps.

Simple Solutions

Actions: Simple Solutions is an eight-session healthy lifestyle curriculum for families designed for at-risk young families with children ages 0 and 5 and young pregnant women. The program is instituted through agencies that provide home-visitations. While the bulk of the curriculum focuses on creation of a healthy feeding and a physically active environment, other broad well-being behaviors such as sleep hygiene, mindfulness and limitation of screen time are part of the curriculum. Using the train-the-trainer model, Simple Solutions plans to reach over 400 families in five different agencies in 2017.

Anticipated Impact: This program will embed healthier lifestyle habits related to eating, activity, sleep, etc., and will encourage a more structured, thoughtful, positive approach to health maintenance. Families will gain knowledge, tools and experience over the eight-session program with the end game of preventing obesity and in turn, bolstering cognitive and physical development.

Committed Resources: For 2017 -- \$78,047

Planned Collaboration: Simple Solutions partners with Head Start, Early Head Start, Early Childhood Alliance, Brightpoint, Stop Child Abuse and Neglect (SCAN), Catholic Charities, Lutheran Social Services, Healthier Moms and Babies, and other preschools and childcare providers.

Taking Root School Wellness Challenges

Actions: Designed for 4th and 5th graders, Taking Root is a school-based wellness challenge program that combines education from all components of well-being, structured quarterly challenges and school faculty wellness champions located at each participating school.

Anticipated Impact: Engagement in wellness challenges is expected to show the knowledge gained resulting in lasting behavior changes, particularly as these students are capable of understanding the importance of healthy habits and have the potential self-efficacy to incorporate these changes into their lifestyle. We expect that reduced body fat percentage, reduced BMI, increased aerobic capacity, along with a healthy diet and increased activity will reduce obesity.

Committed Resources: For 2017 -- \$68,703

Planned Collaboration: Taking Root partners with Fort Wayne Community Schools including 4th and 5th grade students, teachers, staff and participating elementary schools (primarily Title I schools).

Cardiovascular and Diabetes Screening Program

Actions: This program provides free cardiovascular and diabetes prevention screenings including blood pressure, and cholesterol/HDL/glucose to underserved, low-income adults. Those screened are provided with education at the point of care by a Parkview community nurse (Registered Nurse). Participants are connected with a medical home and community resources if needed.

Anticipated Impact: This screening program is offered at various events and locations primarily in low-income zip codes to assist clients to overcome barriers to obtaining such screening such as anxiety, transportation and the cost of screenings. The purpose of the program is to promote a decline in strokes, heart attacks, hypertension, diabetes and other related illnesses in this population. Those with abnormal results will learn how and when to seek care for the proper medical management of their condition.

Committed Resources: For 2017 -- \$65,260

Planned Collaboration: Screenings are made available at the Martin Luther King celebration, Healthy Cities Health Fair, McMillen Park Community Center, Charis House (homeless shelter), Amish Health Fair, Allen County Downtown Library, Wellspring Interfaith Social Services, the YMCA, The Courtyard, St. Patrick's Church and Avalon Missionary Church.

OVERVIEW OF THE MATERNAL/CHLD HEALTH INITIATIVE (Part of V.)

Problem Statement: Infant mortality rates in Allen County are unacceptably high. In 2014, the rate in Allen County was 7.9 (number of deaths per 1,000 live births), while Indiana's rate was 7.1, and the national rate 5.8. Even more alarming is the health disparity in which African American infants are 2.5 times more likely to die than white infants in Indiana. Infant mortality affects the 46806 zip code, located on the southeast side of Fort Wayne, at a rate significantly higher than other parts of the state and county. From 2009 to 2013, there were 37 infant deaths in this zip code for an overall infant mortality rate of 15.3. Of these 37 deaths, 29 were African American infants.

Strategy Summary: Parkview Health has developed multiple evidence-based strategies to address infant mortality through improved prenatal and inpatient care and in working with partner organizations to make our community a healthier place for families. Strategies include the following:

- Implementing programs designed to reduce risks and increase healthy behaviors among pregnant women
- Addressing health disparities and seeking ways to improve health outcomes in the 46806 zip code
- Building upon existing strengths to lead the region in perinatal care and services for families
- Increasing efforts to raise awareness and build relationships with community partners

Goal: The goal of this initiative is to reduce infant mortality (deaths occurring before a baby's first birthday) through improved prenatal care, adherence to perinatal standards, and educational and supportive services for women, infants, and families.

