2022 Community Health Needs Assessment

Parkview Hospital, Inc.

PARKVIEW HEALTH

PARKVIEW MIRRO CENTER FOR RESEARCH AND INNOVATION

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EXECUTIVE SUMMARY

Introduction & Purpose

Parkview Health is pleased to share the 2022 Community Health Needs Assessment (CHNA) for Parkview Hospital, Inc. in Allen County. This report provides an overview of the approach taken to identify and prioritize significant health needs in Allen County, as federally required by the Affordable Care Act. The Health Services and Informatics Research (HSIR) group at Parkview's Mirro Center for Research and Innovation designed and conducted both primary and secondary data collection and analysis activities. Data collection was focused on the eight counties in northeast Indiana that comprise Parkview's primary service area and where a Parkview hospital is located, including: Allen, DeKalb, Huntington, Kosciusko, LaGrange, Noble, Wabash and Whitley.

The purpose of this CHNA report is to offer a comprehensive understanding of the health and social needs of Allen County, to guide Parkview Hospital, Inc.'s strategic community health improvement plan for addressing the identified needs (*CDC - Assessment and Plans - Community Health Assessment - STLT Gateway*, 2019). Parkview Hospital, Inc. in Allen County will use the findings in this report to identify and develop efforts to improve the health and quality of life for residents in the counties we serve.

Approach

The HSIR group assessed the overall health needs of the Parkview Health region, as well as the needs of each individual county. Community health needs of interest were based on past CHNAs and secondary data from the Healthy Communities Institute (HCI) database. The HSIR team used surveys to gather input from individual community members and healthcare and social service providers (i.e., physicians, nurses, social workers) to understand local health concerns, needs, and service availability.

Historically, we have found that Hispanic, Amish and people of Burma (Myanmar) populations have been an underrepresented voice in our CHNA surveys. Thus, the HSIR group used contacts familiar to these populations to distribute surveys and sent a mobile team of surveyors to target locations to ensure that we captured the community health concerns of these special populations.

Summary of Findings

The findings in this report are a result of the analysis of an extensive set of secondary data (over 200 indicators from national and state data sources) and primary data (2842 surveys) collected from community members and healthcare/social service providers. Below are the top ten health concerns and health service needs as ranked by the Hanlon method and survey data, respectively.

Allen County's Top Ten Health Concerns*	
• Obesity	• Cardiovascular disease (stroke, coronary heart disease)
• Mental health	• Substance use/abuse (drugs, alcohol, tobacco)
• Chronic obstructive pulmonary disease	• Cancer
• Asthma	• Diabetes
• Kidney disease	• Child abuse

* After Hanlon method applied to secondary and primary data; merged categories of concerns are in parentheses

Allen County's Top Ten Health Service Needs*	
• Mental health services	• Access to primary care providers
• Substance use disorder services	• Senior services
• Access to healthy food	• Gun safety
• Access to recreational spaces	• Health insurance
• Access to birth control	• Childcare

* As indicated by community and provider concerns expressed in survey data

Prioritized Areas

In September 2022, the HSIR group convened 23 stakeholders from Allen County to prioritize the significant health issues uncovered in our analysis. In addition to the priority ranking scores, these stakeholders considered the feasibility of interventions for each health concern, which includes the suitability and acceptability of the interventions, availability of resources, cost-benefits ratio, and legality. The stakeholder group identified Obesity and Maternal/Child Health as their top priorities to address, along with Mental Health, the Parkview Health systemwide priority.

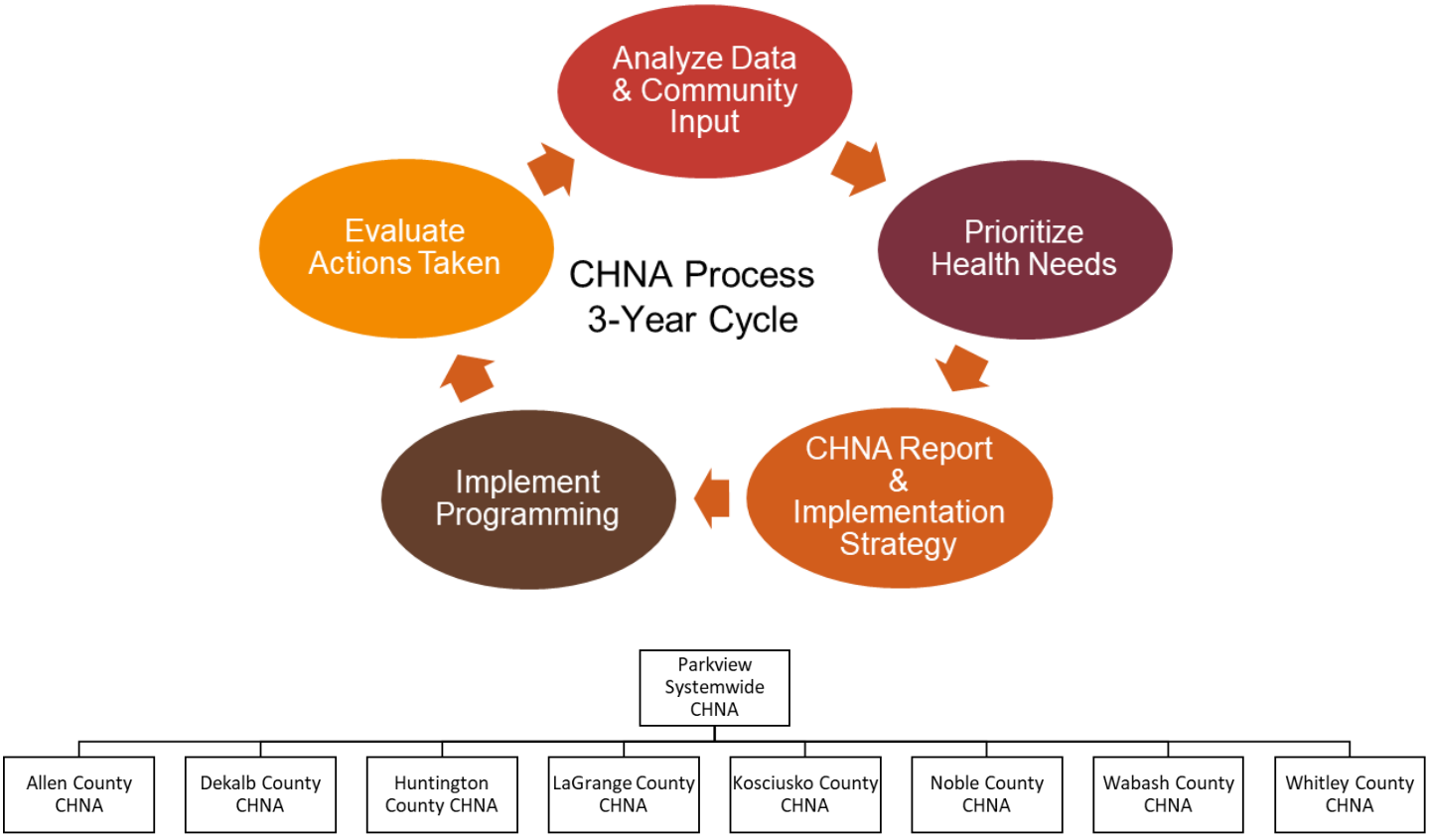
HSIR Group

The Parkview Community Health Improvement department commissioned the Parkview Health Services and Informatics Research (HSIR) group to conduct its 2022 Community Health Needs Assessment (CHNA). The HSIR group is co-located with the Clinical Research group in the Parkview Research Center, which is housed in an 82,000 square feet facility, the Mirro Center for Research and Innovation, with more than 90 rooms and dedicated spaces for research, innovation, and education. HSIR employs multiple research staff, which includes PhD prepared scientists, user experience specialists and project managers. As a research unit embedded in Parkview Health, HSIR has dedicated time to support initiatives that require research skills, such as the CHNA.

Evaluation of Progress Since 2019 CHNA

The CHNA is a continual process that rotates through a three-year cycle (Figure 1). A key component of this process is evaluating the impact of the programming implemented in response to the prioritized health concerns. Reflecting on the progress made on priority areas facilitates the development of strategies to implement in the next CHNA cycle.

Figure 1. Three-Year CHNA Process; Organization of Parkview CHNA reports



Priority Health Needs and Impact from 2019 CHNA

During the 2019 prioritization sessions, substance abuse and mental health were selected as the Parkview Health region's shared health priority for 2020-2022. Additionally, each Parkview licensed hospital selected two other priorities per their county level CHNA report. This report reflects Parkview Hospital, Inc., but each of Parkview's licensed hospital facilities have their own CHNA that reflect priorities specific to their county. The impact report for Parkview Hospital, Inc. can be found in Appendix A. Parkview did not get any written comments in response to our 2019 CHNA.

If you have comments about the 2022 CHNA, please send to Jill.McAllister@parkview.com or Sarah.GiaQuinta@parkview.com.

INTRODUCTION

Parkview Health presents findings from its 2022 Community Health Needs Assessment (CHNA), a requirement for all not-for-profit hospitals to complete every three years (*Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3) | Internal Revenue Service*, n.d.). This report provides an overview of the CHNA processes and methods used to identify and prioritize significant health needs for the community. The purpose of this report is to present information about the health concerns and service needs across Parkview Health's service area to create understanding and establish priorities around these issues. Attention has been given to identify needs of specific community populations, significant health concerns or service gaps and feedback from community members and providers.

About Parkview Health

Parkview Health is a not-for-profit, community-based health system serving a population of more than 895,000. With more than 14,000 employees, Parkview is the region's largest employer. Parkview has been serving the community since its early beginnings as Fort Wayne City Hospital in 1878. Parkview Health System formed in 1995, and the heritage of care and compassion continues today with 11 hospitals and a physician's group of over 800 clinicians across 45 clinical specialties.

Parkview Health Mission & Vision

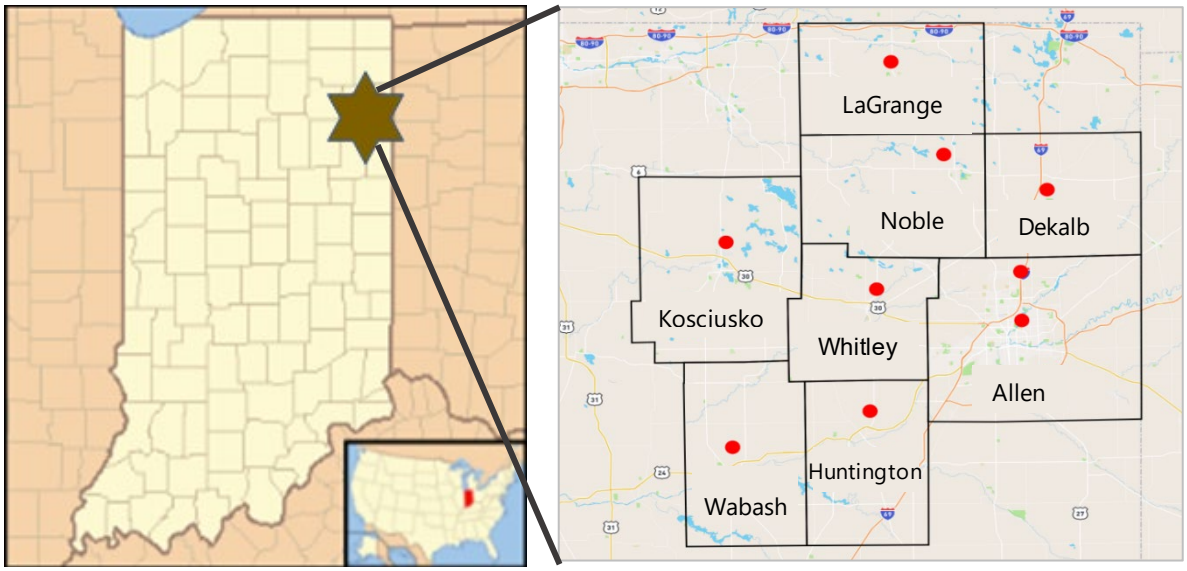
Parkview's mission is to improve the health of our community members and inspire them to take steps to improve their well-being.

Parkview puts their patients at the center of everything they do, as an individual, as an employer and as our community.

Service Area

The scope of this CHNA has been narrowed to reporting data at a county level. Full-service Parkview Health hospitals are in the northeast Indiana counties of Allen, DeKalb, Huntington, LaGrange, Noble, Wabash and Whitley Counties. Kosciusko County is also included in this CHNA as it has a stand-alone emergency medicine facility which operates under the Parkview Whitley Hospital license (Figure 2).

Figure 2. Counties with Parkview Hospitals



DEMOGRAPHICS

The following section presents the demographic profile of the Parkview Health service area, which includes Allen, DeKalb, Huntington, Kosciusko, LaGrange, Noble, Wabash and Whitley Counties. Demographics can impact a community's health concerns, as needs can be related to race/ethnicity, age, gender, and socioeconomic groups. As these groups might have unique cultural/ethnic needs or practices, intervention efforts need to be varied and responsive to differences. The U.S. Census Bureau was used as the main source of demographic data.

Population

The eight-county Parkview Health service area comprises about 10 percent of the total population in Indiana (Table 1). Based on population density, only Allen County is considered urban. The rest of the counties are considered either mixed rural/urban or rural (*Rural Indiana Stats | Geographic Classifications*, n.d.).

Table 1. Population

	Parkview Health Service Area	Indiana	United States
Population	686,494	6,696,893	326,569,308

Source: U.S. Census Bureau (American Community Survey 2016-2020 five-year averages)

As shown in Table 2, Allen County has the largest population in the service area (375,520) followed by Kosciusko County (79,156). While Allen, DeKalb, Kosciusko, LaGrange, Noble and Whitley Counties all experienced population growth between 2017 and 2020, Huntington and Wabash both experienced a slight population decline.

Table 2. Population in Parkview Counties, 2017 and 2020

Year	Allen	DeKalb	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley
2020	375,520	43,193	36,351	79,156	39,537	47,640	31,198	33,899
2017	367,747	42,524	36,520	78,720	38,720	47,421	31,848	33,481

Source: U.S. Census Bureau (American Community Survey 2013-2017 and 2016-2020 five-year averages)

Age

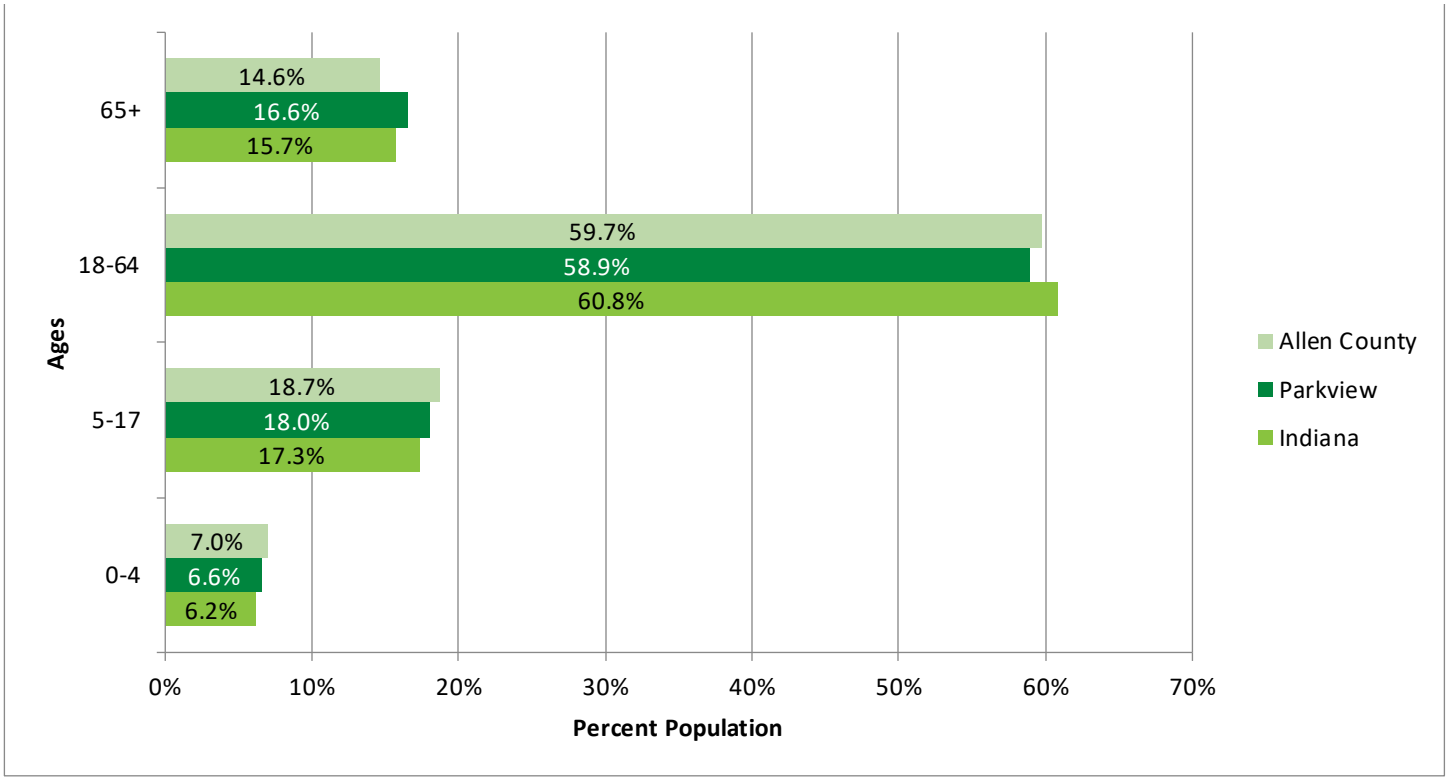
The median age for the Parkview Health service area increased from 36.9 years in 2017 to 37.3 years in 2020. The median age ranges from 31.8 years in LaGrange County to 42.5 years in Wabash County (Table 3). The eight-county Parkview Health service area has a population age breakdown comparable to the rest of Indiana. About 60 percent of the population belongs to the 18–64-year-old age group and only seven percent is within the 0- to 4-year-old age group (Figure 3).

Table 3. Median Age in Years

Year	Allen	DeKalb	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley	Parkview	IN
2020	36.0	38.5	41.4	38.9	31.8	38.9	42.5	41.8	37.3	37.8
2017	35.7	39.1	40.3	38.0	31.5	38.5	42.0	41.0	36.9	37.5

Source: U.S. Census Bureau (American Community Survey 2013-2017 and 2016-2020 five-year averages)

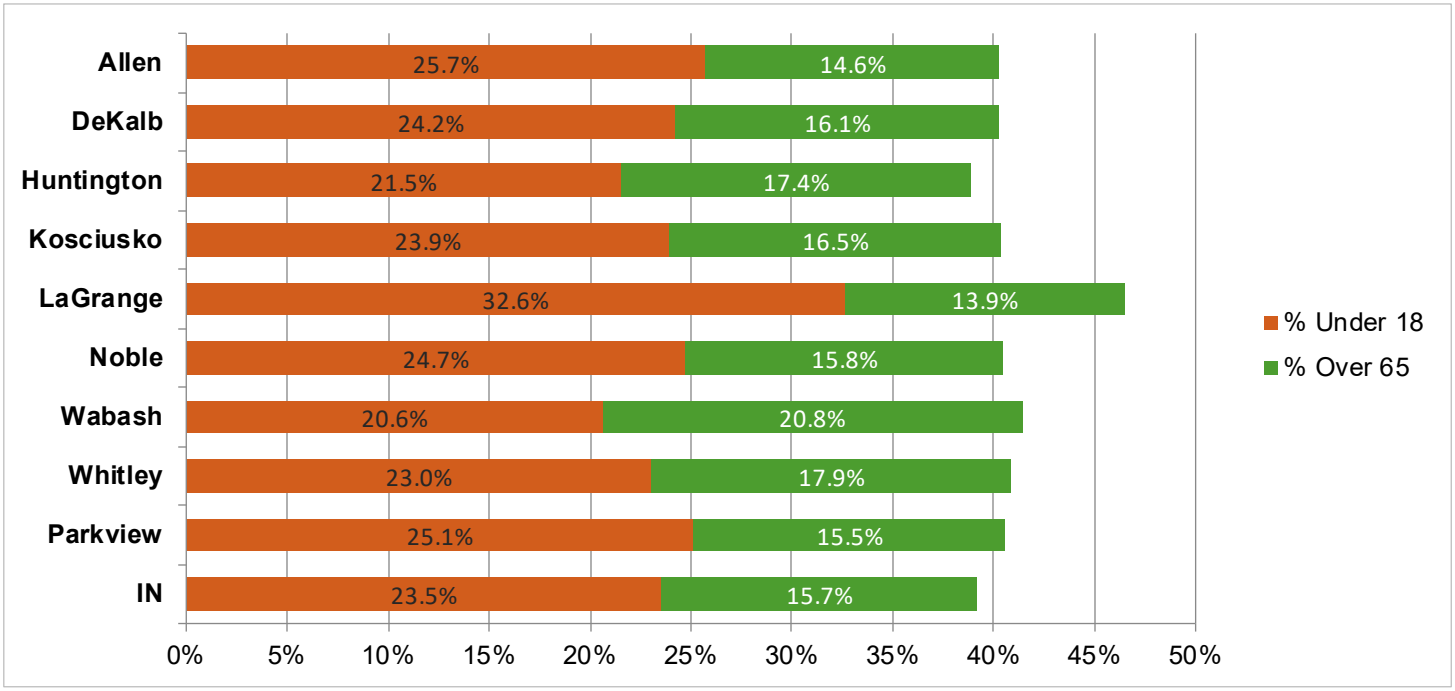
Figure 3. Population by Age Group



Source: U.S. Census Bureau (American Community Survey 2016-2020 Five-year Averages)

Because different age groups can require distinct levels and types of care, strategies for improving community health outcomes should incorporate the needs of each age cohort. The percentage of the population under 18 years is between 20 percent and 26 percent for the eight counties in the Parkview Health region except in LaGrange County, where nearly a third is under 18 years (Figure 4). At the other end of the age spectrum are individuals 65 years and older. Figure 4 demonstrates that the 65 and older population is below 20 percent for all but Wabash County (20.8%). Accessible and adequate senior services can allow the senior population to remain in their household and maintain their quality of life.

Figure 4. Child and Senior Population



Source: U.S. Census Bureau (American Community Survey 2016-2020 Five-year Averages)

Race and Ethnicity

As illustrated by Table 4 and Figure 5, the racial composition of the eight-county Parkview Health region is predominantly non-Hispanic White, which is similar to the rest of Indiana. However, racial diversity has increased in the Parkview Health service area since 2017, due mostly to increases in Hispanic or Latino and other races and ethnicities in all counties, except for DeKalb County where the percent of population comprising 'Other Race or Ethnicity' decreased by 0.2 percent, but the Black or African American population increased by 0.2 percent. Across counties, Allen County has the highest percentage of population comprised of Black or African American individuals (11.3%) and Other Race or Ethnicities (8.1%), and Noble County has the highest Hispanic population (10.4%).

As compared to the rest of the state, the eight-county Parkview Health service area had a lower percentage of Hispanic or Latino and Black or African American individuals and a higher percentage of White and individuals of other races or ethnicities.

One component to diversity that is not reflected in the previous table is the large Amish population present in Northeast Indiana. The 2010 U.S. Religion Census showed that more than 14,000 Amish lived in LaGrange County alone and comprised 37.1 percent of the total LaGrange County population, which makes it the second largest county (by population) of Amish in the United States. Although there is an

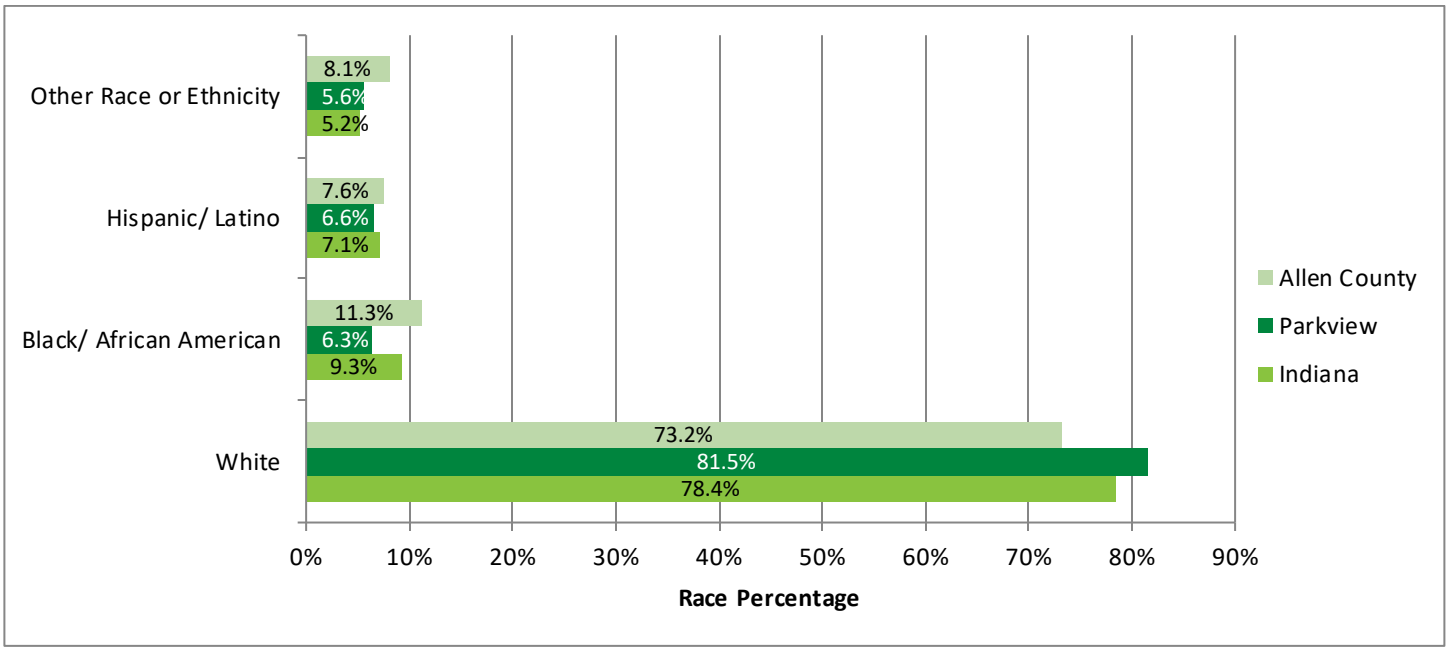
Amish population in other counties, as well, Amish individuals are less likely to live in the urban areas (e.g., less than 1% of the 2010 population of Allen County was Amish).

