



Parkview Hospital

2020 Implementation Strategies

PARKVIEW HEALTH

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Commitment to the Community

Mission and Vision

As a community-owned, not-for-profit organization, Parkview Health is dedicated to improving your health and inspiring your well-being by:

- Tailoring a personalized health journey to achieve your unique goals
- Demonstrating world-class teamwork as we partner with you along that journey
- Providing the excellence, innovation and value you seek in terms of convenience, compassion, service, cost and quality

Within the four walls of Parkview Health facilities, there is an emphasis placed on providing "excellent care, every patient, every day." Another integral part of the mission takes place outside the four walls, in the communities that we serve and is accomplished through the Community Health Improvement outreach programs which focus on improving access to healthcare and addressing identified community health needs especially among those who are the most vulnerable.

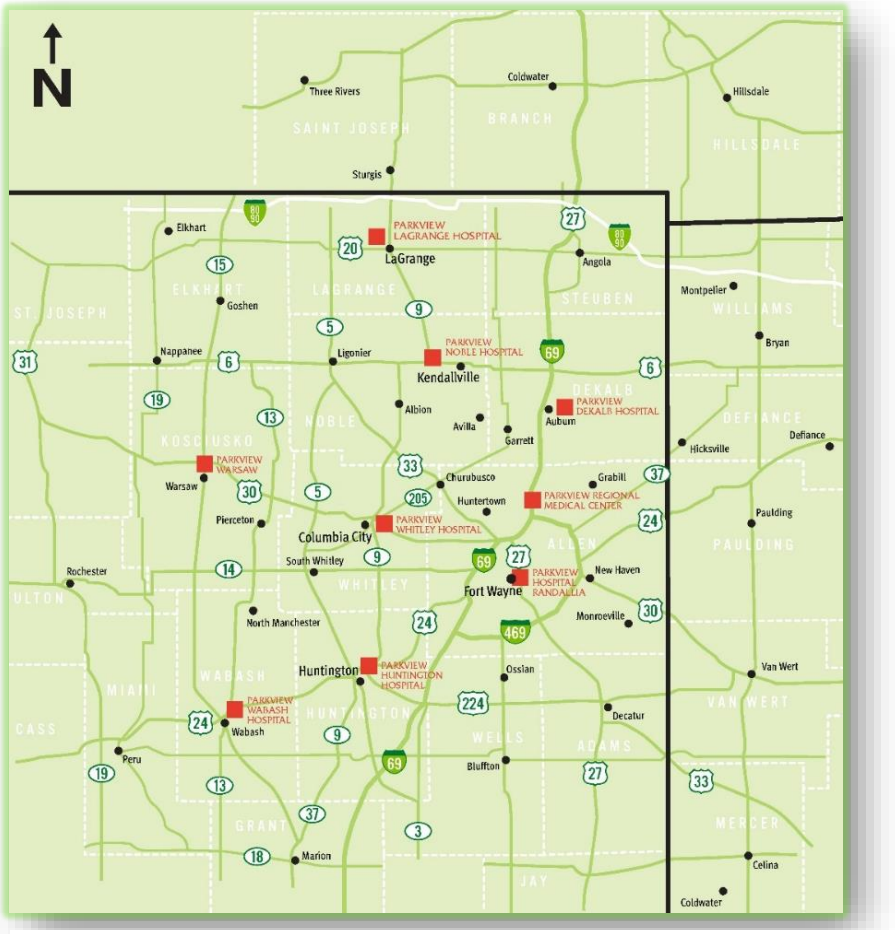

Figure 1: Parkview Health service area

Introduction

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. In fulfilling our commitment, Parkview Health partnered with the Indiana Partnership for Healthy Communities, a collaboration between the Polis Center at IUPUI and the Indiana University Richard M. Fairbanks School of Public Health (FSPH), to design and conduct the 2019 CHNA in a seven-county area. Counties include Allen, Huntington, Kosciusko, LaGrange, Noble, Wabash and Whitley of Indiana. This entire process is outlined on page 7, figure 2.

This report seeks to define Parkview Hospital's implementation strategy for 2019 using the county-specific data reported in the 2019 CHNA for Allen County. In doing so, this report will define and describe:

- The community served
- The community's top health needs
- The CHNA/implementation strategy process
- How the hospital is addressing community needs
- Identified needs not being addressed

The contents of this report were formed in compliance with the requirements set forth by the IRS for tax-exempt health systems and hospitals.

