PARKVIEW

COMMUNITY HEALTH IMPROVEMENT

# 2026 Implementation Strategy

## Parkview Kosciusko 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 prepare 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 Kosciusko 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

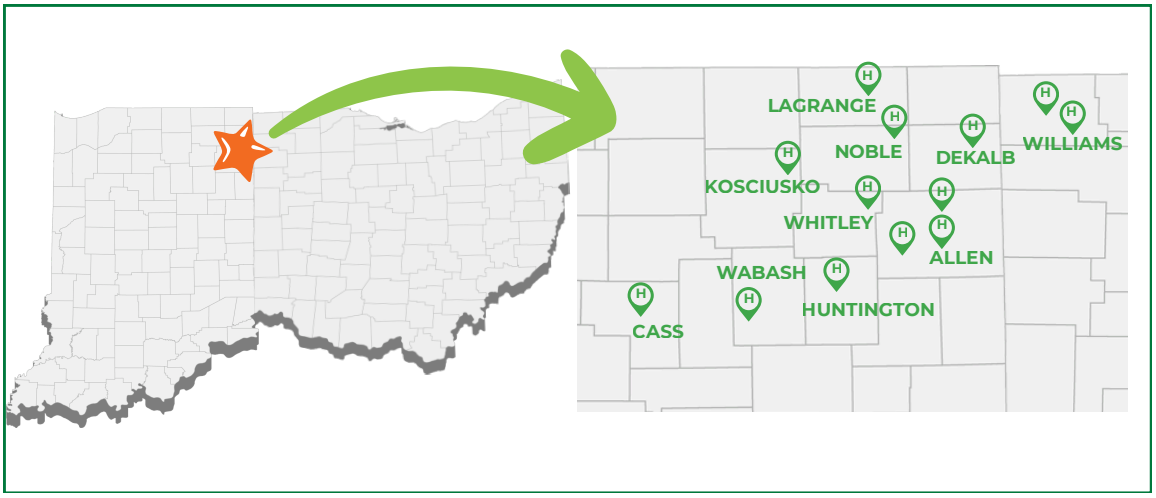
Parkview is a not-for-profit, community-based health system. It serves a population of more than 1.3 million in Indiana and Northwest Ohio. With more than 17,500 employees, Parkview is the region's largest employer. Parkview started as Fort Wayne City Hospital and has been serving the community since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

Kosciusko County, home to Parkview Kosciusko Hospital, serves a population of 80,357 residents, according to the 2025 Parkview Kosciusko Hospital CHNA. The county's median household income is approximately $73,922, with 9.7 percent of households living below the federal poverty level. Additionally, 11.1 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

### Kosciusko County's Top Five Health Concerns

- Cancers
- Diabetes
- Housing Affordability
- Mental Health and Mental Disorders
- Obesity

# Prioritization Process

## Prioritization Overview

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

## Community Prioritization Sessions

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

## Selected Health Priorities

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

**Selected Priorities for Parkview Health–Kosciusko County**

- Cancers
- Mental Health and Mental Disorders
- Obesity and Diabetes

# Implementation Strategy Process

In addressing each prioritized health issue identified, Parkview Kosciusko 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 Whitley Hospital's Community Health Improvement committee, made up of hospital board members, hospital leadership, and community stakeholders, reviewed and adopted the implementation strategy on behalf of Parkview Kosciusko Hospital on May 4, 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: Community Partnership Implementation | | | |
|---|---|---|---|
| **Goal**: Support unhoused individuals by addressing mental health challenges through comprehensive services that promote healing, stability, and long-term well-being. | | | |
| **Objectives**<br>• Increase access and engagement in mental health services.<br>• Improve mental health outcomes and coping skills.<br>• Strengthen community partnerships and coordinated care. | | | |
| **Indicator** | **Interventions** | **Anticipated Impact** | **Internal/External Partners** |
| • Service participation<br>• Engagement rate<br>• Progress toward personal goals<br>• Improvement in mental health and emotional stability | • Provide teen parents with structured group sessions focused on mental health education, relationship building, and life skills development<br>• Individualized mentor pairings for ongoing support<br>• On-site trauma-informed counseling by licensed mental health therapists<br>• Confidential one-on-one sessions<br>• Connect teen parents, residents, and first responders to external mental health providers, healthcare services, and community resources | • Increased engagement in mental health services<br>• Improved coping skills and emotional regulation<br>• Improve overall well-being of community<br>• Counseling services will be more accessible | • Fellowship Missions team<br>• Bowen Health<br>• Parkview Health<br>• McArthur Counseling Center<br>• Healthcare providers |