Table 4. Percent of Population by Race and Ethnicity

Race and Ethnicity	Year	Allen	DeKalb	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley	Parkview	IN
White	2020	73.2%	95.0%	94.4%	87.5%	94.0%	86.8%	94.1%	94.7%	81.5%	78.4%
	2017	74.6%	95.1%	95.2%	88.6%	94.4%	87.6%	94.5%	95.7%	82.6%	79.8%
Black/ African American	2020	11.3%	0.4%	0.9%	0.7%	0.2%	0.5%	1.1%	0.4%	6.5%	9.3%
	2017	11.3%	0.2%	0.8%	0.7%	0.1%	0.4%	0.9%	0.4%	6.4%	9.1%
Hispanic/ Latino	2020	7.6%	2.9%	2.5%	8.1%	4.1%	10.4%	2.7%	2.1%	6.6%	7.1%
	2017	7.2%	2.8%	2.2%	7.9%	3.9%	10.2%	2.5%	1.9%	6.3%	6.7%
Other Race or Ethnicity	2020	8.1%	1.7%	2.2%	3.8%	1.7%	2.2%	2.2%	2.8%	5.6%	5.2%
	2017	6.9%	1.9%	1.8%	2.8%	1.6%	1.8%	2.1%	2.0%	4.7%	4.4%

Source: U.S. Census Bureau (American Community Survey 2013-2017 and 2016-2020 five-year averages)

Figure 5. Race and Ethnicity



Source: U.S. Census Bureau (American Community Survey 2016-2020 Five-year Averages)

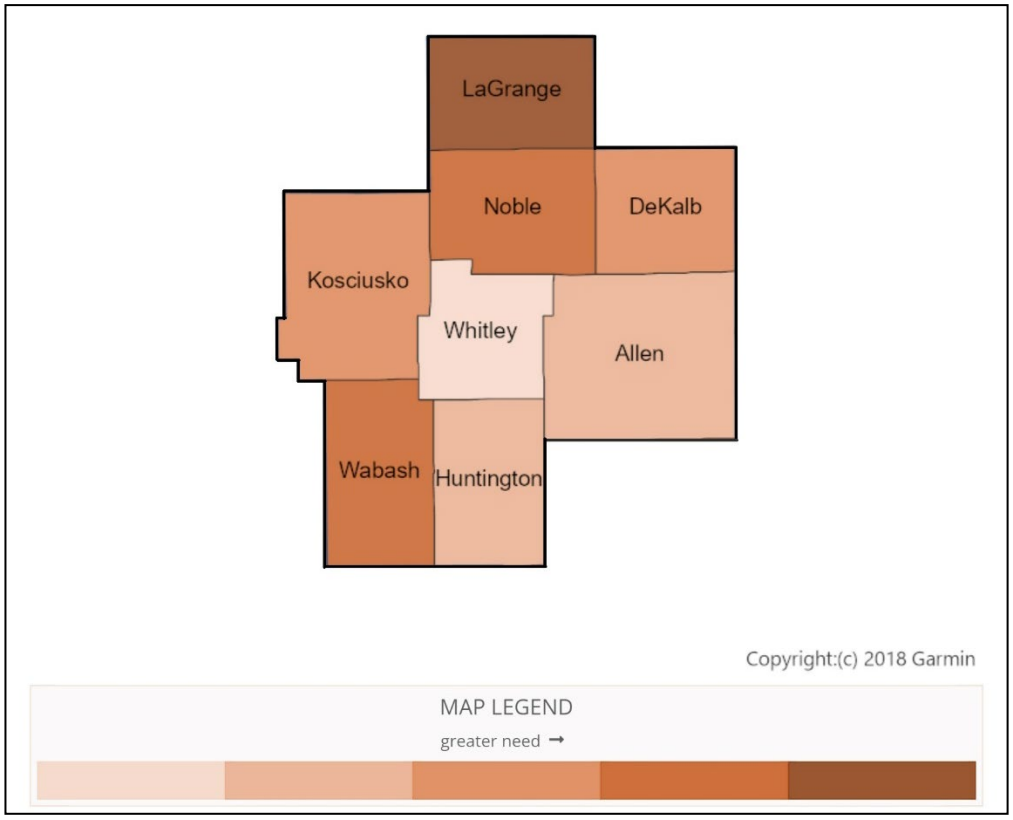
Social Determinants of Health

Social determinants of health (SDOH) are the "conditions in which people are born, grow, live, work and age that contribute to health outcomes" (*Social Determinants Resources*, n.d.). These indicators affect a wide range of health risks and outcomes (Artiga & Hinton, 2019). SDOH include factors like socioeconomic status, education, neighborhood, physical environment, employment, and social support networks, as well as access to healthcare. The effect of individual social determinants of health is difficult to discern as these factors are interdependent and interconnected. Evidence shows that poverty limits access to food, safe neighborhoods, and high-quality education. Also, poorer neighborhoods are significantly impacted by food insecurities and lower educational status, which can lead to poor health outcomes and reduced life expectancies.

In the United States, racial and ethnic minority groups continue to experience higher mortality rates and increased incidence of a wide range of illnesses compared to their white counterparts. These health disparities are inextricably linked to inequities in the following social determinants of health: social and community context (discrimination and racism), healthcare access, physical environments and neighborhoods, workplace conditions, education, and income gaps. Health equity is accomplished when all individuals have a fair and just opportunity to attain their highest level of health (*Health Equity | CDC*, 2022). Efforts toward health equity require economic, social, and other barriers to health be identified and addressed.

The Health Equity Index developed by Conduent Healthy Communities identifies geographic areas at highest risk for experiencing health inequities correlated with preventable hospitalizations and premature death based on validated indicators related to income, employment, education, and household environment. Counties were given an index value ranging from 0 (indicating lowest need) to 100 (indicating highest need). Counties in the Parkview Health service area were then ranked from 1 (low need) to 5 (high need) based on their relative index value. As shown in Figure 6 and Table 5, LaGrange County had the highest level of socioeconomic need.

Figure 6. Health Equity Index County Map



Measurement period: 2021. Data Source: Conduent Healthy Communities

Table 5. Health Equity Index Scores and Rank by County

County	Index	Rank
LaGrange	71.7	5
Noble	51.9	4
Wabash	51.5	4
Kosciusko	43.8	3
DeKalb	41.5	3
Allen	37.9	2
Huntington	32.6	2
Whitley	25.9	1

Measurement period: 2021. Source: Conduent Healthy Communities

Median Household Income

The median household income in the eight-county Parkview Health service area ranges from $54,286 in Huntington County to $69,331 in LaGrange County (Table 6). Since 2017, the median household income across counties has increased by 15 percent overall, with the smallest increase in Huntington County (8.4%) and the largest increase LaGrange County (18.8%).

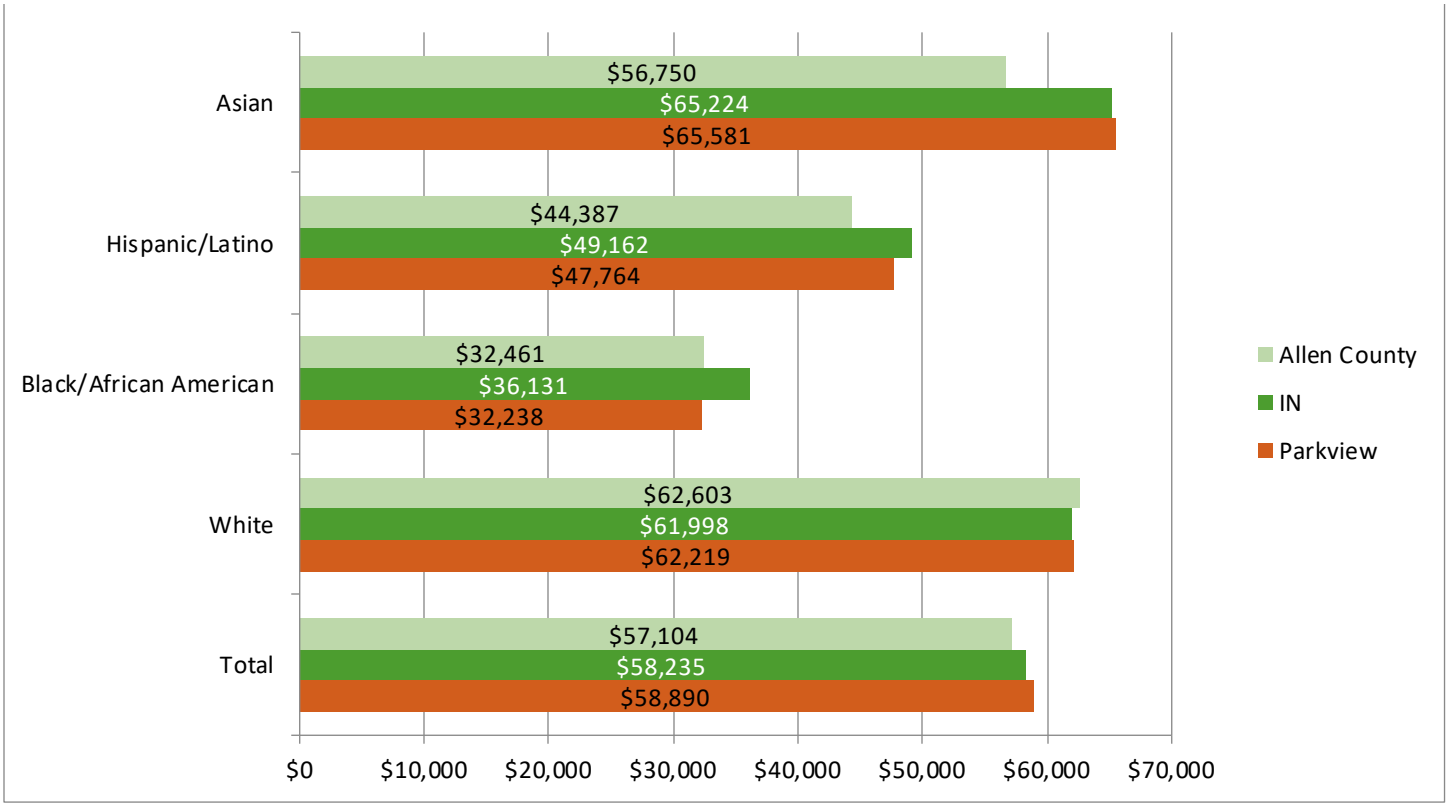
Table 6. Median Household Income in Dollars

Year	Allen	DeKalb	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley	Parkview	IN
2020	57,104	58,415	54,286	62,789	69,331	58,947	56,573	64,992	58,890	58,235
2017	51,091	51,374	50,063	57,190	58,336	52,393	49,052	57,041	52,466	52,182

Source: U.S. Census Bureau (American Community Survey 2013-2017 and 2016-2020 five-year averages)

Racial disparities in median household income are evident in Figure 7. Median Household Income by Race and Ethnicity. The median household income for Black and African American households in the Parkview Health service area is much lower than for White households in this area and is lower than the median household income for Black and African American households in Indiana.

Figure 7. Median Household Income by Race and Ethnicity



Source: U.S. Census Bureau (American Community Survey 2016-2020 Five-year Averages)

Poverty

The percentage of the population living below poverty in the Parkview Health service area (11.1%) is lower than the state percentage (12.9%). Although the percentage of the population below poverty ranges from a low of 6.0 percent in LaGrange County to a high of 12.6 percent in Allen County (Table 7), each of the counties has a poverty rate that is below that of the state of Indiana.

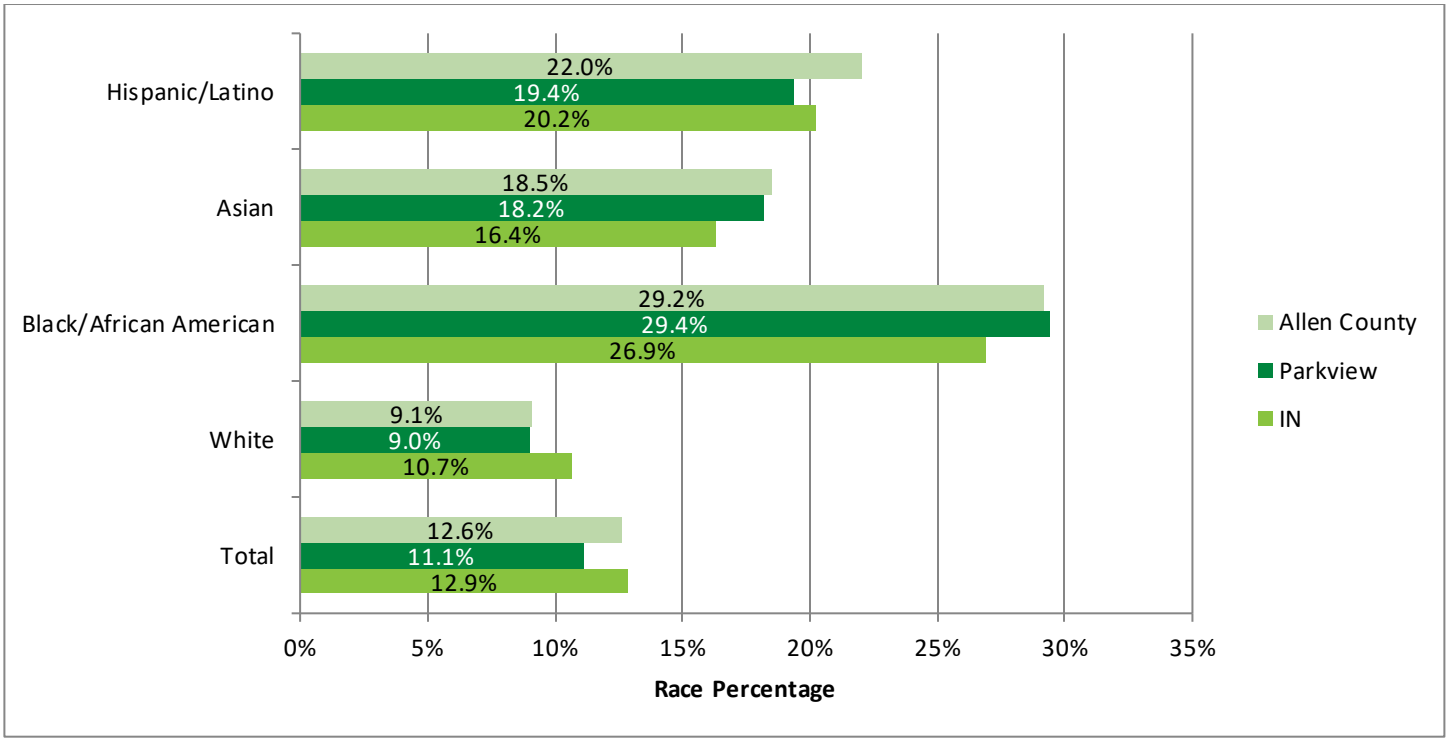
Regarding the percentage of the population living below the poverty level, racial disparities are evident in both the Parkview Health service area and the state of Indiana. As compared to the poverty rate for the White population in the Parkview Health service area (9.0%), Black and African American populations are almost three times as likely to be living below poverty level (29.4%), and Hispanic and Latino and Asian populations are almost twice as likely to be living below poverty level (19.4% and 18.2%, respectively). As compared to state averages by race and ethnicity, the poverty rates for the White population, and the Hispanic and Latino populations in the Parkview Health service area are lower than their respective Indiana averages. In contrast, the poverty rates for Black and African American populations and Asian populations in the Parkview Health service area are higher than their respective Indiana averages. See Figure 8.

Table 7. Percentage of Population Below Poverty Line

Year	Allen	DeKalb	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley	Parkview	IN
2020	12.6%	11.0%	11.2%	9.3%	6.0%	7.8%	11.5%	9.6%	11.1%	12.9%
2017	14.7%	12.5%	11.6%	11.2%	9.1%	9.3%	13.3%	9.5%	13.0%	14.6%

Source: U.S. Census Bureau (American Community Survey 2013-2017 and 2016-2020 Five-year Averages)

Figure 8. Population Below the Federal Poverty Level by Race and Ethnicity



Source: U.S. Census Bureau (American Community Survey 2016-2020 Five-year Averages)

Unemployment

The unemployment rate is another indicator of the social and economic status of a geographic area or population. Unemployment in the Parkview Health service area is lower than the state overall. Unemployment ranges from 2.4 percent in Huntington County to 5.0 percent in Allen County (Table 8), which is only slightly higher than the rate overall for the eight-county Parkview Health service area (4.4%) and the state of Indiana (4.7%).

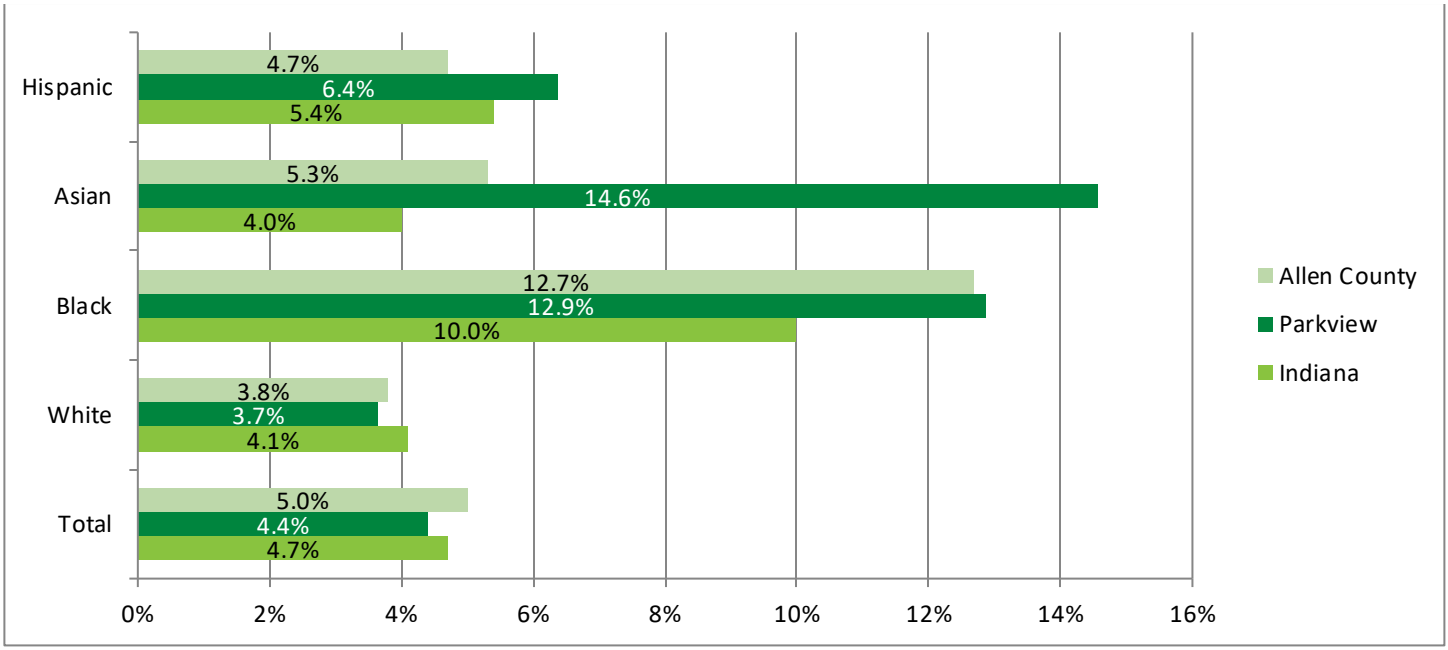
Like the disparities present in income and poverty level, racial disparities are also seen with unemployment rates. The Black and African American, Hispanic, and Asian populations in the Parkview Health service area have higher unemployment rates than their corresponding unemployment rates for the state (Figure 9).

Table 8. Percentage of Population Unemployed

Year	Allen	DeKalb	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley	Parkview	IN
2020	5.0%	3.8%	2.4%	3.6%	3.4%	4.0%	4.3%	4.4%	4.4%	4.7%
2017	6.3%	4.6%	3.9%	4.6%	2.9%	5.7%	5.5%	3.6%	5.5%	6.1%

Source: U.S. Census Bureau (American Community Survey 2013-2017 and 2016-2020 five-year averages)

Figure 9. Unemployment Rate by Race/Ethnicity



Source: U.S. Census Bureau (American Community Survey 2016-2020 Five-year Averages)

Education

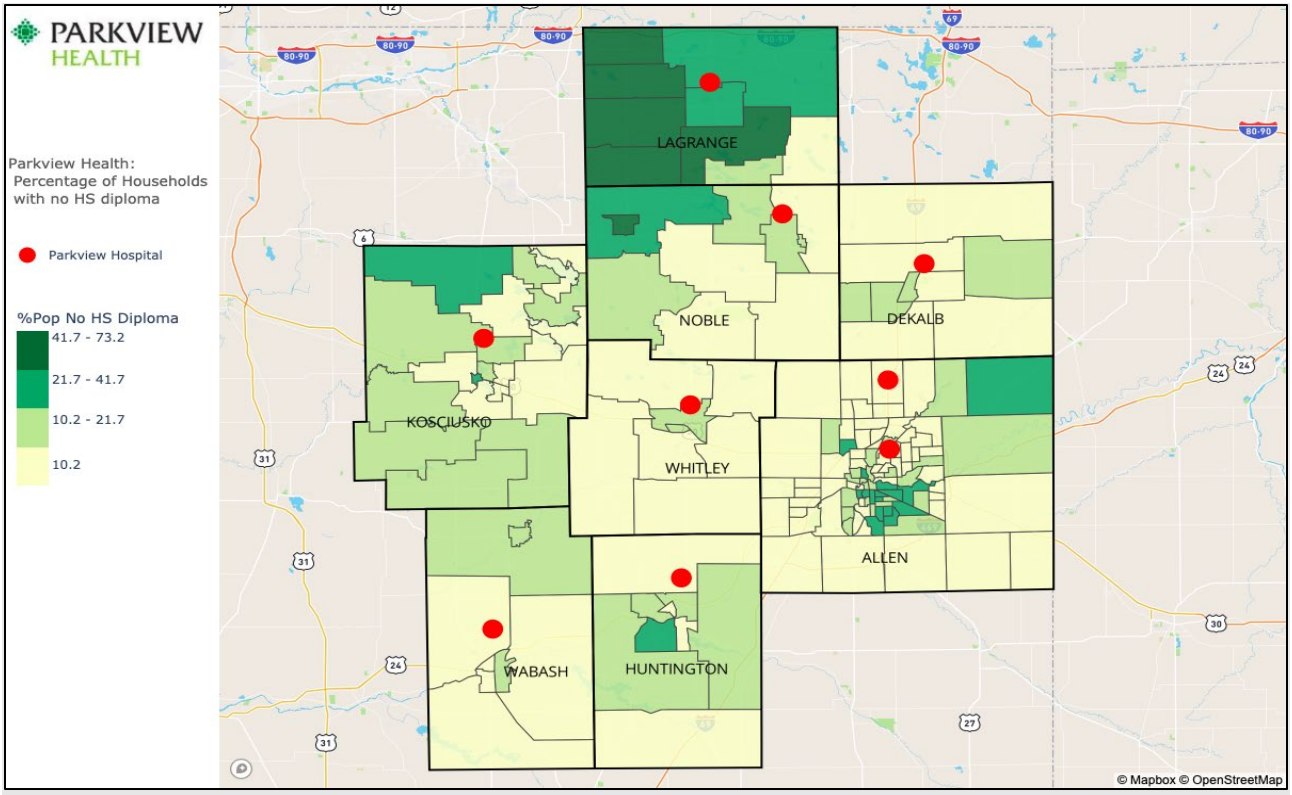
Education is related to several other social measures, including income, poverty, and unemployment. Limited education can be a key marker for identifying populations who may have health service needs. The percentage of the population without a high school diploma or equivalent is shown in Table 9. LaGrange County has the highest proportion of individuals without a high school diploma (38.9%) and the highest percentage of households with no high school diploma (Figure 10), which is due to the concentration of Amish communities in the county. Individuals in Amish communities have other training or economic options outside of a high school education. Noble and Kosciusko Counties have the second and third highest rate of individuals without a high school diploma, which may also be reflective of a relatively high proportion of Amish individuals in these counties (each has a population 1,000-4,999 Amish individuals).