Parkview Hospital

As a charitable, not-for-profit, community-owned hospital, Parkview consists of a 441-bed regional tertiary referral center (Parkview Regional Medical Center), as well as a 196-bed community hospital (Parkview Hospital Randallia) and an 83-bed behavioral health hospital (Parkview Behavioral Health Institute) located in Fort Wayne, the primary urban area in the region. Parkview serves a population of 890,000, in 16 counties throughout northeast Indiana and northwest Ohio.

Parkview Hospital offers the community an array of specialty services that include: Parkview Heart Institute; a certified primary stroke center; Parkview Women's & Children's Hospital; Parkview Cancer Institute; Outpatient Service Center; a verified level II adult & pediatric trauma center; Samaritan medical flight and ground transport services among others.

Community Served

Even though Parkview's patient service area extends over multiple counties, addressing population health priorities is based largely on how accessible assistance programs, community resources, etc., are to vulnerable populations. In an effort to make the greatest impact on population health through its implementation strategy, Parkview Hospital's, community health improvement initiatives are primarily offered in Allen County.

Allen County has a total population of 367,747 and is considered the urban area in northeast Indiana. The poverty rate is 14.7%. The uninsured population stands at 10.8%.[1]

The Health Resources and Services Administration identified a medically underserved population in central Allen County located in downtown Fort Wayne. A Federally Qualified Health Clinic (FQHC), Neighborhood Health Clinic, resides in this area. A satellite clinic exists in southeast Fort Wayne, Parkview Neighborhood Health Clinic, where Parkview's community nursing program provides preventive health education to local residents.