# Obesity and Diabetes

Program/Initiative: Combined Community Services (CCS)–Expanding Access to Nutritious Food

**Goal**: Increase access to nutritious food for low-income residents in Kosciusko County by distributing 400 pounds of food to 100 households through the CCS food pantry.

**Objectives**

- Establish a collaborative network of at least five local farms, organization or community partner with the first year to support the growing, harvesting, and distribution of fresh produce with minimal financial burden.
- Increase access to fresh, nutritious food for low-income residents in Kosciusko County by distributing 400 pounds of fresh produce annually through raised garden beds and community gardens.
- Develop a referral partnership with at least three healthcare providers, hospitals, or community organization with two years to connect families experiencing food insecurity or nutrition related health concerns with fresh, nutrient-dense foods through CCS.

| Indicator | Interventions | Anticipated Impact | Internal/External Partners |
|---|---|---|---|
| • Total pounds of fresh produce grown and distributed monthly through raised beds and the CCS food pantry<br>• The number of low-income households receiving fresh produce through the program each month<br>• Number of active partnerships with local farms, organization, and community groups supporting food production, harvesting, or distribution<br>• Number of referrals received from healthcare providers, hospitals, or community organizations connecting families to fresh, nutrient-dense food resources | • Working with Celebration Creation, local farms, planning seasonal crops, installing and maintaining raised garden beds<br>• Initiated outreach to local farms, ag partners, and gardens to explore collaboration opportunities and growing food rescue/produce recovery<br>• Begin outreach to local clinics, healthcare providers, and community organizations to develop a pathway so providers can connect families experiencing food insecurity or nutrition-related concerns directly to CCS<br>• CCs will demonstrate intentional program development, community collaboration, and set forth an easy pathway<br>• Prepare a formal process for tracking the expanded growth and the increased distribution methods | • CCS will establish formal community/farm partnerships and healthcare referral partners so that more households are connected with nutrient-dense foods<br>• CCS will impact Kosciusko County by increasing fresh produce distribution and reaching more low-income families<br>• Increasing fresh produce distribution and producing nutritious food will expand access to healthy food to low-income families supporting better nutrition, chronic disease prevention, and overall community health.<br>• Establishing farm, community, and healthcare partnerships will create a coordinated response to food insecurity, reduce financial burden, and build a more sustainable/collaborative impact in Kosciusko County | • Combine Community Services staff<br>• Volunteers<br>• Board of directors<br>• Self-sufficiency participants<br>• K21 Health Foundation<br>• Celebration Creation<br>• LiveWell Kosciusko<br>• Harrison Elementary<br>• Pleasantview Bible Church |

# Obesity and Diabetes

Program/Initiative: Northeast Indiana Local Food Network–Power of Produce (POP) Kosciusko County Farmers Markets, Winona Lake and Warsaw

**Goal**: Increase fruit and vegetable consumption by empowering children through nutrition education and providing them with financial incentives (POP Bucks) to purchase healthy produce from local farmers.

