



# PARKVIEW

## COMMUNITY HEALTH IMPROVEMENT



### 2026 Implementation Strategy Parkview Allen County Hospitals



**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 Allen County Hospitals' 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

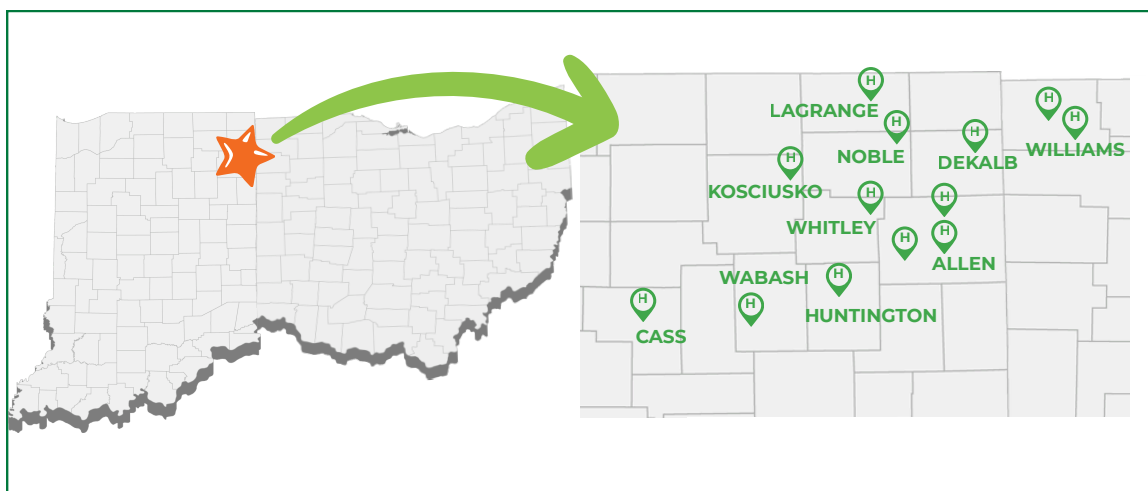
Parkview is a not-for-profit, community-based health system. It serves a population of more than 1.3 million in Indiana and northwest Ohio. With more than 17,500 employees, Parkview is the region's largest employer. Parkview started as Fort Wayne City Hospital and has been serving the community since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

Allen County, home to the Parkview Regional Medical Center, Parkview Hospital Randallia, and the Parkview Behavioral Health Institute, serves a population of 388,791 residents, according to the 2025 Parkview Allen County Hospitals CHNA. The county's median household income is approximately \$68,839, with 12.2 percent of households living below the federal poverty level. Additionally, 8.2 percent of Allen County 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 2024–25 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

### Allen County’s Top Five Health Concerns

- Access to Mental Healthcare and Addiction Services
- Affordable and Healthy Food
- Housing Affordability
- Insurance for Healthcare
- Mental Health and Mental Disorders



# Prioritization Overview

## 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–Allen County

- Affordable and Healthy Food
- Maternal and Child Health
- Mental Health and Mental Disorders



# Implementation Strategy Process

In addressing each prioritized health issue identified, Parkview Allen County Hospitals created the following implementation strategy to define how the hospital intend 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 Allen County Hospitals' Community Health Improvement committee, 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.

## Mental Health and Mental Health Disorders

Program/Initiative: Community Nursing–Homeless Outreach Program

**Goal:** Improve access to healthcare services and care coordination each year by supporting clients at local shelters needing assistance with care navigation and other healthcare needs.

**Objective:** Assist 100 percent of clients seeking our help with mental health care navigation by providing them with the tools and resources needed to better self-regulate.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>Total numbers served at shelters</li> <li>Number of 911 calls related to mental health needs</li> <li>Number of people connected to behavioral health services (mental health navigation)</li> <li>Number of people connected to medical home</li> <li>Percentage with health insurance</li> <li>Number of pharmacy runs</li> </ul>	<ul style="list-style-type: none"> <li>Provide nursing care/ medical education to clients and staff</li> <li>Connect to behavioral health services when appropriate</li> <li>Support clients who need assistance with care navigation for medical home and behavioral health services, health insurance, medication assistance, medication pickup at pharmacies, medication preauthorization with providers, follow-up appointments, compliance with care, discharge instructions, and connecting to community resources</li> </ul>	<ul style="list-style-type: none"> <li>Increase connection to behavioral health services when appropriate</li> <li>Increased knowledge</li> <li>Behavior change</li> </ul>	<ul style="list-style-type: none"> <li>Parkview Behavioral Health</li> <li>SOS Team</li> <li>Park Center</li> <li>Bowen Center</li> <li>Local emergency rooms</li> <li>Alliance Health</li> <li>Rescue Mission</li> <li>Salvation Army</li> <li>Charis House</li> <li>St. Joseph’s Missions ER Women Shelter</li> <li>Vincent Village</li> <li>FWCS FACE Center</li> <li>community resources</li> </ul>

Program/Initiative: Community Partnership–Community Based Behavioral Health Services

**Goal:** Support programming or health-related events designed to enhance the communities mental health.

**Objective:** Promote and support the hospitals’ Community Impact grant programs.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>Number of people served</li> <li>Number of mental health related grants</li> </ul>	<ul style="list-style-type: none"> <li>Mini-grant program</li> <li>Program Support grant</li> </ul>	<ul style="list-style-type: none"> <li>Increase in available mental health services for the community</li> </ul>	<ul style="list-style-type: none"> <li>Community Impact Team</li> </ul>

# Access to Mental Healthcare and Addiction Services

While Access to Mental Health Care and Addiction Services was not selected as a top three priority for Parkview Allen County Hospitals, Allen County will continue to incorporate this priority into its strategy.

Program/Initiative: Prenatal Substance Use Disorder Coordinator

**Goal:** Increase the number of patients identified to counsel, treat, and aid that are pregnant (up to 12 months) or postpartum with substance use disorder.