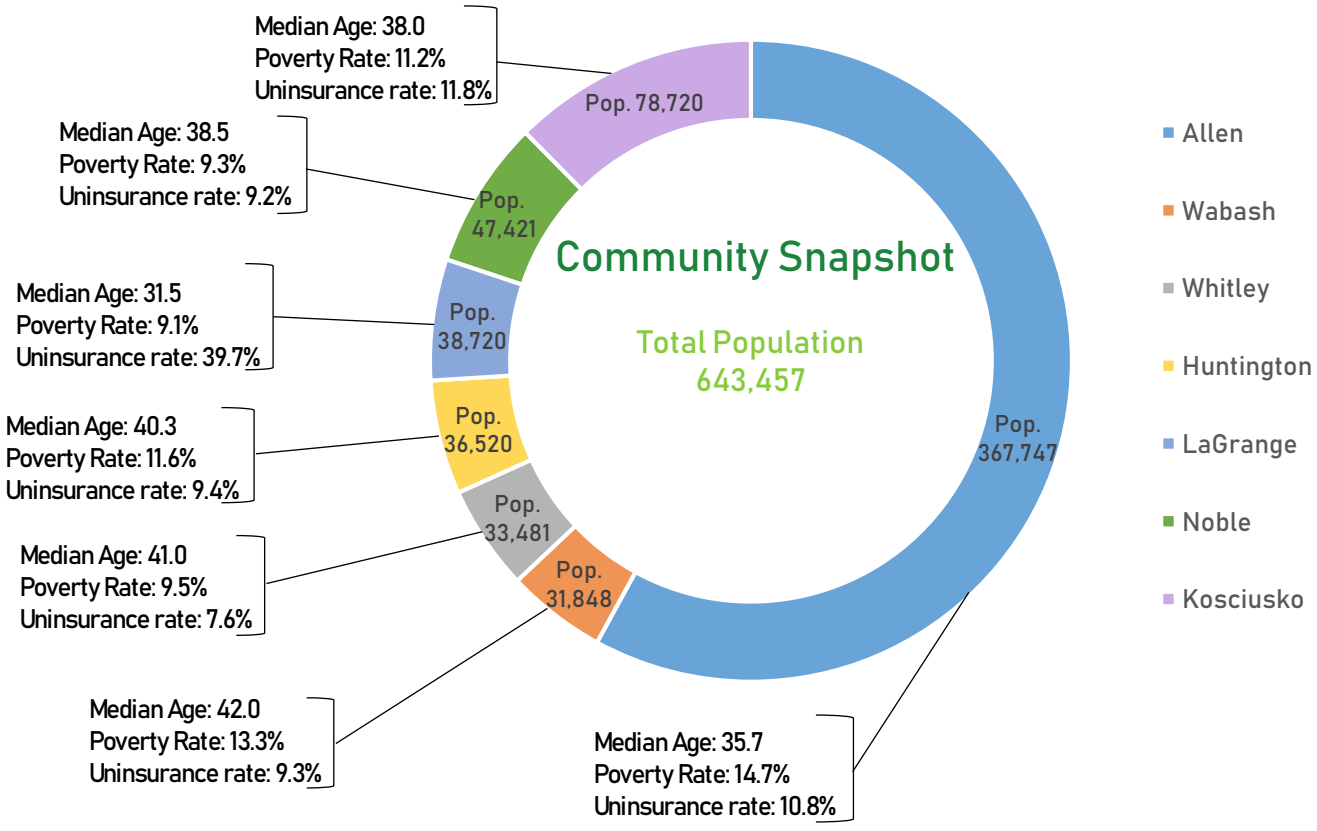

Figure 2

[1] "US Census Bureau (American Community Survey 2013-2017 Five-year Averages)." United States Census Bureau, July 1, 2018, https://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/2017/.

Ranking of Community Health Needs

The 2019 top-ranking indicators for Allen County are shown in Table 1 below. As illustrated below, three of the top five health concerns are etiologically and clinically related health issues—cardiovascular disease, diabetes, and obesity. Two of the other top priorities are also very closely tied together—drug and alcohol use and addiction, and mental health. These rankings are indicative of interrelated and interconnected health conditions, providing a broader picture of the health issue experienced by the community and rendering credence to the methodology adopted for this purpose. Comparing the 2016 and 2019 CHNA rankings for the Parkview Region, we see that Cardiovascular Disease (Rank 6 to 1) and Aging (Rank 12 to 5) moved to the top five. Changes in the methodology for calculating "size of the health issue" and "effectiveness of intervention" may have contributed to this change.

Health Need / Concern	Health Indicator	2019 Rank								2016 Rank
		Allen	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley	Avg. Rank	
1. Cardiovascular Disease	Stroke Hospitalizations	1	2	1	1	1	1	1	1.1	6
	Heart Disease Hospitalizations	1	1	1	1	1	1	3	1.3	
2. Diabetes	Adults 20+ ith Diabetes	1	2	1	1	1	1	3	1.4	3
3. Aging	Alzheimer's Disease	5	4	4	1	4	4	3	3.6	12
4. Obesity	Adults 20+ who are Obese	5	6	6	1	4	4	3	4.1	2
5. Drug & Alcohol Use and Addiction	Non-Fatal ED Visits due to Opioid Overdoses	1	4	4	12	10	4	11	6.6	5
6. Mental Health	Percent of Population with Frequent Mental Distress	7	7	7	10	6	7	7	7.3	10
Drug & Alcohol Use and Addiction	Adults who Drink Excessively	8	7	8	6	6	10	9	7.7	5
7. Tobacco Use	Adults who Smoke	8	7	12	8	8	8	7	8.3	1
8. Maternal Child Health	Child Abuse and Neglect	10	10	17	6	8	8	1	8.6	4

Table 1: Top Ranking Indicators (2019 CHNA Page 54)[2]

[2] "2019 Community Health Needs Assessment Parkview Hospital, Allen County," Community Health Improvement (Local Health Needs), Parkview Health, December 2019, https://www.parkview.com/community/community-health-improvement/local-health-needs.

CHNA/Implementation Strategy Process

Based on the 2019 community health needs assessment (CHNA) results, our internal team along with external partner organizations plan to continue to build on health initiatives that have been developed and have evolved over the last six years. Due to some changes in the 2019 rankings, we combined two groups of closely related health issues to be two of our priority areas for the next three years.

For example:

- 2016 Obesity vs. 2019 Cardiovascular/Diabetes
- 2016 Mental Health vs. 2019 Opioid Use Disease and Mental Health
- 2016 Maternal/Child Health addressing infant mortality remains the same for 2019

As we work to address prioritized health issues, we will build upon previous efforts. Community health improvement staff, program leads, community nurses and partner organizations worked together to formulate the implementation strategy. The community health improvement committee, committee of the hospital board of directors, reviewed and adopted the implementation strategy on May 13, 2020.

