

# PARKVIEW

## COMMUNITY HEALTH IMPROVEMENT



### 2026 Implementation Strategy Parkview Huntington 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 Huntington 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

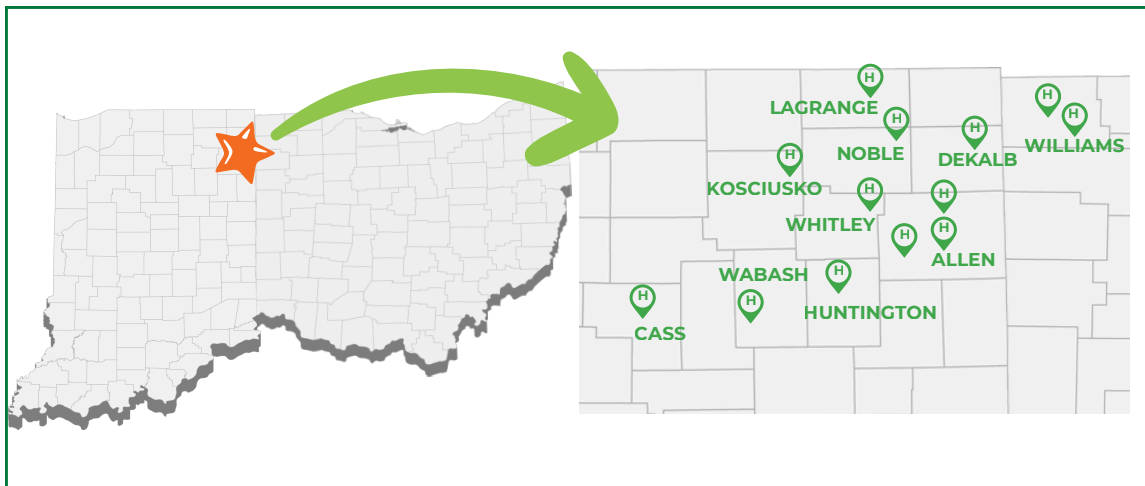
Parkview is a not-for-profit, community-based health system. It serves a population of more than 1.3 million in Indiana and northwest Ohio. With more than 17,500 employees, Parkview is the region's largest employer. Parkview started as Fort Wayne City Hospital and has been serving the community since 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 Huntington County, Indiana.

Huntington County, home to Parkview Huntington Hospital, serves a population of 36,757 residents, according to the 2025 Parkview Huntington Hospital's CHNA. The county's median household income is approximately \$62,734, with 10.1 percent of households living below the federal poverty level. Additionally, 6.3 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

### Huntington County’s Top Five Health Concerns

- Access to Mental Healthcare and Addiction Services
- Cancers
- Diabetes
- Housing Affordability
- 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 – Huntington County

- Access to Mental Healthcare and Addiction Services
- Child Abuse and Neglect
- Obesity



# Implementation Strategy Process

In addressing each prioritized health issue identified, Parkview Huntington 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 Huntington Hospital's board, made up of hospital board members, hospital leadership, and community stakeholders, reviewed and adopted the implementation strategy on May 6, 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.

## Access to Mental Healthcare and Addiction Services

Program/Initiative: Cancer Services of Northeast Indiana-Client Advocate Program for Huntington

**Goal:** The Client Advocate Program increases access to healthcare, improves financial stability for at-risk families, and provides mental health and wellness opportunities for local families devastated by cancer.

### Objectives

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

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Number of clients served and number of client advocate service interactions</li> <li>• Healthcare supplies distributed and durable medical equipment loans</li> <li>• Financial assistance and transportation assistance provided</li> <li>• Participation in wellness activity or educational opportunities and mental health counseling sessions provided</li> </ul>	<ul style="list-style-type: none"> <li>• Each client is connected to a client advocate who assesses the client’s support needs and ensures that the client has a mental health screening</li> <li>• Client advocate helps client access practical services such as supplies, financial assistance or transportation aide to increase access to healthcare</li> <li>• Client advocate connects client to mental health support services and mental health counseling</li> </ul>	<ul style="list-style-type: none"> <li>• Increased access to mental health support and services</li> <li>• Increased access to healthcare</li> </ul>	<ul style="list-style-type: none"> <li>• Program staff, therapist, and client advocates</li> <li>• The medical community as well as other mental healthcare providers</li> </ul>

# Access to Mental Healthcare and Addiction Services

Program/Initiative: Huntington County Council on Aging-Huntington Area Transportation 2026

**Goal:** Stabilize and lower transportation fares for riders by offsetting operational costs. This will ensure that fares remain affordable for 90 percent or more of current riders over the next 12 months.