Raising Community Awareness and Education about Infant Mortality

Actions: Parkview actively seeks ways to educate and engage the community about maternal and infant health. Parkview Community Nurses regularly visit churches, schools, libraries, and locations and events attended by families. They provide community members with resources and education about a variety of topics including safe sleep, breastfeeding, the importance of early prenatal care, presumptive eligibility, and other topics involving maternal and infant health. In 2016, community nurses reached 4,047 community members in presentations and discussions about maternal and infant health.

Parkview representatives also seek out opportunities to educate and engage key stakeholders. In 2016, presentations were given at the Summit City Rotary Club, Ft. Wayne NAACP, Southeast Area Partnership, and Multicultural Council, among others. In August 2016, Parkview, in conjunction with City Life Center and Remedy Live, sponsored *Ignite! Own Your Future*, an event geared towards high school students in the 46806 and surrounding zip codes. This event sought to encourage teens to connect with mentors and organizations that would support them in making healthy life decisions.

Anticipated Impact: Outreach efforts provide community members with knowledge and resources. In reaching key stakeholders, Parkview creates synergy with other community agencies. Through these outreach efforts, community members have increased knowledge and are able to locate and assess resources they need, leading to improved health behaviors and outcomes.

Committed Resources: Parkview provides staffing and supplies for outreach events.

Planned Collaboration: Community nurses collaborate with a variety of organizations including, but not limited to, the following: Fort Wayne Housing Authority, Allen County Public Library, Fort Wayne Urban League, Healthy Cities, and Stop Child Abuse and Neglect (SCAN). Presentations are also held at local churches, carnivals, block parties, community baby showers and back-to-school events.

Prenatal Infant Care (PIC) Network

Actions: The PIC Network began in 2015 as an active learning community bringing together stakeholders who serve mothers, infants, and families and is growing into a broad coalition. Quarterly meetings provide education on key prenatal health issues, allow for networking and collaborating opportunities, and include an online reference center for sharing resources. In 2017, Parkview will participate on an Advisory Council for expanding the PIC Network and will assist in choosing topics, speakers, and setting a strategic direction for the network.

Anticipated Impact: The PIC Network is a growing coalition which is bringing together key stakeholders for collaboration, networking, and educational opportunities. As a result of the networking, we expect referrals for community resources for pregnant women to increase. Growth and strengthening of this network will allow for coordination of community efforts and improved prenatal services to women in Allen County. The network is growing; attendance at quarterly luncheons and educational opportunities will be measured.

Committed Resources: Parkview staff participates in the PIC Network and will serve on the Advisory Council in 2017.

Planned Collaboration: PIC Network organizational members include A Hope Center, Women's Care Center, St. Joseph Community Health Foundation, Healthier Moms and Babies, Brightpoint, Lutheran Health Network, Associated Churches, Inc., March of Dimes, Neighborhood Health Clinics, Park Center, SCAN, Women's Health Link, A Baby's Closet, and the Fort Wayne Allen County Health Department, among others.

Fetal Infant Mortality Review (FIMR)

Actions: FIMR is a two-tiered process consisting of a Case Review Team (CRT) and a Community Action Team (CAT). The CRT, consisting of social workers, physicians, nurses, mental health professionals, and others who work with pregnant women and infants, examine individual cases of fetal and infant mortality to look for trends in community strengths and opportunities for improvement. After reviewing many cases, the CRT gives recommendations to the CAT whose membership includes a broader cross section of stakeholders to make positive changes in the community. As of January 1, 2017, the CRT had reviewed a total of 23 cases. The CAT is scheduled to meet and receive recommendations on March 16, 2017. FIMR is a strategy recommended by the CDC.

Anticipated Impact: FIMR CRT will review individual cases of infant mortality and look for trends specific to our community. Strengths and opportunities for improvement will be noted and recommendations will be provided to the CAT. CAT members will work individually or collaboratively to enhance, improve, and build on existing community resources. The FIMR CRT measures the number of cases reviewed. The CAT is in the process of developing initiatives at this time.

Committed Resources: Parkview provides a coordinator for the FIMR as well as representation on both the CRT and CAT. A two-year grant (10/2015 through 9/2017) received from the Indiana State Department of Health will contribute \$18,750 to fund the program in 2017.