**Objectives**

- Complete appropriate screenings and interventions to connect patients to services and provide education as early as possible to maximize the chances of success and decrease recovery time.
- Provide OB-GYNs, residents, and clinical staff with education and specialized training to better assist this patient population.
- Work with community programs to educate and collaborate on substance use disorders and associated stigma.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Screening for SUD, counseling on SUD and MOUD, referral to treatment, and receipt of Naloxone</li> <li>• Completion of internal education for those providing care to pregnant and postpartum patients with SUD</li> <li>• Educate community (e.g. schools) on SUD and stigma surrounding SUD</li> <li>• Financial assistance to qualifying patients within the PSUD Program</li> </ul>	<ul style="list-style-type: none"> <li>• Utilization and completion of measures within the AIM bundle (Care of Pregnant and Postpartum individuals with Substance Use Disorder [CPPPPSUD])</li> <li>• Education/training with providers, residents, and clinical staff on SBIRT, anti-stigma, MOUD 5Ps, trauma-informed care, maternal mental health, etc.</li> <li>• Creation of specialized pathways for treating SUD patients</li> <li>• Revision of Substance Use policy</li> <li>• Distribution of Naloxone kits</li> <li>• Creation of Epic referrals for PSUD program</li> <li>• Care coordination between AMB and IP for identified patients</li> </ul>	<ul style="list-style-type: none"> <li>• Increased awareness of patient population needs</li> <li>• Increased competency among the providers, residents, clinical staff, and community</li> <li>• Increased collaboration for continuity of care</li> <li>• Decreased financial burden and stressors for patients</li> <li>• Increased patient-provider trust and relationships</li> <li>• Increased patient recovery rates</li> <li>• Decreased maternal morbidity and mortality</li> <li>• Increased percentage of infants remaining in birthing parent(s) custody</li> </ul>	<ul style="list-style-type: none"> <li>• Women’s and Children’s navigation team</li> <li>• Family Birthing Centers</li> <li>• NICU</li> <li>• Pediatrics</li> <li>• PBHI (Park Center, Addictions Residential, MAT Clinic, IOP)</li> <li>• City of Fort Wayne</li> <li>• Residential/recovery Programs</li> <li>• Indiana Department of Health</li> <li>• Local colleges (Ivy Tech, IU Fort Wayne, Manchester)</li> </ul>

# Affordable and Healthy Food

Program/Initiative: Food Assistance and Support Team (FAST)

**Goal:** Connect individuals identified as food insecure with community and government food assistance programs to increase access to nutritious foods and improve health outcomes for at least 50 percent of participants within one year of enrollment.

**Objectives**

- Screen eligible Parkview patients for food insecurity during medical visits.
- Connect at least 75 percent of those who screen positive to emergency, short-term, and/or long-term food assistance resources.
- Enroll referred individuals into nutrition programs (e.g., SNAP, WIC) and provide targeted nutrition education.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Number of patients screened for food insecurity</li> <li>• Number and percentage of patients connected to food assistance resources</li> <li>• Number and percentage of participants enrolled in federal nutrition programs (e.g., SNAP/WIC)</li> <li>• Self-reported improvement in food security status at follow-up</li> </ul>	<ul style="list-style-type: none"> <li>• Community Health Worker outreach to assess needs and navigate resources for food-insecure individuals, in collaboration with a Registered Dietitian (RDN) to support nutrition-related navigation and guidance</li> <li>• Offers education and assistance with applications for federal nutrition programs like SNAP and WIC</li> <li>• Coordinating access to emergency food assistance, farmacy programs, food pantry resources, and distribution sites</li> </ul>	<ul style="list-style-type: none"> <li>• Increased awareness and use of available food assistance resources</li> <li>• Higher enrollment in federal nutrition support programs</li> <li>• Improved food security status among participants</li> <li>• Better nutrition and health outcomes, including reduced hospitalization and chronic disease risk</li> </ul>	<ul style="list-style-type: none"> <li>• Parkview FAST Team</li> <li>• Parkview Greenhouse and Learning Kitchen</li> <li>• Parkview Greenview Pantry</li> <li>• Parkview Well-being</li> <li>• Parkview Mirro Center for Research and Innovation</li> <li>• Indiana Department of Health</li> <li>• Local food assistance programs</li> <li>• Community organizations</li> </ul>

# Affordable and Healthy Food

## Program/Initiative: Fresh Food Farmacy

**Goal:** Increase nutrition quality and other healthy habits in young families, senior participants, and type 2 diabetic cancer patients undergoing surgical interventions

### Objectives

- Dispense healthy groceries through monthly boxes (\$25 worth of culturally-tailored groceries, nutrition education materials, and local resources) for three months to 50 food-insecure families with children age five and under.
- Dispense medically-tailored groceries through monthly boxes (\$25 worth of culturally-tailored groceries, nutrition education materials, and local resources) for three months to 50 food-insecure seniors (ages 50 and older).
- Dispense healthy groceries through monthly boxes (\$25 worth of culturally-tailored groceries, nutrition education materials, and local resources) for three months to cancer patients undergoing surgical interventions with type 2 diabetes.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Percentage of participants that identify as food insecure post program</li> <li>• Number of servings of vegetables consumed in the last 24 hours</li> <li>• Number of servings of fruits consumed in the last 24 hours</li> <li>• Number of fresh boxes delivered per year</li> </ul>	<ul style="list-style-type: none"> <li>• Medically tailored grocery boxes</li> <li>• Deliver lessons through nutrition education handouts and recipes</li> <li>• Survey participants pre and post program</li> <li>• Provide additional community resources in boxes</li> </ul>	<ul style="list-style-type: none"> <li>• Through improved health strategies, increased development, growth, cognition, immunity, and behavior in children 5 year old and younger</li> <li>• Improved health, quality of life, and access to healthy food for seniors (ages 50 and older)</li> <li>• Improved health and access to healthy foods for type 2 diabetic cancer patients undergoing surgical interventions</li> </ul>	<ul style="list-style-type: none"> <li>• Safety Pin</li> <li>• FAST (Food Assistance Support Team)</li> <li>• Parkview Seniors Club</li> <li>• Internal/external providers and community agencies</li> <li>• Parkview Packnett Family Cancer Institute Oncology providers</li> </ul>

## Program/Initiative: VeggieRx

**Goal:** Administer a produce prescription program engaging physicians to offer lifesaving produce to their medically underserved population with chronic disease, reducing the financial barrier to healthy eating.