**Objective:** Maintain or increase ridership by five percent while keeping fares stable.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>Total number of rides provided annually compared to the previous year</li> <li>Number of active transportation contracts maintained or expanded during the grant period</li> <li>Percentage of trips arriving on time or within 15 minutes of the scheduled pickup window</li> </ul>	<ul style="list-style-type: none"> <li>Launch of Advertising Revenue Program</li> <li>Secure additional transportation contract</li> <li>Transportation tracking software</li> </ul>	<ul style="list-style-type: none"> <li>Increased nonfare revenue through advertising and contracted transportation services</li> <li>Stabilization of the current fare structure with no fare increases</li> </ul>	<ul style="list-style-type: none"> <li>Huntington County Council on Aging</li> <li>Huntington Area Transportation</li> <li>Parkview Huntington Hospital</li> <li>Huntington County residents</li> </ul>

Program/Initiative: Place of Grace Operational Support

**Goal:** Increase recovery capital and long-term stability for justice-involved individuals in recovery by providing structured residential programming, employment readiness support, and holistic recovery services, with each participant demonstrating a minimum ten percent improvement in recovery capital.

**Objectives**

- Provide safe, structured residential housing and recovery programming that promotes stability and healthy routines.
- Deliver employment readiness training and life-skills development through programming and social enterprise participation and strengthen long-term recovery outcomes through relational support, case management, and community reintegration planning.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>Recovery Capital assessment scores (entry vs. reassessment)</li> <li>Program retention and phase progression rates</li> <li>Employment-readiness participation and engagement levels</li> <li>Housing stability outcomes at program completion or transition</li> </ul>	<ul style="list-style-type: none"> <li>Structured residential programming including recovery programming, case management, and peer support</li> <li>Employment readiness development through Gracefully Gourmet and life-skills training</li> <li>Relational mentorship, recovery planning, and community integration support</li> </ul>	<ul style="list-style-type: none"> <li>Improved stability, increased recovery engagement, and measurable growth in recovery capital</li> <li>Sustained recovery, improved workforce readiness, reduced recidivism risk, and stable housing outcomes</li> </ul>	<ul style="list-style-type: none"> <li>Residential Program Team, Graduate Housing Program, Gracefully Gourmet Employment Readiness Program</li> <li>Leadership</li> <li>Case Management Team</li> <li>Local treatment providers, probation/parole partners</li> <li>Community churches</li> <li>Workforce partners</li> <li>Local nonprofits providing wraparound services</li> </ul>

# Access to Mental Healthcare and Addiction Services

Program/Initiative: Youth Services Bureau-Skills for Life

**Goal:** To equip youth with the knowledge and practical skills necessary to empower them for a successful future. This is achieved through engaging discussions, hands-on activities, and personalized one-on-one mentorship.

**Objective:** One-on-one conversations with each client that have open dialog in both directions.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Before and after tests are used to measure the expansion of knowledge and track participant progress</li> <li>• Progress is measured using pre- and post-assessments for each discussion topic related to life challenges</li> <li>• Participants complete a pre-test before the topic discussion begins and a post-test after the discussion</li> </ul>	<ul style="list-style-type: none"> <li>• Begin each session with ice breaker to help clients focus on something positive and fun</li> <li>• Minimize distractions by having clients leave phones and backpacks in a basket and along the wall</li> </ul>	<ul style="list-style-type: none"> <li>• Increase program accessibility, reduce waitlists, and provide more targeted support tailored to different age groups and skill levels</li> <li>• Increased client knowledge about the dangers of drug, alcohol, and tobacco use</li> <li>• Reduce the number of community members entering the court system or experiencing incarceration</li> </ul>	<ul style="list-style-type: none"> <li>• YSB staff</li> <li>• Lake City Bank</li> <li>• Public Service Credit Union</li> <li>• Boys &amp; Girls Club</li> <li>• United Way of Huntington County</li> <li>• Huntington County Chamber of Commerce</li> <li>• City of Huntington</li> <li>• Salvation Army</li> <li>• Huntington County Visitors Bureau</li> <li>• YMCA</li> <li>• Century 21 Realty</li> <li>• Huntington County Sheriff's Department</li> <li>• Rain Solutions</li> </ul>

# Obesity

Program/Initiative: Parkview Boys & Girls Club-Healthy Habits

**Goal:** To equip youth ages 6–18 with the knowledge, skills, confidence, and social-emotional tools to make healthy eating choices, lead physically active lifestyles, and develop lifelong wellness habits.

