PARKVIEW

COMMUNITY HEALTH IMPROVEMENT

2026 Implementation Strategy

Parkview LaGrange Hospital

PARKVIEW HEALTH

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About this Report

To grow and ensure the continued quality of Parkview Health's commitment to improving the health of our community, each of our licensed hospitals prepares a Community Health Needs Assessment (CHNA) and subsequent implementation strategy on a triennial basis. Using the knowledge gained from the 2025 CHNA results, this report will define Parkview LaGrange Hospital's community health implementation strategy for the 2025–28 assessment cycle as federally required by the Affordable Care Act. In doing so, this report will accomplish the following:

- Define the community we serve
- Summarize the 2025 CHNA and implementation strategy processes
- Summarize how top health needs were prioritized
- Describe how the hospital is addressing these community needs
- Describe unmet needs that were identified by 2025 CHNA

IRS Mandate

The contents of this report were formed in compliance with the requirements of Internal Revenue Code 501(r)(3)(A) set forth by the Internal Revenue Service for tax-exempt health systems and hospitals, defined within the Patient Protection and Affordable Care Act.

About Parkview Health

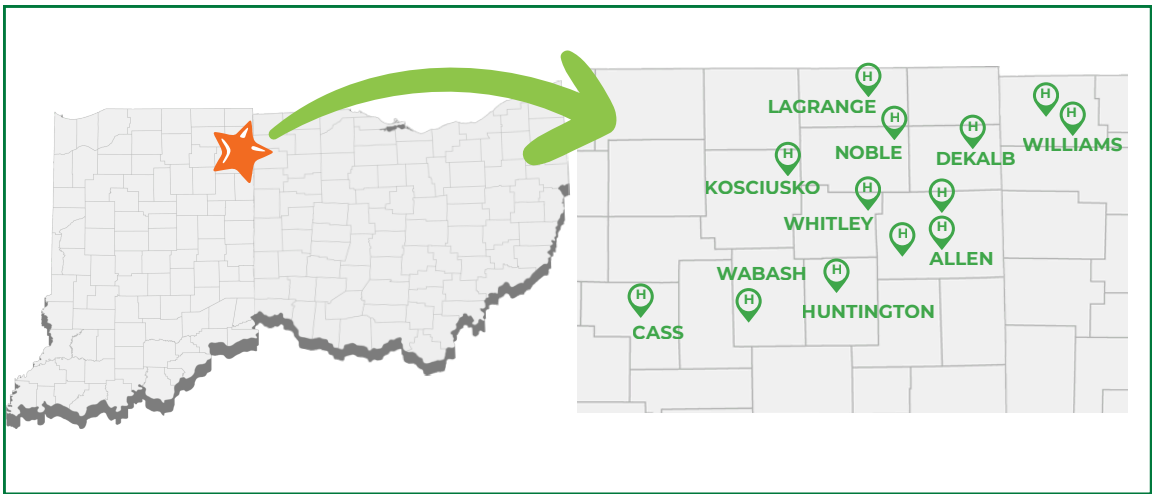
Parkview is a not-for-profit, community-based health system. It serves a population of more than 1.3 million in Indiana and northwest Ohio. With more than 17,500 employees, Parkview is the region's largest employer. Parkview started as Fort Wayne City Hospital and has been serving the community since 1878. Parkview Health formed in 1995, and the heritage of care and compassion continues today with 15 hospitals and over 300 outpatient centers and physician offices.

Parkview has a mission to improve health and inspire well-being in the communities we serve.

Community Served

For the purposes of this implementation strategy, the Parkview Health service area consists of the counties where a full-service Parkview hospital is located. This includes Allen, Cass, DeKalb, Huntington, Kosciusko, LaGrange, Noble, Wabash, and Whitley Counties in Indiana and Williams County in Ohio. Within this broader service area, the "Community Served" for this implementation strategy is defined specifically as LaGrange County, Indiana.

LaGrange County, home to Parkview LaGrange Hospital, serves a population of 40,596 residents, according to the 2025 Parkview LaGrange Hospitals CHNA. The county's median household income is approximately $83,741, with 5.8 percent of households living below the federal poverty level. Additionally, 44.3 percent of residents are uninsured. More detailed demographic and health data for each county within the Parkview Health service area is available on the Community Data Hub.