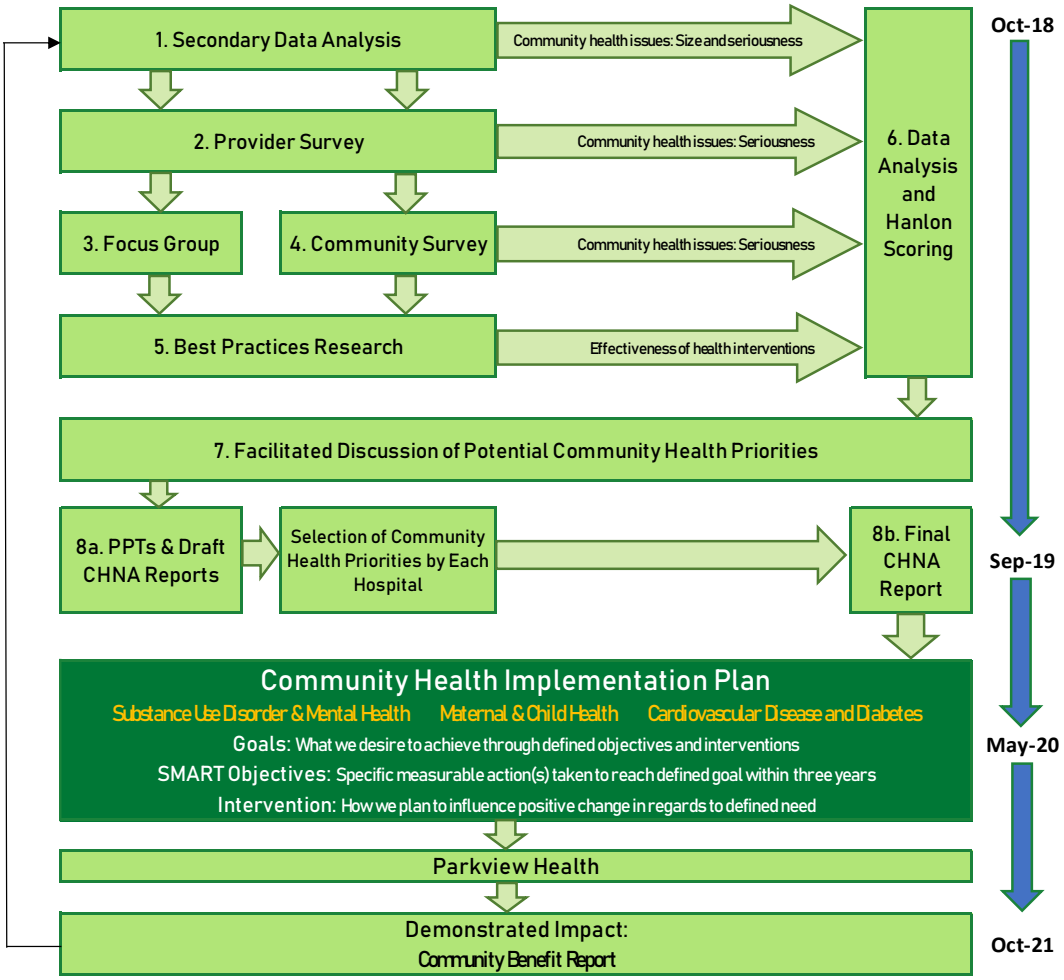

Figure 3: Key activities of the CHNA and implementation strategy development

Prioritization Process

A modified Hanlon Method prioritized health concerns for Parkview Health hospital communities. This method, also known as the Basic Priority Rating System (BPRS) 2.0, is recommended by the National Association of County and City Health Officials (NACCHO) for prioritizing community health needs (Guide-to-Prioritization-Techniques.pdf, n.d.). Although complex to implement, it is useful when the desired outcome is an objectively selected list. Explicit identification of factors must be considered to set priorities which enables a transparent and replicable process. Priority scores are calculated based on the size of the health problem, seriousness of the health problem and the availability of effective health interventions.

The Indiana Partnership for Healthy Communities presented an overview of the Regional CHNA findings on July 16, 2019, to attendees representing the Parkview Health system. In total over 60 individuals participated in the prioritization process, including representatives from hospital service lines, community hospitals, healthcare providers/physicians, executive leadership team, community health and hospital board of directors. After a thorough review of the data and considerable discussion, the group used an electronic voting system to rank the various health needs identified in the CHNA. Ultimately, the group voted on **Substance Use Disorder/Mental Health**, as the shared health priority across the health system.