Planned Collaboration: FIMR is a community-based project and includes the following partners: A Hope Center, Bowen Center, March of Dimes, Dupont Hospital, Lutheran Hospital, St. Joseph Hospital, Healthier Moms and Babies, Fort Wayne Community Schools, Allen County Public Library, Purdue Extension of Allen County, First Steps, St. Joseph Community Health Foundation, Neighborhood Health Clinics, Associated Churches, Inc., Health Visions of Fort Wayne, Anthony Wayne Foundation, Lutheran Foundation, United Way 2-1-1, Women's Care Center, ECHO, SCAN, and several local physicians. The Allen County Child Fatality Review (CFR) shares recommendations with the FIMR CAT on the infant cases they review.

Centering Pregnancy – Group Prenatal Care

Actions: The group prenatal model of care includes a health assessment, group support and educational classes aimed at reducing preterm births and low birth weights. The program includes evidence-based strategies and activities to address several causes known to be risk factors for preterm births including poor nutrition, tobacco, alcohol, recreational drug use, stress and inadequate prenatal care. County Health Rankings (CHR) rates Centering as a scientifically-supported program.

Anticipated Impact: The group prenatal model of care includes educational programming on a healthy diet, smoking cessation, stress reduction, and the importance of avoiding alcohol and recreational drugs. Peer support helps reinforce these healthy behaviors. Activities include prenatal yoga, discussions with a registered dietician, fresh fruits and vegetables as incentives, one-on-one smoking cessation counseling and mental health referrals. In addressing known risk factors for preterm birth and low birth weight, we anticipate improved pregnancy outcomes. Behavioral outcomes including water, fruit and vegetable intake, smoking reduction/cessation, stress level reduction, and perinatal knowledge levels are measured as well as overall enrollment.

Committed Resources: Group prenatal care activities are facilitated by Parkview prenatal care providers and staff. Registered dietitians and mental health counselors are available for referrals. Parkview is supporting the Centering program with \$22,600 in 2017. March of Dimes grant funding is pending.

Planned Collaboration: In 2016, Parkview began collaborating with Healthier Moms and Babies (HMB) in this effort. HMB participants who are also PPG patients attend educational group sessions facilitated by HMB staff. During the sessions, PPG providers and staff address the women's individual medical needs and handle documentation. Smoking cessation

partners include the March of Dimes, Indiana Quit Line, and Freedom from Smoking class, a seven-week class offered through Parkview's Center for Healthy Living.

Period of PURPLE Crying

Actions: The Period of PURPLE Crying Program was developed by the National Center on Shaken Baby Syndrome (NCSBS) and has two primary aims. One goal is to improve parental self-efficacy and care of infants by teaching parents about the normal patterns of increased infant crying in healthy infants in the first few months of life and providing evidence-informed strategies for parents to try to soothe a crying infant. Secondly, the program strives to reduce the incidence of Shaken Baby Syndrome/Abusive Head Trauma (SBS/AHT) and infant physical abuse by teaching the dangers of shaking an infant, techniques to cope with infant crying that may be frustrating and empowering parents to put their infant down in a safe place when they are frustrated. This education is provided to all parents of infants delivered at Parkview facilities. Outreach is conducted at events attended by families, in schools and to other social service agencies.

Anticipated Impact: Parkview educates the parents of all infants born at Parkview facilities and other caregivers through a variety of outreach efforts about the dangers of SBS/AHT and how to better cope with infant crying. Educating caregivers about normal behavior and the proper response when feeling frustrated, will result in fewer SBS/AHT incidents and deaths. We measure the number of community outreach events attended and the number of persons receiving education at these events.

Committed Resources: In 2017, Parkview Community Health Improvement will fund \$12,973 for this program. An additional \$13,625 grant was awarded by the Fort Wayne Children's Foundation.

Planned Collaboration: Parkview will partner with Healthier Moms and Babies and other social service agencies for staff trainings. Education will be provided to East Allen County School and Fort Wayne Community School students as well as libraries, health fairs and other events attended by families.

Safe Sleep Initiative

Actions: The CDC calls Sudden Unexpected Infant Death (SUID) "the death of an infant less than one year of age that occurs suddenly and unexpectedly and whose cause of death is not immediately obvious before the investigation." SUID accounts for approximately 3,500 deaths in the United States annually. Following the safe sleep practices ABCs, putting baby to bed Alone, on his or her Back and in a Crib is an effective way to decrease the incidence of these deaths. Parkview Health is a Cribs for Kids Certified Safe Sleep Hospital. In 2015, Parkview was recognized by Cribs for Kids with the Gold Safe Sleep Champion Award. This commitment to best practices and education continues both inside and outside our hospital walls today.