**Objectives**

- Provide nutrition education to 5–12-year-olds in Kosciusko County.
- Distribute up to $8 in POP Bucks to each participating child to empower them to purchase fresh produce.
- Ensure that market managers and vendors at the Winona Lake Farmers Market and Kosciusko County. Farmers & Artisans Market are trained to accept and redeem the currency.

| Indicator | Interventions | Anticipated Impact | Internal/External Partners |
|---|---|---|---|
| • Total participation–the number of children ages 5–12 reached through the program<br>• Redemption rate–the percentage of distributed POP Bucks successfully spent at vendor<br>• Knowledge retention–the percentage of children who can identify a new fruit or vegetable after a lesson<br>• Economic impact–the total dollar value of POP Bucks reimbursed to local farmers | • Weekly educational programming–deliver 10–15 minute nutrition lessons at local farmers markets led by Purdue Extension educators or master gardeners<br>• Incentives and vendor coordination–distribute POP Bucks (up to $8 per child per session) and coordinate with vendors to accept them, linking education to local food purchases<br>• Participation tracking–use sign-in sheets to track attendance, distinguish new vs. returning participants, and record total incentives distributed | • Empowerment–the program shifts children from passive consumers to active participants who have the knowledge and agency to choose fresh produce<br>• Health equity–direct financial incentives (POP Bucks) reducing the cost obstacle to healthy eating or nutrition -insecure families<br>• Preventative Health–by fostering lifelong healthy habits in children ages 5–12, the program acts as a long-term community health intervention to reduce future diet-related chronic diseases<br>• Economic Linkages–the program creates a sustainable circular system where funding flows directly to local farmers via the children's purchases | • Northeast Indiana Local Food Network<br>• Purdue Extension Community Wellness<br>• Purdue Extension, Master Gardeners<br>• Winona Lake Farmers Market, Kosciusko County Farmers & Artisans Market |

# Obesity and Diabetes

Program/Initiative: Parkview Warsaw YMCA–Mom's on the Move

**Goal**: Provide an affordable (Free), safe, supportive community where mothers can build strength, restore movement, and feel confident caring for their bodies throughout pregnancy and postpartum recovery.

**Objectives**

- For new and expectant mothers to participate and access free exercise program focused on their specific needs.
- Reach a population that does not typically have access to a gym or instructors trained in specific fitness focused on this demographic.
- Engage the mothers to a sense of community by offering these services and providing them with a key resource to support them on their health and wellness journey.

| Indicator | Interventions | Anticipated Impact | Internal/External Partners |
|---|---|---|---|
| • Ask each mother which hospital she plans to or has delivered her baby<br>• Survey mother for their feedback on their mental and physical health by being a part of this program<br>• Attendance<br>• Note each mother's fitness improvements in their exercise and wellness journey | • Changing the program to be offered year-round instead of a six-week model<br>• Implementing a weekly fitness class with a rotation of the focus of the class and now being offered year-round compared to the previous six-week model | • Growth in participation and additional class offerings like nights and weekends<br>• Become a long-standing program instead of a one-off program.<br>• Provide a sustainable program that is more easily accessible to the population and targeted audience<br>• Provide a sense of community and belonging | • Parkview Kosciusko Hospital<br>• Parkview Warsaw YMCA<br>• Lilly Pad Café and playcenter within the YMCA lobby<br>• B.A.B.E. Boutique |

# Cancer

Program/Initiative: Cancer Services of Northeast Indiana–Client Advocate Program

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

**Objectives**

- Clients, particularly low-income, at-risk, and vulnerable individuals, will utilize financial assistance, transportation assistance and advocacy support to improve access to healthcare.
- 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 and exercise classes) to gain knowledge and skills to manage chronic illness and live healthier lives.