**Objective:** Increase access to and intake of fresh produce. Embed knowledge of diet, disease, and utilization of fresh produce to participants.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Food insecurity status</li> <li>• Percentage utilization of incentives</li> <li>• Increase consumption of fresh fruits and vegetables</li> <li>• Number of provider referrals (internal and external)</li> </ul>	<ul style="list-style-type: none"> <li>• Physician referral</li> <li>• RD consultation</li> <li>• Nutrition education led by registered dietitian</li> <li>• Incentive distribution</li> <li>• Surveys and follow-up</li> </ul>	<ul style="list-style-type: none"> <li>• Behavior change</li> <li>• Increased knowledge</li> <li>• Increased consumption of fresh fruit and vegetables</li> <li>• Skill building for future diet improvements</li> <li>• Improved access to community resources</li> </ul>	<ul style="list-style-type: none"> <li>• PPG offices</li> <li>• Parkview Community Greenhouse and Learning Kitchen</li> <li>• External provider offices</li> <li>• Fort Wayne's Farmers Market</li> <li>• HEAL Farm Markets</li> <li>• YLNI Barr Street Market</li> </ul>

# Affordable and Healthy Food

## Program/Initiative: Farm to School

**Goal:** Educate students (grades pre-K through 12) about nutrition and agriculture lessons by fostering collaboration among local farmers and food system partners.

### Objectives

- Increase students' awareness of local farms, how food is grown, and its impact on health.
- Facilitate networking and collaboration among farmers, educators, and food systems organizations.
- Foster collaboration across the local food system to share knowledge, outcomes, and best practices.
- Promote and distribute curriculum to at least two schools and/or early childhood centers.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Program reach (number of farmers, number of schools and/or early childhood centers)</li> <li>• Number of collaborations and partnerships</li> <li>• Curriculum implementation</li> </ul>	<ul style="list-style-type: none"> <li>• Actively participate in local and regional Farm to School meetings and events</li> <li>• Align curriculum with state education and early learning standards</li> <li>• Distribute curriculum materials in accessible digital formats</li> </ul>	<ul style="list-style-type: none"> <li>• Enhanced student understanding of food systems</li> <li>• Improved nutrition awareness and health literacy</li> <li>• Strengthened relationships among local food system networks</li> </ul>	<ul style="list-style-type: none"> <li>• Office of Sponsored Projects</li> <li>• Youth Well-being Team</li> <li>• Community Health Improvement</li> <li>• Community Well-Being Team</li> <li>• Schools</li> <li>• Farms</li> <li>• Early childhood centers</li> <li>• Northeast Local Food Network</li> <li>• Farmwise</li> <li>• IDOE</li> <li>• IDOH</li> </ul>

## Program/Initiative: Parkview Community Greenhouse and Learning Kitchen

**Goal:** Promote access and importance of fresh produce through farmers markets (eight weeks per year), nutrition and growing education classes (minimum of 36 per year), and facilitation of food insecurity programs/events (>400 participants over three years).

**Objective:** Increase understanding of nutrition's role in health, fresh produce consumption, and knowledge of how to grow fresh foods at home by residents in surrounding zip codes.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Number of participants</li> <li>• Percentage of participants from 05/06 zip codes</li> <li>• Percentage of produce sold per farmers market</li> <li>• Number of classes provided per year</li> <li>• Number of participants that learned recommendation of fruits and vegetables</li> </ul>	<ul style="list-style-type: none"> <li>• HEAL partner engagement classes</li> <li>• VeggieRx education</li> <li>• Seasonal HEAL farm markets</li> <li>• Yearly nutrition and growing classes</li> <li>• Directly engage those living and working in the 03/05/06 via marketing and outreach strategies and feedback sessions</li> <li>• Development of provider-focused Culinary Medicine series</li> </ul>	<ul style="list-style-type: none"> <li>• Increased knowledge</li> <li>• Behavior change</li> <li>• Improved access to fresh produce</li> <li>• Increased confidence in growing food at home</li> <li>• Advanced local food systems</li> </ul>	<ul style="list-style-type: none"> <li>• The HEAL program (St. Joe Foundation and Northeast Indiana Local Food Network, Plowshares and Rose Avenue Farm Burmese Farmers)</li> <li>• Purdue Extension</li> <li>• Fort Wayne Community Schools</li> <li>• VeggieRx program</li> <li>• Other community partner organizations</li> </ul>

# Affordable and Healthy Food

Program/Initiative: Harvest of the Month

**Goal:** Expose students (grades pre-K through 12) to a variety of locally grown produce throughout the school year.

**Objectives**

- Provide a variety of locally grown produce items to partners (schools and early childhood centers) throughout the school year.
- Increase students' exposure to and engagement with fresh produce through participation in the HOTM program.
- Collaborate with local farms to source fresh produce.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Number of students reached</li> <li>• Amount of produce distributed</li> <li>• Number of farm partners</li> </ul>	<ul style="list-style-type: none"> <li>• Develop relationships with local farms</li> <li>• Develop relationships with schools and early childhood centers</li> <li>• Collect produce orders from schools and early childhood centers</li> <li>• Identify farms who can fulfill produce orders</li> <li>• Purchase and distribute produce</li> <li>• Provide age-appropriate learning resources for each produce item</li> <li>• Gather feedback from participants</li> </ul>	<ul style="list-style-type: none"> <li>• Exposure to fresh produce</li> <li>• Increased willingness among students to try new produce items</li> <li>• Increased knowledge of area farms</li> <li>• Increased understanding of the health benefits of produce</li> <li>• Increased understanding of how food is grown</li> <li>• Increased consumption of produce</li> <li>• Increase support for sustainable, local food systems</li> <li>• Strengthen partnerships between schools, early childhood centers, and local farms</li> </ul>	<ul style="list-style-type: none"> <li>• Office of Sponsored Projects</li> <li>• Youth Well-being Team</li> <li>• Community Impact Team</li> <li>• Schools</li> <li>• Farms</li> <li>• Early childhood centers</li> <li>• Northeast Local Food Network</li> <li>• Farmwise</li> <li>• IDOE</li> <li>• IDOH</li> </ul>

# Affordable and Healthy Food

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

**Goal:** By December 31, 2028, decrease obesity and the effects of chronic disease among children ages 5–17 and their families who participate in the program.