Parents of every baby born at Parkview hospitals are educated about the importance of safe sleep. Proper safe sleep behaviors are modeled by staff at all times in patient rooms and families have access to resources should they need them.

Parkview Community Nursing holds weekly Safe Sleep classes open to all community members and provides eligible caregivers with safe sleep instruction, Safe Sleep kids, and free Pack 'n Play Cribs® to assure every baby in our community has a safe place to sleep. In 2016, a total of 377 cribs were distributed in Allen County and another 169 were distributed in surrounding counties. The Safe Sleep Initiative supports NIH's Safe to Sleep campaign.

Anticipated Impact: Educating caregivers on the safe sleep practices ABCs and providing free cribs to eligible families helps to ensure that all babies are sleeping Alone, on their Backs, and in a Crib, reducing the risk of SUID and decreasing the rate in infant mortality in the community. We measure the number of caregivers receiving the safe sleep education and the Pack 'n Play® cribs.

Committed Resources: Parkview maternity nurses educate all new parents on safe sleep while in the hospital. Parkview Community Nursing facilitates Safe Sleep classes at a variety of locations throughout the city. Community Nursing's safe sleep program 2017 budget: \$113,259.

Planned Collaboration: Parkview collaborates with the Indiana State Department of Health in the distribution of cribs through grant funding provided by the Department of Children's Services (DCS) and partnership with the Cribs for Kids Program. In 2016, Parkview began collaborating with the Three Rivers Ambulance Authority (TRAA). Emergency responders (paramedics) provide in-home safe sleep education, distribution of Infant Survival Kits as well as Pack 'n Play® cribs to assure there is a safe place for the infant to sleep. They also offer a monthly Safe Sleep class that is open to the community.

Breastfeeding Support and Education – Community

Actions: Parkview provides new mothers with breastfeeding education and support as hospital inpatients, in the community, and in their own homes. This multi-pronged approach recognizes that mothers need ongoing support to initiate and maintain breastfeeding.

Prior to delivery, expectant mothers may take a prenatal breastfeeding class taught by an International Board Certified Lactation Consultant (IBCLC), offered free to community members. A Breastfeeding Moms' Group facilitated by a lactation consultant meets regularly and offers mothers both peer and professional support. Breastfeeding Drop-In Clinics are located in target zip codes (46803, 46806, and 46816) to best aid underserved and low income women. In prior years, Parkview was a recipient of grant funding seeking to reduce disparities and increase the breastfeeding initiation rate and duration of African American women; these programs have continued. Drop-in Clinics at A Baby's Closet and Parkview's Center for Healthy Living Southeast offer incentives, such as diapers, breast pads, and nipple ointment, for attendance. Lastly, in conjunction with SCAN's Healthy Families program, community nurses provide in-home breastfeeding support. Breastfeeding promotion programs and home visits are scientifically supported by County Health Rankings.

Anticipated Impact: Promoting breastfeeding initiation and duration leads to improved infant health. We measure the number of mothers who attend classes, support groups, and drop-in clinics and who receive home visits.

Committed Resources: Parkview contributes staffing for community nurses, lactation consultants, venues for classes, incentives and supplies. Community Nursing program 2017 budget related to breastfeeding: \$60,396.

Planned Collaboration: Community partners for breastfeeding education and support include SCAN, A Baby's Closet and Parkview Center for Healthy Living Southeast.

Indiana Presumptive Eligibility Program

Actions: According to Indiana's Family and Social Services Agency, "Presumptive Eligibility for Pregnant Women (PEPW) is a process that offers temporary coverage of prenatal care services to pregnant women while their Medicaid applications are pending." A lack of coverage is a significant barrier to obtaining prenatal care. Women who receive early prenatal care are more likely to have positive pregnancy outcomes than those who receive late prenatal care or no prenatal care at all. A Brightpoint representative is located at the PPG OB/GYN office on Carew Street.

Anticipated Impact: Assistance in obtaining presumptive eligibility Medicaid coverage allows women to begin prenatal care earlier in their pregnancies. Women who receive early prenatal care have better pregnancy outcomes. We measure the number of women enrolled in insurance coverage, thereby increasing their access to prenatal care.