**Objectives**

- By the end of 14 sequential, interactive sessions, at least 85 percent of participating youth will accurately define health and demonstrate the ability to apply basic nutrition concepts by planning and preparing a balanced snack or meal.
- Throughout the program, at least 80 percent of youth will demonstrate growth in social-emotional competencies, including identifying emotions, impulse control, stress management, problem-solving, perseverance, and healthy relationship-building as measured by staff observation checklists and youth self-assessments.
- By program completion, at least 85 percent of youth will set and achieve at least one personal healthy eating or lifestyle goal and actively participate in hands-on food selection, preparation, and environmental improvement activities, as documented through participation tracking and youth feedback surveys.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Program success will be measured using pre- and post-evaluation surveys administered by age group immediately before and after completing Healthy Habits</li> <li>• A follow-up survey, also by age group, can be used at any specified time after the program to assess lasting impact</li> <li>• Youth participation and engagement in all 14 sessions will be tracked, and staff will observe skill development, confidence, and application of healthy behaviors during activities and snack preparation</li> </ul>	<ul style="list-style-type: none"> <li>• Delivering 14 sequential, interactive sessions by age group</li> <li>• Providing suggested healthy snacks to reinforce lessons</li> <li>• Tracking participation and administering pre-, post-, and follow-up surveys</li> </ul>	<ul style="list-style-type: none"> <li>• Increased nutrition knowledge and awareness, engagement in hands-on nutrition activities, and greater confidence and motivation to make healthy-food choices</li> <li>• Reduced risk of diet-related health issues, positive impact on overall youth wellness and community health, and lifelong healthy eating habits and physically active lifestyles</li> </ul>	<ul style="list-style-type: none"> <li>• Senior program directors and youth development professionals.</li> <li>• 21st Century</li> </ul>

# Obesity

Program/Initiative: Parkview Huntington YMCA-Momentim Matters Program

**Goal:** Assist community members to overcome personal barriers and create behavior patterns that lead to improved health and well-being.

## Objectives

- Medical professionals will refer patients to the YMCA.
- A wellness coach will meet with the participant (patient). Barriers are discussed, and solutions are proposed.
- Participant starts with very simple task of "showing up," then progressing into full workouts with a personal trainer.
- After Four months of guidance, participants will develop new behaviors and have the knowledge to continue on their own.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Number of referrals</li> <li>• Number of participants</li> <li>• Attendance measurements are continuous and ongoing, as participants log in daily.</li> <li>• Physical assessments every four weeks if the participants request it</li> </ul>	<ul style="list-style-type: none"> <li>• Letter and referral trifold have been created and ready to distribute to medical professionals</li> <li>• The parameters and curriculum of the program have been developed</li> <li>• Two additional staff members have been hired and trained as fitness coaches and are prepared to begin</li> </ul>	<ul style="list-style-type: none"> <li>• Participants will be supported throughout the 16 weeks, from medical to fitness to behavior modification</li> <li>• Participants will learn to overcome barriers, feel more comfortable in a fitness atmosphere</li> <li>• Participants will learn exercise techniques, creating a path to successful health improvement</li> </ul>	<ul style="list-style-type: none"> <li>• Fitness coaches</li> <li>• Medical professionals</li> </ul>

# Obesity

Program/Initiative: United with Love-Nutrition and Wellness for Families

**Goal:** Improve healthy eating habits and reduce food insecurity by providing at least 250 Huntington County households each month with access to nutritious foods and practical nutrition education through the food pantry and recipe resources.

**Objectives**

- Provide nutritious food and healthy recipe resources to at least 250 households per month through health and wellness education.
- Ensure that least 50 percent of distributed food includes fresh or nutrient-dense items (produce, lean proteins, whole grains).
- Increase awareness of balanced meals and healthy cooking by incorporating recipe discussions or highlights during pantry visits and nutrition education classes.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Number of households served through the food pantry each month</li> <li>• Pounds and types of food distributed, including the proportion of nutrient-dense items</li> <li>• Number of participants in health and wellness classes and number of MyPlate resources and recipes distributed</li> </ul>	<ul style="list-style-type: none"> <li>• Providing healthy recipes and MyPlate educational materials to neighbors during pantry visits to encourage practical meal preparation using pantry items</li> <li>• Offering informal guidance and conversations with participants about balanced meals, portion sizes, and ways to prepare healthy foods on a budget</li> <li>• Tracking pantry usage, recipe distribution, and participant feedback</li> </ul>	<ul style="list-style-type: none"> <li>• Increased awareness of healthy eating practices and balanced meals through recipes and MyPlate education</li> <li>• Greater confidence among participants in preparing meals using pantry items</li> <li>• Improved eating habits and more consistent incorporation of nutritious foods</li> <li>• Reduced barriers to meal preparation for families</li> </ul>	<ul style="list-style-type: none"> <li>• United with Love Staff</li> <li>• Huntington County Health Department</li> <li>• Parkview Health</li> <li>• Local food donors and businesses</li> <li>• Referring community partners</li> <li>• Social service agencies</li> </ul>

# Obesity

Program/Initiative: VeggieRx

**Goal:** Improve access and provide education to members of Huntington County who are experiencing food insecurity and are managing a diet-related chronic condition.