**Objectives:**

- Improve obesogenic risk scores and well-being behaviors of participants (children ages 5–17 and their families).
- 50 percent of referred participants show no change or decrease their body fat percentage and their body mass index.
- Increase positive behavior score by at least 1 point for 50 percent of referred participants.
- 50 percent of referred participants increase knowledge/competency score by at least one point.
- 50 percent of referred participants have at least a 5 percent increase in their score on the Family Nutrition and Physical Activity (FNPA) screening tool between pre and post assessments.
- 50 percent of referred participants 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
<ul style="list-style-type: none"> <li>• Family nutrition and physical activity screening tool</li> <li>• Referred child biometric values</li> <li>• Retention rate</li> <li>• Lifestyle and behavioral surveys</li> <li>• Psychosocial functioning survey</li> </ul>	<ul style="list-style-type: none"> <li>• Physician referral</li> <li>• Assessment</li> <li>• Goal setting sessions</li> <li>• Education sessions</li> <li>• Movement activities</li> <li>• Follow-up sessions</li> </ul>	<ul style="list-style-type: none"> <li>• Behavior change</li> <li>• Increased knowledge</li> </ul>	<ul style="list-style-type: none"> <li>• PPG specialty clinics, primary care clinics, and pediatric clinics</li> <li>• External primary care and pediatric clinics</li> <li>• HealthNet of West Michigan</li> <li>• Other community organizations, including but not limited to City of Fort Wayne Parks and Recreation, Covenant Impact Center, Fort4Fitness, Fort Wayne Zoo, and the Allen County Public Libraries.</li> <li>• Huntington University</li> <li>• Parkview Marketing</li> <li>• Parkview Legal</li> <li>• HSIR</li> <li>• Community Impact Teams</li> <li>• Research Tech Team</li> </ul>

# Affordable and Healthy Food

Program/Initiative: Planting Healthy Seeds

**Goal:** Develop and implement an updated after-school curriculum that integrates evidence-based nutrition education, engaging physical activity opportunities, and social-emotional learning (SEL) strategies to support the overall well-being of participating youth.

**Objectives:**

- Within one year, develop an after-school curriculum reflecting evidence-based strategies and community reported needs related to nutrition, physical activity, and social-emotional health.
- Pilot curriculum with at least one youth-serving organization
- Gather feedback from pilot partners to inform modifications of curriculum and its implementation.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Number of lessons created for inclusion in Planting Healthy Seeds Curriculum</li> <li>• Number of lessons implemented with pilot sites</li> <li>• Number of participants reached</li> <li>• Survey feedback:               <ul style="list-style-type: none"> <li>◦ Participant (youth) data collection</li> <li>◦ Agency (staff) data collection</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Curriculum development and readiness: Develop lessons covering nutrition, physical activity, and social-emotional learning, including facilitator guides, materials lists, time estimates, and adaptation tips.</li> <li>• Pilot Site Preparation and Training: Identify pilot partners, survey training preferences (e.g., virtual, in person, synchronous vs. asynchronous), and trial training with one to two members at each site.</li> <li>• Implementation and Reach: Pilot curriculum at after school site(s)</li> <li>• Feedback and Curriculum Refinement: Gather feedback from partners</li> </ul>	<ul style="list-style-type: none"> <li>• Develop evidence-based curriculum and refine using survey feedback to strengthen program quality and sustainability</li> <li>• Provide nutrition education, physical activity, SEL strategies, and preventative mental health education to support youth well-being</li> <li>• Equip partner agencies with resources that promote high-quality, affordable, and safe youth health and wellness programming</li> <li>• Increase youth's knowledge and application of key wellbeing concepts and build a sustainable, scalable model for expanding preventative well-being education across the health system's service area</li> </ul>	<ul style="list-style-type: none"> <li>• Internal partners</li> <li>• Marketing</li> <li>• Digital communications team</li> <li>• Legal</li> <li>• Community Impact Teams</li> <li>• HSIR</li> <li>• Research Tech Team</li> <li>• Behavioral and mental health experts</li> <li>• After school programs</li> <li>• Youth and family community organizations</li> <li>• Community serving area partners</li> </ul>

# Affordable and Healthy Food

## Program/Initiative: Taking Root Health Challenge Program

**Goal:** By December 31, 2028, Taking Root will help reduce childhood obesity in Allen County among program participants.

### Objectives

- Improve knowledge/competency and well-being behaviors of program participants (grades 3–5).
- Increase average positive behavior score by a half point for all participating students.
- Increase average knowledge/competency score by a half point for all participating students.
- Decrease average mile run time change by 15 seconds for all participating students
- Increase average VO2 change by 1.25 mL/kg/min for all participating students.
- Increase number of participating schools by at least one (i.e., 22 schools participated in 2025–26 school year; aim for at least 23 for 2026–27 school year).

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Aerobic capacity</li> <li>• Mile-run test</li> <li>• Behavior score change</li> <li>• Knowledge/Competency score change</li> <li>• Number of student participants</li> <li>• Number of participating schools</li> </ul>	<ul style="list-style-type: none"> <li>• Healthy lifestyle habit education and application activities</li> <li>• Aerobic challenges</li> <li>• Motivational support provided by health champions</li> </ul>	<ul style="list-style-type: none"> <li>• Behavior change</li> <li>• Increased knowledge</li> </ul>	<ul style="list-style-type: none"> <li>• Fort Wayne Community Schools</li> <li>• School staff/faculty and health champions</li> <li>• Parkview Marketing</li> <li>• Parkview Legal</li> <li>• Research Tech Team</li> </ul>

## Program/Initiative: Matthew 25 Health and Care Registered Dietitian Services

**Goal:** Increase access to nutrition education to patients of Matthew 25 Health and Care.

### Objectives

- Allocate eight hours per month to provide outpatient RDN services at Matthew 25 Health and Care.
- Evaluate changes in lab values, nutrition knowledge, and health behaviors of patients who return for follow-up appointments.
- Collaborate with the medical team to facilitate 3 nutrition education classes per cohort of the Community Farmacy program.
- Evaluate changes in nutrition knowledge of patients who complete the Community Farmacy nutrition education sessions.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Number of patients seen</li> <li>• Total appointments</li> <li>• Hgb A1c changes</li> <li>• Percentage of weight changes</li> <li>• Correctly answering comprehension/knowledge evaluation</li> </ul>	<ul style="list-style-type: none"> <li>• Nutrition counseling appointments for individualized education and goal setting for behavior changes for blood glucose management, weight management, and heart health conditions</li> <li>• Nutrition education classes for patients with diabetes to promote healthy eating behaviors, increase access to food and improve nutrition knowledge</li> </ul>	<ul style="list-style-type: none"> <li>• Improvements in Hgb A1c values</li> <li>• Behavior change</li> <li>• Increased knowledge</li> </ul>	<ul style="list-style-type: none"> <li>• Matthew 25 Health and Care</li> <li>• Community Harvest Food Bank</li> </ul>