Committed Resources: Parkview provides in-kind office space for Brightpoint.

Planned Collaboration: Parkview collaborates with Brightpoint to provide this enrollment service.

Mental Health in the Perinatal Period

Actions: The results of the 2016 FIMR study indicated that the mental health needs of pregnant and post-partum women must be addressed. Perinatal Mood Disorders are the most common complication of childbirth and mental health issues can be a risk factor for preterm birth. The FIMR Community Action Team has formed a Mental Health Taskforce to determine and then implement initiatives to address this need. These plans are currently in development.

Anticipated Impact: Undetected and untreated mental health issues can negatively affect pregnancy and lead to problems with infant development. In the most serious cases, it can lead to maternal and/or infant death. Identifying mental health needs in pregnant and post-partum women will increase maternal and infant well-being. As the FIMR Taskforce begins planning and implementing their initiatives, goals and outcomes to measure will be determined.

Committed Resources: Parkview provides staff and training to administer screenings and is well-represented on the FIMR Taskforce.

Planned Collaboration: The FIMR Mental Health Taskforce includes representatives from Associated Churches, African American Healthcare Alliance, and Mental Health America of Northeast Indiana. Mental health concerns may be referred to a variety of community partners, including Parkview Behavior Health, Bowen Center, and the Department of Health, among others.

Other Maternal/Child Health Initiatives

Parkview offers eight different prenatal classes that help to prepare, encourage and support families prior to the birth of a new baby. These group-based parenting classes include the following: Preparing for Childbirth, Basic & Beyond Parenting, Breastfeeding Class, Pet-Friendly Class, Grandparents Class, Sibling Class, Multiples Class, and Dad's Boot Camp. All classes are free and open to the public. Group parenting classes are rated as scientifically supported by the County Health Rankings.

The Child Maltreatment Symposium is an annual event sponsored by Parkview Pediatric Trauma Center, Parkview Women's and Children's Hospital, Isaac Knapp Dental Society, and the Community Foundation of Greater Fort Wayne through the Isaac Campbell Kidd Fund. The event, open to anyone who works with children, covers the scope of child abuse in Indiana, predicting risk factors for child abuse, forensic psychology, and how to report abuse if it is suspected.

The Child Protection Team consists of a multi-disciplinary team of health professionals, including a pediatric intensivist emergency department physician, trauma medical director, and nurses, who review suspected cases of child abuse and maltreatment. The goal of the review process serves two purposes: 1) Retrospective identification of suspected child abuse and 2) Performance improvement in caring for infants and children. Suspected cases of child abuse identified by the team during the review process are promptly reported. In reviewing cases, team members identify staff educational needs and opportunities to improve assessment skills.

OVERVIEW OF THE MENTAL HEALTH INITIATIVE (Part of V.)

Problem Statement: Mental and behavioral health (MBH) just like physical health is a crucial aspect of overall well-being for individuals who reside within our communities. In fact, MBH is the one aspect of health that impacts all other aspects of health. The statistics around MBH are staggering, with one in four or 25% of individuals in a given year experiencing a diagnosable MBH condition. Nearly one in two or 50 percent of individuals will meet the criteria at some point within their lifetime. Unfortunately, due to stigma, the lack of funding, access to care and consistency in screening and treatment, the average time span from the onset of symptoms to treatment is eight years. Left undiagnosed and untreated, MBH conditions are costly for all aspects of society. The impact is significant on healthcare costs, outcomes and, most importantly, to the individual and their families.

Strategy Summary:

- Address the stigma associated with MBH through the development of common messaging and strategies that encourage individuals to be willing to seek care earlier in the disease process.
- Increase awareness of resources, i.e., the Behavioral Health HelpLine, MBH resources within the community and Parkview including emergent and urgent care.
- Improve access to care for individuals whose lives are impacted by MBH disorders, through enhanced programming options and navigation services.
- Provide education and skill-building training for the community members regarding suicide and how to recognize and respond to an individual in crisis.

Goal: With strategic partnerships, Parkview Behavioral Health (PBH) will work to address mental health needs of the community supporting each person to achieve their optimal mental and behavioral health.

Care Navigation

Actions: Two care navigators provide education and navigation to nearly 3,000 individuals annually who present to our Emergency Department or Assessment Center and are not admitted as an inpatient. Prior to the development of this program, these individuals may have been provided resources, but we did not know how many were able to follow through or needed additional support.