2025 CHNA Process and Methodology

The CHNA is conducted every three years to identify and address the most pressing health needs in the Parkview Health service area. The 2025 CHNA was led by Parkview Health and the Health Services and Informatics Research (HSIR) team at Parkview's Mirro Center for Research and Innovation. By using various data sources, we identified the top health needs in the community. We compared needs at the county level with those of the Parkview Health service area and the entire state. Findings were shared with the community and hospital partners to determine which health needs were most pressing.

Primary Data

Primary data for the 2025 CHNA was gathered by using surveys and focus groups. Surveys were conducted between September 2024 and December 2024, engaging 5,030 residents and 960 key informants through online and paper formats in five languages. These surveys assessed demographics, health concerns, healthcare access, mental health, and digital access. Focus groups were held from March 2025 to May 2025, with 34 sessions across the service area, each involving 5 to 15 participants from diverse backgrounds. These discussions explored health needs, barriers, and available resources.

Secondary Data

The Metopio platform was instrumental in gathering data from multiple sources, which, when combined with survey and focus group findings, provided a comprehensive view of each community's health landscape. This secondary data offered valuable insights into health behaviors, outcomes, and social factors, using the most recent five-year averages or single-year data. Once all data was analyzed, the findings were shared with community and hospital partners, leading to the identification of priority health needs for 2025–28. The overall process focused on understanding community needs, prioritizing the most pressing issues, and identifying available resources and gaps to guide strategic planning and improve health outcomes.

Top Five Identified Health Needs

LaGrange County's Top Five Health Concerns

- Access to Mental Healthcare and Addiction Services
- Housing Affordability
- Insurance for Healthcare
- Mental Health and Mental Disorders
- Obesity

Prioritization Process

Prioritization Overview

After gathering and analyzing the data, the HSIR team used a structured process to pinpoint the community's most urgent health needs. This process was meant to be inclusive and data driven, ensuring that the chosen priorities represented both community members' experiences and health trends. The process involved meetings with community stakeholders and final selection of top health needs by hospital leaders.

Community Prioritization Sessions

- Sessions were carried out between March 2025 and May 2025 for each hospital.
- Attendees were professionals who provide a wide range of services to community members from diverse backgrounds.
- Ahead of the meeting, attendees were sent a printed scorecard with the top health needs identified for their county and related data.
- A presentation at the meeting covered data trends on the top health needs.
- Attendees participated in a discussion with a focus on benefits and challenges to addressing the health needs.
- Attendees voted to rank the top health needs based on significance, severity, relation to social drivers of health, and suitability for intervention.

Selected Health Priorities

The list of top health needs from each session was shared with hospital leadership in June 2025. With consideration given to resources, prevalence of the health need, and suitability to address the health need, hospital leaders reached consensus on the final following top health priorities:

Selected Priorities for Parkview Health–LaGrange County

- Access to Care
- Mental health and Mental Disorders
- Obesity

Implementation Strategy Process

In addressing each prioritized health issue identified, Parkview LaGrange Hospital created the following implementation strategy to define how the hospital intends to address each top health need, in addition to our ongoing commitment to improving access to care. This collaborative planning process includes senior leadership, the hospital board, Community Health Improvement staff, program leads, community nurses, community health workers, and partner organizations working alongside the results of the 2025 CHNA. Through this process, we work diligently to align the top health needs of our community with hospital resources and capabilities to create our implementation strategy in compliance with the requirements set by the Internal Revenue Service for tax-exempt health systems and hospitals.

Parkview LaGrange Hospital's board, made up of hospital board members, hospital leadership, and community stakeholders, reviewed and adopted the implementation strategy on May 8, 2026.

2026 Implementation Strategy

This section will report the strategies and program initiatives the hospital will implement, fund, or pursue in collaboration with community partners to address priority health needs over the next three years.

All planned activities align with the hospital's mission, priorities, and operational capacity. The plan is intended to be flexible and may be revised as circumstances evolve, including changes in community needs or available resources.

Mental Health and Mental Disorders

Program/Initiative: Client Advocate Program

Goal: Increase access to healthcare, improve financial stability for at-risk families, and provide mental health and wellness opportunities for local families devastated by cancer.