# Maternal and Child Health

Program/Initiative: Safe Sleep Education and Pack 'n Play® distribution program

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

## Objectives

- Increase knowledge and behavior change related to safe sleep practices in 100 percent of program participants.
- 100 percent of program participants can assemble and disassemble their Pack 'n Play™ at delivery.
- 100 percent of program participants self-report during their two-week follow-up call they are placing infant on back to sleep.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Infant mortality resulting from unsafe sleep per 1,000 live births</li> <li>• Number of program participants</li> <li>• Number of referrals to safe sleep classes</li> <li>• Number of one-on-one education sessions</li> <li>• Number of interpreters utilized for education</li> <li>• Number of PNP and sheets distributed</li> <li>• Number of Safe Sleep Kits (safe sleep sacks and book)</li> <li>• Number of eighth graders completed Infant Safety classes (Completed by McMillen Center for Health Education)</li> </ul>	<ul style="list-style-type: none"> <li>• Safe sleep education offered at no cost</li> <li>• Distribution of safe sleep kit - (including Pack 'n Play®) to families without a crib or PNP</li> <li>• Referrals to safe sleep classes</li> <li>• Cultural support and interpretation</li> <li>• Infant safety classes for eighth graders in FWCS (completed by McMillen Center for Health Education)</li> </ul>	<ul style="list-style-type: none"> <li>• Increased knowledge</li> <li>• Behavior change</li> <li>• Reduced infant death</li> </ul>	<ul style="list-style-type: none"> <li>• Community Health Worker (Safety PIN)</li> <li>• Community Nursing</li> <li>• Parkview Family Birthing Centers and NICU</li> <li>• A Baby's Closet</li> <li>• A Hope Center</li> <li>• A Mother's Hope</li> <li>• Courtyard</li> <li>• FWCS</li> <li>• Healthier Moms and Babies</li> <li>• Women's and Children's Service Line Nurse Navigators</li> <li>• Community partners</li> <li>• McMillen Center for Health Education</li> </ul>

# Maternal and Child Health

## Program/Initiative: Community Lactation Support

**Goal:** Increase the number of new mothers who engage in breastfeeding by providing lactation support and education to vulnerable mothers in the targeted zip codes.

**Objective:** Increase knowledge of breastfeeding health benefits, mechanics, and support resources in 100 percent of program participants.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>Number of women reporting an increase in knowledge</li> <li>Number of breastfeeding initiations</li> <li>Number of duration milestones achieved</li> </ul>	<ul style="list-style-type: none"> <li>Instruction on breastfeeding health benefits, mechanics, and resources for on-going support</li> <li>Follow-up phone calls</li> <li>Follow-up virtual visits or home visits</li> </ul>	<ul style="list-style-type: none"> <li>Increased knowledge</li> <li>Improved health outcomes for mom and baby</li> </ul>	<ul style="list-style-type: none"> <li>Community Health Worker (Safety PIN) program</li> <li>Healthier Moms and Babies</li> <li>Women's &amp; Children's Service Line Nurse Navigators</li> <li>Family Birthing Center</li> <li>A Baby's Closet</li> <li>Courtyard</li> <li>IRIS/Healthy Families</li> <li>A Mother's Hope</li> </ul>

## Program/Initiative: Maternal Nurse Navigation

**Goal:** Complete screenings for at least 97 percent of all pregnant women for SDOH.

**Objective:** Identify concerns and connect clients to resources as indicated in a timeline indicated by the level of risk.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>Compare the numbers of clients screened to the number of patients coming to care for pregnancy</li> <li>Identify high risk pregnancies with MFM and another point of contact to confirm the plan of care is implemented</li> <li>Identify patients at high risk for PP Depression and encourage early recognition and support</li> <li>Compare numbers of clients screen 5P and who engage with supports</li> </ul>	<ul style="list-style-type: none"> <li>Screening of all new OB patients for SDOH needs, mental health &amp; readiness for pregnancy/parenting</li> <li>Identification of medically high-risk clients (i.e. diabetes, pre-eclampsia, and fetal anomalies)</li> <li>Collaborate with CHW's and social work team to address Social Drivers of Health</li> <li>Identify clients in need of SUD support</li> </ul>	<ul style="list-style-type: none"> <li>Improve follow up</li> <li>Knock down barriers for receiving equitable care</li> <li>Assist with care coordination and escalation to higher level of care for delivery when needed</li> <li>Decrease maternal mortality rates</li> <li>Decrease fetal/infant mortality rates</li> <li>Improved community Support to grow resiliency</li> <li>Improved health literacy</li> </ul>	<ul style="list-style-type: none"> <li>Social workers</li> <li>Community health workers</li> <li>OB providers</li> <li>Perinatal substance use disorder Coordinator</li> <li>Maternal Fetal Medicine</li> <li>FIMR coordinators</li> <li>OB departments</li> <li>Fetal care coordinator</li> <li>Maternal care coordinator</li> </ul>

# Maternal and Child Health

Program/Initiative: Pediatric Nurse Navigation

**Goal:** Support the parents of medically complex children as they navigate a new or complex diagnosis.

**Objective:** Identify and support families in meeting co-created goals to optimize outcomes and/or coping, health literacy, disease management, and mitigate barriers.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>Referrals from PCP and/or peds specialists</li> <li>Length of support/needs and degree of medical complexity at time of referral</li> <li>Create shared plans of care to update the entire team of care providers and this is shared among community partners like schools</li> </ul>	<ul style="list-style-type: none"> <li>Meet with families to assess barriers and resources already established and identify gaps</li> <li>Cocreate goals for optimizing outcomes, knowledge and coping</li> <li>Collaborate with all care team members to improve efficiency, quality and safety</li> </ul>	<ul style="list-style-type: none"> <li>Increase patient compliance to care plans by reducing barriers</li> <li>Decreasing financial burdens to families who are eligible for waivers for Medicaid and other funding sources</li> <li>Decreases in missed appointments and duplicated services with enhanced care coordination</li> </ul>	<ul style="list-style-type: none"> <li>Pediatric specialty providers and teams</li> <li>Primary care providers</li> <li>Social work</li> <li>Case management</li> <li>First Steps</li> <li>Outpatient therapy teams</li> <li>Nutritional services</li> </ul>