The navigation team attempts to contact the individual within two business days of their visit. During the initial contact, the plan of care is reviewed, questions are answered, safety is assessed and referral to additional resources is made if indicated. If it is determined that the patient's condition has deteriorated, they are assisted in getting into a provider more quickly, or if indicated, return to PBH for immediate care. If the client is unable to be reached, a letter is sent to their home advising them of the support available through the navigation team. The individual is encouraged to contact the navigators for support. The navigators attempt to reach the individuals two more times. If they are not successful, the individual is documented as unreachable for follow up care. Once an individual is reached, they have the option of engaging in further care navigation. More than 95 percent of those reached opt into the program. Individuals then receive another phone call within two weeks, and if indicated, a third and final call is provided at four to six weeks.

Anticipated Impact: The primary program outcomes include a reduction in the percentage of individuals engaging in care navigation needing inpatient care within thirty days versus those who did not engage in care navigation. Other outcomes include an increase in the percentage of people who are able to see a mental health provider for follow up within seven days and thirty days of their visit. Perhaps the most significant outcomes are in the lives of those we are able to serve, the barriers that have been overcome and the support that is felt as individuals and families walk the journey of behavioral healthcare.

Committed Resources: PBH with the support of funding from Parkview Hospital's Community Health Improvement program in the amount of \$132,041 supports two full-time care navigators who administer the program. PBH also provides oversight for the program through salary support of the Director of Outreach.

Planned Collaborations: PBH partners with numerous community mental health and social service providers based on client needs.

Access to Care Enhancement

Individuals in need of mental health counseling often find themselves facing a prolonged wait for mental health services.

Actions: In response to the difficulty with delay of treatment for urgent needs, PBH has instituted a rapid care model for therapy. In this model, therapists are available within one to two business days after calling the HelpLine or presenting to the Emergency Department for urgent care. A psychiatric care navigator is assigned to follow up on each of these individuals. The navigator will answer questions, assess for barriers to care and support the individual in accessing services needed.

Anticipated Impact: The goal of this model of care is to reduce the time spent by licensed therapists on social needs and increase their time available to provide mental healthcare. The second goal is to support care by providing navigation services. Navigation services help to assure clients receive needed support services to help them manage mental healthcare. This additional support by navigators on social needs will allow therapy staff more time to provide mental health counseling. Once the program is fully operational, we anticipate seeing fifty new clients weekly.

Committed Resources: In addition to urgent care staff, Parkview through community health improvement funding in the amount of \$61,000 provides a full-time navigator who will support individuals in securing needed supportive services.

Planned Collaborations: Parkview will work through various community partners to increase awareness of this service including the employed physician group, community mental health centers, churches and the "Look Up" (local mental health resources) website.

Opiate and Heroin Addiction

It is estimated that more than 40,000 individuals in Allen County have a substance use disorder. Overdose deaths continue to climb with over 67 confirmed deaths and a potential of sixteen additional deaths projected for 2016. The incidence of probable overdose rates for 2017 thus far has outpaced that experienced in 2016 and without significant intervention will far exceed that observed in 2016.

Actions:

In response to the increased incidence of opiate and heroin substance use disorders, and the incidence of overdose deaths, Parkview actively participates in both local and state level task forces. Task force involvement has been instrumental in developing a framework for evidence based public health and treatment strategies as well as serving as a voice to legislators and other government officials to secure resources for the area. Through these collaborative efforts, programs such as the syringe exchange program, additional treatment options and a better understanding of the disease of addiction has occurred.

In response to the closure of two pain management practices, Parkview Physicians Group (PPG) worked with the community to emergently meet the needs of individuals who were displaced by the closures. The actions of these providers including that of PPG pain management providers and primary care supported individuals until a full pain management evaluation could be completed. In addition, PBH developed a partial hospitalization program which provides more intensive support in the early phase of treatment for addiction.

Public educational opportunities through media sources and educational conferences were developed. In 2016, PBH developed and led a full-day seminar targeted toward all levels of providers to increase the understating of addiction and to share the various treatment options available.

In partnership with other community leaders, Parkview developed a PBS educational event. The event centered around addiction, including understanding of the disease and treatment options. Partners included local Community Mental Health Centers (CMHC), the local department of health, funders as well as representatives from the Indiana legislature. The PBH Helpline was featured as a means to access care services for the region.