Objectives

- Maintain or increase the number of clients, particularly low-income, at-risk, and vulnerable individuals who utilize financial assistance, transportation assistance, and advocacy support to improve access to healthcare assistance per year.
- Maintain or increase the number of clients who have access to affordable mental health counseling and emotional support services to learn coping skills and tools to better maintain their mental health and reduce stress per year.
- Maintain or increase the number of clients who participate in wellness and educational programming (nutrition workshops, exercise classes, etc.) to gain knowledge and skills to manage chronic illness and live healthier lives per year.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
• Number of clients served • Number of client advocate service interactions • Number of healthcare supplies and durable medical equipment loans distributed • Quantity of financial assistance and transportation assistance provided • Number of clients participating in wellness activities, educational opportunities, and mental health counseling sessions	• Connect clients to a client advocate who proactively assesses their support needs and ensures that they have a mental health screening • Client advocate helps clients access practical services such as supplies, financial assistance, or transportation aide to increase access to healthcare • Client advocate connects clients to mental health support services and mental health counseling • Invite clients to wellness and mental health activities through email and phone calls	• Increase access to affordable mental health counseling for at-risk clients • Increase number of vulnerable individuals able to access healthcare services	• Cancer Services of Northeast Indiana • Medical community • Mental healthcare providers

Mental Health and Mental Disorders

Program/Initiative: LaGrange Campus Life			
Goal: Improve teens' mental, spiritual, and social well-being through mentorship, small groups, and community engagement.			
Objectives: • Connect with at least 200 teens and know on a first-name basis per year. • Connect with at least 140 teens in deeper, more consistent, conversational relationships per year.			
Indicator	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Number of teens who are known by name by members of the Campus Life Team • Number of teens who are connected in conversational relationships with members of the Campus Life Team	• Weekly Campus Life club meetings and small groups • One-on-one mentoring conversations addressing stress, anxiety, and depression • Youth leadership opportunities and community service • Youth events such as spring break trips, summer camp and winter camp • Support the Campus Life director and their ministry team through the regional ministry director • Train staff to use a new Youth Management system, designed by YFC USA, to strengthen how young people are served and supported	• Local young people have positive connections with supportive adults and peers • Young people have a support system to make healthy decisions and connections to mental health and other resources • Local young people have a sense of belonging, healthy relationships, and a support system to live a healthy lifestyle • Healthy young people have a positive impact on their peers, their families, and the community	• Youth for Christ (YFC) of Northern Indiana • LaGrange County Schools • Local churches • Like-minded youth-serving organizations

Program/Initiative: Question, Persuade, and Refer (QPR) adult suicide prevention training			
Goal: Improve knowledge and awareness related to identifying signs in individuals at risk for suicide.			
Objective: Increase participation in suicide prevention training by 15 percent throughout LaGrange County, with 90 percent of participants reporting improved knowledge, by the end of 2028.			
Indicator	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Number of participants trained • Data from pre- and post-tests	• Market the classes to internal and external community partners • Provide training to internal and external community partners • Provide referral information and resources to internal and external community partners	• Increase knowledge • Reduce stigma around mental health • Behavior change • Reduction in suicide attempts and completions • Increase community awareness and engagement around mental health	• LaGrange County EMS • LifeBridge Senior Program • LaGrange County Mental Health Collaborative

Obesity

Program/Initiative: Cole Center Family YMCA Support			
Goal: Engage youth in sports and swim lessons and adults and seniors in group wellness programming both at the LaGrange and Noble Site, encouraging healthy living to reduce the number of individuals with BMI >29.9 and other chronic disease related illnesses			
Objective: Maintain levels of participation in classes and programming at both Noble and LaGrange sites			
Indicator	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Number of scans at LaGrange site • Number of youth in programming • Number of total scholarships awarded	• Market programs in LaGrange and Noble Counties • Offer scholarships • Offer 24-hour access to Noble site • Maintain increased numbers in facility usage	• Increase participation in group wellness classes, youth sports, and swim lessons • Increase access to physical activity opportunities through awarding scholarships • Build relationships with and among participants to increase relational connection and motivation, leading to an increase in physical and mental wellness	• Cole Center Family YMCA • LaGrange County Council on Aging • County Parks Department • County Health Departments