**Objective:** Provide eligible patients who struggle with food insecurity among other social determinants of health the opportunity to receive financial and educational assistance to improve clinical outcomes and encourage lifelong sustainable change through improvement in diet and lifestyle.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Number of community members experiencing food insecurity</li> <li>• Number of eligible patients identified in Huntington County PPG locations</li> <li>• Voucher redemption rate</li> <li>• Number of patients expressing the need for assistance to PPG provider</li> <li>• The amount of active engagement from participants in program</li> <li>• Decreased patient reported consumption of fresh produce</li> <li>• Clinical indicator of high levels of A1c, blood pressure, BMI, heart disease diagnoses, and number of at-risk pregnancies in the community</li> <li>• Number of community members on government food assistance programs</li> </ul>	<ul style="list-style-type: none"> <li>• Partner with local farmers markets and produce growers to increase access</li> <li>• Screen patients for food insecurity using the hunger vital signs screening tool</li> <li>• Provide VeggieRx to patients who can benefit</li> <li>• Provide dietitian led nutrition education</li> <li>• Work with local food banks to provide resources to patients who might need them</li> </ul>	<ul style="list-style-type: none"> <li>• Decrease in food insecurity</li> <li>• Increased consumption of fruits and vegetables</li> <li>• Decrease in hospitalizations, readmissions, and ED visits</li> <li>• Decrease in healthcare utilization costs</li> <li>• Decrease in hemoglobin A1c, BMI, blood pressure values, and heart disease</li> <li>• Improved management of diet-related chronic conditions</li> <li>• Long-term changes in poor lifestyle habits</li> <li>• Local economic impact</li> </ul>	<ul style="list-style-type: none"> <li>• Huntington County PPG clinical providers</li> <li>• Patient encounter locations (Medsurg, Lab, ED)</li> <li>• Parkview registered dietitians</li> <li>• Nutrition Services</li> <li>• Community Health Improvement leaders</li> <li>• Local grocery stores and produce farmers</li> <li>• Community food pantries</li> <li>• United with Love</li> <li>• Local food security coalitions</li> <li>• Community outreach programs</li> <li>• Local healthcare providers/networks</li> </ul>

# Child Abuse and Neglect

Program/Initiative: Blessings in a Backpack-Weekend Food Program

**Goal:** Provide food to financially qualified HCCSC elementary students each weekend during the academic school year to reduce negative impacts of childhood hunger in our community.

**Objective:** Ensure consistent and reliable food delivery to 100 percent of students registered ensuring access to food for all registered students and achieve 85 percent or higher satisfaction rate of our program amongst school personnel.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>Measure weekly bags delivered per school with delivery date noting any missed or delayed deliveries</li> <li>Annual survey of school personnel will be used to determine percentage of respondents rating their satisfaction with our program overall as "Satisfied" or "Very Satisfied"</li> </ul>	<ul style="list-style-type: none"> <li>Schedule weekly or bi-weekly packings</li> <li>Committee identifies resources should a packing group be unable to fulfill a commitment to pack</li> <li>Backup drivers are identified to assist in event primary driver cannot make a delivery</li> </ul>	<ul style="list-style-type: none"> <li>Increase community engagement and understanding of hunger to ensure a sustainable program supporting children</li> <li>Increase access to food for students experiencing food insecurity by providing weekend meals each week</li> </ul>	<ul style="list-style-type: none"> <li>Huntington County Community School Corporation guidance counselors and teachers</li> <li>Huntington County families indirectly through school personnel, volunteer groups in our community to assist with weekly packings</li> </ul>

Program/Initiative: Family Centered Services-Healthy Families

**Goal:** Reduce instances of child abuse and neglect by promoting supportive environments that optimize child growth and development, increase protective factors and encourage resilient, healthy families.