Program/Initiative: Fetal/Infant Mortality Review team (FIMR)

**Goal:** Identify recommendations from case abstractions and reviews that will help mitigate future losses.

**Objective:** Abstract cases and share with the multidisciplinary team for review to determine recommendations.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>Numbers of cases reviewed as compared to the number of deaths occurred</li> <li>Number of cases reviewed when a maternal interview was captured</li> </ul>	<ul style="list-style-type: none"> <li>Abstract cases from medical records and offer maternal or family interviews who have experienced the loss</li> <li>Host meetings with key stakeholders to review contributing factors to the loss with review of charts, interviews of parents, and group discussion</li> <li>Community partners have improved networking and sharing resources in 2025</li> <li>Clinical action teams and QI projects will be starting in 2026</li> </ul>	<ul style="list-style-type: none"> <li>Case review teams share findings with community action teams</li> <li>Community partners work to implement some recommendations</li> <li>Next, we will be adding a more clinical team to focus on those recommendations</li> <li>Fetal movement surveillance will be taught to at least 50 percent of all pregnant women</li> <li>Improved access to mental health resources and social supports</li> </ul>	<ul style="list-style-type: none"> <li>WIC offices</li> <li>OB department leaders, staff nurses</li> <li>Providers and clinical support staff</li> <li>Local health departments</li> <li>Parkview Nurse Navigators</li> <li>Pregnancy resource centers</li> <li>Community health workers</li> <li>Bereavement Coordinators</li> <li>Social workers</li> <li>Every Birth Network</li> <li>Prenatal and Infant Care Network (Allen County)</li> <li>Indiana FIMR team</li> <li>Child Fatality Review teams</li> <li>Department of Child Services</li> <li>Community Health Improvement teams</li> </ul>

# Maternal and Child Health

Program/Initiative: Maternal/Child Community Health Workers–Safety PIN

**Goal:** Provide home visits to vulnerable families with social, emotional, financial, or other barriers to optimize pregnancy and birth outcomes and decrease infant mortality.

**Objective:** Complete home or community visits to provide health education on maternal/child topics like safe sleep, infant feeding, and mental health screening and support. These are designed as monthly visits until the baby's first birthday.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Referrals to program from NN and other community partners</li> <li>• Completed home or community visits with clients</li> <li>• Adequate length of support measured in average numbers of visits</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule home visits within three business days of receiving the referrals for all clients.</li> <li>• Complete home visits monthly for established patients and more/less often as desired by the client/family over the prenatal period until the baby's first birthday</li> <li>• Assist client in setting and achieving goals around attaining resources and health literacy</li> </ul>	<ul style="list-style-type: none"> <li>• Improved access to resources with increased awareness and focused, individual support for clients and families</li> <li>• Reduced barriers to care through education and augmented health literacy</li> <li>• Improvement in birth outcomes, breastfeeding success, and a decrease in unsafe sleep behaviors in the community from education, screening, and motivational interviewing</li> </ul>	<ul style="list-style-type: none"> <li>• WIC</li> <li>• PIC network</li> <li>• Safe Sleep Task Force</li> <li>• Parkview Community Nursing team</li> <li>• Every Birth Network</li> <li>• A Baby's Closet</li> <li>• Alliance Health</li> <li>• Healthier Moms and Babies</li> <li>• Parkview nurse navigation and social workers</li> <li>• Parkview Behavioral Health</li> <li>• OB-GYN providers and teams</li> </ul>

# Maternal and Child Health

## Program/Initiative: Simple Solutions

**Goal:** Improve maternal and early childhood health by equipping pregnant women and families with young children with the knowledge, tools, and support needed to adopt healthier nutrition, physical activity, and daily lifestyle habits, ultimately reducing risks for obesity, chronic disease, and adverse pregnancy outcomes.

### Objectives

- Train and support home visitors/facilitators from community partner agencies to deliver the 8-session Simple Solutions curriculum.
- Require facilitators to earn a minimum score of 80 percent on the knowledge assessment to confirm competency of the train-the-trainer curriculum.
- Encourage partner agencies to engage up to 200 Allen County families in completing all eight sessions of the curriculum through video lessons, interactive workbook activities, and goal-setting during home visits.
- We anticipate that participants (pregnant women and families with children) will show improvements from pre- to postassessment in the categories below if they complete 100 percent of the Simple Solutions curriculum training.
- Develop a fully sustainable, replicable project model for broader use across the health system's service areas.
- Decrease childhood obesity rates at the community level
- Improve maternal and early childhood health outcomes

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Number of lessons created for inclusion in Planting Healthy Seeds Curriculum</li> <li>• Number of lessons implemented with pilot sites</li> <li>• Number of participants reached</li> <li>• Survey feedback:               <ul style="list-style-type: none"> <li>◦ Participant (youth) data collection</li> <li>◦ Agency (staff) data collection</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Training home visitors and community health workers to deliver the eight-session curriculum</li> <li>• Providing agencies and families with printed curriculum booklets (English and Spanish)</li> <li>• Ongoing evaluation of family engagement, lesson reinforcement, and testing throughout the year using an online data collection platform</li> <li>• Working with agency leads to track facilitators and potential facilitators Collaborating with Parkview Legal, Compliance, Marketing, Research, and other internal partners for program support</li> <li>• Monitor family and facilitator engagement throughout the year by supporting home visitors in reinforcing lessons, administering assessments, and conducting ongoing evaluation during home visits</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthened program planning, execution, and sustainability</li> <li>• Participants increase healthy habits, including more shared family meals, greater fruit and vegetable intake, and more consistent breakfast consumption</li> <li>• Participants reduce unhealthy behaviors such as sugary beverage intake and recreational screen time</li> <li>• Participants adopt healthier daily routines, getting at least seven hours of sleep and engaging in physical activity five or more days per week</li> <li>• Families experience better long-term health</li> <li>• Parents and caregivers adopt lasting healthy behaviors including an increased intake of nutritious foods, more active play with reduced screen time, and improved balanced feeding practices</li> </ul>	<ul style="list-style-type: none"> <li>• Parkview Legal, Corporate Compliance, Marketing, Digital Storefront, Research, Research Tech Team, Accounts Payable, and Translation Services</li> <li>• SCAN</li> <li>• Lutheran Social Services of Indiana</li> <li>• Parkview Health-Women and Children's Community Outreach: Safety PIN</li> <li>• Parkview Health-Community Health Workers</li> <li>• Healthier Moms and Babies</li> <li>• Other youth and family serving agencies</li> </ul>

# Access to Care

While access to care was not selected as a top three priority for Parkview Allen County Hospitals, Allen County will continue to incorporate this priority into its strategy.