Program/Initiative: Preventative Health Education for LaGrange County			
Goal: Increase knowledge in topics related to obesity such as nutrition and fitness by 35 percent, or higher, among LaGrange County students in preventative health education sessions conducted by McMillen Health.			
Objectives: Provide preventive health education programming sessions to approximately 260 LaGrange County students in grades Preschool–12, conducting pre- and post-tests for students in grades two and above.			
Indicator	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Number of participants, maintaining an average of 21.67 students per session • Pre- and post-tests conducted during each session for students in grades 2 and above	• Market programs to schools in LaGrange County • Use *Feathr* to market programs more effectively • Schedule education sessions with interested teachers • Educate school-aged students about nutrition and fitness • Provide strategies to mitigate and avoid unhealthy habits	• Increase knowledge on preventive health related topics • Equip students to share information with their peers and families, increasing the impact of the program beyond the students initially served • Improve quality of life by providing awareness of how healthy and unhealthy habits affect one's overall health • Improve the health of the community as a whole overtime	• Harold W McMillen Center for Health Education • LaGrange County Schools

Obesity

Program/Initiative: VeggieRx (produce prescription program)			
Goal: Increase access and consumption of fresh produce in targeted populations by 15 percent per year while equipping them with knowledge of diet, disease, and fresh produce utilization.			
Objective: Administer at least one produce prescription program cohort per year that engages physicians to offer lifesaving produce to their medically underserved population with chronic disease, reducing the financial barrier to healthy eating.			
Indicator	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Number of participants • Retention rate of program participants • Number of cohorts offered 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 sessions led by registered dietitian • Goal setting • Voucher distribution • Surveys and follow-up	• Positive behavior change • Increase nutrition knowledge • Increase consumption of fresh fruit and vegetables • Skill building for future diet improvements • Improve access to community resources	• Parkview Physicians Group (PPG) offices • External provider offices • Parkview Community Well–Being Team • Local grocery stores and markets • LaGrange County Wellness Collaborative • Area colleges and universities

Program/Initiative: Harvest of the Month			
Goal: Increase utilization of produce for educational purposes by 10 percent per year in LaGrange County K–12 grade classrooms.			
Objective: Communicate monthly opportunities to local schools and deliver produce based on teachers' orders, reducing the barrier of access to incorporating fresh produce into school curriculum.			
Indicator	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Number of program participants • Count/pounds of produce given to schools	• Market program in schools • Provide opportunities to taste fruits and vegetables • Provide opportunities to incorporate produce education into school curriculum	• Increase participation in group wellness classes, youth sports, and swim lessons • Increase access to physical activity opportunities through awarding scholarships • Build relationships with and among participants to increase relational connection and motivation, leading to an increase in physical and mental wellness	• LaGrange County Schools • Parkview Youth My Well-Being Team • Area produce farmers

Obesity

Program/Initiative: FitKids360 (stage two pediatric obesity treatment program)

Goal: Improve obesogenic risk scores and well-being behaviors of at least 50 percent of cohort participants (children ages 5–17 and their families).

Objectives: Administer at least one stage two pediatric obesity treatment program cohort per year and see the following objectives met.

- 50 percent 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 percent of referred participants
- 50 percent of referred participants have at least a 5 percent increase in their score between pre- and post-assessments
- 50 percent of referred participants report a decrease screen time
- 50 percent of referred participants increase their moderate to vigorous physical activity
- 50 percent of referred participants increase their fruit and vegetable intake
- 70 percent family retention rate

Indicator	Interventions	Anticipated Impact	Internal/External Partners
• Family (children only) biometric values • Family nutrition and physical activity screening tool • Lifestyle and behavioral surveys • Psychosocial functioning survey • Retention rate	• Physician referral • Assessments • Health education sessions • Goal setting • Physical activities • Surveys and follow-up	• Positive behavior change • Increase health knowledge • Strengthen family relationships • Decrease in the number of those who identify themselves as having frequent physical distress • Decrease in the number of those who identify themselves as having poor physical health	• Parkview Physicians Group (PPG) offices • External provider offices • Parkview Community Well-being Team • LaGrange County Wellness Collaborative • Area colleges and universities

Access to Care

Program/Initiative: LaGrange County Area Transit (LCAT)–Access to Transportation Program

Goal: Increase access to safe, reliable, and affordable transportation for LaGrange County residents, particularly older adults and individuals with limited mobility, thereby reducing transportation-related barriers to healthcare, nutrition, and essential services.