PBH, local CBS affiliate WANE TV, the local Veterans Administration and the Lutheran Foundation have an ongoing collaboration to develop a series of media awareness programs targeted to increase understanding and access to care for addiction. A three-part news mini-series was developed and highlighted the crisis, treatment options and where individuals can seek help. Ongoing planning continues to address the community crisis, addiction and the use of the media as a means of education and action.

In response to rising overdose rates, PBH in conjunction with other community stakeholders is working with local pharmacies to increase standardization and education on obtaining and administering the reversal medication (Naloxone). This medication is used to reverse the effects of heroin and other opioids in the event of accidental overdose. The goal of this group is to increase the community's understanding of the use of the medication and community treatment options available.

Anticipated Impact:

- Proper care for those individuals who had been seen by another pain specialist to assure that pain needs are met safely and if indicated, they are offered treatment to addiction.
- Enhanced treatment services for those who are dealing with a substance use disorder including an enhanced partial hospitalization program as well as increased inpatient services to support those who are seeking treatment.
- Reduction of stigma around mental and behavioral health needs and a willingness to seek services.
- Enhanced education for providers and care givers around addiction and options for treatment.
- Improved safety for those who accidentally overdose on an opiate through increased training of safe administration of Naloxone.

Committed Resources: PBH expanded services to include a partial hospitalization program for addiction and pain management. PPG Pain Management increased staffing to meet the need of the increased provider demand. The Director of Outreach participated on numerous work groups to achieve these objectives.

Planned Collaboration: PBH and Parkview Hospital collaborate with the Fort Wayne Allen County Department of Health, Park Center, Bowen Center, Lutheran Foundation, WANE TV, Veterans Administration, Attorney General's office, local pharmacies, Indiana State Senator Jim Merritt, Riley Children's Hospital and local churches. Task force includes members of public health, law enforcement, emergency medical services, treatment providers, representatives from the judicial system, coroner's office, foundations and others.

Suicide Prevention and Reduction

Suicide continues to be the second highest cause of death for teens and young adults. In 2015, Indiana was identified as the highest in the nation at 19 percent of youth having considered suicide and second in the nation of the percentage of youth who have tried to end their lives by suicide. In addition to youth, suicide is also prevalent within the middle-aged male population. Suicide incidence has also increased within healthcare settings and healthcare providers are increasingly being called upon to increase safety within their environments.

Actions: In an effort to create a culture of safety inside and outside of the organization, Parkview leaders attended a two-day seminar in 2016 to learn about the Zero Suicide Model of Care. Zero Suicide is an evidence based framework that is based on the National Suicide Prevention Plan. Upon completion of this training, Parkview opted to participate in a Zero Suicide work group led by Community Health Network in Indiana. Through this workgroup, Parkview is participating in monthly conferences to share lessons learned and efforts around adoption of the Zero Suicide Model of Care. Over the next three years, we will work internally to enhance education, and policy and procedures with numerous service areas. We are currently in the process of identifying a physician champion and a process leader to support and develop this evidence based framework for suicide reduction.

Identified staff and community members within the region will be trained in an evidence based suicide prevention strategy known as Question, Persuade and Refer (QPR). This material can be taught in a 90 to 120-minute period of time and provides the trainee with the skills and knowledge needed to recognize and respond to a mental health crisis much like that of CPR for the heart. Each community will adopt the training level to meet their respective needs. In order to train

more individuals in the community, a minimum of 40 people will be trained as instructors. These instructors will then train a minimum number of people each quarter. This training will be provided free of charge with educational booklets provided for the first 5,000 participants. Participants will also receive education regarding community resources.

Once the instructors have been trained, communities will identify a day that will be designated as Super QPR day. This day will serve to increase awareness of suicide prevention and training opportunities. The goal is to engage a wide range of stakeholders while reducing stigma and increasing awareness of resources. Traditional and social media will serve as means to engage the community. The ultimate goal is to hold this "Super QPR" day annually and to encourage participation in training programs held through-out the year. The goal is to have over 5,000 individuals trained in this life saving technique by the end of 2018.

PBH along with Indiana Purdue Fort Wayne, Huntington and Trine Universities hosted a half day inter-disciplinary educational event regarding suicide prevention. The event allowed graduate students from numerous disciplines to collaborate around assessing and managing suicide risk while evaluating the role they each play in the care process and how vital communication is across disciplines to assure optimal care and safety.