Table 9. Population Without High School Diploma

Year	Allen	DeKalb	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley	Parkview	IN
2020	10.1%	9.0%	8.1%	13.2%	38.9%	16.1%	10.3%	8.6%	12.3%	10.7%
2017	10.6%	10.4%	9.5%	15.2%	36.7%	15.0%	11.3%	8.9%	12.8%	11.7%

Source: U.S. Census Bureau (American Community Survey 2013-2017 and 2016-2020 five-year averages)

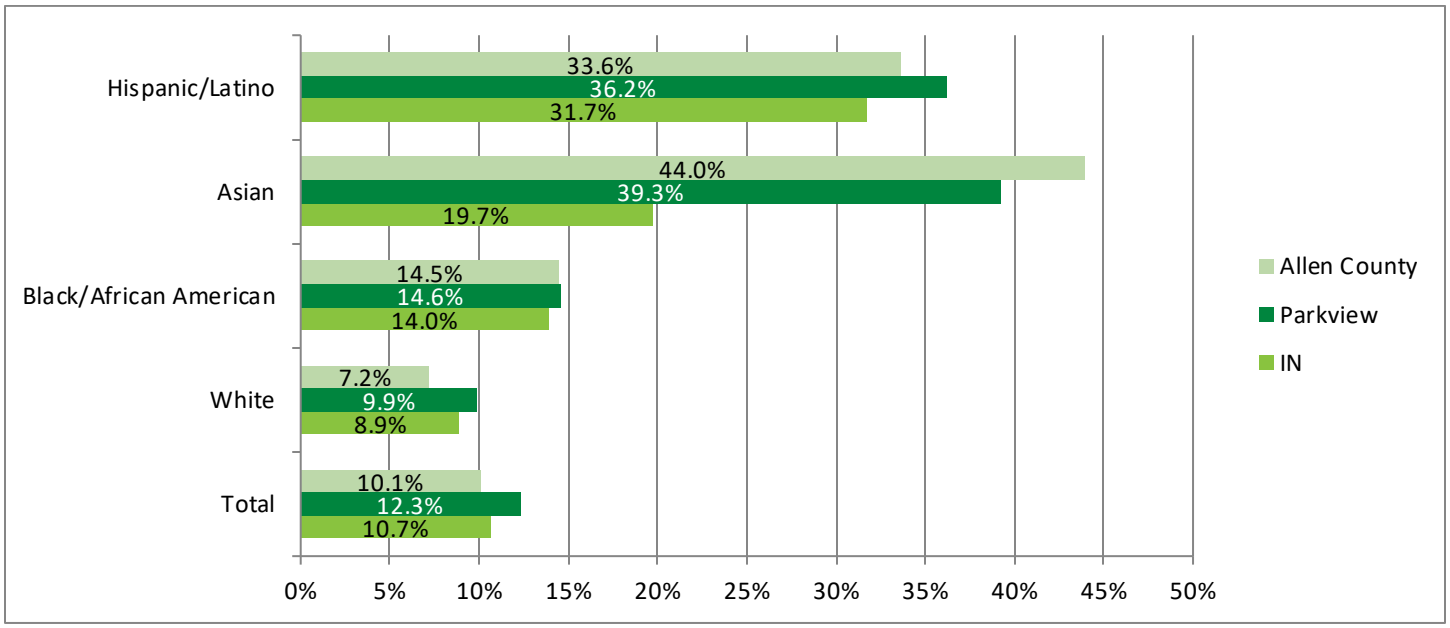
Figure 10. Percent of Households With No High School Diploma



Source: U.S. Census Bureau (American Community Survey 2016-2020 Five-year Averages)

Overall, the Parkview Health service area has a slightly higher percentage of population without a high school diploma compared to the Indiana rate. Additionally, racial disparities are evident in educational attainment (Figure 11). Notably, 36.2 percent of the Hispanic/Latino population and 39.3 percent of the Asian population is without a high school diploma. With these racial minorities already at a disadvantage in terms of income and poverty, this added inequity further impacts their health outcomes.

Figure 11. Population Without a High School Diploma by Race/Ethnicity



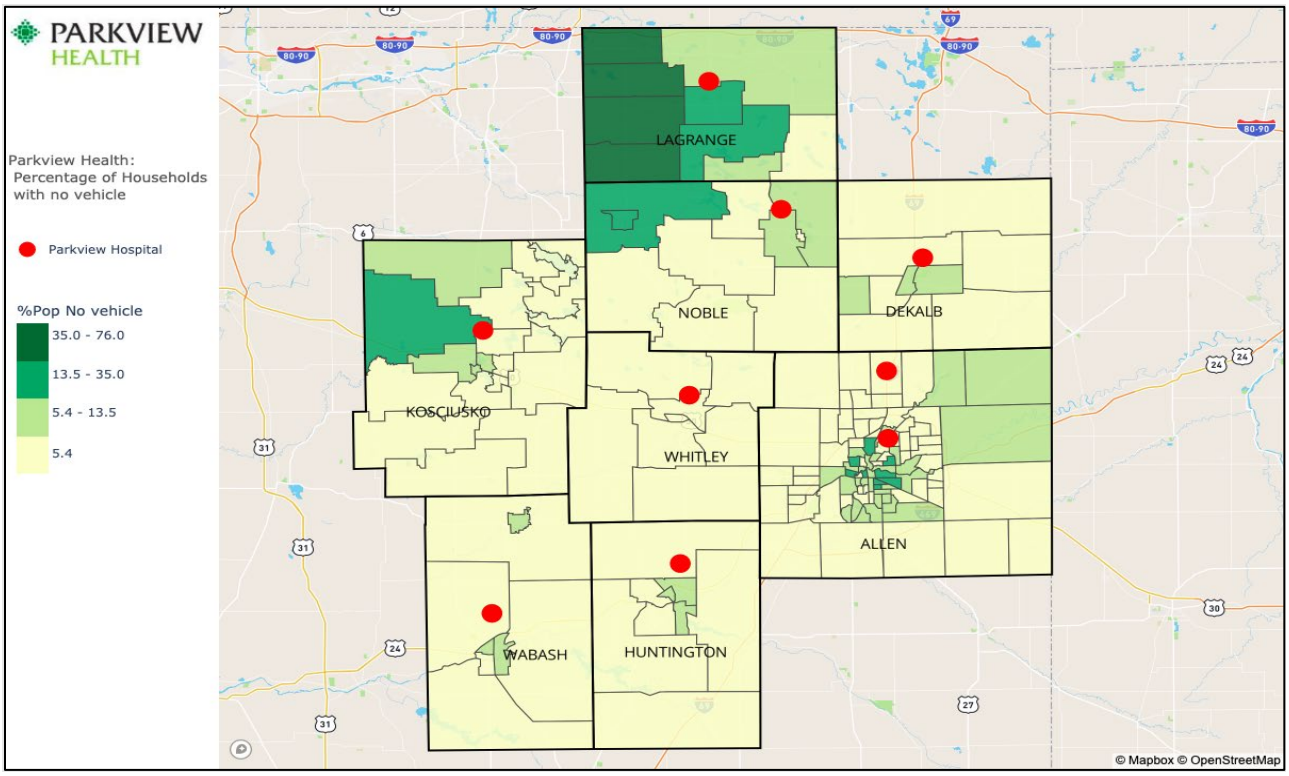
Source: U.S. Census Bureau (American Community Survey 2016-2020 Five-year Averages)

Transportation

Availability of transportation is an important factor for individual and community health, especially in rural or mixed urban/rural areas (i.e., seven of the eight Parkview Health service area counties), where having a personal vehicle is important because of lower population density for shared ridership and smaller tax base for public transportation systems.

As shown in Figure 12 below, most counties have few households (i.e., ≤ 5.4% households) without a vehicle, except for LaGrange County. The high percentage of houses with no vehicle in LaGrange County (i.e., 35 – 76% for the years 2016-2020) is likely due to the large Amish population in LaGrange County, who typically rely upon on horse carriages and wagons for their transport purposes. A slightly higher percentage of homes without a vehicle is also seen in the northeast part of Allen County.

Figure 12. Households With No Vehicle



Source: U.S. Census Bureau (American Community Survey 2016-2020 Five-year Averages)

Food Access

Food security includes accessibility and affordability of food. In a food insecure environment, children and adults may experience adverse health outcomes, such as an increased risk of depression, cardiovascular disease, and peripheral arterial disease in older populations (Laraia, 2013). Across the eight-county service area, approximately one in ten individuals was food insecure in 2020, ranging from a low of 9.2 percent in LaGrange County to a high of 13.3 percent in Allen County. Access to healthy, nutritious food – including fruits and vegetables – is important for a healthy lifestyle. Additionally, Allen County had the highest percentage (9.8%) both low-income and with low access to a grocery store (Table 10).

Table 10. Food Insecurity and Limited Access to Healthy Food

Measure	Year	Allen	DeKalb	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley	Parkview	IN
Food Insecurity*	2020	13.3%	11.0%	11.4%	10.0%	9.2%	9.4%	11.9%	10.1%	12.0%	13.3%
	2017	14.9%	12.3%	12.8%	11.4%	11.8%	11.5%	13.3%	11.3%	13.6%	15.3%
Limited Access to Healthy Foods**	2020	9.8%	8.5%	8.5%	5.6%	0.1%	2.1%	4.7%	1.9%	7.5%	6.9%
	2017	10.1%	8.5%	7.3%	7.1%	0.5%	3.1%	3.2%	1.8%	7.7%	6.3%

*Percent population lacking adequate access to food **Percent population low-income and do not live close to a grocery store
Source: County Health Rankings and Roadmaps

Neighborhood and Built Environment

The built environment is the space in which we live, work, learn, and play and includes workplaces and housing, business and schools, landscapes, and infrastructure. The neighborhoods in which people live and the built environment influence the public's health, particularly in relation to safety and chronic diseases. Exposure to violent crime, access to locations for physical activity and access to broadband internet connection are just a few measures related to community safety and health.

Violent Crime

High crime rates can lead to mental distress, a lower quality of life, an increase in negative health outcomes, premature death or nonfatal injuries (Margolin et al., 2010). An example of the negative effect of a high crime rate in the neighborhood is a reluctance of residents to walk outdoors or permit their children to play or bike outside which can lead to obesity and related health issues. Violent crime rates in 2016 varied widely across the eight-county Parkview Health service area. The violent crime rate was highest in Allen County at 296 offenses per 100,000 population and lowest in Huntington County at 33 per 100,000 population in 2016 (Table 11).

Table 11. Number of Reported Violent Crime Offenses per 100,000 Population

Year	Allen	DeKalb	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley	IN
2016	296	117	33	159	103	158	51	.	385
2014	283	123	126	253	75	73	60	.	356

Source: County Health Rankings and Roadmaps

Exercise Opportunities

As shown in Table 12, the percent of the population that has adequate access to locations for physical activity decreased in several counties in the Parkview service area from 2017-2020. DeKalb, Kosciusko, LaGrange, Noble, Wabash and Whitley counties all have lower access to exercise opportunities compared to the state of Indiana.

Table 12. Percent of Population that has Access to Locations for Physical Activity

Year	Allen	DeKalb	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley	Parkview	IN
2020	78.2%	59.2%	76.5%	65.4%	24.4%	63.8%	68.6%	58.0%	69.9%	75.2%
2017	81.8%	69.4%	82.4%	70.2%	32.0%	57.8%	57.2%	63.3%	73.1%	74.8%

Source: County Health Rankings and Roadmaps

Broadband Access

More recently, broadband access has emerged as a social determinant of health. Digital equity is necessary to achieve health equity; employment opportunities, access to education, healthcare access, and social connectedness are all reliant on broadband internet connection to a degree. Rural areas and low-income urban areas are most likely to be affected by limited broadband access. The percentage of households with broadband internet connection increased in several counties within Parkview Health's service area from 2015-2019 to 2016-2020 (Table 13). However, DeKalb, Huntington, LaGrange, Noble and Wabash counties had a lower percentage of connected households compared to the state of Indiana in 2016-2020.

Table 13. Percent of Households With Broadband Internet Connection

Year	Allen	DeKalb	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley	Parkview	IN
2020	86.7%	80.5%	78.8%	83.0%	62.3%	80.7%	79.8%	84.0%	83.2%	83.2%
2019	84.2%	78.1%	78.8%	79.8%	58.8%	79.7%	74.7%	81.1%	81.4%	80.1%

Source: County Health Rankings and Roadmaps (Five-year Averages)

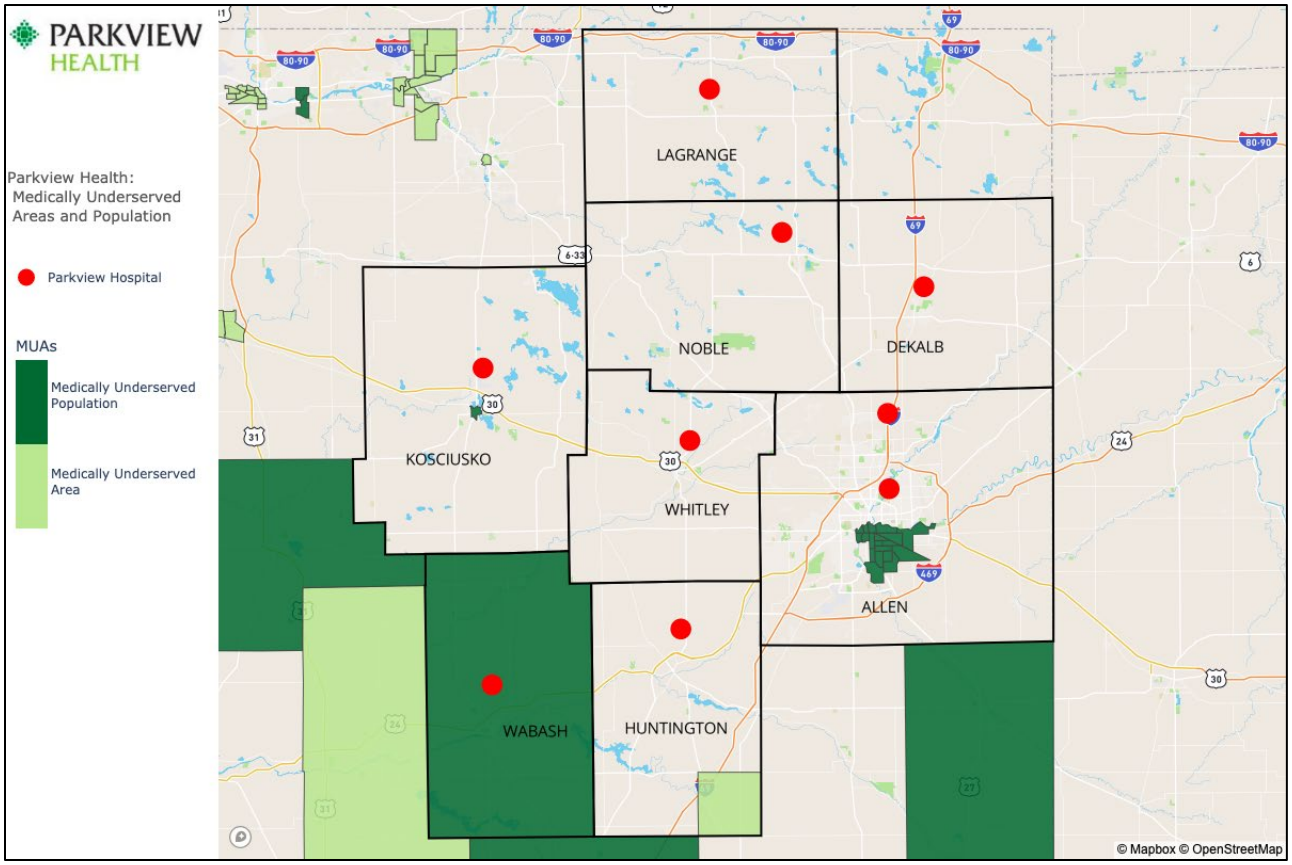
Access to Healthcare

Access to healthcare is critical to receiving necessary care in a timely manner. Indicators for access to healthcare include identifying medically underserved geographic areas and populations and rates of uninsured individuals.

Medically Underserved Areas and Populations

Medically underserved areas (MUA) and medically underserved populations identify geographic areas and populations with access barriers to primary care services. Using Health Resources & Services Administration 2022 data, medically underserved areas (Figure 13, light green) were mainly identified in Huntington County and in the southwest area bordering the Parkview Health primary service area. Several medically underserved populations were identified (Figure 13, dark green) mainly in Wabash County, Allen County, and in the south/southwest areas bordering the eight-county region.

Figure 13. Medically Underserved Areas and Populations



Source: Health Resources & Services Administration, 2022

Health Insurance

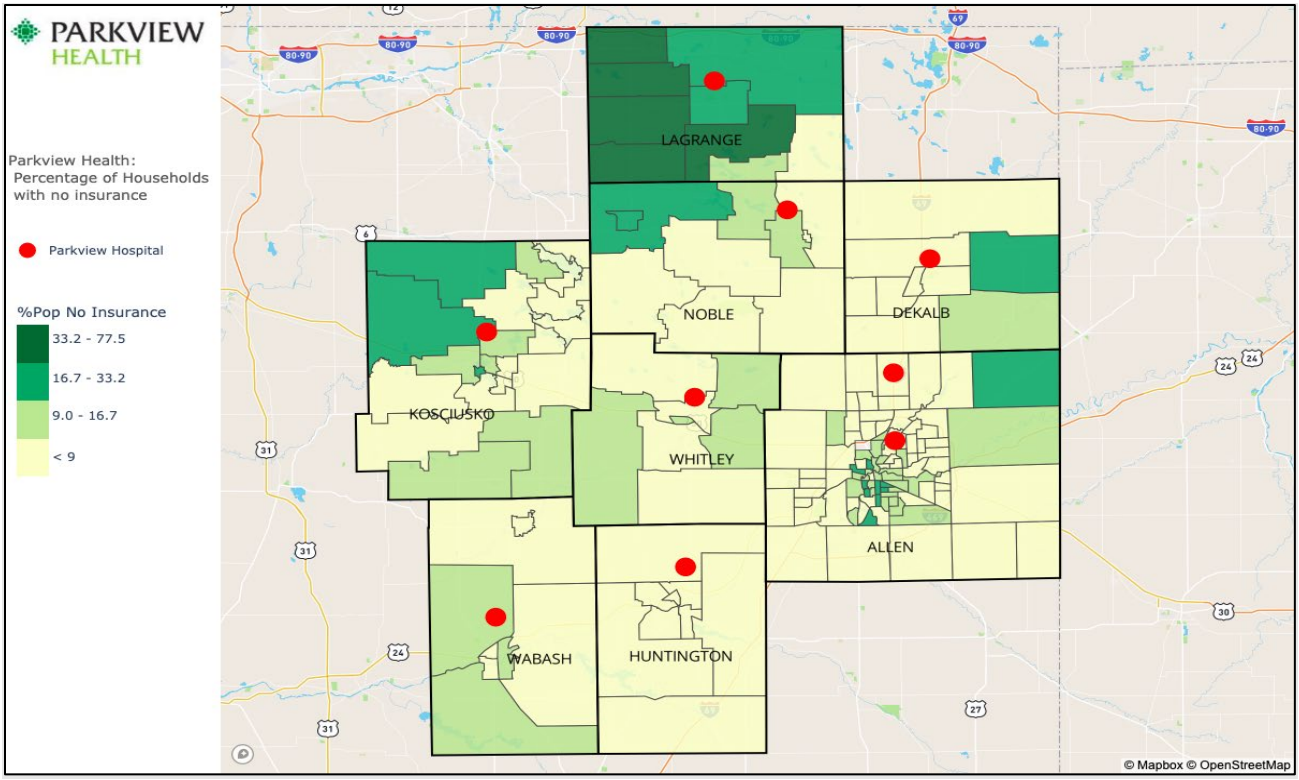
The percentage of the population without health insurance ranged from 7.1 percent in DeKalb County to 42.6 percent in LaGrange County, with 57.9 percent of children in LaGrange County without health insurance (Table 14). Individuals living in Amish communities are less likely to have traditional health insurance policies and instead rely upon their own community resources, which accounts for the high rate of uninsured individuals in LaGrange County. The map in Figure 14 illustrates the percentage of households without health insurance at the census tract level, highlighting areas in several counties with more than 16.7 percent of households having no health insurance.

Table 14. Percent of Population Without Health Insurance

	Year	Allen	DeKalb	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley	Parkview	IN
All	**2020**	8.0%	7.1%	6.6%	10.8%	42.6%	9.9%	8.2%	7.4%	10.3%	8.0%
	2017	10.8%	10.5%	9.4%	11.8%	39.7%	9.2%	9.3%	7.6%	12.1%	10.3%
Adults (<65)	**2020**	10.8%	8.6%	9.7%	13.4%	40.7%	12.0%	11.8%	9.6%	12.7%	10.7%
	2017	14.7%	13.1%	12.2%	15.1%	37.7%	12.1%	13.3%	10.9%	15.4%	14.0%
Children	**2020**	5.9%	8.0%	3.6%	11.3%	57.9%	10.2%	6.0%	7.3%	9.9%	6.3%
	2017	7.5%	10.2%	8.3%	10.5%	53.1%	7.1%	6.4%	4.4%	10.4%	7.0%

Source: U.S. Census Bureau (American Community Survey 2013-2017 and 2016-2020 Five-year Averages)

Figure 14. Percent of Population with No Health Insurance



Source: U.S. Census Bureau (American Community Survey 2016-2020 Five-year Averages)

CRITICAL HEALTH CONCERNS

The current Community Health Needs Assessment was aimed at identifying critical health concerns for the Parkview Health service area. As such, both primary and secondary data were collected and synthesized to understand current health concerns. Health indicators for the Parkview Health service area were identified using secondary data from the Healthy Communities Institute (HCI) dashboard. Primary data were collected to identify community perceptions of health concerns and related service needs using survey methods. Healthcare and social services providers (e.g., physicians, nurses, social workers, etc.) and community residents throughout eight Parkview Health service area counties were invited to participate. These data sources are described in the following sections.

Secondary Data: County Level Health Indicators

The U.S. Census Bureau American Community Survey and the Parkview Health Community Dashboard developed by HCI were used as the main sources of secondary data. The dashboard includes data from the Indiana Hospital Association as well as the Indiana State Department of Health, National Cancer Institute, Centers for Disease Control and Prevention (CDC), Centers for Medicaid and Medicare Services, the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Institute for Health Metrics and Evaluation, County Health Rankings Roadmaps, U.S. Census Bureau, U.S. Department of Agriculture, and other sources. Additional relevant data for counties in the Parkview Health region was obtained from the Health Resources & Services Administration and the Association of Religion Data Archives, Mental Health America, CDC PLACES, CDC Underlying Cause of Death database, CDC Chronic Kidney Disease Surveillance System, CDC National Environmental Public Health Tracking Network, American Cancer Society, Indiana Youth Institute, and Alzheimer's Association.

The Parkview Health Community Dashboard developed by Healthy Communities Institute (HCI) was used to identify county indicators performing in the bottom quartile of U.S. Counties based on a sample of over 3,000 counties and county equivalents (Figure 15). If a comparison to U.S. counties was not available for an indicator, then a regional comparison to the Indiana state value was used. If neither a comparison to U.S. counties nor the Indiana region was available, then the indicator was not evaluated for performance. Clinical care ranking and physical environment ranking were the only indicators not available in the 2022 dashboard data compared to previous reports.

Figure 15. Example Snapshot from HCI Dashboard

Based upon review of 200+ indicators, Table 15. County Health Indicators Performing in the Bottom Quartile of U.S. Counties describes the health outcomes and behaviors for which any of the eight counties in the Parkview Health service area was in the lowest performing quartile of U.S. counties or was significantly worse than the Indiana region.

Forty-seven (47) HCI health indicators were either in the bottom performing quartile of U.S. counties or significantly worse compared to the Indiana region. Some health indicators relate to the same health condition (e.g., adults 20+ with diabetes and age-adjusted death rate for diabetes). If at least one indicator for a related health issue was in the bottom performing quartile or significantly worse than the state region, then that health issue was considered as a potential community health concern for Parkview Health. The 47 indicators were categorized into 16 general health issues, as shown in Table 15, County Health Indicators Performing in the Bottom Quartile of U.S. Counties.

Table 16 and Table 17 list the **social indicators (21) and access indicators (33)**, respectively, for which counties in the Parkview Health service area are in the bottom-performing quartile compared to U.S. counties or significantly worse than the Indiana region.

Table 15. County Health Indicators Performing in the Bottom Quartile of U.S. Counties

Health Issue	Health Indicator	Allen	DeKalb	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley
Aging *2 of 10 indicators in bottom quartile*	Alzheimer's Disease or Dementia*	X						X	
	Osteoporosis*			X					
Alcohol Use *1 of 3 indicators in bottom quartile*	Alcohol-Impaired Driving Deaths	X							
Cancer *7 of 11 indicators in bottom quartile*	Breast Cancer†				X				
	Oral Cavity and Pharynx Cancer†							X	
	Prostate Cancer‡	X		X			X		X
	Colorectal Cancer†		X	X				X	
	Colorectal Cancer‡							X	
	Lung and Bronchus Cancer†		X				X		X
	Lung Cancer‡		X				X		
Cardiovascular Disease *2 of 13 indicators in bottom quartile*	Cerebrovascular Disease (Stroke)‡			X		X		X	
	Heart Attack‡§				X				
Chronic Diseases *2 of 5 indicators in bottom quartile*	Chronic Kidney Disease*			X					
	Kidney Disease‡			X		X			
	Adults with COPD					X			
	COPD*						X		
Chronic Respiratory Diseases *3 of 3 indicators in bottom quartile*	Adults with Current Asthma					X			
	Asthma*	X		X	X			X	
	Chronic Lower Respiratory Diseases‡		X	X				X	
Diabetes *2 of 3 indicators in bottom quartile*	Diabetes (Adults 20+)	X		X					
	Diabetes‡				X			X	
Drug Use *2 of 6 indicators in bottom quartile*	Controlled Substances Dispensed§					X		X	
	Non-Fatal Emergency Department Visits due to Opioid Overdose			X		*N/A*		X	X
Infectious Diseases *5 of 8 indicators in bottom quartile*	Salmonella Infection†§			X	X	X	X		X
	COVID-19 Daily Average†			X					
	Gonorrhea†	X					X		
	Chlamydia†	X							
	Hepatitis C Prevalence§					*N/A*		X	*N/A*
Maternal/Child Health *6 of 6 indicators in bottom quartile*	Mothers not Receiving Early Prenatal Care§	X	X		X	X	X		X
	Child Abuse Rate§		X				X	X	X
	Babies with Low Birth Weight§	X		X	X			X	
	Preterm Births§			X	X			X	
	Infant Mortality Rate§				X		X		*N/A*
	Teen Birth Rate (15-19) §	X	X		X		X	X	X

Mental Health *5 of 6 indicators in bottom quartile*	Depression (Adults Ever Diagnosed)					X			
	Depression*	X		X				X	
	Frequent Mental Distress					X			
	Poor Mental Health: 14+ days					X			
	Poor Mental Health: Average number of days					X			
Obesity *2 of 2 indicators in bottom quartile*	Adults 20+ with Obesity	X	X	X		X	X		
	Sedentary (Adults 20+)				X				
Oral Health *1 of 1 indicator in bottom quartile*	Adults 65+ with Total Tooth Loss					X			
Public Safety *1 of 4 indicators in bottom quartile*	Motor Vehicle Traffic Collisions‡							X	
Tobacco Use *2 of 2 indicators in bottom quartile*	Adults who Smoke					X		X	
	Mothers who Smoked During Pregnancy§		X	X	X		X	X	X
Wellness and Lifestyle *2 of 6 indicators in bottom quartile*	Frequent Physical Distress					X			
	Poor Physical Health: Average number of days					X			
County		**Allen**	**DeKalb**	**Huntington**	**Kosciusko**	**LaGrange**	**Noble**	**Wabash**	**Whitley**
# Indicators in Lowest Quartile of U.S. Counties Or Significantly Worse than Indiana Region		**12**	**9**	**17**	**12**	**16**	**12**	**19**	**8**

Source: Parkview Health Community Dashboard, 2022. *Medicare Population. †Incidence Rate. ‡Age-Adjusted Death Rate. §Significantly Worse than Indiana Region.