Objectives

- Increase the number of completed rides provided to older adults and vulnerable populations for medical, nutritional, and essential service appointments by 10 percent per year.
- Maintain or increase the proportion of rides provided for medical and essential trips.
- Increase the number of unduplicated riders services year-over-year.
- Maintain rider satisfaction scores related to reliability and accessibility of 90 percent or higher.
- Reduce missed or delayed medical appointments related to lack of transportation.
- Improve awareness of available public transportation services among residents, healthcare providers, and referral partners.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
• Number of one-way trips provided annually • Percentage of rides provided for medical and essential service purposes • Number of unduplicated riders served per year • Rider satisfaction scores related to reliability and accessibility	• Revise the scheduled, demand-response transportation throughout LaGrange County for medical, nutrition, employment and well-being needs • Coordinate with healthcare providers, social service agencies, and nursing homes, as well as our emergency management team in LaGrange County • Educate Medicaid brokers on services provided • Work with limited income individuals when they are not able to pay the total price for medical care trips • Expand outreach and education to healthcare providers and community partners regarding transportation availability • Evaluate route optimization (software needs updated), scheduling tools, or extended service hours to better meet rider needs	• Increase utilization of public transportation services • Reduce transportation-related appointment cancellations or no-shows • Improve access to healthcare, nutrition, and supportive services for older adults and rural residents • Enhance independence and quality of life for individuals with limited transportation options	• LaGrange County Council on Aging - LaGrange County Area Transit • Local healthcare providers and hospitals • Senior centers • Social service agencies • Community organizations • Referral partners serving older adults and vulnerable populations

Access to Care

Program/Initiative: Miles for Smiles Expanding Care Across Communities			
Goal: Transform lives by providing essential dental services to those in need.			
Objectives • Provide 100 dental visits to LaGrange County residents per year. • Apply more than 50 fluoride varnishes and 50 sealants for children and youth per year. • Relieve acute pain in 70 percent of adult patients within two weeks per year.			
Indicator	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Number of completed visits • Quantity of services • Quality of care	• Equip mobile unit to serve the dental population • Communicate with dental offices about mobile services • Distribute flyers in areas served • Coordinate with local Head Start programs to target preventative-care age group	• Measurable improvement in oral health and quality of life, while lowering long-term costs for families and the healthcare system • Improve school attendance and performance in children • Support consistent employment in adults	• St. Martin's Healthcare – St. Martin's Dental • Delta Dental • Community Foundations of Noble and DeKalb County • Olive B. Cole Foundation • Isaac Knapp District Dental Society

Program/Initiative: Drive-up Influenza Immunization Clinic			
Goal: Increase access to receiving influenza immunization in LaGrange County.			
Objective: Increase the number of influenza immunizations administered by 10 percent per year (2025 baseline of 31 regular and 40 high-dose influenza doses administered).			
Indicator	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Number of regular flu doses given • Number of high flu doses given • Number of Medicaid-covered vaccines • On-site registration logs	• Market to local community • Provide drive-up immunization services • Provide streamlined traffic flow with volunteer help • Provide on-site registration • Cover cost for Medicaid immunization expenses	• Reduce barrier of receiving immunization • Improve participant satisfaction • Reduce the spread of the influenza virus • Lower the risk of complications from contracting influenza	• LaGrange County Health Department • Lagrange County Council on Aging • Community volunteers

Access to Care

Program/Initiative: Families Thrive with Family Resource Centers			
Goal: Provide no-wrong-door case management services and resources to 100 families in crisis in LaGrange County by the end of 2028.			
Objectives • Open a Family Resource Center by April of 2026. • Reach at least 100 families in the first year of operation. • Families rating "services as useful" is at least 90 percent. • Provide prenatal programming to 25 expectant mothers. • Provide educational programming to engage the local community.			
Indicator	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Number of families reached • Number of initial interactions with families • Number of follow-up interactions with families • Number of families participating in programming • Number of resources given and referrals requested to understand common needs • Data from pre- and post-surveys measuring family impact	• Open location by mid-March 2026 • Market to local families • Market prenatal programming throughout the community in multiple languages to ensure access • Establish partnerships in LaGrange County for local access through the community outreach coordinator • Host workshops and classes at public locations to engage local community based on emerging needs and research findings • Host services at central public locations to engage the local community and reduce transportation barriers • Services are offered in multiple languages to increase access when possible	• Children grow up to be safe, stable adults with healthy families of their own, increasing the overall health and shifting the generational trajectory of the community • Families do not experience a lapse in stability or functioning due to stress or lack of education • Build healthy family habits and support systems that result in generational change throughout the community with healthier homes, families, and outcomes • Reduce child abuse and neglect rates as stress levels are lowered for families in crisis and support networks are increased throughout the county	• Iris Family Support Center's Community Outreach Program • Prevent Child Abuse (PCA) Council of LaGrange County • LaGrange County Schools • LaGrange County Health Department