As a continuation of the prioritization process, Parkview Hospital, Inc. (Allen County) formed an internal, multi-disciplinary advisory council to select additional health priorities for Parkview Hospital, Inc. This group of stakeholders met on August 16, 2019 and discussed the results of the CHNA. After a thoughtful review of the data and extensive discussion, the advisory committee selected **Maternal/Child Health** and **Cardiovascular Disease/Diabetes** as additional priorities.

We also held three community sessions to share the Allen County CHNA results and to gather feedback from local non-profit and public health organizations. In each community engagement meeting, participants worked in small groups to complete a “Roadmap” outlining their vision for our community, potential interventions, barriers and other factors related to the hospital’s three health priorities. Additionally, the top three health priorities were presented to and adopted by Parkview Hospital’s Community Health Improvement Committee, a committee of the hospital board of directors.

Community Health Implementation Plan

Implementation Plan for each Health Priority

Implementation strategies are illustrated below according to health priority. Each health priority is highlighted in a separate color.

Substance Use Disorder/Mental Health

Identified Health Need: Substance Use Disorder/Mental Health				
Goal: Reduce the number of opioid overdoses and deaths due to overdose in Allen County.				
Objective: Increase the number of those Allen County residents staying in recovery for at least one year.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Peer Support Services for opioid use disorder	• # of participants • Length of time participating in recovery • # engaged in Medical Assisted Therapy (MAT) • # of hospitalizations secondary to overdose	• Peer recovery coach navigation, education and support throughout the recovery process • Development of personal plan for support and recovery	• Behavior change • Increased knowledge	• Emergency department • Local behavioral healthcare services
Planned Resource Commitment: $300,000 Annually (Grant Funded)				

Identified Health Need: Substance Use Disorder/ Mental Health				
Goal: Reduce the number of pre-term births in Allen County.				
Objective: Decrease the health risks due to substance use disorder for mom and baby during pregnancy and the post-partum period.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Perinatal Substance Use Disorder Navigator program for pregnant women with substance use disorder	• Length of stay in NICU • # of participants • # of participants who continue to engage in treatment post-delivery • Length of time in treatment • Average gestational age	• Coordination of local medication assistance treatment programs and psychosocial resources • Coordination of communication related to patient, physician and local recovery services • Navigation of patients through the appropriate level of care	• Improved health outcomes for mom and baby • Increased knowledge • Behavior change	• PPG OB-GYN practices • Women's & Children's Hospital
Planned Resource Commitment: $76,000 Annually				

Identified Health Need: Substance Abuse Disorder/ Mental Health				
Goal: Decrease in the number of suicide deaths for all age groups in Allen County.				
Objective: Increase the number of individuals at-risk for suicide who are identified through QPR screening and referred to behavioral health services.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Zero Suicide Program	• # of QPR trainers • # of healthcare workers and community members trained in QPR • # of times QPR skills utilized post training	• Training the QPR trainers • Training healthcare workers and community members in QPR • Identifying and referring potential suicidal individuals through use of QPR skills	• Increased awareness of those in emotional distress • Increase of those seeking behavioral health services when appropriate	• Emergency department • Healthcare workers • Community organizations • Youth ages 16 & over • Adult community members
Planned Resource Commitment: $ 61,000 Annually				

Cardiovascular Disease & Diabetes

Identified Health Need: Cardiovascular Disease & Diabetes				
Goal: Reduce childhood obesity in Allen County.				
Objective: Improve biometrics and well-being behaviors of program participants (4th & 5th graders).				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Taking Root Health Challenge Program (school-based)	• Body fat percentage • Body mass index • Aerobic Capacity • Behavior score change • # of program participants	• Healthy lifestyle habit education • Aerobic challenges • Motivational support provided by health champions	• Behavior change • Increased knowledge	• Fort Wayne Community Schools • School staff/faculty and health champions
Planned Resource Commitment: $57,000 Annually				

Identified Health Need: Cardiovascular Disease & Diabetes				
Goal: Decrease rates of obesity and chronic disease.				
Objective: Increase access and consumption of fresh produce in underserved areas of Allen County.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Healthy Eating Active Living (HEAL) initiative	• Amount of fresh fruit and vegetable consumption • # of participants who accessed HEAL Farm Markets • Number of SNAP, WIC and senior vouchers collected and matched • # of participants of Our Healing Kitchen food preparation classes	• Serve as cashier at HEAL Farm Markets that accept and double SNAP, WIC and senior vouchers • Our Healing Kitchen food preparation education using train-the-trainer and peer-to-peer approaches	• Behavior change • Increased knowledge • Increased access to fresh produce • Significant community awareness and engagement	• St Joseph Community Health Foundation • Parkview Community Greenhouse • Area churches • Community organizations • Local farmers • Purdue Extension • HealthVisions
Planned Resource Commitment: $75,000 Annually				