Table 16. County Social Indicators in the Bottom-Performing Quartile of U.S. Counties

Social Issue	Indicator	Allen	DeKalb	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley
Economy *2 of 13 indicators in bottom quartile*	Households that are Asset Limited, Income Constrained, Employed (ALICE)§					X	X		
	Persons with Disability Living in Poverty				X				
Education *9 of 9 indicators in bottom quartile*	4th Grade Proficiency in English/Language Arts§	X	X				X		X
	4th Grade Proficiency in Math§	X					X	X	X
	8th Grade Proficiency in English/Language Arts§				X		X	X	
	8th Grade Proficiency in Math§	X			X			X	X
	People 25+ w/ a bachelor's degree or Higher					X	X		
	People 25+ w/ a High School Degree or Higher					X	X		
	Student-to-Teacher Ratio	X	X						
	Youth not in School or Working				X	X			
	Child Care Centers§					X	X		
Employment *2 of 4 indicators in bottom quartile*	Female Population 16+ in Civilian Labor Force					X			
	Total Employment Change		X						
Environmental Health *2 of 4 indicators in bottom quartile*	Annual Ozone Air Quality	X	*N/A*		*N/A*	*N/A*	*N/A*		*N/A*
	Blood Lead Levels in Children (≥5 micrograms per deciliter)§	X	*N/A*	X	*N/A*	*N/A*		*N/A*	*N/A*
Social Environment *6 of 7 indicators in bottom quartile*	Households w/ Internet Subscription					X			
	Households w/ ≥1 Types of Computing Devices					X			
	Persons w/ Internet Subscription					X			
	People 65+ Living Alone			X					
	Social Associations (membership per 10,000 population)					X			
	Voter Turnout: Presidential Election§	X							
County		**Allen**	**DeKalb**	**Huntington**	**Kosciusko**	**LaGrange**	**Noble**	**Wabash**	**Whitley**
# Indicators in Lowest Quartile of U.S. Counties or Significantly Worse than Indiana Region		**7**	**3**	**2**	**4**	**10**	**7**	**3**	**3**

Source: Parkview Health Community Dashboard, 2022. §Significantly Worse than Indiana Region.

Table 17. County Access Indicators in the Bottom Performing Quartile of U.S. Counties

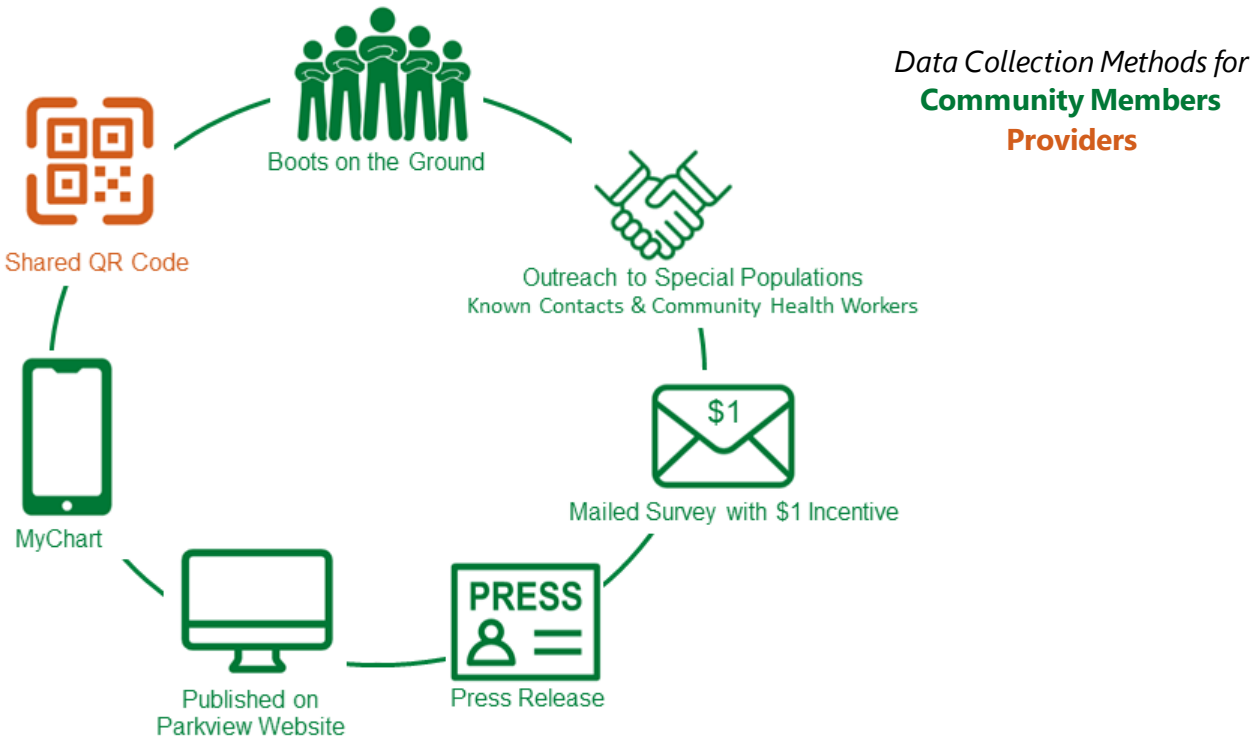
Access Issue	Indicator	Allen	DeKalb	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley
Access to Health Services *8 of 11 indicators in bottom quartile*	Adults with Health Insurance: 18-64					X			
	Persons with Health Insurance					X			
	Children with Health Insurance				X	X	X		
	Non-Physician Primary Care Provider Rate†					X	X	X	X
	Primary Care Provider Rate†					X	X		
	Dentist Rate†					X	X		
	Mental Health Provider Rate†					X			
	Preventable Hospital Stays*		X				X		
Food Access *6 of 17 indicators in bottom quartile*	Children with Low Access to a Grocery Store	X							
	People with Low Access to a Grocery Store	X							
	Households' w/o Car & Low Access to a Grocery Store					X			
	Grocery Store Density†		X						X
	Fast Food Restaurant Density†			X	X			X	
	SNAP Certified Stores					X			X
Safe & Healthy Environment *2 of 2 indicators in bottom quartile*	Houses Built Prior to 1950		X	X			X	X	
	Access to Exercise Opportunities					X			
Housing Affordability & Supply *4 of 10 indicators in bottom quartile*	Homeowner Vacancy Rate					X		X	
	Overcrowded Households§				X	X	X		
	Median Monthly Owner Costs for Households w/o a Mortgage§								X
	Median Housing Unit Value§	X	X	X			X	X	
Preventive Care *9 of 12 indicators in bottom quartile*	Adults who Visited a Dentist					X			
	Cervical Cancer Screening: 21-65					X			
	Cholesterol Testing History					X			
	Colon Cancer Screening					X			
	Mammogram in Past 2 Years: 50-74					X			
	Mammography Screening*		X						
	Persons Fully Vaccinated Against COVID-19				X	X	X	X	
	Received Rec'd Preventive Services: Male 65+	X			X	X	X		X
	Received Rec'd Preventive Services: Female 65+		X			X	X	X	
Transportation *4 of 6 indicators in bottom quartile*	Household without a Vehicle					X	X		
	Workers Commuting by Public Transportation		X						
	Workers who Drive Alone to Work		X	X				X	X
	Workers who Walk to Work		X						X
County		**Allen**	**DeKalb**	**Huntington**	**Kosciusko**	**LaGrange**	**Noble**	**Wabash**	**Whitley**
# Indicators in Lowest Quartile of U.S. Counties or Significantly Worse than Indiana Region		**4**	**9**	**4**	**5**	**21**	**12**	**8**	**7**

Source: Parkview Health Community Dashboard, 2022 *Medicare Population. †Per 100,000 population. §Significantly Worse than Indiana Region.

Primary Data: Survey Methods & Results

Parkview service area community member and provider input was gathered via multiple recruitment and data collection methods (Figure 16): 1) e-mail to healthcare and social service providers with an embedded online survey link; 2) mailed paper and e-mailed online surveys to community members; 3) paper surveys distributed to individuals, clinics or organizations serving Hispanic, Amish, or People of Burma populations; 4) in-person recruitment at locations providing services to low-income populations throughout the eight counties and 5) press release and social media notifications with a survey link. The relevant data collection methods are described below. Descriptive statistics were calculated for all survey items. A summary of responses by community, special populations, and providers for each county is provided for health concerns (Table 18) and service needs (Table 19).

Figure 16. Multi-Pronged Approach to Primary Data Collection



Community Survey

A survey (Appendix B), conducted from March through May 2022, was designed to collect community member perspectives of the top health issues and services needed in their local communities. A multi-pronged approach was used to obtain community input: 1) a recruitment email with an embedded survey link was sent via the Parkview patient portal to all Parkview patients with portal communication preferences indicating a willingness to receive surveys/questionnaires; 2) printed paper surveys were mailed to 2500 randomly selected households in each county (it is unknown if members of these households have ever been served by Parkview); 3) paper surveys were distributed to community health workers and locations serving Hispanic, Amish, or People of Burma populations; 4) press release and social media notifications were posted with links to the survey; and 5) in-person teams of research assistants recruited participants at various public locations, such as libraries, YMCAs, and retail stores throughout the eight-county service area (Table 20). The research team coordinated with local health departments and known contacts in each county to identify locations to survey underrepresented or vulnerable populations. Table 20 details the targeted population and location for each county.

Table 18. Top Ranked Health Concerns from Community and Provider Survey Data

	COMMUNITY PERCEPTIONS by COUNTY								SPECIAL POPULATIONS			PROVIDERS	MEAN
	Allen	DeKalb	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley	Hispanic	Amish	People of Burma		
Obesity	1	1	2	2	2	2	2	1	1	4	3	3	**2.0**
Substance Abuse	4	2	1	1	1	1	1	3	2	5	8	2	**2.6**
Chronic Disease	2	4	4	3	3	5	3	2	5	3	1	4	**3.3**
Mental Health	3	3	3	4	4	4	4	4	3	6	4	1	**3.6**
Alcohol Abuse	5	6	6	7	5	6	6	7	4	2	6	6	**5.5**
Tobacco Use	7	5	5	8	6	3	7	5	6	1	13	5	**5.9**
Aging	6	7	8	5	7	7	5	6	9	9	11	7	**7.3**
Child Abuse	8	8	7	6	8	8	8	8	8	8	15	8	**8.3**
Violent Crime	9	12	11	9	14	10	11	14	7	12	10	10	**10.8**

Table 19. Top Ranked Service Needs from Community and Provider Survey Data

	COMMUNITY PERCEPTIONS by COUNTY								SPECIAL POPULATIONS			PROVIDERS	MEAN
	Allen	DeKalb	Huntington	Kosciusko	LaGrange	Noble	Wabash	Whitley	Hispanic	Amish	People of Burma		
Mental Health	1	1	2	2	2	2	2	1	3	4	7	1	**2.2**
Substance Abuse	2	2	1	1	1	1	1	2	1	1	13	2	**2.4**
Food	3	4	3	3	8	4	3	3	5	7	1*	5	**4.1**
Primary Care Provider	6	6	4	6	4	5	10	7	4	5	4	11	**6.0**
Senior Services	7	7	8	5	6	9	9	4	12	12	1*	6	**7.1**
Recreational Spaces	4	3	7	7	3	3	11	5	11	3	17	10	**7.4**
Childcare	10	5	6	4	5	6	5	10	6	10	17	3	**7.5**
Health Insurance	9	8	5	8	11	8	4	6	2	16	12	9	**8.0**
Gun Safety	8	10	10	9	7	7	7	11	8	2	5	16	**8.4**
Birth Control	5	9	11	10	9	11	8	8	7	15	1*	12	**9.2**
Job Training	12	11	9	11	14	10	6	9	10	11	14	14	**10.9**
Transportation	16	15	12	16	12	16	15	15	16	9	15	4	**13.7**

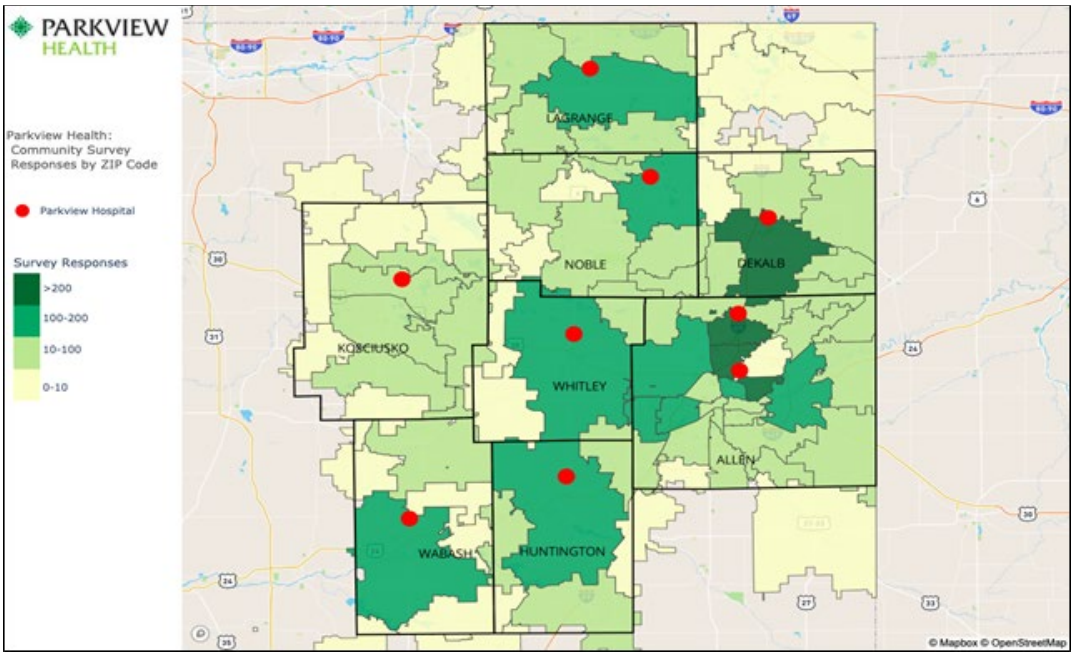
*Food, senior services, and birth control tied for top concern.

Table 20. Community Survey Outreach

Community Location	Description
YMCA – Allen, DeKalb, Huntington, Kosciusko, Noble, Wabash, and Whitley counties	The YMCA is a non-profit, community-centered organization that provides programs and services to foster community development and help people (including underserved community members) learn, grow, and thrive.
Public Library – Allen, DeKalb, LaGrange, and Noble counties	Public libraries aim to enrich the community and encourage lifelong learning by providing services that meet the informational, educational, and recreational needs of diverse populations, such as learning job skills, finding health information, and exploring digital technologies.
Lutheran Church – Allen County	This Lutheran church serves a diverse population and supports the local community through involvement with area neighborhood associations, social services, and schools.
Pharmacy – LaGrange County	This pharmacy promotes the health and welfare of the community by providing healthcare services and health education for a predominantly Amish population.
Coffee Shop – Noble and Wabash counties	These coffee shops serve a diverse population and support community outreach at local events.
Thrift Store – Wabash County	This thrift store is a non-profit organization that supplies clothing, household items, hygiene products, and Holiday food baskets for low-income or otherwise struggling community residents.

Our data collection methods recruited a convenience sample, as such the results are subject to selection bias and reduced generalizability to the entire eight-county service region. The survey contained demographic questions (gender, race, ethnicity, age, zip code), a list of 17 health issues, and 18 service needs. Respondents indicated whether each health issue was a concern (yes/no) and the importance of each service need (1=least important, 5=most important). Service needs rated as "5 Most Important" are reported. Frequencies reported for the full sample were algorithmically weighted to account for differences in the demographic composition of survey participants compared to the demographics of each county. Figure 17 shows the number of respondents across the eight Parkview Health service area counties.

Figure 17. Community Survey Respondents by ZIP Code



Community Survey Results

The demographics of the Allen County community survey respondents can be found in Table 21. Overall, the majority of respondents were female (62.5%), White (86.4%), and respondents 65 years and older were well-represented (44.9%). Community respondents ranked obesity as their top health concern, followed by chronic disease and mental health (Figure 18). Mental health counseling was most frequently indicated by community respondents as a top social service issue for their community, followed by substance abuse services and access to food (Figure 19).

Table 21. Sample Demographics by County and Overall

Demographic	Allen n=2685	DeKalb n=406	Huntington n=254	Kosciusko n=206	LaGrange n=347	Noble n=350	Wabash n=193	Whitley n=216	All n=4657
Female	62.5%	61.6%	68.3%	62.1%	66.9%	69.1 %	61.7%	63.4%	63.5%
Male	35.9%	36.7%	31.4%	36.4%	32.0%	29.1%	37.8%	35.2%	35.0%
Transgender	0.2%	0.5%	0%	0%	0%	0%	0%	0%	0.2%
Other	0.5%	0%	0%	1.0%	0%	0.6%	0%	0%	0.3%
Decline	1.0%	1.2%	0.4%	0.5%	1.2%	1.1%	0.5%	1.4%	1.0%
18-44 years	22.0%	29.4%	21.5%	18.5%	34.3%	28.9%	19.6%	15.4%	23.5%
45-64 years	33.1%	32.7%	37.5%	29.7%	34.3%	33.3%	34.9%	38.3%	33.6%
65+ years	44.9%	38.0%	41.0%	51.8%	31.4%	37.8%	45.5%	46.3%	42.9%
American Indian/ Alaskan Native	0.7%	0.5%	0.8%	0%	0.6%	0%	2.1%	1.4%	0.7%
Asian	4.3%	0%	0%	0.5%	0.3%	0.6%	1.0%	0.5%	2.6%
Black/African American	4.5%	0.3%	0.8%	0%	0.9%	0.3%	1.6%	0.9%	2.9%
Native Hawaiian/ Pacific Islander	0%	0%	0%	0%	0%	0%	0.5%	0%	0.02%
White	86.4%	95.1%	97.2%	97.6%	94.8%	96.0%	93.8%	95.4%	90.3%
Other	2.4%	2.2%	0.4%	1.5%	1.4%	0.6%	2.1%	0.9%	2.0%
Decline	2.7%	2.5%	2.0%	1.5%	2.9%	2.6%	1.0%	2.3%	2.5%
Hispanic/Latino	3.5%	1.7%	0.8%	1.0%	3.2%	1.4%	1.1%	0.5%	2.7%
< $35,000	14.1%	17.1%	14.4%	13.6%	18.1%	20.1%	22.1%	13.3%	15.4%
$35,000-$74,999	31.2%	25.9%	29.2%	32.3%	28.4%	27.9%	29.0%	28.0%	30.0%
$75,000+	40.1%	43.2%	37.6%	36.9%	43.8%	41.3%	33.7%	40.8%	40.2%
Decline	14.6%	13.8%	18.8%	17.2%	9.7%	10.8%	15.3%	18.0%	14.4%
Household with children	24.9%	26.3%	21.5%	18.5%	36.7%	33.3%	18.2%	17.1%	25.4%

Figure 18. Top Community Health Concerns (Community Perceptions)

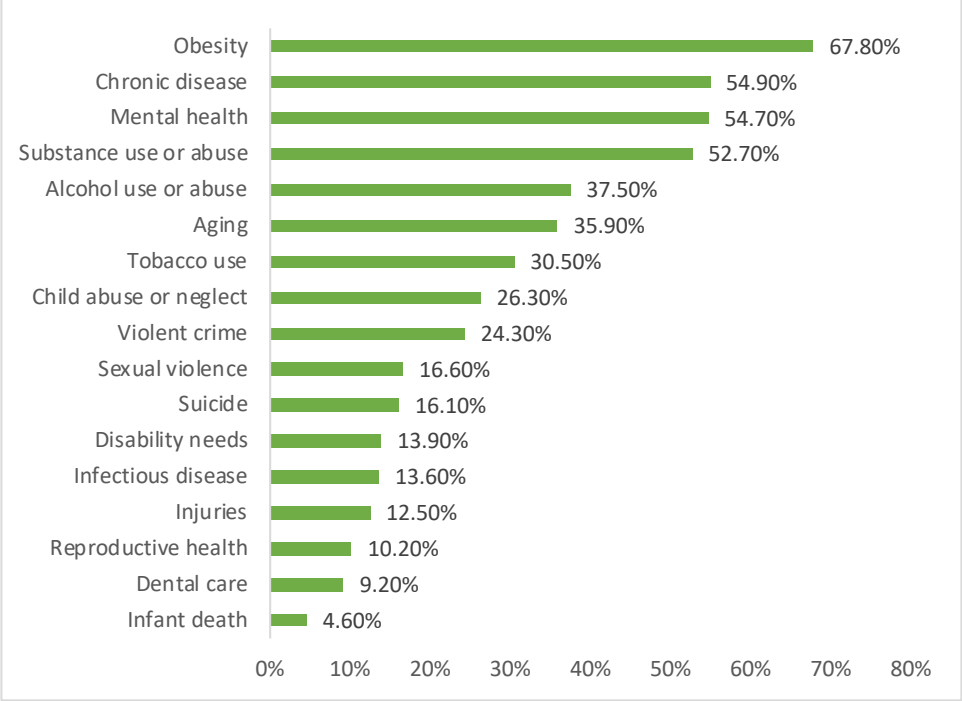
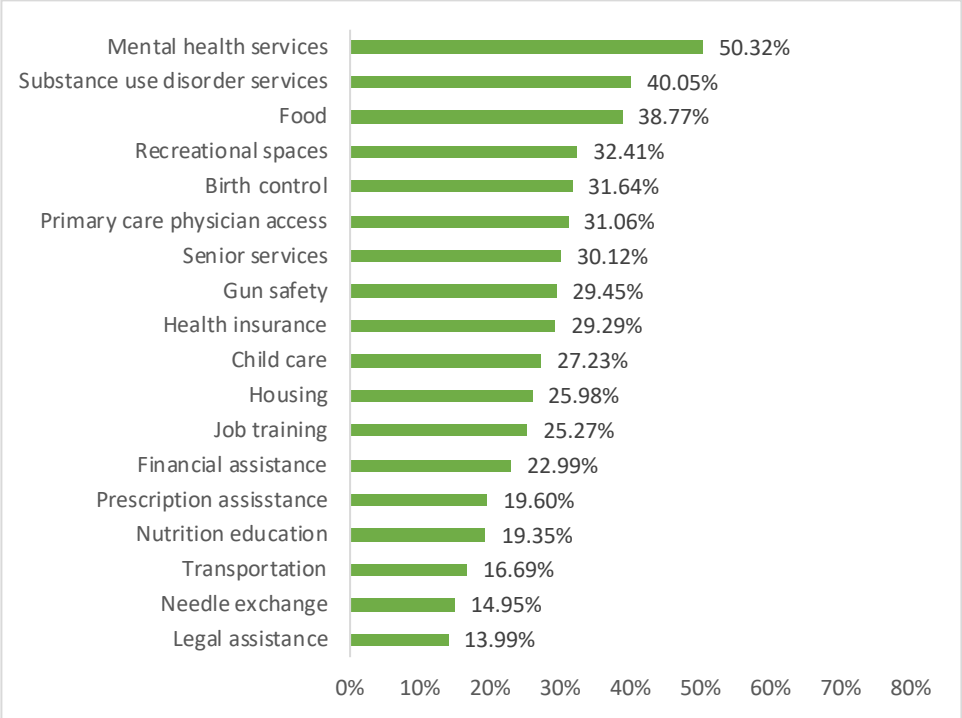


Figure 19. Top Social Service Needs (Community Perceptions)



Community Survey - Special Populations

Hispanic, Amish, and People of Burma (Myanmar) populations have been underrepresented groups in past CHNA surveys. To increase survey response for these populations, surveys were: 1) translated into Spanish and Burmese; and 2) individuals known to these groups recruited participants and distributed surveys. Survey results for these special populations are presented in the 2022 CHNA Parkview Health Systemwide Report.

Provider Survey

An online survey of health and social service providers in the Parkview service area was conducted to assess perceptions of community health concerns and service needs. Providers were invited to participate during a Parkview provider quarterly meeting (February 2022) and via an email with a link to the survey sent to Parkview employed and non-Parkview employed healthcare and community service providers throughout the eight-county service area. The survey used in the previous health needs assessment was updated by adding COVID-19 to the list of infectious diseases. The survey covered aspects of the provider's work including the setting in which they practiced, the duration of time in practice in the region/county, and their perception of the chief public health concerns, barriers to care, and awareness of available resources in their communities. We did not collect the workplace organization name to protect the privacy of the respondents.