Anticipated Impact: The goal of Zero Suicide is to increase safety within and outside of organizations related to suicide prevention and management. The goal is to have 5,000 individuals trained in QPR of which 40 will become QPR instructors. In addition, an annual event will be held to increase suicide prevention awareness.

Committed Resources: PBH will leverage grant funding to train forty individuals as QPR instructors and will provide 5,000 booklets to those instructors to train community members. Parkview will also provide support for data collection and supply management.

Planned Collaboration: Parkview will collaborate with community groups, churches, businesses, Bowen Center, Park Center, schools and universities to train individuals in this life saving education.

Collegiate Regional Mental Health Coalition

Actions: Northeast Indiana is home to numerous small and midsize universities. In partnership with Indiana Purdue Fort Wayne (IPFW), a collegiate mental health coalition has been formed. Participants besides PBH and IPFW include the following universities; Huntington, Grace, St. Francis, Trine, Indiana Tech, Ivy Tech, Ball State and Manchester. The three projects the coalition is focusing on are reduction of stigma and awareness of campus/community resources, suicide prevention education and eating disorders.

Anticipated Impact: Through this initiative, we anticipate the following outcomes: 1) Six hundred faculty and staff trained in QPR, 2) Twenty staff trained as QPR Instructors and 3) Twenty staff trained in ASIST, an evidence based two-day class for those working with mental health clients experiencing suicidality or depression 4) Production of a student led video project around reducing mental health stigma and increasing awareness of campus and community supported resources.

Once these baseline objectives have been achieved, the group will define an extended development plan to meet the mental health needs of college students and their families.

Committed Resources: In partnership with Community Health Network and their Garrett Lee Smith grant, we have been funded \$49,183 to meet these objectives.

Planned Collaboration: The following universities are involved in this coalition; Huntington, Grace, St. Francis, Trine, Indiana Tech, Ivy Tech, Ball State, Manchester and Indiana Purdue Fort Wayne.

VI. Significant Health Needs Not Addressed include:

- a. Health needs identified and why the hospital does not intend to address and a brief explanation of the hospital's reason for not addressing:
 - i. Tobacco Use – Tobacco Free Allen County (TFAC) is the lead organization in Allen County related to tobacco free efforts. TFAC provides information on resources about local smoking cessation programs and advocates for no-smoking public policy. Parkview Hospital is a source of smoking cessation programs and operates a tobacco free campus.
 - ii. Diabetes, Cardiovascular Disease and Cancer – While Parkview Hospital did not select these chronic diseases as top health priorities, our intent is to help to prevent and reduce the presence of chronic conditions like the aforementioned diseases by addressing obesity through nutrition

education, increased access to healthy foods, active living programs and education on other healthy lifestyle habits.

- iii. Drugs/Alcohol Abuse and Addiction – One of Parkview Hospital’s community health priorities is mental health. Many of individuals being assisted and referred through Parkview Behavioral Health care navigation program are affected by drug and alcohol abuse and addiction.
- iv. Sexually Transmitted Diseases (STDs) – The Fort Wayne-Allen County Health Department, in conjunction with Matthew 25 Health Clinic, operates a Sexually Transmitted Disease (STD) Clinic. The NE Indiana Positive Resource Connection (formerly the AIDS Task Force) provides STD prevention education to teens and adults.
- v. Chronic Kidney Disease – Major risk factors related to chronic kidney disease are diabetes, high blood pressure and age of 60 and older. The local chapter of the National Kidney Foundation focuses on prevention education and serves as a resource to those affected by kidney disease and their families. Additionally, the foundation provides KEEP Healthy kidney screening events.
- vi. 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 to a more proactive care approach. The program includes education, information, and strategies for follow-up care that are both inexpensive and effective. This program incorporates multiple best practices, bundles many of the resources already available and in use, and applies principles of case management/care navigation and provides services to patients in a series of one-on-one contacts over time to facilitate long-term asthma management.
- vii. Aging – Aging and In-home Services of Northeast Indiana serves older adults, persons with disabilities and their caregivers in nine counties as a part of this region. This not-for-profit, community-based organization is a federal and state designated Area Agency on Aging and an Aging and Disability Resource Center which provides a streamlined access to information, care options, short-term case management, and benefits enrollment across a spectrum of long-term care services. Through the Care Transitions program, Aging and In-home Services partners with Parkview Health in an effort to reduce Medicare readmissions.