Identified Health Need: Cardiovascular Disease & Diabetes				
Goal: Reduce the percentage of childhood and adult obesity and reduce the effects of chronic disease.				
Objective: Improve obesogenic risk scores and well-being behaviors of participants (children ages 5 to 17 and their families).				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• FitKids360 (a stage two pediatric obesity treatment program)	• Family nutrition and physical activity screening tool • Family biometric values • Retention rate • Lifestyle and behavioral surveys • Psychosocial functioning survey	• Physician referral • Assessment • Goal setting sessions • Education sessions • Physical activities	• Increased knowledge • Behavior change	• PPG specialty clinics • Health Net of West Michigan • Other community organizations
Planned Resource Commitment: $96,621 Annually				

Identified Health Need: Cardiovascular Disease & Diabetes				
Goal: Reduce the long-term complications and slow the progression associated with diabetes for vulnerable populations with pre-diabetes or a diabetes diagnosis.				
Objective: • Improve nutrition and increase physical activity in preventing diabetes. • Decrease A1C levels in those with a diabetes diagnosis.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Diabetes Education Program	• Self-reported decline in A1C levels • Pre- and post-tests for knowledge and behavior change	• Administer diabetes Healthy Lifestyle Education Classes including the AADE7 self-care behaviors • Provide opportunities for screening and A1C testing	• Lifestyle behavior change • Increased knowledge	• Community Registered Dietitians • YMCA • Schools • The Rescue Mission • Matthew 25 Medical & Dental Clinic • Community Harvest Food Bank • Diabetes Treatment Center • PPG offices
Planned Resource Commitment: $60,000 Annually				

Identified Health Need: Cardiovascular Disease & Diabetes				
Goal: Reduce effects of food insecurity and impact of chronic disease for those referred to the program.				
Objective: • Increase access to and intake of fresh produce. • Reduce the effects of chronic disease through disease management.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Veggie RX (a nutrition prescription program)	• Vegetable intake • Fruit intake • Confidence in using/preparing fresh produce • Food insecurity scale • Client retention	• Physician referral • RD consultation • HgbA1C/BP screening, education & produce voucher distribution • Surveys and follow-up HgbA1C/BP screening	• Behavior change • Increased knowledge	• PPG offices • Population Health • Community Health Worker (Safety PIN) program • Ronald McDonald Care Mobile • YMCA • Parkview Community Greenhouse • HEAL Farm Markets
Planned Resource Commitment: $25,400 Annually				

Identified Health Need: Cardiovascular Disease & Diabetes				
Goal: Prevent overweight/obesity in children participants during the critical early years from 0 to 3 years of age.				
Objective: Increase good nutrition, physical activity and other healthy habits in young family participants.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Simple Solutions for Healthy Living	• # of fresh meals prepared weekly • # of meals shared together weekly • % of families turning off TV & electronics during mealtime • % of families reporting increase in preparing balanced meals • % of decrease in overall screen time • % of increase of those engaging in active play	• Train the trainers, i.e., agency home visitors • Family goal setting sessions • Deliver lessons through various media tools • Survey participants throughout the process	• Through improved health strategies, increase development, growth, cognition, immunity and behavior in children 0 to 3 years of age	• SCAN • Lutheran Social Services of IN • Network for Safe Families • Job Works program • Healthier Moms & Babies • Early Childhood Alliance
Planned Resource Commitment: $30,000				

Identified Health Need: Cardiovascular Disease & Diabetes				
Goal: Decrease the risks associated with obesity and chronic illness for uninsured participants.				
Objective: Increase knowledge and positive behavior change to promote well-being and quality of life.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Nutrition/Exercise Programming	• % of nutrition/food prep education participants who reported learning at least one new piece of information • % of participants attending more than one exercise session • # of program participants	• Nutrition counseling, group classes and cooking demonstrations • Stress management education • Exercise programming	• Behavior change • Increased knowledge	• Community Health Nursing dietitians • Matthew 25 Medical & Dental Clinic • Community Harvest Food Bank • Schools • Fort Wayne Parks Department • YMCA • PPG offices • Community organizations
Planned Resource Commitment: $53,000 Annually				