| Indicator | Interventions | Anticipated Impact | Internal/External Partners |
|---|---|---|---|
| • Number of clients served and number of client advocate service interactions<br>• Healthcare supplies distributed and durable medical equipment loans<br>• Financial assistance and transportation assistance provided.<br>• Participation in wellness activity or educational opportunities and mental health counseling sessions provided | • Each client is connected to a client advocate who assesses the clients support needs and ensures the client has mental health screening<br>• Client advocate helps client access practical services such as supplies, financial assistance, or transportation aide to increase access to health care<br>• Client advocate connects client to mental health support services and mental health counseling<br>• All clients will be proactively assessed<br>• Clients will receive phone class inviting them to wellness or mental health activities as well as receiving email invitations | • Increased access to mental health support and services<br>• Increased access to healthcare<br>• At-risk clients will have access to affordable mental health counselling<br>• An increased number of vulnerable people will be able to access health care services | • Medical community<br>• Mental healthcare providers |

# Insurance for Health Care

While Insurance for Health Care was not selected as a top three priority for Parkview Kosciusko Hospital, Kosciusko 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 healthcare coverage. | | | |
| **Objectives**<br>• Complete 250 applications for Kosciusko County residents.<br>• Over 80 percent of Kosciusko Covering Kids & Families applications will enroll in public health coverage programs.<br>• The program will also provide 800 support services to help Kosciusko County residents with using and keeping public health benefits. | | | |
| **Indicator** | **Interventions** | **Anticipated Impact** | **Internal/External Partners** |
| • Number of public health insurance applications submitted<br>• Application approval rate<br>• Number of supportive services provided to ensure consumers use and maintain their benefits<br>• Number of outreach activities participated in to ensure public awareness of public health insurance programs | • All enrollment assistance is provided by licensed and certified staff to ensure that services meet state and federal requirements<br>• Quality assurance processes such as weekly application reviews, monitoring outcomes to maintain accuracy and meet program objectives<br>• Participation in community outreach and education activities, including presentations, resource fairs and one-on-one information sessions to increase awareness<br>• CKF will distribute save-the-Date notices to all schools to promote attendance and ensure that school staff are informed about the annual school conference<br>• CKF will participate in a community outreach event in Kosciusko County to raise awareness of health coverage options and connect residents with enrollment assistance resources | • Improve consumer understanding of health coverage and active engagement in using their benefits<br>• Reduce gaps in health coverage for consumers<br>• Earlier access to care can lead to better health outcomes and reduce the use of emergency services<br>• Increase community awareness of available health coverage resources | • L.I.T.E. Recovery<br>• Health Services Pavilion<br>• Bowen Health,<br>• Heartline Pregnancy Center<br>• WIC |

# Access To Healthcare

While Access was not selected as a top three priority for Parkview Kosciusko Hospital, Kosciusko County will continue to incorporate this priority into its strategy.

| Program/Initiative: Kosciusko County Free Clinic–Labs and X-rays for indigent patients | | | |
|---|---|---|---|
| **Goal**: Provide primary healthcare to the uninsured and underserved community with free primary health care. | | | |
| **Objective**: Provide education on high blood pressure, high A1Cs, obesity, smoking cessation, and recovery to patients. | | | |
| **Indicator** | **Interventions** | **Anticipated Impact** | **Internal/External Partners** |
| • Blood pressure–monitor every two weeks<br>• Glucose–monitored every two weeks<br>• Weight–monitored monthly | • Education on diet<br>• Refer interested patients to smoking cessation classes<br>• Work closely with NIMCHN as they test for HIV, AIDS, STDs and will treat patients for free | • Improve the health of the vulnerable population<br>• Keep track of the patients but they are also transient which provides a challenge<br>• Improve community members' health so they can return to work or find employment | • Lab and radiology community health improvement<br>• Health First, Soup Kitchen<br>• Fellowship Missions<br>• NIMCHN<br>• Spectacle Shoppe<br>• Sean Rhodes, DPM |

# Identified Health Needs Not Addresssed

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

- 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 Kosciusko County. For additional information about Parkview Kosciusko Hospital's 2025 CHNA or 2026 Implementation Plan, please contact us at Community.Health@parkview.com.

## Board Approval

Approved by the Community Health Improvement Committee of
Parkview Whitley Hospital's Board of Directors on behalf of
Parkview Kosciusko Hospital on May 4, 2026