A total of 396 providers responded to the survey. Most respondents practiced in Allen County (39.7%), followed by Huntington County (19.2%) (Table 22). Respondents were primarily female (68.9%) and White (91.7%). Providers were asked how long they had practiced in their county in the Parkview Health service area. About one-third (30.6%) of the respondents had been in practice for more than 20 years. This suggests that a good proportion of the responding providers had spent most of their careers in the county they specified, thus were more likely to be aware of the community's needs and concerns. About a quarter (24.5%) of providers were relatively new, with one to five years of practice in this region.

Overall, the most frequent provider type was physician (23.2%) and the most frequent work setting was outpatient clinic (primary care: 19.9%; specialized care: 18.9%) (Table 23).

Table 22. Provider Survey Respondents Demographics by County and Overall (percentage)

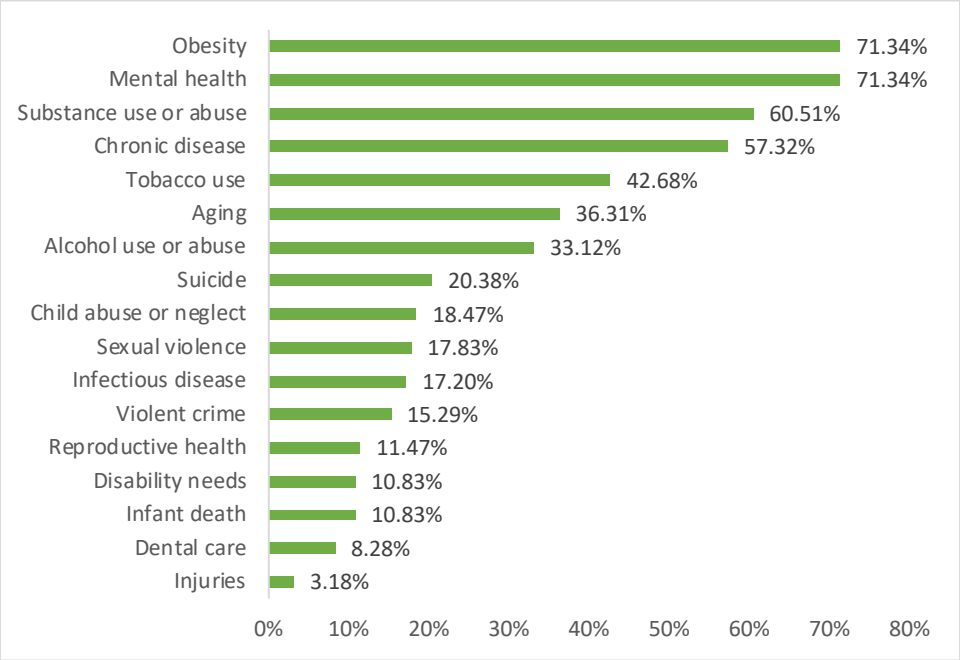
Characteristic	Allen (n=157)	DeKalb (n=16)	Huntington (n=76)	Kosciusko (n=17)	LaGrange (n=36)	Noble (n=41)	Wabash (n=16)	Whitley (n=32)	All (n=396)
Female	65.6	56.3	68.4	70.6	75.0	73.2	75.0	75.0	68.9
Male	31.8	43.8	30.3	29.4	22.2	22.0	25.0	25.0	29.0
Decline	2.5	0.0	1.3	0.0	2.8	4.9	0.0	0.0	2.0
White	84.7	100.0	94.7	100.0	97.2	95.1	100.0	100.0	91.7
Black	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5
Asian	4.5	0.0	2.6	0.0	0.0	0.0	0.0	0.0	2.5
Other	0.6	0.0	0.0	0.0	2.8	4.9	0.0	0.0	0.3
Decline	5.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0
Hispanic	0.0	0.0	2.6	0.0	0.0	0.0	0.0	6.3	1.0
Years in Practice									
< 1 year	5.1	12.5	7.9	5.9	2.8	7.3	12.5	0.0	6.3
1-5 years	30.6	18.8	14.5	5.9	38.9	19.5	31.3	21.9	24.5
6-10 years	19.1	18.8	13.2	23.5	25.0	9.8	12.5	6.3	16.2
11-15 years	5.7	12.5	17.1	17.6	11.1	19.5	12.5	21.9	12.1
16-20 years	6.4	25.0	15.8	0.0	5.6	7.3	12.5	6.3	9.1
> 20 years	33.1	12.5	28.9	47.1	16.7	34.1	18.8	43.8	30.6
Not Answered	0.0	0.0	2.6	0.0	0.0	2.4	0.0	0.0	1.3

Table 23. Provider Survey Respondents Type and Work Setting by County and Overall (percentage)

Type/Setting	Allen (n=157)	DeKalb (n=16)	Huntington (n=76)	Kosciusko (n=17)	LaGrange (n=36)	Noble (n=41)	Wabash (n=16)	Whitley (n=32)	All (n=396)
Provider Type									
Physician	38.9	31.3	13.2	5.9	2.8	4.9	12.5	25.0	23.2
Physician's Assistant	3.8	0.0	0.0	0.0	0.0	0.0	0.0	3.1	1.8
Nurse Practitioner	28.0	18.8	5.3	0.0	0.0	7.3	25.0	6.3	15.4
Registered Nurse	1.9	6.3	11.8	5.9	22.2	14.6	18.8	9.4	8.6
Mental/Behavioral Health	8.3	12.5	6.6	5.9	41.7	12.2	0.0	3.1	10.6
Other Health Care	3.8	0.0	19.7	5.9	0.0	9.8	6.3	3.1	7.3
Community/Social Services	5.1	18.8	15.8	29.4	5.6	24.4	18.8	25.0	12.9
Public Health/ Community Health	1.9	0.0	3.9	23.5	2.8	0.0	12.5	12.5	4.3
Social Work/Case Management	7.0	6.3	7.9	23.5	16.7	0.0	6.3	6.3	7.8
Public Sector	0.6	6.3	7.9	0.0	2.8	22.0	0.0	3.1	4.8
Education	0.0	0.0	5.3	0.0	2.8	2.4	0.0	3.1	1.8
Not Answered	0.6	0.0	2.6	0.0	2.8	2.4	0.0	0.0	1.5
Setting									
Outpatient - Primary Care Clinic	22.9	37.5	17.1	5.9	0.0	7.3	43.8	34.4	19.9
Outpatient - Specialized Care	35.7	6.3	9.2	5.9	8.3	9.8	0.0	6.3	18.9
Urgent Care Clinic	3.2	6.3	0.0	0.0	0.0	0.0	0.0	0.0	1.5
Community Health Center	1.3	6.3	5.3	11.8	8.3	7.3	6.3	3.1	4.3
County Health Department	0.6	6.3	1.3	5.9	5.6	2.4	0.0	12.5	2.8
Hospital - Specialized Care	13.4	0.0	9.2	0.0	8.3	9.8	6.3	0.0	9.3
Hospital - Emergency Care	1.3	0.0	3.9	0.0	2.8	4.9	0.0	3.1	2.3
School	1.3	0.0	27.6	17.6	27.8	7.3	25.0	15.6	12.1
In home	4.5	0.0	1.3	5.9	19.4	0.0	0.0	0.0	4.0
Not-for-Profit	8.9	18.8	13.2	41.2	5.6	24.4	18.8	21.9	14.1
Public Sector/Out in the community	0.6	6.3	6.6	5.9	5.6	19.5	0.0	3.1	4.8
Behavioral Health	5.7	12.5	3.9	0.0	8.3	4.9	0.0	0.0	4.8
Not answered	0.6	0.0	1.3	0.0	0.0	2.4	0.0	0.0	1.0

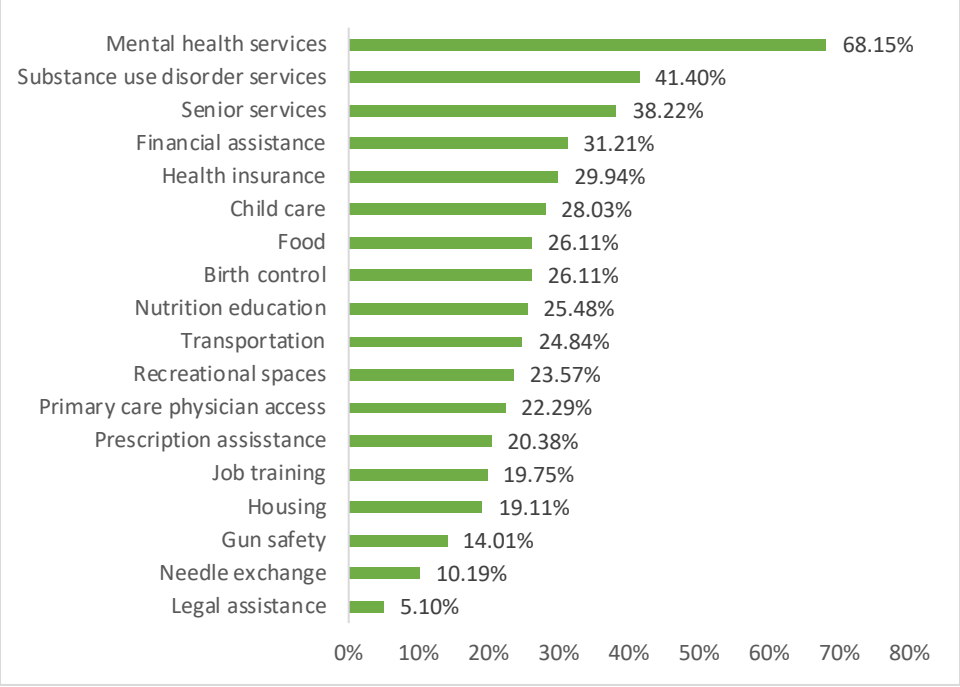
Providers perceived that the top three greatest community health needs were obesity, mental health, and substance use or abuse (Figure 20).

Figure 20. Community Health Issues of Greatest Concern (Provider Perceptions)



The most important service needs identified by providers in Allen County included mental health counseling, substance abuse services, and senior services (Figure 21).

Figure 21. Greatest Social Service Needs (Provider Perceptions)



Data Considerations and Limitations

The HSIR team and Parkview Health employed innovative data collection methods to gather survey data from all counties and vulnerable or under-represented groups. As well, a wide range of existing

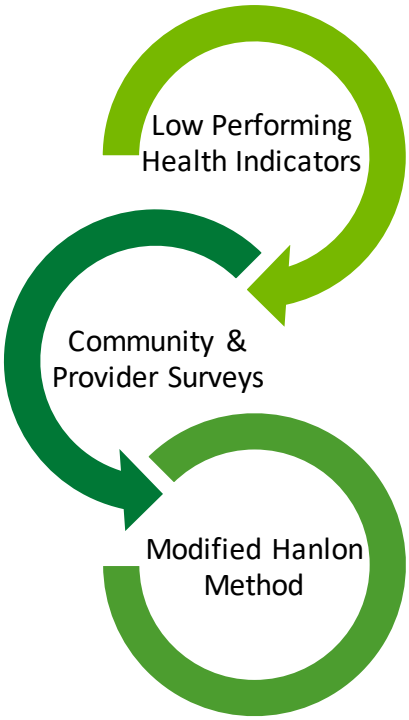
secondary data sources were used. However, several limitations of the data should be considered when interpreting the findings. Although the health concerns and service needs represent a broad set of health-related issues, available secondary data varied in the number of related health indicators. For some health concerns, multiple health indicators have been established, while for other health concerns, the available health indicators were limited in number or relevance. The survey data was collected from a convenience sample as a random-sampling approach was not feasible in this type of project. As a result, the survey data are limited in the extent to which they represent the characteristics of the Parkview Health service area.

PRIORITIZATION OF HEALTH NEEDS

Data Synthesis

To organize and rank order significant health needs across the Parkview Health eight-county region, primary data from community and provider surveys and secondary data were combined using a modified Hanlon score (Figure 22). Each health indicator corresponded to a health concern from the survey, thus health domains from the survey were used to cluster health indicators.

Figure 22. Culmination of Data to Create List of Top Ten Health Priorities



Secondary data: county-level health indicator data in the bottom performing quartile of U.S. counties or significantly worse than Indiana average **(N=47)**

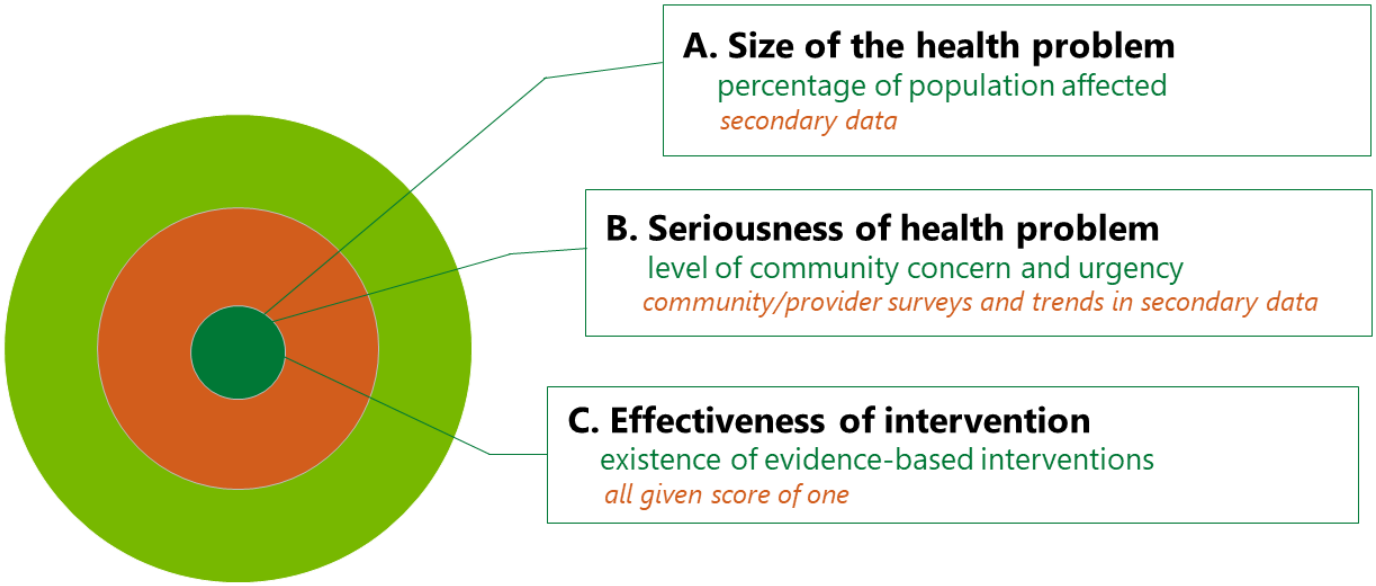
Primary data: survey data from community members **(N=4657)** and providers **(N=396)**

Data Synthesis: Hanlon Calculation

For each health indicator, scores for percentage of the population affected (size), percentage of community respondents endorsing the corresponding health concern (seriousness), percentage of provider respondents endorsing the corresponding health concern (seriousness), trend in health indicator (seriousness), and existence of evidence-based interventions (effectiveness of intervention) were assigned.

Figure 23 displays the separate elements comprising the Hanlon score (Appendix C). Hanlon Priority scores were calculated using the following equation: Priority Score D = [A + (4.167 x B)] x C

Figure 23. Modified Hanlon Method



As shown in Table 24, Hanlon scores ranged from 27.5 to 5.81 for the 31 bottom-performing health indicators, with higher scores indicating a higher priority. According to the Hanlon scores, the top health concerns were mental health, obesity, and chronic disease (see Table 24).

Prioritization Process

A prioritization session was convened on September 21, 2022, with 26 attendees. Attendees included providers, administrators, board members, and community health partners (see Appendix E). Survey data collection methods were explained, and the 10 health concerns with the highest Hanlon scores were presented via slides. Once all 10 health concerns were presented, attendees discussed and amended the categories. Through this process, consensus emerged around the top four priorities. A large-group discussion ensued around these four health issues, and attendees were then asked to vote to rank the four health concerns in terms of their top priorities for Parkview Health. Twenty-three individuals (3 HSIR employees did not vote) participated in the voting.

Attendees used Mentimeter, an anonymous, synchronous polling system, to score each health concern using four criteria (see Appendix D): (1) significance of the health problem (i.e., how many people are affected?); (2) severity of the health problem (i.e., how likely is it to limit length and quality of life?); (3) suitability for a strategic intervention (i.e., can Parkview address the problem?; and (4) SDOH (i.e., do social determinants of health drive health disparities in rates and outcomes?). For each health concern, participants were asked to score each criterion on a scale of 1 (very little) to 10 (very much).

The health concerns obesity and maternal/child health were selected as the top priorities. Mental health was determined to be the single shared priority across Parkview Health at the system-wide prioritization session held in August.

Table 24. Hanlon priority scores by bottom performing Healthcare Indicator

Survey Domain	Health Indicator	Size of Health Problem		Seriousness of Health Problem				Effectiveness of Intervention	Priority Score	Rank
		Size of Problem	Score	Community Concern	Provider Concern	Urgency	Score	Score		
Obesity	Adults with obesity	32.3	9.0	1.5	1.5	2.0	10.8	1	30.67	**1**
Mental health	Adults with depression	22.0	8.0	1.0	1.5	2.0	9.7	1	27.50	**2**
Chronic disease	Adults with COPD	7.8	6.0	1.0	1.0	2.0	8.7	1	23.33	**3**
Chronic disease	Adults with current asthma	9.7	6.0	1.0	1.0	2.0	8.7	1	23.33	**4**
Obesity	Sedentary adults	22.6	8.0	1.5	1.5	0.5	7.6	1	23.17	**5**
Chronic disease	Adults with kidney disease	3.0	5.0	1.0	1.0	2.0	8.7	1	22.33	**6**
Mental health	Frequent mental distress	14.0	7.0	1.0	1.5	1.0	7.6	1	22.17	**7**
Mental health	Poor mental health for 14+ days	14.9	7.0	1.0	1.5	1.0	7.6	1	22.17	**8**
Chronic disease	Adults who experienced stroke	3.4	5.0	1.0	1.0	1.5	7.6	1	20.17	**9**
Substance use	Non-fatal opioid overdose (ED)	0.07	2.0	1.0	1.5	1.5	8.7	1	19.33	**10**
Chronic disease	Adults with cancer	6.8	6.0	1.0	1.0	1.0	6.5	1	19.00	**11**
Alcohol use	Excessive drinking	17.8	8.0	0.5	0.5	1.5	5.4	1	18.83	**12**
Tobacco use	Adults who smoke	19.8	8.0	0.5	1.0	1.0	5.4	1	18.83	**13**
Chronic disease	Adults with diabetes	10.3	7.0	1.0	1.0	0.5	5.4	1	17.83	**14**
Chronic disease	Adults with coronary heart disease	6.5	6.0	1.0	1.0	0.5	5.4	1	16.83	**15**
Child abuse	Child abuse and neglect	1.3	5.0	0.5	0.0	2.0	5.4	1	15.83	**16**
Injuries	Motor vehicle traffic collision death	9.5	6.0	0.0	0.0	2.0	4.3	1	14.67	**17**
Chronic disease	Chronic lower respiratory disease death	0.06	2.0	1.0	1.0	0.5	5.4	1	12.83	**18**
Infectious disease	Chlamydia	0.65	4.0	0.0	0.0	2.0	4.3	1	12.67	**19**
Reproductive	Babies with low birthweight	8.7	6.0	0.0	0.0	1.5	3.2	1	12.50	**20**
Infectious disease	Gonorrhea	0.27	3.0	0.0	0.0	2.0	4.3	1	11.67	**21**
Aging	Alzheimer's disease or dementia	2.2	5.0	0.5	0.5	0.5	3.2	1	11.50	**22**
Aging	Osteoporosis: medicare population	1.1	5.0	0.5	0.5	0.5	3.2	1	11.50	**23**
Disability needs	Frequent physical distress	12.1	7.0	0.0	0.0	1.0	2.2	1	11.33	**24**
Reproductive	Mothers not in early prenatal care	39.6	9.0	0.0	0.0	0.5	1.1	1	11.17	**25**
Infant death	Infant mortality rate	7.5	6.0	0.0	0.0	0.5	1.1	1	8.17	**26**
Reproductive	Preterm births	9.6	6.0	0.0	0.0	0.5	1.1	1	8.17	**27**
Infectious disease	Salmonella infection	0.011	1.0	0.0	0.0	1.5	3.2	1	7.50	**28**
Infectious disease	Hepatitis C	0.05	2.0	0.0	0.0	1.0	2.2	1	6.33	**29**
Reproductive	Mother smoked during pregnancy	8.5	6.0	0.0	0.0	0.0	0.0	1	6.00	**30**
Reproductive	Teen births	2.2	5.0	0.0	0.0	0.0	0.0	1	5.00	**31**

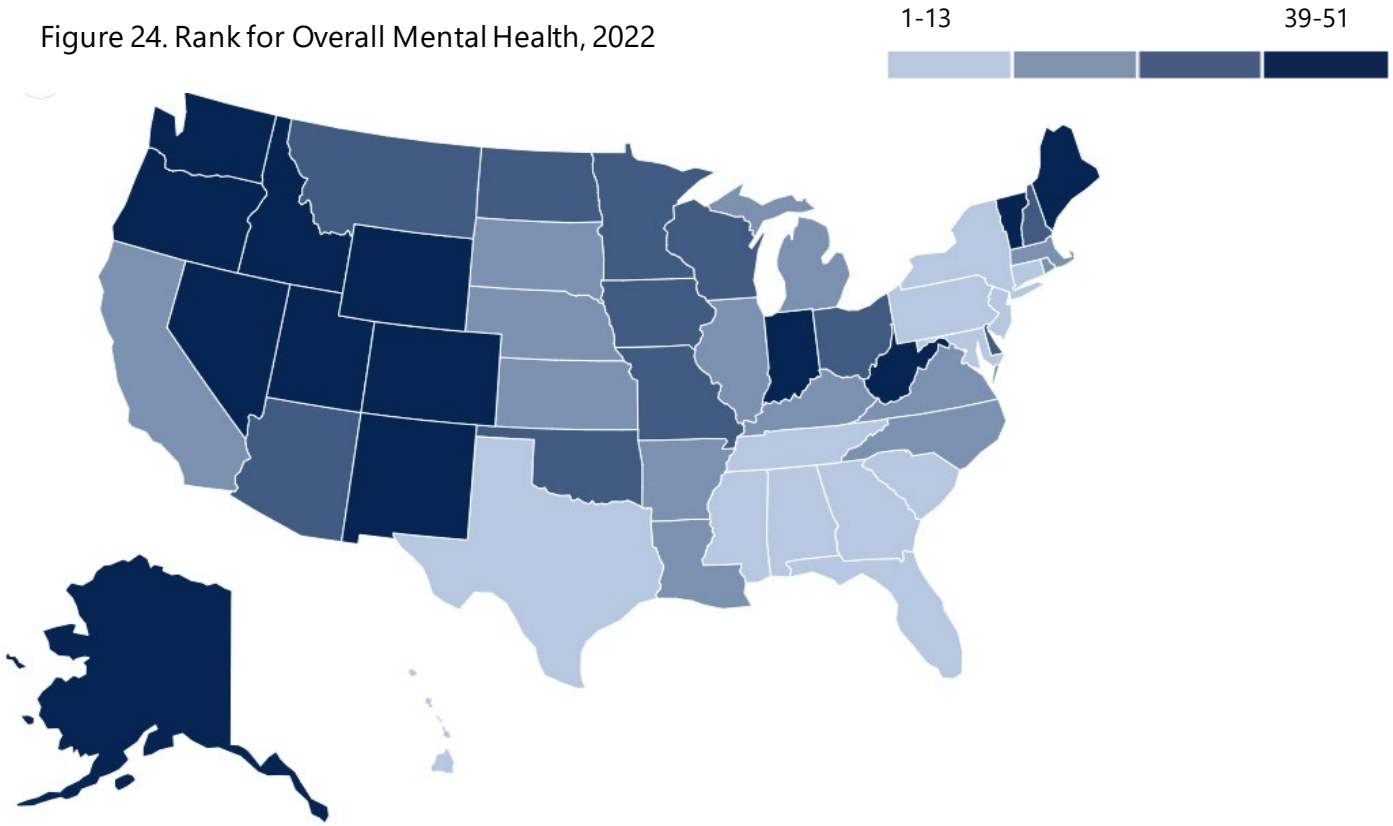
Prioritized Health Needs

This section presents the top 10 health concerns included in the prioritization session. Mental Health was selected as the systemwide shared health priority for Parkview Health for 2022-2025.

Mental Health

Mental health is a critical component to overall physical health and a sense of well-being throughout the lifespan. However, as depicted in Figure 24, Indiana is one of the lowest ranked states across the U.S. In 2022, Indiana was ranked 26th for youth mental health, 43rd for adult mental health, and 42nd for overall mental health. These rankings incorporate measures of both prevalence of mental illness and access to mental health services. The following six conditions were included in defining 'overall' mental illness: (1) adults with any mental illness, (2) adults with substance use disorder in the past year, (3) adults with serious thoughts of suicide, (4) youth with at least one major depressive episode in the past year, (5) youth with substance use disorder in the past year, and (6) youth with severe major depressive episode.

Figure 24. Rank for Overall Mental Health, 2022



Source: Mental Health in America

As shown in Table 25, the number of poor mental health days and percentage of adults experiencing frequent mental distress showed an increasing trend across all eight counties included in the Parkview Health service area. Though the ratio of mental health providers to the population improved from 2017 to 2020 in the Parkview Health service area, five counties were below the Indiana state level, and all eight counties were below the best performing counties in the U.S., which have a ratio of one mental health provider for every 250 people. For three counties, the number of deaths due to suicide increased from 2017 to 2020.