**Objectives**

- Recruit families to the program to perform risk assessments.
- Provide parent education to teach positive discipline techniques.
- Monitor safety and wellbeing of both mother and child in the home.
- Build protective factors for the family, including connecting to community resources.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>Number of Family Resilience and Opportunities for Growth Scale (FROG) screenings</li> <li>Edinburgh Postpartum Depression Scale</li> <li>Qualitative data including state of the parent, child and home; parent child interaction; all DCS calls made; child milestones via the Ages and Stages Questionnaire (ASQs)</li> <li>Referrals made and followed up on</li> </ul>	<ul style="list-style-type: none"> <li>Social media promotion</li> <li>Purchasing activity box items to help assess child development and parent-child interaction as well as model emotionally-engaged and developmentally-appropriate play</li> <li>Safety items such as baby gates and pack and plays (for safe sleep) are being provided to clients who cannot afford them</li> </ul>	<ul style="list-style-type: none"> <li>Increase in referrals and an increase in enrollment</li> <li>Increase in the quality of parent-child interactions and family wellbeing, and reduced instances of neglect or abuse</li> </ul>	<ul style="list-style-type: none"> <li>Huntington County Schools</li> <li>Parkview Birthing Center</li> <li>Youth Services Bureau</li> </ul>

# Child Abuse and Neglect

Program/Initiative: Indiana Family Care Center-Dream Center, Mentorship 2026

**Goal:** Strengthen parents, expectant mothers, and Spanish-speaking families in Huntington County through structured mentorship that equips them with parenting skills, leadership development, and life-readiness tools—resulting in healthier families and a stronger community.

**Objectives**

- Consistent appointments set with mentees.
- Consistent goal setting. We believe it is important to set goals based on the current situation so we can measure progress throughout their time with us.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Attendance</li> <li>• Completing specific homework/goals based on the needs of each client</li> <li>• Mentee-specific outcome goals such as for child growth, parent-child relationship development, finding a job, or achieving a job-specific certification</li> </ul>	<ul style="list-style-type: none"> <li>• Weekly appointments where clients sit down with a mentor and discuss the previous weeks progress, asses where they are at with their goals and if applicable, set new ones</li> <li>• Clients can access mentors between sessions if needed as well as they can come to our office if needed between sessions.</li> </ul>	<ul style="list-style-type: none"> <li>• Clients will feel like they have someone supportive in their corner</li> <li>• Clients will realize the impact that was made in their life and encourage them to serve within the community to give back and be support for others during their hardship</li> </ul>	<ul style="list-style-type: none"> <li>• Program has two staff members who are directly involved with the mentorship program</li> </ul>

# Child Abuse and Neglect

Program/Initiative: Iris Family Support Center-Child Safety Matters in Huntington County

**Goal:** Support the Huntington County Prevent Child Abuse (PCA) Council and provide training to equip children tasked with caring for young siblings with the skills and knowledge they need to provide a safe home environment.

**Objective:** Partner with school system to offer Safe Sitter training, continue engagement with local community and advocates to support PCA Council, and partnership with PCA Council, execute community awareness campaign.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Amount of children trained in Safe Sitter</li> <li>• Percentage of children who retain knowledge of training based on post-test</li> <li>• Engagement of local community and advocates with PCA Council</li> <li>• Community touchpoints with PCA Council</li> </ul>	<ul style="list-style-type: none"> <li>• Connections with schools to offer training</li> <li>• Monthly facilitation of PCA meetings</li> <li>• Community-based implementation of strategic framework</li> </ul>	<p><b>For Safe Sitter:</b></p> <ul style="list-style-type: none"> <li>• Children understand how to provide safe care at home.</li> <li>• Avoidable accidents and cases of child neglect do not occur due to proactive education and outreach.</li> </ul> <p><b>For PCA Council:</b></p> <ul style="list-style-type: none"> <li>• Strategic planning and collaboration to understand and address key county indicators for child abuse and neglect.</li> <li>• Creating a long-term focus on healthy childhood outcomes that results in generational change and a thriving community.</li> </ul>	<ul style="list-style-type: none"> <li>• Iris Community Outreach program and the staff</li> <li>• Community Outreach Coordinators.</li> <li>• Firefly</li> <li>• Youth Service Bureau</li> <li>• Huntington Community Schools</li> <li>• Department of Child Services</li> <li>• United Methodist Church</li> <li>• City of Huntington</li> <li>• Huntington University</li> <li>• McKenzie's Hope</li> <li>• Bowen Center</li> <li>• United Way</li> <li>• Pathfinder Services</li> <li>• Community Foundation</li> </ul>

## Identified Health Needs Not Addressed

While prioritizing the hospital's 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:

- Cancer
- Diabetes
- 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 Huntington County. For additional information about Parkview Huntington Hospital's 2025 CHNA or 2026 Implementation Plan, please contact us at [community.health@parkview.com](mailto:community.health@parkview.com).

## Board Approval

Approved by Parkview Huntington Hospital's Board of Directors  
on May 6, 2026