## Program/Initiative: Community Nursing - Care Navigation and Education for Vulnerable Populations

**Goal:** Improve access to healthcare services for underserved community members through community nursing outreach, navigation, and care coordination.

**Objective:** Increase access to primary and preventive healthcare for underserved community members by achieving successful care connections for community nursing clients.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>Percentage of clients connected to a primary care provider/medical home</li> <li>Insurance or financial assistance enrollment initiation rate</li> <li>Percentage of clients with key access barriers addressed (transportation, insurance, SDOH)</li> <li>Repeat ED utilization among enrolled clients where appropriate for programs</li> <li>Number of Medication Runs completed</li> <li>Number of Immunizations given through FACE Clinic</li> </ul>	<ul style="list-style-type: none"> <li>Identify clients without a PCP during intake and provide warm handoffs with partner agencies</li> <li>Screen clients for insurance status and initiate Medicaid, marketplace, or hospital financial assistance applications</li> <li>Assess transportation, insurance, and social needs and connect clients to appropriate resources</li> <li>Provide targeted follow-up, care education, and coordinated primary care or specialty referrals for clients with repeat ED use to support appropriate care utilization</li> <li>Facilitate medication runs to address access barriers</li> <li>Provide immunizations to students at the FACE Clinic and through in-school clinics</li> </ul>	<ul style="list-style-type: none"> <li>Increased access to primary care, insurance coverage, needed medications, and supportive services, resulting in more appropriate care utilization and reduced barriers for underserved populations</li> </ul>	<ul style="list-style-type: none"> <li>Community Nursing Team</li> <li>Primary care and specialty clinics</li> <li>ER departments</li> <li>Social workers and case management teams</li> <li>Care Coordination Team</li> <li>PBH and Park Center</li> <li>WIC</li> <li>Matthew 25</li> <li>Enrollment Center and Marketplace</li> <li>MAP</li> <li>Alliance Health</li> <li>NHC</li> <li>IRIS Family Services</li> <li>FWCS</li> </ul>

# Access to Care

Program/Initiative: Better Future Clinic

**Goal:** To improve the health and wellness of the communities that Parkview serves and to increase community awareness of Parkview Health as a public service.

**Objective:**

- To fill the gap of providing ongoing care and healing for children who need follow-up medical and emotional support after suspected abuse.
- Offer a multidisciplinary approach to adequately evaluate and treat child abuse victims.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Number of people served</li> <li>• Recidivism</li> </ul>	<ul style="list-style-type: none"> <li>• Collaborate with Iris Family Support Center to provide navigation services for families to best connect them with community resources and programs that meet the developmental, social, and mental health needs of both the child and caregivers</li> <li>• Offer follow-ups to ensure that any physical injuries are healing correctly and to promote the overall health of each child seen in the clinic</li> <li>• Provide access to counseling and therapy services to help children process their feelings and recover emotionally</li> <li>• In alignment with the Kids First Indiana child abuse and neglect prevention strategy - Provide political and educational advocacy to promote awareness that child abuse is preventable</li> <li>• Develop professionals that work with children to understand mandatory reporting</li> <li>• Disseminate print material to professionals who work with children</li> </ul>	<ul style="list-style-type: none"> <li>• Children feel supported and cared for in a stable environment</li> <li>• Breaking the cycle of abuse</li> <li>• By addressing emotional and psychological trauma early on, the follow-up clinic helps reduce the burden on mental health services and decreases the likelihood of the child developing chronic mental health issues in adulthood</li> <li>• Early detection and treatment of abuse-related injuries and trauma can reduce the need for more extensive medical treatments later in life.</li> <li>• Clinic will prevent injuries, fatalities, and child abuse and neglect by creating awareness of child abuse, reporting mechanisms, and providing resources to the community</li> </ul>	<ul style="list-style-type: none"> <li>• IRIS</li> <li>• Indiana Department of Child Services</li> <li>• Law enforcement</li> <li>• Social Workers</li> </ul>

# Access to Care

Program/Initiative: In-Kind Lab and Imaging Services for Matthew 25 Health and Care

**Goal:** Improve access to lab and imaging services for vulnerable populations.

**Objective:** Improve timely diagnosis and continuity of care for vulnerable populations by increasing access to lab and imaging services through collaborative partnerships.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>Number of people served</li> </ul>	<ul style="list-style-type: none"> <li>Collaborate with Matthew 25 Health and Care to provide navigation services for families to best connect them with community resources and programs that meet the developmental, social, and mental health needs of both the child and caregivers</li> </ul>	<ul style="list-style-type: none"> <li>Decreased financial barriers to essential diagnostics</li> <li>Timely diagnosis and treatment of conditions</li> <li>Will help manage chronic conditions more effectively, decreasing crisis-driven care</li> </ul>	<ul style="list-style-type: none"> <li>Community Impact Team</li> <li>Parkview Lab Services</li> <li>Parkview Imaging Services</li> <li>Matthew 25 Health and Care</li> </ul>

Program/Initiative: findhelp.org

**Goal:** Increase the public's awareness of the resources available locally in the community.

**Objective:** Increase community awareness of local resources by promoting and encouraging use of findhelp.org through outreach, education, and community engagement efforts.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>Number of site visits</li> <li>Number of searches</li> </ul>	<ul style="list-style-type: none"> <li>Share information related to findhelp.org through community impact communications</li> <li>Make <b>findhelp.org</b> available through Parkview.com</li> </ul>	<ul style="list-style-type: none"> <li>Increased awareness of resources available in community</li> <li>Reduced barriers to addressing social determinants of health needs</li> </ul>	<ul style="list-style-type: none"> <li>Findhelp</li> </ul>