Table 25. Mental Health Indicators and Trends by County

County	Number of poor mental health days [1] Average number in the past 30 days, age adjusted			Population: Mental health providers [2] Ratio of Population: One Provider			Frequent mental distress % Adults reporting 14+ days poor mental health per month			Number of deaths due to suicide Count			Deaths due to suicide Age-adjusted rate per 100,000 population[3]		
	2017	2020	Trend	2017	2020	Trend	2017	2020	Trend	2017	2020	Trend	2017	2020	Trend
Allen	3.9	4.5	^	657:1	546:1	v	11.8	14.0	^	62	44	v	16.3	11.3	v
DeKalb	3.9	4.6	^	1852:1	**1601:1**	v	11.7	13.6	^	5	4	v	.	.	.
Huntington	3.9	4.4	^	1593:1	**1250:1**	v	11.6	13.4	^	6	3	v	.	.	.
Kosciusko	3.8	4.2	^	696:1	606:1	v	11.2	13.0	^	6	12	^	.	**15.1**	^
LaGrange	4.1	4.6	^	3234:1	**2314:1**	v	12.2	13.5	^	5	4	v	.	.	.
Noble	4.0	4.1	^	1224:1	**1080:1**	v	11.8	12.9	^	6	7	^	.	.	.
Wabash	4.0	4.5	^	527:1	417:1	v	11.9	13.8	^	5	3	v	.	.	.
Whitley	3.7	4.4	^	1591:1	**1217:1**	v	10.8	13.0	^	6	7	^	.	.	.
Indiana		**4.7**			**623:1**			**15.0**			**1017**			**14.9**	

Notes: [1]Top performers in U.S.: 4.0 days or less, [2]Top performers in U.S.: 250:1, [3]Rates are only provided for counties with 10 or more reported deaths from suicide. Source: County Health Rankings and Roadmaps and the Indiana State Department of Health

Table Key:

Improving Trend	v or ^
Worsening Trend	v or ^
Stable Trend	–
Data Not Available	.
Worse than State Average	#

Obesity

The medical criterion for obesity is met when body mass index is greater than 30.0. Obesity occurs in all age groups and disproportionately affects people of lower socioeconomic status and minority racial/ethnic groups. Many complications can occur as a direct or indirect result of obesity, such as high blood pressure, asthma, and low self-esteem (CDC Overweight & Obesity, 2022). Table 26 shows the percentage of adults with obesity. Rates of obesity in 2020 increased from 2017 in seven of eight counties in the Parkview Health service area and ranged from a low of 30.3% in DeKalb County to a high of 38.2% in Noble County. These high rates for obesity coincided with decreasing access to locations for physical activity, resulting in 21.8–28.5% of adults being physically inactive across the Parkview service area.

Table 26. Obesity Indicators and Trends by County

County	Adult obesity % Adults (>age 18) with BMI ≥ 30 kg/m^2			Physical inactivity % Adults (>age 18) with no leisure physical activity			Access to exercise opportunities % Population who have access to locations for physical activity		
	2017	2020	Trend	2017	2020	Trend	2017	2020	Trend
Allen	30.1	32.3	^	23.3	22.6	v	81.8	78.2	v
DeKalb	32.8	30.3	v	24.3	21.8	v	69.4	**59.2**	v
Huntington	32.6	**37.4**	^	26.5	**28.5**	^	82.4	76.5	v
Kosciusko	33.2	**34.4**	^	23.2	25.8	^	70.2	**65.4**	v
LaGrange	34.2	**37.0**	^	26.2	25.3	v	32.0	**24.4**	v
Noble	31.8	**38.2**	^	25.8	**28.5**	^	57.8	**63.8**	^
Wabash	31.6	**34.5**	^	34.4	26.2	v	57.2	**68.6**	^
Whitley	32.0	**36.6**	^	26.1	26.3	^	63.3	**58.0**	v
Indiana		**33.4**			**26.7**			**75.2**	

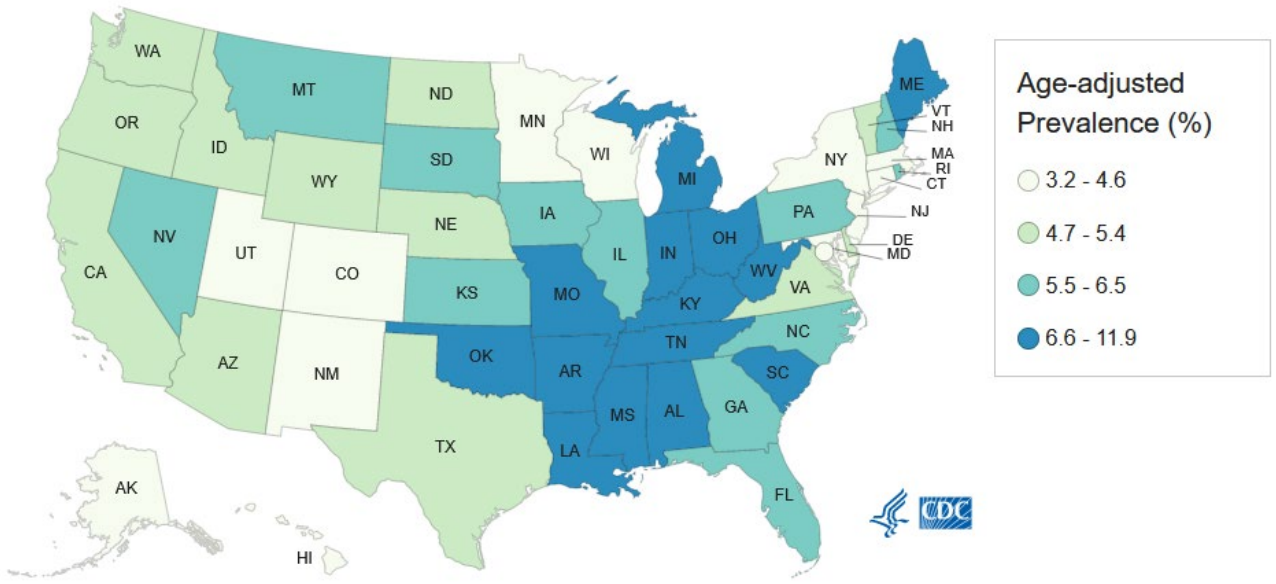
Source: County Health Rankings and Roadmaps

Chronic Disease

The following chronic diseases were scored highly and included in the prioritization session: chronic obstructive pulmonary disease, asthma, chronic kidney disease, cardiovascular disease, and diabetes.

Respiratory diseases, such as chronic obstructive pulmonary disease (COPD) and asthma, affect the lungs and other parts of the respiratory system. **COPD** includes a group of diseases that lead to breathing-related problems. As shown in Figure 25, age-adjusted prevalence of COPD is 6.6–11.9 in Indiana. Smoking is a leading cause of COPD. As shown in Table 27, rates of smoking tobacco increased from 2017 to 2020 in seven of eight counties in the Parkview Health service area.

Figure 25. Prevalence of Chronic Obstructive Pulmonary Disease (COPD) Among Adults ≥ 18 (2020)



Data source: Centers for Disease Control and Prevention

Table 27. COPD Indicators and Trends by County

County	Deaths from chronic lower respiratory disease Age-adjusted rate per 100,000 population			% Adults who are current smokers		
	2017	2020	Trend	2017	2020	Trend
Allen	49.9	52.0	^	17.8	19.8	^
DeKalb	75.4	**66.1**	v	18.8	19.8	^
Huntington	85.7	**80.0**	v	18.0	18.8	^
Kosciusko	58.3	52.2	v	18.3	19.0	^
LaGrange	59.2	41.6	v	19.1	18.9	v
Noble	78.4	**58.5**	v	17.8	18.9	^
Wabash	69.0	**63.5**	v	17.0	18.6	^
Whitley	60.3	56.6	v	16.2	18.5	^
Indiana		**53.7**			**21.8**	

Source: Indiana State Department of Health and County Health Rankings and Roadmaps

Asthma is a chronic, incurable disease which makes breathing difficult due to the inflammation and narrowing of a person's airways. Symptoms include wheezing, coughing and chest tightness (CDC Asthma, 2022a). Though rates for deaths from chronic lower respiratory disease improved in seven of eight counties in the Parkview Health service area, five counties sustained rates above the Indiana state level (see Table 28). Hospitalizations due to asthma showed improvement in four counties, while Emergency Department (ED) visits due to asthma improved in six counties. Unfortunately, trends in air pollution worsened for the entire Parkview Health service area.

Table 28. Asthma Indicators and Trends by county

County	Deaths due to chronic lower respiratory disease Age-adjusted rate per 100,000 population			Hospitalizations due to asthma Age-adjusted rate per 10,000 population			Emergency department visits due to asthma Age-adjusted rate per 10,000 population			Air pollution Average daily density of fine particulate		
	2017	2020	Trend	2017	2019	Trend	2017	2019	Trend	2017	2020	Trend
Allen	49.9	52.0	^	5.8	**5.4**	v	35.7	36.1	^	11.3	**12.6**	^
DeKalb	75.4	**66.1**	v	4.3	3.1	v	19.9	23.7	^	11.0	**12.4**	^
Huntington	85.7	**80.0**	v	4.2	3.6	v	30.6	25.4	v	11.2	**12.3**	^
Kosciusko	58.3	52.2	v	1.7	1.9	^	33.0	24.7	v	11.3	**12.8**	^
LaGrange	59.2	41.6	v	.	1.2	^	26.5	19.8	v	11.1	**12.7**	^
Noble	78.4	**58.5**	v	3.4	3.3	v	27.6	20.0	v	11.1	**12.8**	^
Wabash	69.0	**63.5**	v	3.4	**4.0**	^	27.7	19.3	v	11.2	**12.3**	^
Whitley	60.3	**56.6**	v	1.7	**4.1**	^	27.1	22.4	v	10.9	**11.9**	^
Indiana		**53.7**			**3.6**			**39.3**			**11.8**	

Source: Indiana State Department of Health and County Health Rankings and Roadmaps

Chronic kidney disease develops as kidney function declines significantly over time. The body's ability to filter wastes from blood becomes impaired and, if left untreated, can lead to kidney failure and death. In the early stages, kidney disease can be difficult to detect as physical symptoms are not present. Uncontrolled diabetes and high blood pressure are common causes of chronic kidney disease (*Chronic Kidney Disease Initiative | CDC*, n.d.). Table 29 shows that Huntington County had the highest age-adjusted death rate for kidney disease and the highest rate of chronic kidney disease among the Medicare population compared to the other seven counties.

Table 29. Chronic Kidney Disease Indicators and Trends by County

County	Deaths from kidney disease Age-adjusted rate per 100,000			Chronic kidney disease patients Per 100 Medicare eligible patients		
	2015-2017	2018-2020	Trend	2017	2019	Trend
Allen	21.8	16.2	v	23.8	**25.2**	^
DeKalb	16.6	**18.4**	^	12.7	13.3	^
Huntington	27.6	**22.3**	v	31.5	**36.8**	^
Kosciusko	13.1	**18.3**	^	22.3	22.3	_
LaGrange	.	.	.	11.4	13.9	^
Noble	23.4	15.3	v	24.5	**28.8**	^
Wabash	16.3	.	.	24.8	19.3	v
Whitley	20.6	**18.6**	v	23.4	14.4	v
Indiana		**17.4**			**22.9**	

Source: CDC Underlying Cause of Death database 3-year averages and the CDC Chronic Kidney Disease Surveillance System

Cardiovascular disease affects the heart and blood vessels, potentially leading to heart attacks and strokes when blood is prevented from flowing to the heart or brain. Cardiovascular disease is estimated to be the leading cause of death worldwide. Table 30 shows that the percentage of adults experiencing a stroke from 2018 to 2019 was stable or improved in seven of eight counties in the Parkview Health service area. However, in five of eight counties, the rate of age-adjusted death from stroke increased from 2017 to 2020. Additionally, incidence of hospitalization due to stroke increased in seven counties during this time.

Table 30. Cardiovascular Disease (Stroke) Indicators and Trends by County

County	% Adults who experienced a stroke			Deaths from stroke Age-adjusted rate per 100,000 population			Hospitalizations due to stroke Age-adjusted incidence rate per 10,000 population		
	2018	2019	Trend	2017	2020	Trend	2017	2019	Trend
Allen	3.5	3.4	v	36.5	**42.8**	^	26.5	**26.6**	^
DeKalb	3.5	**3.5**	—	45.6	**45.0**	v	29.6	23.0	v
Huntington	3.6	**3.6**	—	42.6	**56.6**	^	20.8	**29.2**	^
Kosciusko	3.5	3.4	v	38.3	34.4	v	21.6	22.1	^
LaGrange	3.9	**3.9**	—	34.8	**54.2**	^	21.9	**24.5**	^
Noble	3.6	**3.6**	—	46.2	**46.1**	v	22.6	**25.9**	^
Wabash	4.1	**4.1**	—	45.5	**57.7**	^	17.3	**26.6**	^
Whitley	3.5	**3.6**	^	37.9	**45.5**	^	24.5	**29.5**	^
Indiana		**3.4***			**40.4**			**24.4**	

*This is average for the U.S., not Indiana. Source: CDC PLACES Data, CDC Underlying Cause of Death database 3-year averages, and the Indiana Department of Health

Coronary heart disease affects people of all races and genders, often emerges in mid-life, and may result from high cholesterol and blood pressure, adverse outcomes of diabetes, and/or a family history of heart disease (*Coronary Artery Disease* | CDC, 2021). Though the percentage of adults that experienced coronary heart disease improved from 2018 to 2019 in the Parkview Health service area, in all counties the percentage is higher than the Indiana state level (Table 31). Age-adjusted deaths due to coronary heart disease improved from 2017 to 2020 in six of eight counties; and age-adjusted deaths due to heart attack improved from 2017 to 2019 in six of seven counties (LaGrange County did not have available data). Only four of eight counties experienced a reduction in inpatient hospitalizations due to heart disease from 2017 to 2019.

Table 31. Cardiovascular Disease (Coronary Heart Disease) Indicators and Trends by County

County	% Adults who experienced coronary heart disease			Deaths due to coronary heart disease Age-adjusted rate per 100,000			Deaths due to heart attack Age-adjusted rate per 100,000			Hospitalizations due to heart disease Age-adjusted rate per 10,000		
	2018	2019	Trend	2017	2020	Trend	2017	2019	Trend	2017	2019	Trend
Allen	7.2	**6.5**	v	85.1	85.3	^	62.5	57.8	v	90.5	88.4	v
DeKalb	7.5	**6.9**	v	119.4	**97.1**	v	74.3	56.3	v	82.6	86.4	^
Huntington	7.7	**7.2**	v	99.6	95.1	v	63.1	53.8	v	118.5	**109.9**	v
Kosciusko	7.3	**6.8**	v	93.0	87.9	v	76.3	**68.2**	v	86.8	**95.3**	^
LaGrange	8.0	**7.6**	v	92.7	81.2	v	.	60.4	.	77.0	76.8	v
Noble	7.6	**7.0**	v	96.1	**118.8**	^	58.4	58.6	^	89.9	91.2	^
Wabash	8.7	**8.4**	v	120.1	76.1	v	79.0	60.9	v	95.2	**118.1**	^
Whitley	7.5	**7.3**	v	90.6	83.8	v	64.1	57.9	v	92.1	87.1	v
Indiana		**6.2***			**95.8**			**62.5**			**93.0**	

*This is the average for the U.S., not Indiana. Source: CDC PLACES, CDC Underlying Cause of Death database 3-year averages, CDC National Environmental Public Health Tracking Network, and the Indiana Department of Health

Diabetes is a chronic disease in which blood glucose levels are elevated because the body does not produce enough insulin or does not use insulin effectively. Insulin is a hormone that is necessary for the maintenance of normal glucose levels. Chronically high blood sugar can lead to other more serious health complications such as heart disease and vision loss (*What is Diabetes?* | CDC, 2022b). In the United States, diabetes is the seventh leading cause of death and possibly underreported because one in five people who suffers from diabetes is undiagnosed (*Diabetes Quick Facts | Basics | Diabetes | CDC*, 2022). Table 32 shows that Wabash County had the highest age-adjusted death rate from diabetes, and Whitley County had the highest prevalence of diabetes in the Medicare population compared to the other seven Parkview counties.

Table 32. Diabetes Indicators and Trends by County

County	% Diabetes prevalence Adults 20+ years old			Deaths from diabetes Age-adjusted rate per 100,000		
	2017	2020	Trend	2017	2020	Trend
Allen	10.3	**10.4**	^	25.2	**40.3**	^
DeKalb	10.0	7.1	v	28.5	**31.7**	^
Huntington	12.7	**14.1**	^	25.8	**30.5**	^
Kosciusko	10.4	**13.3**	^	31.1	**42.8**	^
LaGrange	11.2	10.3	v	38.5	26.3	v
Noble	11.8	11.3	v	33.2	**41.3**	^
Wabash	13.9	**13.1**	v	33.5	**64.2**	^
Whitley	10.6	**14.5**	^	24.2	24.4	^
Indiana		**11.9**			**29.6**	

Source: County Health Rankings and Roadmaps and the Indiana State Department of Health

Substance Use and Abuse

Substance use and abuse involves illegal drug use, misuse of prescription drugs, alcohol abuse and tobacco use. The possible subsequent dependence on these substances can result in accidental death, unintentional injury, and other immediate and chronic health problems. Substance use disorders are preventable, and treatments are available. Huntington and Noble counties were above the Indiana state incidence rate for non-fatal drug overdose visits to the Emergency Department (Table 33). Allen, Kosciusko, and Wabash counties had increasing numbers of drug overdose deaths between 2017 and 2020. Allen, DeKalb, Kosciusko, and LaGrange counties were above the Indiana state percentage for adults reporting binge/heavy drinking, while Allen, Huntington, Noble, and Wabash counties were above the state percentage for driving deaths with alcohol involvement. Except for LaGrange County, all counties experienced increases in the percent of adults who smoke from 2017 to 2020.

Table 33. Substance Use/Abuse Indicators and Trends by County

County	ED visit non-fatal drug overdose* Incidence rate per 100,000			Drug overdose deaths Crude rate per 100,000			% Adults reporting binge/ heavy drinking			% Driving deaths with alcohol involvement			% Adults who are current smokers		
	2017	2020	Trend	2017	2020	Trend	2017	2020	Trend	2017	2020	Trend	2017	2020	Trend
Allen	214.8	178.8	v	15.5	22.5	^	18.6	**17.8**	v	32.4	**35.3**	^	17.8	19.8	^
DeKalb	224.1	207.0	v	12.6	9.3	v	16.1	**18.4**	^	22.2	17.6	v	18.8	19.8	^
Huntington	333.0	**331.3**	v	17.3	14.7	v	16.6	17.6	^	7.7	**22.2**	^	18.0	18.8	^
Kosciusko	214.0	183.7	v	7.2	18.1	^	17.5	**17.8**	^	31.0	19.4	v	18.3	19.0	^
LaGrange	119.6	93.4	v	.	.	.	16.8	**18.1**	^	27.0	11.1	v	19.1	18.9	v
Noble	229.7	**226.2**	v	.	8.4	.	16.1	17.2	^	12.5	**20.0**	^	17.8	18.9	^
Wabash	308.5	212.9	v	17.6	**26.5**	^	15.7	17.6	^	27.5	**33.3**	^	17.0	18.6	^
Whitley	216.3	156.0	v	.	.	.	17.9	16.6	v	25.0	17.2	v	16.2	18.5	^
Indiana		**220.4**			**25.0**			**17.6**			**19.7**			**21.8**	

*On August 27, 2020, statistics for 2016-2018 were updated to reflect updated guidance from the CDC. Please be cautious when analyzing overdose data as the numbers have changed. Source: County Health Rankings and Roadmaps and the Indiana State Department of Health

Cancer

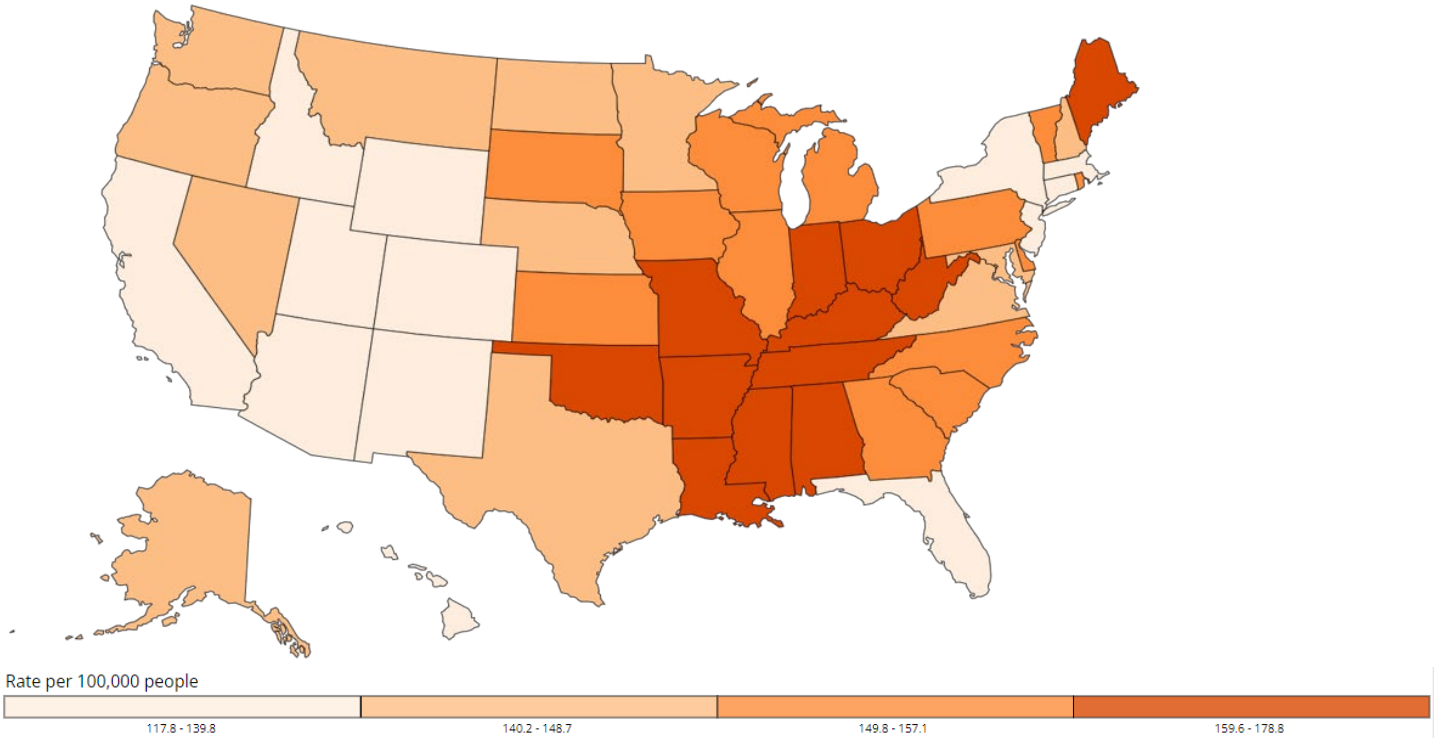
Collectively, cancer is the second leading cause of death in the United States. Table 34 presents the prevalence, incidence, and age-adjusted death rates of cancers by county. Kosciusko and Whitley counties had the highest age-adjusted incidence rate for breast cancer in 2018. Meanwhile, Allen and Wabash counties had the highest age-adjusted incidence rates for prostate cancer in 2018. For seven of eight counties, the age-adjusted incidence rate for lung and bronchus cancer increased from 2017 to 2018. In contrast, only two counties had increasing trends for colorectal cancer age-adjusted incidence rates.

Table 34. Cancer Indicators and Trends by County

County	Breast cancer Age-adjusted incidence rate per 100,000			Colorectal cancer Age-adjusted incidence rate per 100,000			Oral cavity and pharynx cancer Age-adjusted incidence rate per 100,000			Prostate cancer Age-adjusted incidence rate per 100,000			Lung and bronchus cancer Age-adjusted incidence rate per 100,000		
	2017	2018	Trend	2017	2018	Trend	2017	2018	Trend	2017	2018	Trend	2017	2018	Trend
Allen	119.7	122.8	^	38.2	37.9	v	12.1	12.3	^	94.8	**97.7**	^	65.5	65.2	v
DeKalb	104.6	110.7	^	52.2	**49.4**	v	10.2	11.4	^	82.2	77.5	v	75.8	**82.0**	^
Huntington	139.4	122.4	v	47.9	**49.7**	^	9.1	8.4	v	75.9	66.8	v	63.8	66.1	^
Kosciusko	133.7	**137.7**	^	46.7	**45.5**	v	11.6	**13.1**	^	86.6	94.8	^	70.1	**72.0**	^
LaGrange	115.7	117.8	^	35.3	33.7	v	11.1	9.6	v	70.8	71.2	^	50.8	62.7	^
Noble	122.6	121.8	v	38.1	36.0	v	14.2	**13.9**	v	59.8	74.5	^	77.9	**78.5**	^
Wabash	115.4	122.3	^	52.0	**51.1**	v	17.1	**16.1**	v	101.2	**112.6**	^	59.8	62.6	^
Whitley	123.8	**128.4**	^	44.9	**45.1**	^	7.0	6.8	v	59.7	66.1	^	74.3	**79.7**	^
Indiana		**124.5**			**41.7**			**12.8**			**96.5**			**69.9**	

Source: National Cancer Institute 5-year Averages

Figure 26. Rate of Cancer Deaths in the U.S., 2019



Source: Centers for Disease Control and Prevention

As shown in Figure 26, Indiana is one of the U.S. states with the highest death rate from all cancer types. Age-adjusted death rates were highest for lung cancer in 2019 across all counties. Age-adjusted death rates for breast cancer showed improvement in five of eight counties; though, three of these counties had death rates above the Indiana state rate (see Table 35). Colorectal cancer age-adjusted death rates improved in four of eight counties between 2018 and 2019; while age-adjusted death rates due to prostate cancer improved in three of six counties between 2017 and 2019.