Access to Care

Program/Initiative: Reduce Barriers to Healthcare

Goal: Offer respectful and culturally sensitive healthcare with sliding fee scales, patient navigation, and reduction in transportation barriers

Objectives:
- Provide culturally sensitive care at affordable costs
- Provide a medical home model for the underserved patient population to navigate the healthcare system
- Provide the resources needed to get access to care
- Provide care navigation to at least 75 percent of patients seen each month

Indicator	Interventions	Anticipated Impact	Internal/External Partners
• Patient data • Number of patients who used the medical home care navigator • Number of provided resources needed to access care • Number of follow-up supports given to ensure patients received care and resources	• Train clinical staff to provide quality, affordable, and culturally sensitive care • Train Care Coordinator to provide and support patient families • Set up appointments, transportation options, pharmacy needs, therapy services, etc., and follow up to see that services were rendered • Provide follow-up visits to confirm resources used and patient satisfaction using the medical home care model • Utilize Community Health Fare with over 40 collaborators for resources the patient families can use • Build a formal data point plan for reporting	• Reduce disparities • Promote preventative health • Strengthen a community-based healthcare system • Provide a culturally sensitive environment for special needs patients • Build trust in the healthcare system	• The Community Health Clinic Inc–genetic and patient services • Plain Church Group Ministry • LaGrange County Health Department • Indiana Department of Health • Parkview Health • Bowen Health

Insurance for Health Care

While insurance for health care was not selected as a top three priority for Parkview LaGrange Hospital, this need remains as an ongoing commitment for the hospital.

Program/Initiative: Covering Kids and Families (CFK)

Goal: Provide at least 28 LaGrange County residents with accessible health care coverage per year

Objectives:

- Complete at least 35 applications for LaGrange County residents per year
- Over 80% of LaGrange CKF applications will enroll in public health coverage programs per year, demonstrating program quality, precise eligibility determinations, and responsible use of resources
- Provide 100 support services per year to help LaGrange County residents with using and keeping public health coverage benefits
- Participate in at least 120 outreach activities to ensure public awareness of public health insurance programs

Indicator	Interventions	Anticipated Impact	Internal/External Partners
• Number of Public Health Insurance Applications submitted • Percentage of application approval Rate • Number of support services provided • Number of outreach activities increase awareness of public health insurance programs	• Offer enrollment assistance provided by licensed and certified staff to ensure services meet state and federal requirements • Complete quality assurance processes such as weekly application reviews, monitoring outcomes to maintain accuracy, and meet program objectives • Participation in community outreach and education activities, including presentations, resource fairs, and one-on-one information sessions to increase awareness • Distribute save-the-date notices to all schools to promote attendance and ensure school staff are informed about the annual school conference • Host a community outreach event in LaGrange County to raise awareness of health coverage options and connect residents with enrollment assistance and resources	• Improve consumer understanding of health coverage and active engagement in using their benefits • Reduce gaps in health coverage for consumers • LaGrange County residents will have earlier access to care that can lead to better health outcomes and reduced use of emergency services • LaGrange County residents will have increased community awareness of available health coverage resources	• Brightpoint • Northeastern Center • Compassion Pregnancy Centers • LaGrange Partners

Identified Health Needs Not Addresssed

While prioritizing the hospitals top three health concerns with internal and external stakeholders, we consider the data, health–needs significance, severity, our capacity to impact, suitability, resources available, and health disparity related to social determinants of health. Based on these points, we chose to not directly address the following needs identified by our 2025 CHNA:

- Access to Mental Health and Addiction Services
- Housing Affordability

For More Information

Parkview would like to extend gratitude toward its community partners for their collaboration with the 2025 CHNA and 2026 implementation strategy process that addresses the health needs of LaGrange County. For additional information about Parkview LaGrange Hospital's 2025 CHNA or 2026 Implementation Plan, please contact us at community.health@parkview.com.

Board Approval

Approved by Parkview LaGrange Hospital's Board of Directors on May 8, 2026