# Access to Care

Program/Initiative: Ronald McDonald Care Mobile

**Goal:** Increase access to high-quality, equitable, and community-based pediatric healthcare services.

**Objectives**

- Expand care access through mobile preventive, acute, and immunization services.
- Improve immunization rates and early detection of health needs.
- Increase reach into high-need neighborhoods and rural communities.
- Strengthen community referral pathways and family navigation supports.
- Reduce health disparities by addressing social, linguistic, and insurance barriers.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Total annual visits and number of unique children served</li> <li>• Childhood immunizations delivered</li> <li>• Number of counties and community sites served</li> <li>• Community referrals completed</li> <li>• SDoH screens completed with well-child visits</li> <li>• Supportive resources provided</li> </ul>	<ul style="list-style-type: none"> <li>• Operate RMCM at schools, community sites, shelters, food banks, churches; increase site recruitment; maintain consistent calendar</li> <li>• Offer VFC/Private vaccines; provide reminders; coordinate with school nurses; outreach to low-coverage zip codes</li> <li>• Expand site recruitment; coordinate with county agencies; maintain routing based on Community Health Needs Assessment</li> <li>• Provide onsite SDoH screening, care navigation, warm handoffs to Alliance Health, other health care providers, specialist, NHC, First Steps, etc.</li> <li>• Integrate screens into workflow; provide follow-up resources</li> <li>• Provide culturally relevant education; interpreter services; SDoH-informed resource distribution</li> </ul>	<ul style="list-style-type: none"> <li>• Increased access to acute care, well-child visits, immunizations, and urgent needs; reduced delays due to transportation or financial barriers</li> <li>• Improved immunization compliance; decreased school exclusion risk; reduced vaccine-preventable illness</li> <li>• Increased geographic equity; improved access in rural and underserved communities</li> <li>• Improved continuity of care; earlier intervention; reduced long-term complications due to delayed specialized care</li> <li>• Earlier identification of food insecurity, housing instability, transportation barriers, etc.</li> <li>• Reduced health disparities; improved health literacy; stronger caregiver engagement</li> </ul>	<ul style="list-style-type: none"> <li>• Parkview Pediatrics</li> <li>• Parkview Community Nursing</li> <li>• Parkview SDOH team</li> <li>• FWCS and other school districts</li> <li>• Local health departments</li> <li>• VFC Program and other partner sites</li> <li>• Head Start programs</li> <li>• Churches and libraries,</li> <li>• Alliance Health</li> <li>• Matthew 25</li> <li>• Brightpoint</li> <li>• First Steps</li> <li>• Specialty providers</li> <li>• Neighborhood Health Clinic</li> <li>• Local nonprofits</li> <li>• Food banks</li> <li>• Family services</li> <li>• Interpreter services</li> </ul>

# Access to Care

Program/Initiative: Francine's Friends Mobile Mammography Coach

**Goal:** Increase breast cancer screening in all counties served by Parkview Health, specifically targeting counties who have identified cancer as a top priority in their area.

**Objective:** Surpass previous years' screening numbers for each county served within the Parkview Health service area.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>• Number of women screened in each county</li> <li>• Demographic breakout within each county of participants screened</li> <li>• Number of sites visited in each county</li> <li>• Baseline screening mammograms completed</li> </ul>	<ul style="list-style-type: none"> <li>• Develop relationships with key community advocates</li> <li>• Grow partnerships with area businesses employing minority populations</li> <li>• Visit rural communities that lack clinics providing mammograms</li> <li>• Provide culturally relevant educational materials on importance of screening mammograms</li> <li>• Decrease financial barriers to patients by vetting at point of registration</li> <li>• Expand outreach in low-income zip codes</li> </ul>	<ul style="list-style-type: none"> <li>• Exposure and increased connection to Parkview Health</li> <li>• Timely diagnosis and treatment of cancer if found</li> <li>• Increased knowledge of screening parameters and guidelines</li> <li>• Opportunities to share education regarding additional screenings</li> <li>• Navigation to other community-based resources.</li> <li>• Increase patient compliance of yearly cadence (repeat patients)</li> <li>• Strengthen trust to refer friends and family to the coach</li> </ul>	<ul style="list-style-type: none"> <li>• Parkview community health leaders</li> <li>• County health departments</li> <li>• Parkview / BDC marketing</li> <li>• Site coordinators</li> <li>• Physicians/APP's throughout the Parkview system</li> <li>• IN-BCCP regional coordinators</li> <li>• IBCAT grant facilitators</li> <li>• Parkview Health Foundation</li> <li>• OSP representatives</li> <li>• Federally Qualified Heath Centers (FQHC) and rural health clinics</li> </ul>

# Insurance for Healthcare

While Insurance for Healthcare was not selected as a top three priority for Parkview Allen County Hospitals, Allen County will continue to incorporate this priority into its strategy.

**Program/Initiative:** Enrollment Assistance through Brightpoint - Covering Kids & Family Network

**Goal:** Provide all eligible Hoosiers with accessible health care coverage.

**Objective:** Partner with Brightpoint to serve uninsured and underinsured individuals and families to provide free health navigation support to help with enrolling in, using, and keeping public health coverage benefits.

Indicator	Interventions	Anticipated Impact	Internal/External Partners
<ul style="list-style-type: none"> <li>Number of people served</li> </ul>	<ul style="list-style-type: none"> <li>Enrollment services are offered in person and over the phone</li> <li>Brightpoint's state and federal certified Healthcare Navigators work with the Indiana Family and Social Services Administration (FSSA) to approve, renew, and maintain coverage</li> </ul>	<ul style="list-style-type: none"> <li>Decreased financial barriers to healthcare services</li> <li>Reduced uninsured rate among vulnerable populations</li> <li>Decreased coverage gaps</li> <li>Increased use of preventive services</li> </ul>	<ul style="list-style-type: none"> <li>Community Impact Team</li> <li>Brightpoint</li> </ul>

## Identified Health Needs Not Addressed

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:

- Housing Affordability

## For More Information

Parkview would like to extend gratitude towards its community partners for their collaboration with the 2025 CHNA and 2026 implementation strategy process that addresses the health needs of Allen County. For additional information about the Parkview Allen County Hospitals 2025 CHNA or 2026 Implementation Plan, please contact us at [community.health@parkview.com](mailto:community.health@parkview.com).

## Board Approval

Approved by the Community Health Improvement Committee of the Parkview Hospital, Inc. Board of Directors on May 6, 2026