Table 35. Age-adjusted Death Rates for Cancer by County

County	Colorectal cancer Age-adjusted death rate per 100,000			Breast cancer Age-adjusted death rate per 100,000			Lung cancer Age-adjusted death rate per 100,000			Prostate cancer Age-adjusted death rate per 100,000		
	2018	2019	Trend	2017	2019	Trend	2017	2019	Trend	2017	2019	Trend
Allen	12.7	12.2	v	23.4	**21.7**	v	43.0	41.0	v	24.9	**25.2**	^
DeKalb	15.5	13.2	v	16.6	14.4	v	54.9	**53.3**	v	.	17.0	.
Huntington	12.7	14.4	^	19.8	**21.3**	^	46.3	**46.9**	^	24.0	**24.9**	^
Kosciusko	15.8	**15.7**	v	24.5	**20.6**	v	48.2	44.5	v	16.1	12.7	v
LaGrange	12.5	14.3	^	24.0	**22.4**	v	44.0	46.3	^	24.4	**22.5**	v
Noble	15.4	14.5	v	20.1	**20.9**	^	51.8	**52.3**	^	27.1	**26.4**	v
Wabash	16.5	**21.4**	^	15.1	15.3	^	46.3	44.8	v	16.8	18.9	^
Whitley	13.6	**15.9**	^	24.1	19.1	v	53.0	**52.2**	v	18.5	.	.
Indiana		**14.9**			**20.4**			**46.7**			**19.4**	

Child Abuse and Neglect

Child abuse and neglect can have lasting effects on an individual's physical and mental health. Abuse and neglect include the following: physical abuse (physical harm such as hitting or kicking); sexual abuse (coercing or forcing a child to participate in sexual acts); emotional abuse (harm to a child's emotional well-being); and neglect (failure to meet a child's physical and emotional needs) (*Fast Facts*, 2022). As shown in Table 36, seven of eight counties showed improved trends for abuse and neglect rates and the percentage of children in need of services between 2017 and 2020. However, abuse and neglect incidence rates in DeKalb, Huntington and Wabash counties remained above rates for Indiana, with DeKalb having the highest rate at 26.2 per 1,000 children.

Table 36. Child Abuse Indicators and Trends by County

County	Abuse and neglect rate Incidence rate per 1,000 children			% Children in need of services Active cases		
	2017	2020	Trend	2017	2020	Trend
Allen	12.9	10.0	v	20.0	**18.7**	v
DeKalb	**32.5**	**26.2**	v	18.8	7.9	v
Huntington	18.2	**19.3**	^	11.8	14.6	^
Kosciusko	6.6	8.7	v	12.7	8.8	v
LaGrange	10.7	8.5	v	9.0	7.1	v
Noble	16.3	12.0	v	**24.9**	12.9	v
Wabash	**27.9**	**21.7**	v	**32.4**	**24.8**	v
Whitley	**25.3**	9.5	v	19.0	10.0	v
Indiana	**23.1**	**17.2**	v	**22.4**	**16.6**	v

Source: Indiana Youth Institute

Other Findings

To explore the extent to which specific demographic groups varied in perceived health concerns, additional figures were constructed to reflect health concerns by age, income, rural/urban environment, and minority group. Survey results for these other findings are presented in the 2022 CHNA Parkview Health Systemwide Report.

Conclusion

This Community Health Needs Assessment (CHNA), conducted at the request of Parkview Health, collected a comprehensive set of healthcare indicators and, community and provider survey data to establish the top 10 significant health needs in Allen County. The Allen County prioritization process identified Obesity and Maternal/Child Health as priorities to address, along with Mental Health, the Parkview Systemwide priority. The findings in this report will be used to select interventions and implement programs to address these priorities.

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APPENDICES

Appendix A – Impact Report

Overview

The findings of the 2019 CHNA guided our decision to adopt three health priorities for our community:

1. Mental Health/Substance Use Disorder
2. Cardiovascular Disease and Diabetes
3. Maternal and Child Health

Over the last three years, Parkview Hospital funded 19 external community partners annually. Community health improvement funding supported both community-based organizations focused on healthcare access and health promotion and provided support to Parkview community outreach programming addressing these health priorities. Parkview Hospital's community health improvement program invested over $8.3 million in these initiatives between 2020 and 2022. In addition, Parkview was awarded over $3 million in grants from SAMHSA and HRSA in support of mental health and substance use disorder program initiatives.

Community Impact

Mental Health/Substance Use Disorder

Peer Recovery Program

The Peer Recovery Program was developed to meet the needs of individuals and families who are dealing with the disease of addiction. The goal of this program was to establish a set of peer recovery coaches who would serve patients in the following three roles:

Mentor - Personal guide and mentor for individuals seeking to achieve or sustain long-term recovery from addiction, regardless of pathway to recovery.

Connector - Connect to instrumental recovery supportive resources, including housing, employment, and other professional and nonprofessional services.

Liaison - Liaison to formal and informal community supports, resources and recovery-supporting activities.

In 2019, the Peer Recovery Program had more than 500 individuals referred to the program and the peer recovery coaches completed 200 face-to-face encounters, 81 of which were linked to treatment, and 175 engaged with peer services. In 2020, the program averaged about 1,000 referrals, 300 (low due to COVID-19) face-to-face encounters, 100 linked to treatment and 391 agreed to peer support services. In 2021, the program had fully expanded to multiple counties and received more than 3,000 referrals from Parkview area hospitals and communities. Of those referrals, 2,375 were drug related, either opiate or stimulant or a combination of both). Although Parkview hospital staff were still adhering

to COVID-19 protocols, there were 805 face-to-face encounters and 177 links to SUD treatment and/or services. So far in 2022 (January through August), there have been 1,800 referrals to peer recovery coaches, of which 1,300 were either opioid and/or stimulant related. In addition, there were 600 face-to-face encounters and 219 links to treatment.

This program experienced significant geographic expansion in these time periods, from a central treatment hub at the Allen county-based Medication-Assisted Treatment (MAT), to spokes in Parkview hospitals in surrounding counties, including rural counties, a mobile response unit (in conjunction with the Fort Wayne Police Department and The Lutheran Foundation), Huntington Drug Courts, and other community organizations that serve individuals in recovery (e.g., residential facilities and workplace support).

Key project outcomes:

- The volume of individuals being referred to our program has highlighted the necessity of programming and treatment for individuals in need. This has allowed us to firmly establish multiple lines of support including Hope and Recovery Team (HART) social workers, mobile response team, Suicide Obviation Support (SOS), maternal specialist, Certified Community Behavioral Health Clinic.
- We have implemented quicker response to linkage to treatment.
- Family members report feeling less isolated than they did in previous years.
- Continued community education has helped lessen stigma to receiving care.
- State and Federal researchers report that our data has been used to drive workforce development.
- State-wide policies are being changed/improved because of Peer Coach "voices" - relating successes and challenges on a monthly basis.
- We have been able to create an interdisciplinary team with key community stakeholders: health care workers, Fort Wayne Police Department, Lutheran Social Services, Inc.
- Individuals struggling with stimulant use are now included within our grant to assist in securing treatment.

SAMHSA SUD/OUD Peer Recovery Coach Program

The overall goal of the SUD/OUD Peer Recovery Coach program was to provide evidence-based Medication Assisted Treatment (MAT) and recovery support to individuals in the communities Parkview serves. We used our resources to help 780 individuals in Year One, 360 in Year Two, and 360 in Year Three (for a total of 1,500 unique clients over the grant period). The goal of the program was to assist individuals in recovery from their opioid addiction and, thereby: (1) decrease fatal and non-fatal opioid overdoses by 20 percent, (2) increase the length of engagement in treatment by 20 percent, and (3) reduce relapse by 20 percent among program participants, as compared to the rates of same in Indiana overall.

After we received our grant, we established a baseline of MAT treatment engagement at our Parkview facilities. We then developed a plan to develop a "hub and spoke" system of nine MAT clinics (one hub and eight spokes) to serve Parkview's entire 16-county service area.

Key project outcomes:

- Hired and put into service eleven coaches and one manager who served individuals in recovery
- Peer recovery coaches connected with over 800 clients per year
- As part of our Substance Abuse and Mental Health Services Administration (SAMHSA) funded grant from 2018-2021 (N=861), we had a multitude of positive outcomes including:
    - Program retention: 69 percent remained engaged for 180 days
    - Abstinence: 75 percent did not relapse at six months
    - Depression: 42 percent reduction at six months
    - Anxiety: 39 percent reduction at six months
- As part of our Indiana Division of Mental Health and Addiction (DMHA) grant from 2020-present (N=612), we have accomplished:
    - Integrating our peer recovery coaches into FWPD (Fort Wayne Police Department) mobile response unit, which responds to overdose calls in our community
    - Achieving better outcomes (in terms of client improvement) than many other funded programs in the state

Suicide Obviation Support and Domestic Violence

In response to the dire need to support individuals at risk for suicide and/or domestic violence, which was exacerbated by the COVID-19 pandemic, the overarching aim of this program was to employ a network of Suicide Obviation and Support navigators (SOS navigators) throughout Parkview Health EDs in Northeastern Indiana. Based on our previous success with integrating a peer support network for opioid use disorder, we embedded four SOS navigators in EDs throughout our service area and connected the SOS navigators to our inpatient psychiatric facility (Parkview Behavioral Health Institute; PBHI), local DV organizations, and emergency shelters. The role of the SOS navigator was one of providing at elbow support and care coordination for patients recently discharged from the ED or PBHI and for those obtaining services through organizations serving victims of DV, thus ensuring continuity of care and wraparound support. This program was funded through a SAMHSA grant.

As shown in Table 1, by December 2020, four SOS navigators were employed and began taking referrals and enrolling clients. As there was a COVID surge in December 2021, several of the SOS navigators were redeployed to other positions within the hospital to meet immediate COVID needs. At that time, the Grant Program Manager and one SOS navigator assumed the work of continued communication with the enrolled clients. Though the number of referrals varied across SOS navigators, they fielded and had first encounters with approximately 20 to 50 new referrals each month during their service period.

Table 1. Total referrals and first and last client enrollment by SOS navigator

Navigator	Total # referrals	Total # enrollees	% Eligible enrollees with 6-month NOMs	% Eligible enrollees with 12-month NOMs	First client enrollment	Last client enrollment
SOS1	129	47	15.9%	0%	12/2020	03/2021
SOS2	377	112	32.7%	22.9%	12/2020	12/2021
SOS3	87	20	30.0%	--	09/2021	12/2021
SOS4	578	107	62.9%	55.8%	12/2020	11/2021
SOS5	169	34	70.0%	--	08/2021	12/2021
SOS6	569	88	63.1%	41.7%	11/2020	12/2021
Average	250	68	47.3%	32.1%		

Note. SOS1 left for medical leave. SOS2, SOS4, SOS5, and SOS6 redeployed to different hospital work in 12/2021 and returned to grant work in 03/2022. SOS3 and SOS5 were hired less than 12 months before the end of the grant period and did have any enrollees eligible for 12-month NOMs.

During the grant, we expected to enroll approximately 350 clients. Notably, we had approximately 1909 referrals to our program for suicidality, domestic violence, or both, and our SOS navigators were successful in making phone or face-to-face contact with 1121 (59%) of these potential clients. Referrals came mostly from emergency departments, inpatient psychiatric care centers, and behavioral health service centers in the multi-county Parkview service area in Northeast Indiana. This high referral rate can be attributed to our strong community connections. During the entire course of the grant, we had fantastic support for the program from acute inpatient care, emergency care and inpatient and outpatient behavioral health services. We also built meaningful connections to primary care providers and community agencies that offered a variety of wraparound services. Ultimately, we enrolled 408 individuals throughout the course of the grant period. Client outcomes are shown in Table 2.

Table 2. Change in National Outcome Measures over Grant Period

Measure	Number of Consumers	Baseline Interview	6-month Interview
Functioning in everyday life	176	22.20%	55.10%
Experiencing serious psychological distress (Past 30d)	176	69.90%	33.00%
Using illegal substances (Past 30d)	175	43.40%	29.10%
Binge drinking (Past 30 days)	174	32.80%	12.60%
Experienced physical violence (Past 30d)	172	19.80%	5.80%
Retained in the Community	176	9.10%	77.30%
Hospitalized for Mental Health Care (Past 30d)	176	83.00%	13.60%
Utilized an emergency room for behavioral health issues (Past 30d)	176	93.80%	17.60%
Socially connected	175	52.60%	71.40%

Note: ns vary as the NOMs allows individuals to skip questions.

Homeless Outreach Programming

The Parkview Community Nursing homeless outreach team seeks to help the homeless in our community navigate and obtain services in the health care system. The team works with local shelters to improve access and coordinate for their residents/clients. The overall goal is to connect homeless individuals to a medical home and mental health providers, insurance, and to assure residents have medications in order improve their overall health and minimize Emergency Room visits. The team spends many hours navigating the homeless to mental health services as this this need continues to rise sharply within all the shelters.

The homeless outreach team has been working with Parkview Behavioral Health and Alliance Health, a Federally Qualified Health Clinic (FQHC), to better serve clients experiencing mental health issues and crises after discharge and between visits through assistance with medication adjustments, prescriptions, and prn counseling.

Key project outcomes during COVID-19 pandemic:

- Two registered nurses were enlisted to serve the Rescue Mission, Salvation Army, Charis House, Courtyard, Vincent Village, and St. Joe Mission House:
    - Promoted safety during COVID-19 by following Centers for Disease Control and Prevention (CDC) guidelines.
    - Promoted COVID-19 screening by working with the Allen County Board of Health to lock down shelters.
    - Over 1,000 COVID-19 tests were administered during 2021 at shelters in collaboration with the Fort Wayne/Allen County Department of Health to alleviate influx to walk-in clinics and Emergency Rooms. Testing continued in 2022.
    - Staffed to assist unsheltered men and women in northeast Indiana.
    - Moved Rescue Mission to new building during the pandemic safely.
- Region 3 COVID-19 Quarantine Shelter:
    - April 2020: Community partners identified the need for a safe location to shelter unhoused adults with COVID-19, symptoms of COVID-19, or required isolation due to exposure.
    - Parkview Community Nursing supported this program and was integral to getting it opened in May 2020.
    - Parkview clinical professionals (Dr. Joshua Kline, Dr. Sarah Giaquinta, Chris Howell, BSN, RN, HN-BC) wrote clinical policies and protocols.
    - PPE's and medical supplies were provided by Parkview including blood pressure cuffs, glucometer, thermometer, pulse oximeter, over-the-counter medications, etc.
    - Eight community nurses logged a total 1,164 hours at the shelter (at no cost to the program).
    - Community nurses provided 870 hours of 24/7 on-call coverage from April to July 3, 2020 (at no cost to program).
    - In 2021, community nurses staffed the Rescue Mission's Emergency Overnight Community Shelter for a total of 768 hours. The Rescue Mission never closed its door during 2021.

The outcomes in terms of number of individuals served by the program by different organizations are displayed in the tables and figure below.

Table 3. Service Provision Project Outcomes: Rescue Mission

Rescue Mission	2019	2020	2021	2022*
Total Number Served (Individuals)	5,836	11,774 (710)	7,160 (653)	2,296 (327)
Number referred to Medical Home	152	267	393	208
Proportion with Health Insurance	83%	92%	98%	99%
Number of ER visits	169	129	235	114
Medication Boxes Set Up	N/A	530	1,199	N/A
Pharmacy Runs	421	106	275	211
Navigated to mental health services	N/A	96	153	72

**Note:* Data for 2022 includes 1/1/22 through 5/1/22.

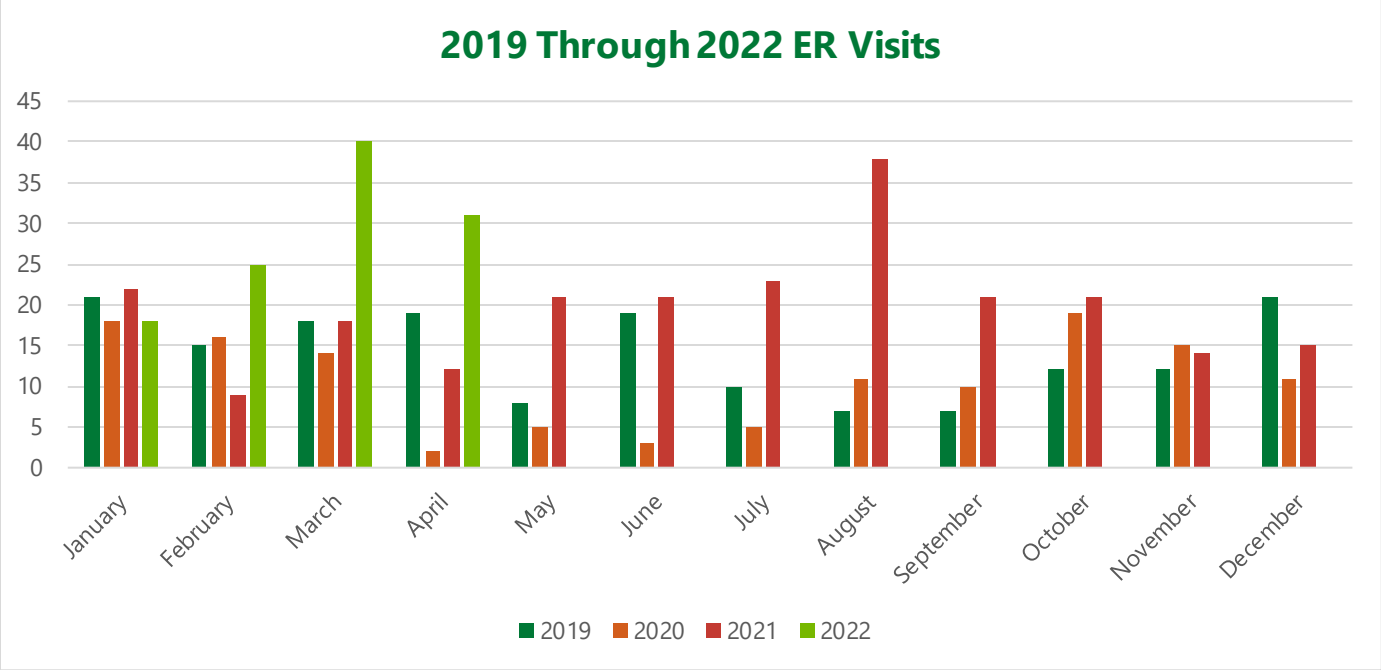

Figure 1. ER visits by month 2019-2022

Table 4. Service Provision Project Outcomes: Salvation Army

Salvation Army	2019	2020	2021	2022*
Total Numbers Served	569	449 (168)	379 (163)	120 (56)

**Note:* Data for 2022 only includes 1/1/22 to 5/1/22.

Classes Taught: Staff taught Freedom from Smoking® classes and Narcan Training (staff)
Duties during Pandemic: Testing and consulting by phone during lockdown

Table 5: Service Provision Project Outcomes: Charis House

Charis House	2019	2020	2021	2022*
Total Number Served	1047	337 (77)	433 (97)	114 (42)

**Note:* Data for 2022 only includes 1/1/22 to 5/1/22.

Classes Taught: Freedom from Smoking®, Heart Saver®, First Aid and CPR, and Health Education
Duties during Pandemic: Isolation and testing help along with trouble shooting health issues during periods of lock down

Table 6. Service Provision Project Outcomes: Vincent Village

Vincent Village	2019	2020	2021	2022*
Total Number Served	261	14 (14)	35 (23)	16 (15)

**Note:* Data for 2022 only includes 1/1/22 to 5/1/22.

Duties during Pandemic: Isolation and testing help along with trouble shooting health issues during periods of lock down

Table 7. Service Provision Project Outcomes: St. Joseph's Mission

St Joseph's Mission	2019	2020	2021	2022*
Total Number Served	N/A	N/A	31 (19)	49 (33)

**Note:* Data for 2022 only includes 1/1/22 to 5/1/22. This was a new partnership in 2021.

Table 8. Service Provision Project Outcomes: Gateway Woods

Gateway Woods	2019	2020	2021	2022*
Total Number Served	46 TB	50 TB 6 Consults/Resources Provided	26 TB 5 Consults/Resources Provided	42 TB

**Note:* Data for 2022 only includes 1/1/22 to 5/1/22.

Classes Taught: TB testing completed.
Duties during Pandemic: Served as a resource to help troubleshoot as needed.

Table 9. Service Provision Project Outcomes: QPR Suicide Prevention Gatekeeper Program Trainings

QPR Training	2019	2020	2021	2022*
Total Numbers Served	375	0	0	13

**Note:* Data for 2022 only includes 1/1/22 to 5/1/22.

Cardiovascular Disease/Diabetes

Diabetes Education Program

The purpose of the diabetes education program is to slow the progression of and reduce the long-term complications associated with diabetes for vulnerable populations. The goals of this program are to improve nutrition, increase physical activity, and decrease A1C levels in diabetics and pre-diabetics.

Duties during the pandemic: Our referrals for prediabetes/diabetes education were and are currently being sent to the Diabetes Treatment Center due to the COVID-19 pandemic. Classes are free so all

clients can attend, many of whom could not participate in the past due to lack of insurance coverage or inability to pay class fees.

Tables 10 shows the outcomes for programming.

Table 10. Outcomes for Programming

Diabetes/Fitness/A1C Pilot Programming	2019	2020
CN Diabetes Healthy Lifestyle Education Classes		
Number Classes Taught	8 (2-week sessions)	Cancelled - COVID
Number Served	30	0
Pre/Post Test Improvement Response	Yes- 91%	0
A1C Pilot with Health is Wealth Group		
Number served in pilot	N/A	16
Number of A1C above Normal at start of program	N/A	12
Percentage of People Served with improved A1C at end of program	N/A	Not completed COVID

**Note:* data for 1/1/2021 through 5/1/2022 not available due to COVID-19.

Community Cardiovascular and Diabetes Screening Fairs

The purpose of the Community Nursing Cardiovascular and Diabetes Screening Program is to provide free labs to screen for cardiovascular disease and diabetes, educate participants on healthy living practices, and connect clients with a "medical home" and community resources as needed. This Allen County-based program targets those that are underserved, unattached (without a medical home) or uninsured. These free screening events take place intermittently through the year and are held at community-based agencies, churches, and at local events serving vulnerable populations. The goals of this program are to identify risk factors, diagnose chronic disease, and prevent poor health outcomes such as heart attacks, strokes, and diabetes-related complications.

Table 11. Health Fairs

Health Fairs	2019	2020	2021
Number of Health Fairs Completed	2	1-MLK	1-NH
Number Served	54	44	17
Total participants with elevated blood pressures		31	0
Total participants with elevated blood glucose		30	6
Total participants with elevated cholesterol		8	8
Total participants with onsite consultations		44	17
Total participants who verbalized understanding of their results & health recommendations		44	17
Total participants who reported positive life-style changes	54	17	N/A
Total participants who reported F/U with primary healthcare provided	N/A	N/A	N/A

Note: Data for 1/1/2022 through 5/1/2022 was not available due to COVID-19.

Healthy Eating Active Living

The Healthy Eating, Active Living Community Health Initiative (HEAL) is a program that promotes healthy living practices through education and healthy food access for vulnerable Allen county residents. HEAL is co-sponsored by Parkview Health and the St. Joseph Community Health Foundation. Community education, outreach, and access are accomplished through the following two initiatives under HEAL: HEAL Farm Markets and Our HEALing Kitchen.

The primary objective of the HEAL Farm Market initiative is to increase sustainable access to, and regular intake of healthy, local produce. HEAL Farm Markets operate in designated food deserts in Fort Wayne, and all markets accept Veggie RX vouches and offer incentives to purchase produce by doubling the value of Supplemental Nutrition Assistance Program (SNAP) benefits, Women, Infants, and Children (WIC) vouchers, and Senior Farmers Market Nutrition vouchers. Since 2020, markets have been managed by HealthVisions, a local non-profit dedicated to addressing disparities and promoting health equity in Fort Wayne.

Key project outcomes:

- Markets have extended their selling season from 8 to 16 weeks at both the Southside and Parkview locations
- Hardy's market has been added to the list of HEAL markets, which allows participants to use and double their SNAP, WIC, and Senior Vouchers after the McCormick Place market closes for the season.
- HEAL Farm Markets continue to be the second largest WIC redemption sites in Indiana.
- Spanish and Burmese interpreters are now available at each market.
- Overall, there have been 11,284 farm market transactions as part of the initiative.

The outcomes in terms of market performance and match funding are summarized in the table below.

Table 12. HEAL Market Statistics

	2019	2020	2021
Number- of markets held	-	39	41
Sales	$51,000	$40,848	$42,055
Redemption – WIC vouchers and match	-	$18,944	$15,192

Our Healing Kitchen (OHK), the other initiative that is part of HEAL, is based on a 'garden to table' curriculum that teaches participants food preparation skills and the importance of healthy food/produce consumption. This train-the-trainer based program has actually seen growth post-COVID, and many of the OHK grantees continue this work even after the program is completed. with well-being engagements after OHK is over, as they have formed a strong bond with their classes.

Key project outcomes:

- Increased fruit and vegetable consumption by participants.
- Promotes confidence and empowers participants to lead healthier lives.
- Reduction in chronic disease risk factors including lower blood pressure, lower blood sugar, and weight loss.

The outcomes in terms of OHK total number of community partners and participants are summarized in the table below:

Table 13. Our Healing Kitchen Statistics

Our healing kitchen	2019	2020	2021	2022
Number of community partners	30	6	14	Anticipating 20
Number of participants	400	60	500	600

The Saint Joseph Community Health Foundation was recently awarded the Indiana State Department of Health SNAP-Ed grant of $25,000 to expand OHK into 12 Fort Wayne Community School's Middle Schools. Parkview Registered Dietitians are currently working on a new youth-specific OHK curriculum.

Veggie RX

In 2019, the Parkview Community Well-Being team piloted a new program called Veggie RX, a nutrition prescription program providing produce vouchers to local individuals who are food insecure or are low-income with chronic disease. Veggie Rx participants receive produce vouchers each month for the duration of the program that can be redeemed at HEAL Farm Markets and other select farm markets around the city. Additionally, as a part of this program, participants are required to attend education sessions led by registered dieticians where they are taught the health impacts of produce consumption and how to make the most of the monthly vouchers. Over the last three years, this program has grown significantly, both in terms of total participants but also in scope of populations served.