Identified Health Need: Cardiovascular Disease & Diabetes				
Goal: Promote health and well-being and reduce food insecurity.				
Objective: Increase consumption of fresh produce by residents in surrounding zip codes.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Parkview Community Greenhouse and Learning Kitchen	• # of participants and repeat participants • Amount of fruit and vegetable consumption • % of participants from target zip codes • Indicators specific to programs using greenhouse/learning kitchen as part of their curriculum	• HEAL partner engagement classes • Simple Solutions education • Veggie Rx education • Seasonal HEAL farm markets • Horticulture education & demonstrations	• Increased knowledge • Behavior change • Improved access to fresh produce	• The HEAL program • Simple Solutions program • Veggie Rx program • Other community partner organizations
Planned Resource Commitment: $ 285,000 Annually				

Maternal/Child Health

Identified Health Need: Maternal/Child Health				
Goal: Reduce the number of infant deaths (<1 year of age) in Allen County due to unsafe sleep.				
Objective: Increase knowledge and behavior change related to safe sleep practices in 100% of program participants.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Safe Sleep classes and Pack 'n Play™ distribution program	• Infant mortality resulting from unsafe sleep per 1,000 live births • # of program participants • # of referrals to safe sleep classes • # of one-on-one education sessions • # of unsafe in-home environments corrected	• Safe sleep education offered at no cost • Distribution of Safe Sleep kit (including Pack 'n Play™) • Referrals to safe sleep classes • Cultural support and interpretation • In-home safe sleep environment inspections	• Behavior change • Increased knowledge • Reduced infant death	• Community Health Worker (Safety PIN) program • Parkview Community Nursing • Baby's Closet • Healthier Moms and Babies • Women's & Children's Nurse Navigators • SCAN • Community partners
Planned Resource Commitment: $180,000 for portion provided by community nursing annually				

Identified Health Need: Maternal/Child Health				
Goal: Increase the number of new moms in priority populations who engage in exclusive breastfeeding.				
Objective: Increase knowledge of breastfeeding health benefits, mechanics and support resources in 100% of program participants.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Community breastfeeding classes and support	• # of women reporting an increase in knowledge • # of breastfeeding initiations • # of exclusive duration milestones achieved	• Instruction on breastfeeding health benefits, mechanics and resources for on-going support • Follow-up phone calls	• Behavior change • Increased knowledge • Improved health outcomes for mom and baby	• Community Health Worker (Safety PIN) program • Healthy Families • PPG offices • Baby's Closet
Planned Resource Commitment: $ 180,000 annually				

Identified Health Need: Maternal/Child Health				
Goal: Reduce vehicular death and injury of infants in Allen County.				
Objective: Increase parental knowledge and skills related to car seat safety among 100% of program participants.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Community Health Worker (Safety PIN) program	• # of car seat installations and education sessions by Child Passenger Safety Technicians • Pre- and post-test scores • Self-assessment of caregiver's confidence level	• One-on-one car seat installation education • Cultural support and interpretation	• Increased knowledge • Behavior change • Caregiver empowerment	• Parkview Community Nursing • Healthier Moms and Babies • Nurse navigators • SCAN
Planned Resource Commitment: $8,300 Annually				

Identified Health Need: Maternal/Child Health				
Goal: Decrease number of infant (<1 year of age) mortality rate in Allen County.				
Objective: 1. Identify community specific factors affecting infant mortality in Allen County through individual case review. 2. Implement community-wide projects to address the recommendations made by the Case Review Team.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Fetal Infant Mortality Review (FIMR) initiative	• # of cases reviewed • # of maternal interviews • # of recommendations • Community-wide projects implemented • # of women screened at initial prenatal visit • # attending Burmese education sessions	• Case reviews • OB Nurse Navigator • Burmese education sessions	• Improved referrals to community resources • Improved understanding of barriers and social needs	• Hospitals • Clinics • Home visitors • Faith-based organizations • Pregnancy resource centers • PPG offices
Planned Resource Commitment: $97,150 Annually (51% grant funded)				

Identified Health Need: Maternal/Child Health				
Goal: Decrease rates of pre-term births.				
Objective: Decrease the number of "no show" prenatal, postpartum and pediatric physician visits for program participants.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Community Health Worker (Safety PIN) program – Visit Attendance	• Identification of social needs • Completion of co-created insurance and transportation goals • # of screens performed for transportation reliability	• One-on-one prenatal care education • Safe sleep education • Referrals to community resources • Cultural support and interpretation • Assistance in accessing resources • Reduce barriers to physician visits • Transportation survey	• Behavior change • Increased knowledge • Decreased pre-term births • Prevent infant death	• Parkview Community Nursing • Healthier Moms and Babies • Brightpoint • Community partners • ISDH OB navigator • PPG OB/GYN • Nurse navigators
Planned Resource Commitment: See bottom of page*				

Identified Health Need: Maternal/Child Health				
Goal: Improve the health of pregnant women and infants in Allen County.				
Objective: Reduce the rate of food insecurity.				
Program	**Indicator**	**Interventions**	**Anticipated Impact**	**Internal/External Partners**
• Community Health Worker (Safety PIN) program—Food Insecurity	• Completion of co-created nutrition goals • # of completed food insecurity screenings • # of referrals to WIC, Community Harvest Food Bank, SNAP, local farm markets and other food resources	• Food insecurity screening • Referrals to resources • Coaching r/t preparation and follow through in obtaining resources	• Increased knowledge • Reduced food insecurity • Increased self-efficacy	• Community Harvest Food Bank • WIC • Brightpoint • Veggie Rx program • Associated Churches • Nurse navigators • HEAL program
Planned Resource Commitment: See bottom of page*				

*Funding for food insecurity, visit attendance and a portion of safe sleep program performed by Community Health Worker (Safety PIN) totals approximately $1 M (fully grant funded).

Significant Health Needs Not Addressed by the Implementation Strategy

Health needs identified and why the hospital does not intend to address these as part of the implementation strategy:

- Aging – Aging and In-Home Services of Northeast Indiana (AIHS) serves older adults, persons with disabilities and their caregivers in nine counties in northeast Indiana. This not-for-profit, community-based organization is a federal and state designated Area Agency on Aging and an Aging and Disability Resource Center which provides a streamlined access to information, care options, short-term case management and benefits enrollment across a spectrum of long-term care services. Through the Care Transitions program, AIHS partners with Parkview Health to reduce Medicare readmissions. In addition, the agency serves as the initial coordinator and fiscal agent for Honoring Choices® Indiana, which is an initiative committed to promoting and sustaining advance care planning (ACP) across the state to ensure individuals' future health care preferences are discussed, documented, and honored. Through Honoring Choices®, Parkview and AIHS work together to train ACP facilitators, promote best practice and increase public awareness about the value of discussing health care decision making in advance of medical crisis
- Obesity – While we are not addressing obesity specifically, combatting the long-term impact of obesity in foundational to our current efforts related to cardiovascular health and diabetes. We plan to continue our current community efforts aimed at reducing/preventing obesity and improving healthy living practices as a means of preventing or treating chronic disease in our community.
- Tobacco Use – Tobacco Free Allen County (TFAC) is the lead organization in Allen County, Indiana, related to tobacco free efforts. TFAC provides information on resources about local smoking cessation programs and advocates for no-smoking public policy at the state level. Their goals include decreasing youth and adult tobacco use, increasing protections against secondhand smoke, and building/maintaining the local tobacco control infrastructure. Parkview Hospital is also a source of smoking cessation programs and operates a tobacco free campus. In addition, a program, Nicotine Free for Baby and Me, was developed and is used in assisting pregnant women to stop smoking as part of Parkview's community outreach programming.

For More Information

Parkview would like to extend gratitude towards its community partners for their collaboration in the 2019 CHNA process and identifying Implementation strategy that address the health needs of Allen County. For additional information about Parkview Hospitals 2019 CHNA or Implementation Plan, please contact us.

Jill McAllister
Community Benefit Manager
Jill.Mcallister@Parkview.com
260-266-2462

Dylan Moore
Community Benefit Coordinator
Dylan.Moore@Parkview.com
260-266-0519

Board Approval

Approved by the Community Health Improvement Committee
of the Parkview Hospital, Inc. Board of Directors
May 2020

References

"US Census Bureau (American Community Survey 2013-2017 Five-year Averages)," United States Census Bureau, July 1, 2018, https://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/2017/.

"2019 Community Health Needs Assessment Parkview Hospital, Allen County," Community Health Improvement (Local Health Needs), Parkview Health, December 2019, https://www.parkview.com/community/community-health-improvement/local-health-needs.