Key project outcomes:

- This program has served individuals with prediabetes, diabetes, cardiovascular disease and vulnerable pregnant women in Allen County.
- Participants reported improvements in blood pressure, general health, fruit and vegetable consumption, quality of eating habits, food choices, and increased comfort in cooking and using fresh produce.
- Over the next three years, this program is projected to offer these same benefits to 850 individuals in Allen County.

The outcomes in terms of Veggie RX total participants and behavior changes are summarized in the tables below:

Table 14. Veggie Rx Participants

	2019	2020	2021	2022
Number enrolled	-	49	122	174
Number of participants who completed program	30	32	109	-

Note: - No data available.

Table 15. Veggie Rx Program Outcomes

Outcomes	2019	2020	2021
At least 50% increase in fruit consumption during program	48%	63%	50%
At least 50% increase in vegetable consumption during program	70%	75%	49%
At least 30% increase in nutrition knowledge of fruit consumption	-	50%	49 %
At least 30% increase in nutrition knowledge of vegetable consumption	22%	88%	68%
Obtain at least 50% participant retention over 3 months	-	64%	89%

Note: - No data available.

Simple Solutions

Simple Solutions is a home-based, healthy living program that has been supported by Parkview community health improvement funding since 2016. In partnership with community agencies, education is provided to young, low-income families in their home. The curriculum offers information on nutrition/feeding in the critical early years of life, as well as overall healthy habit guidance for young vulnerable families. The overarching goal of Simple Solutions is to provide participants with the knowledge and tools they need to feed their families in a healthy way and prevent overweight and obesity in children 0 – 5 years of age.

Key project outcomes:

- Home visitors observed participants making the connection between what they feed themselves and their families and their children's health, growth, and behavior.
- The COVID-19 pandemic reduced the total number of participants served due to this being an in-home program.
- Data showed a reduction in use of electronic devices at mealtime and more families planning ahead for meals and snacks.
- Testimonials showed that participants are more confident in creating balanced meals using more fruits and vegetables as a result of this program.

The outcomes in terms of behavior changes resulting from Simple Solutions are summarized in the table below:

Table 16. Simple Solutions Program Outcomes

Measure	2020	2021	Objective
Percentage of families improved in eating together as a family	50%	44%	At least 50% of families will improve in eating together as a family
Percentage of families improved with children getting 60 minutes of physical activity each day	6%	47%	At least 25% of families with improve overall reduction in screen time and increase active play.
Percentage of families improved with children getting less than 2 hours of screen time daily	45%	27%	At least 25% of families with improve overall reduction in screen time and increase active play.

Community Greenhouse and Learning Kitchen

The Parkview Community Greenhouse and Learning Kitchen was built in response to the high rates of diet-related chronic disease in Allen County. This beautiful structure, located within a food desert in Fort Wayne, offers skill building learning labs (nutrition and gardening); youth well-being food and garden education; weekly HEAL Farm Markets and facilitator trainings, and collaborative cooking demonstrations with Parkview chefs, fitness instructors, and dietitians. All programming is offered to the community at no cost. The target population for Greenhouse and Learning Kitchen classes are those vulnerable adults and children living in the surrounding 46805 zip code. Efforts have also been made to prioritize residents living in food deserts within the 46803, 46806, and 46802 zip codes.

Key project outcomes:

- From January 2019 through September 2022, 5,798 pounds of fresh, local produce grown at the greenhouse has been provided/donated to at-risk populations and to the learning and skill building labs. Produce from the greenhouse offers alternatives to energy dense and nutrient poor convenience foods and provokes interest and creativity related to growing and using fresh, whole foods.
- Advancement of the local food system is in progress and the greenhouse project is becoming known as an architype for the possibilities within the local food movement as it relates to health and well-being.
- Grants have been awarded to provide opportunities for children ages 0 to 17 years to experience nutrition and gardening education and to participate in the planting of the Children's Garden (ages 3 to 5 years), to prepare their own foods with fresh ingredients, and to taste a variety of new fresh foods.
- The greenhouse project team collaborated with the Indiana Farmer's Union and food systems' advocates in 2020 at the Day at the Statehouse with the goal of influencing local representatives to support community initiatives such as the Parkview Community Greenhouse and Learning Kitchen.

- In-person learning and skill building labs had to be paused due to COVID-19 but the team is now reengaging community members through classes, programs, and tours as well as gaining the community's direct feedback regarding what they want to experience at the Greenhouse & Learning Kitchen.
- Farm Friends Club began in June 2022. Our goals for the program were for kids to have fun, create a space where they and their families feel welcome and free to express ideas and try new things while they increase their knowledge and awareness of how to grow food at home and within the community. A total of 17 kids participated in this program over the summer with repeat attendance of eight. During class sessions, 100 percent of the kids stated that they had fun at all the classes, 94 percent shared that they learned something new, 92 percent stated they will use these skills at home, 73 percent stated they tried a new food item, and 57 percent stated that they made a friend by the end of the summer. At the end of the season, kids stated that they practiced 'making healthy snacks', 'knife safety', and 'hydroponics' at home.
- Outcomes related to the Parkview Community Greenhouse and Learning Kitchen classes are as follows: thirty-nine percent of participants enjoyed every recipe prepared and tasted, 10 percent of participants enjoyed 75 percent to 80 percent of the recipes, and 43 percent of participants enjoyed at least 20 percent to 60 percent of the recipes. One participant noted that class content was "down to earth and easy to understand." The same participant indicated they had never tried kale before and that they really enjoyed it and planned to make the recipe at home. In another class, a 13-year-old participant shared that her grandmother insisted she attend. On her survey she stated, "I didn't think that it would be very fun, and it turned out to be very fun and fundamental."
- Partnerships with Early Childhood Alliance, Healthy Eating Active Living, and the Rescue Mission have provided pathways to broaden our impact by spreading our message to those who are not able to attend skill building labs. The local WIC office has also been present at the HEAL farm markets to distribute produce vouchers; another avenue to assist the underserved within the community. This provides an opportunity to show the value of nutrition education offered within the local WIC clinic, in schools, and in our skill building labs. Other participants are referred by other Parkview departments as well as Our HEALing Kitchen classes. The HEAL farm market at the Greenhouse & Learning Kitchen operated during the height of the COVID-19 pandemic in the summer of 2020, as well as the summer of 2021 following CDC COVID-19 safety guidelines.
- Nutrition philosophies in the Greenhouse Project have been consistent with those of Lifestyle Medicine, which deals with research, prevention and treatment of disorders caused by lifestyle factors. The practices are inclusive of a variety of lifestyle-based options offered by Parkview. We have also had the opportunity to expand our team since 2019 with a focus on sharing growing and gardening expertise to our community members. Education centers around offering diverse methods of growing techniques that fit the needs of those we serve, regardless of their prior experience with growing and gardening and their available growing space.

FitKids360

FitKids360 is an eight-week, family-based, healthy living program for children ages 5 to17 years with a body mass index (BMI) in the 85th percentile or higher. This program provides children and their families with information to help them become and stay healthy and active. FitKids360 was designed to decrease the medical cost of obesity in northeast Indiana and increase community awareness of the problem of childhood obesity. Initially, the program accepted referrals from Parkview Physicians Group specialty clinics (e.g., Sleep Medicine, Gastroenterology, and the Weight Management Clinic) with plans to introduce the program in a staged approach to additional providers. In addition to the clinics listed previously, FitKids360 now accepts Neighborhood Health Clinic, regional PPG Pediatric and Primary Care Offices, Fort Wayne Pediatrics, and local schools.

Key project outcomes:

- Since the adoption of the FitKids360 program in 2019, there have been over 150 children referred by regional providers, school nurses, and self-referrals with most of these children having a BMI in the 99th percentile or above.
- Despite not reaching every goal identified in the tables below, the program made significant strides in reducing screen time and increasing the amount of vigorous activity among participants.
- FitKids360 has shown an average retention rate of over 85 percent during the last three years.

The outcomes in terms of behavior changes resulting from FitKids360 are summarized in the tables below:

Table 17. FitKids360 Program Outcomes

Year	Retention Rate[1]	Rate of Referred Participants Who Decreased Screen Time[2]	Rate of Referred Participants Who Increased Moderate to Vigorous Activity[3] (Goal 50%)
Fall 2019	100%	33.3%	66.7%
Fall 2020	75%	25%	100%
2021	81.25%	66.7%	60%

1. Outcome Goal: 70 percent retention rate
2. Outcome Goal: 50 percent of referred participants decrease screen time
3. Outcome Goal: 50 percent of referred participants increase their moderate to vigorous physical activity

Table 18. FitKids360 Program Outcomes

Year	Rate of Referred Participants Who Increased Fruit & Vegetable Consumption[1]	Rate of Referred Participants Who Showed No Change or Decreased Body Fat Percentage[2]	Rate of Referred Participants Who Increased FNPA Score by at Least 20%.[3]
Fall 2019	33.3%	66.7%	66.7%
Fall 2020	66.7%	33.3%	100%
2021	46.7%	53.3%	6.67%

1. Outcome Goal: 50 percent of referred participants increase their fruit and vegetable consumption
2. Outcome Goal: 50 percent of referred participants show no change or decrease their body fat percentage
3. Outcome Goal: 50 percent of referred participants have at least a 20 percent increase in Family Nutrition and Physical Activity (FNPA) Score between pre and post

Taking Root

Taking Root is a school-based, healthy living program aimed at reducing the impact of childhood obesity in local elementary schools. This program combines well-being education with structured challenges over the course of the school year. One to three adults from each participating school serve as wellness champions. They are trained by Parkview's Community Well-Being team to lead school challenges. At the end of the program, a committee reviews data collected from participating schools and awards cash prizes to the top performing schools that can be put toward wellness initiatives.

Although data was limited over the last three school years due to the restrictions with COVID, there continued to be a high need for this program and the education it provided. For the 2021-22 school year, Taking Root was able to safely get back up-and-running in its entirety, leading into over half of the district's elementary schools engaging in the program.

The outcomes in terms of Taking Root participating schools and student biometric changes are summarized in the tables below.

Table 19: Taking Root Program Outcomes

School Year	Average VO2 Change[1]	Average BMI Change[2]	Number of Participating Schools
2019-20 (school closed)	-	-	17
2020-21 (school closed)	-	-	10
2021-22	0.26	0.34	16

1. Outcome Goal: Increase average VO2 change by 1.25 mL/kg/min / all students
2. Outcome Goal: Increase average BMI (Body Mass Index) by 0.75 kg/m2 / all students

Maternal & Child Health

Car Seat Safety Program

According to Safe Kids Worldwide, road injuries are the leading cause of preventable deaths and injuries to children in the United States. They report that, when used correctly, child safety seats can reduce

the risk of death by as much as 71 percent. Unfortunately, more than half of all car seats are not used or installed correctly.

To address this problem, Parkview's Women's & Children's Community Health Workers receive education to become certified as Child Passenger Safety (CPS) Technicians. They provide detailed education on vehicle safety to infant caregivers as well as perform in-car safety checks. In 2020, we began providing families with an infant safety seat if they couldn't afford one with the goal of reducing vehicular death and injury of infants in Allen County. The COVID-19 pandemic created some barriers with when launching this program, but there has been significant growth observed since. Our goal, objective, and program outcomes are displayed below.

Goal: Reduce vehicular death and injury of infants in Allen County.

Objective: Increase parental knowledge and skills related to car seat safety among 100 percent of program participants.

Table 20: Car Seat Safety Program Outcomes

	2019*	2020	2021	2022^
# Car seats distributed	0	43	109	84
# Caregivers correctly installing car Seat	n/a	43 (100%)	109 (100%)	84 (100%)
# Caregivers describing confidence level as either "confident" or "very confident" after initial education	n/a	39 (90.7%)	103 (94.5%)	82 (97.6%)
# Caregivers responding to f/u call	n/a	35	97	72
# Caregivers describing confidence level as either "confident" or "very confident" at follow up	n/a	34 (97.1%)	95 (98.0%)	71 (98.6%)
# Education sessions on car seat safety (may not include in-car safety check, may include duplicate caregivers)	69	470	712	359

Note: *Includes data from Quarter three and Quarter four ^Includes data from Quarter one and Quarter two.

Fetal Infant Mortality Review

The Allen County Fetal Infant Mortality Review (FIMR) team is a multidisciplinary group of professionals that reviews de-identified individual cases of fetal and infant death. After reviewing many cases, the team identifies trends that are supportive to families as well as opportunities for improvement. The team then makes recommendations to the community and implements projects based on these findings. Our goal, objectives, and program outcomes are shown below.

Goal: Decrease 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.

Table 21: Fetal Infant Mortality Program Outcomes

	2019*	2020	2021	2022^
# Fetal cases reviewed	7	17	23	8
# Infant cases reviewed	8	17	14	9
# Total cases reviewed	15	34	37	17
# Interviews offered	15	34	37	17
# Interviews conducted	8	20	11	4

Note: *Includes data from Quarter three and Quarter four ^Includes data from Quarter one and Quarter two.

Keys trends identified and recommendations:

- Unaddressed mental health issues were found to be a root cause of why women were not engaged in a plan of care. We need to increase mental health screening using reliable screening tools and make referrals to support services. As a community, we need to destigmatize mental health issues, especially among communities of color.
- Unmet social needs, such as unreliable transportation, lack of stable housing, and food insecurity, contribute to poor pregnancy outcomes. We need to universally screen pregnant people for social needs and then make connections to community resources to address them.
- Women often do not recognize decreased fetal movement or, if they do recognize it, they neither recognize that it is a problem nor act on it. Sometimes a delay in action was the result of the woman not understanding that help could be sought outside of clinic hours. We need to increase awareness of fetal movement and empower women to seek help when they recognize it is decreased.
- Women are not taking medications as prescribed, often because they can't afford it or don't fully understand why it is important. This has also been a cause of "near miss" maternal mortality.
- Unsupported grief and lack of grief and bereavement support can lead to poor outcomes in subsequent pregnancies. The community needs to increase grief support to families experiencing a fetal or infant loss.
- Healthcare and social services providers have opportunities to improve their cultural competence. Utilizing medical interpreters and diverse support staffs improve patient experiences and outcomes.

Community projects that have addressed trends identified:

- Prenatal Infant Care (PIC) Network educational and networking quarterly meetings gather around 70-80 individuals who work with pregnant women and babies. FIMR trends are used to help guide the topics presented which have included mental health support, motivational interviewing, safe sleep, housing, bereavement, domestic violence, and parenting, among others.

- Both health systems in Allen County have implemented a Bereavement Coordinator position to support families experiencing a fetal or infant death and support includes bedside support as well as one-on-one and group support post-discharge. The FIMR team has worked with McMillen Health to develop materials for families who have experience the death of one twin and are parenting the other, which is a special kind of grief, historically not addressed well.
- Parkview Physician Group OB/GYN in Allen County has implemented a nurse navigation program within the clinic responsible for screening all pregnant women for social and educational needs. When needs are identified, they are referred to appropriate community resources. These nurse navigators are screening approximately 3,000 pregnant women annually.

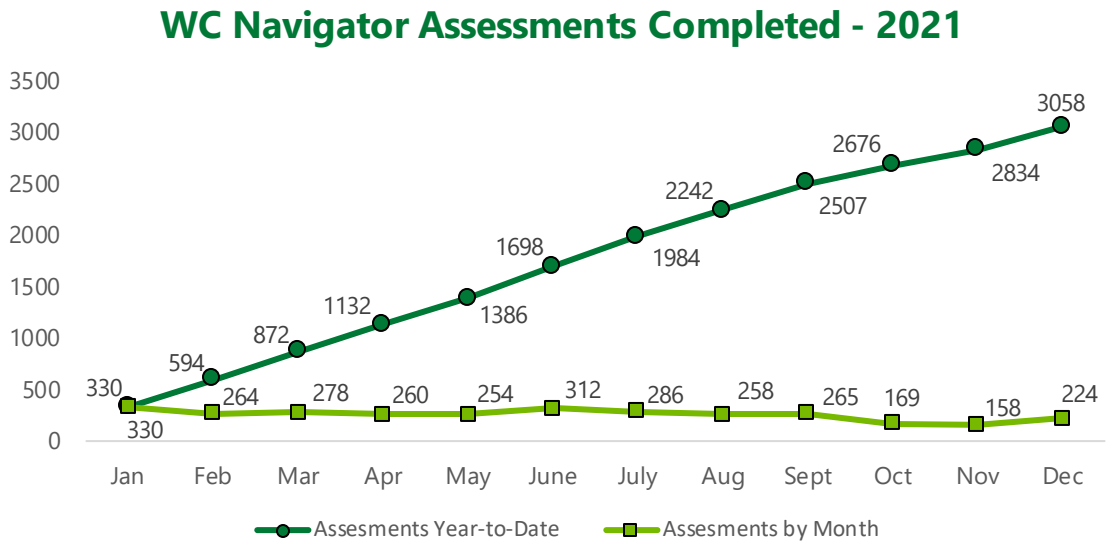

Figure 2. Nurse Navigator Statistics by Month

Transportation Barriers

Early and regular prenatal care is critical to good pregnancy outcomes. Unfortunately, not all women readily access this service. Lack of transportation and uncertainty in how to obtain insurance coverage are two factors that can make it difficult for women to attend visits. Immigrants and refugees face additional barriers, often including language barriers and unfamiliarity of the availability and importance of care. Parkview's Women's & Children's Community Health Workers (CHWs) screen for transportation reliability and address barriers when they are present so that women can attend prenatal and postpartum appointments. Women can then carry this knowledge and access to resources to extend to pediatric visits for their children.

In early 2020, the CHW team distributed questionnaires to assess the voice of the customer and inform service line leaders on patient's experiences, barriers, and desires related to transportation. Participants were women who are currently pregnant or have given birth within the last two years and have been served by a CHW. All were Allen County residents. To be served by a CHW, participants would have already demonstrated a social need or barrier and therefore this survey is not representative of the overall patient population. The informal, voluntary survey was administered b. They were available to

assist in reading, translating, and answer questions about the survey. The survey was broken down along primary language spoken as a pseudo-proxy for culture.

Goal: Decrease rates of preterm births.

Objective: Decrease the number of "no show" prenatal, postpartum, and pediatric physician visits for program participants.

Key program takeaways:

- While transportation was the leading barrier overall at 75 percent, Burmese-speaking participants were more likely (86%) to rate language as a barrier.
- While 76 percent of overall participants have Medicaid coverage, only 17 percent of Spanish-speaking participants were covered through Medicaid. This is important because Medicaid taxi would not be available for these individuals.
- Sixty-five percent of respondents had been late to an appointment due to a transportation barrier out of their control.
- Twenty-four percent had arrived so late for an appointment that the provider was unable to see them.
- Car rides were the most preferred mode of transportation at 93 percent.
- One hundred percent of respondents who had utilized Medicaid taxi had experienced problems with this service (e.g., not showing up for pickups).

CHWs assess for transportation barriers and then provide clients with resources to assist them. Examples of support include teaching them how to request Medicaid taxi transportation and assistance in accessing Uber Health when this service was available.

Table 22: Transportation Barriers Screens Completed

	2019*	2020	2021	2022^
Transportation screens completed	618	2,658	1,024	343

Note: *Includes data from quarters three and four ^Includes data from quarters one and two.

Food Insecurity

Food insecurity negatively affects pregnancy outcomes as well as both the physical and emotional health of the mother. Food insecurity impacts the management of diabetes and can lead to unhealthy weight changes. The release of stress hormones has been linked to preterm birth. The need to assess for food insecurity and mitigate its effects is key to healthy pregnancy outcomes.

All pregnant women who receive prenatal care from PPG OB/GYN Allen County providers are screened for food insecurity near the beginning of their pregnancy by a Nurse Navigator. Sometimes, a referral to a community resource, such as WIC, is sufficient to meet their needs. If this is not sufficient, women are referred to a community health worker (CHW) who can provide more intensive support. Through

home visiting, CHWs develop relationships with the women they serve. When possible, women are matched with a CHW who has a deeper understanding of their culture and preferences and may even speak their language. Through this relationship-building process, they are better able to understand families' needs.

CHWs offer a variety of services to support families who are food insecure. They connect them with food resources in the community, such as WIC, SNAP, food pantries, and special seasonal programs in the community. They help them fill out paperwork and gather documents needed for eligibility. They assist women in navigating bus routes to attend farmers' markets. They can even act as proxies at local food banks if a mother is home with a fragile infant or lacks transportation. Our goal, objective, and screenings are shown below.

Goal: Improve the health of pregnant women and infants in Allen County.

Objective: Reduce the rate of food insecurity.

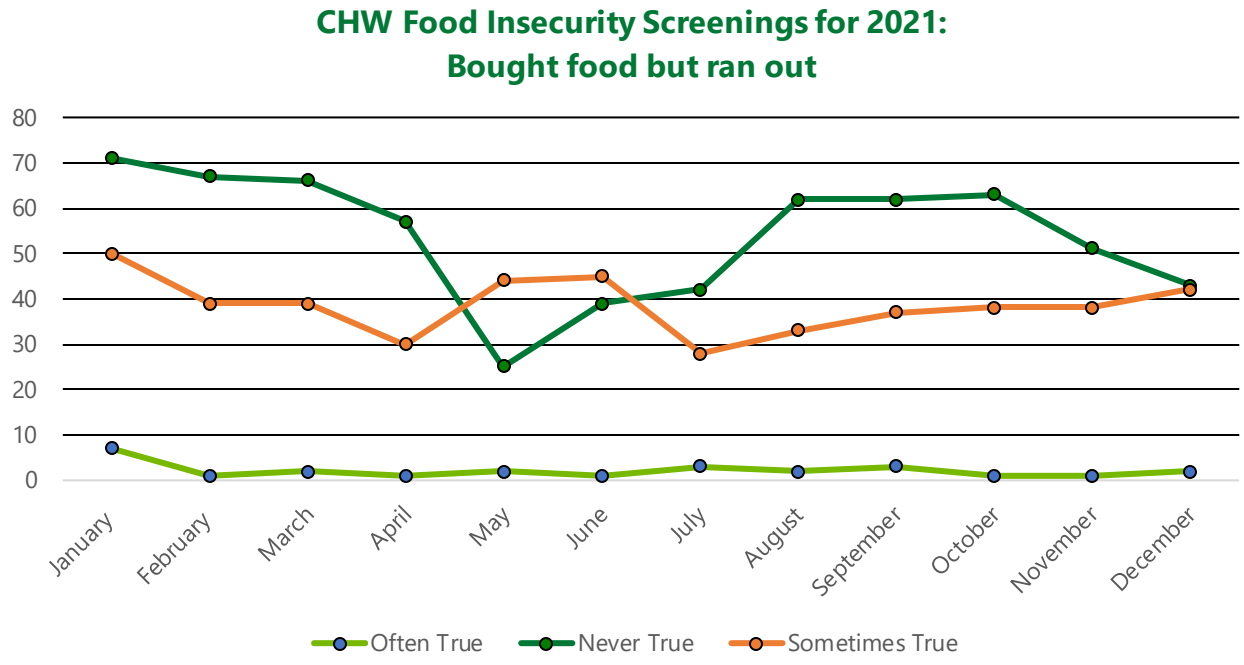

Figure 3. CHW Food Insecurity Screenings for 2021

Safe Sleep Program

The Safe Sleep Program is an education and crib distribution initiative open to any family in Allen County in need of a safe place to sleep for their baby. This program has been supported by Parkview Health since 2009, when unsafe sleep practices contributed to 13 infant deaths in Allen County. Participants receive valuable information on safe sleep practices, infant mortality risk factors, and community resources for pregnant women and new mothers. Those who qualify receive a portable Pack 'n Play™ crib to ensure baby has a safe place to sleep during every nap and at nighttime. Since development and implementation of the program, there has been an overall decrease in the number of infant deaths

due to unsafe sleep. In 2018, there were four for Allen County and in 2019 there were three. Unfortunately, in 2020, there were seven deaths reported for Allen County.

In 2020 and 2021, the community nursing team adapted the program so it could be continued safely during the COVID-19 pandemic. However, even with these changes, we served fewer clients during this period.

Duties during pandemic:

- Conducted educational classes via telephone or virtually
- Some in-person classes were offered, dependent upon guidelines from the CDC.
- One-on-one Pack 'n Play deliveries were provided on front porches initially, then to A Babies Closet and Southeast Center for Healthy Living

Table 23: Safe Sleep Programming Outcomes

Safe Sleep Programming	2019	2020	2021	2022**
Total Number of Classes Taught*	-	127	50	36
Total Number Participants Completed Safe Sleep Education	320	259	173	123
Total Number of Pack 'n Plays™ Distributed	210	220	147	109
Total Number of Safe Sleep Sacks Distributed	210	220	147	123
Total Number of Referrals for EPDS 10 or greater	-	43	23	16
% Of participants able to assemble/disassemble Pack 'n Play™ at delivery (Goal 100%)	-	100%	100%	100%
% Of respondents self-reporting at two-week follow-up call state placing infant on back to sleep (Goal 75%)	-	99% (81/82)	99% (68/69)	100% (28/28)
% Of respondents self-reporting at six-month follow-up call state utilizing PNP (Goal 75%)	-	77% (48/62)	75% (36/48)	-
% Of respondents Self-reporting at 6 Month Follow-up Call state placing infant on back to sleep with nothing in the crib. (Goal 75%) Choices: Always and Almost Always	-	Always 52% (32/62) Almost Always 17% (11/62)	Always 63% (30/48) Almost Always 13% (6/48)	-

Note: * End of October, November, and December 2021. About 50 families were referred from Parkview community nursing and received their Safe Sleep Education and Pack 'n Play™ from SCAN's Healthy Families as they had a grant which still had funds that needed to be used by December 31, 2021. ** From 1/1/2022 through 6/17/2022 - No Record or Not Available

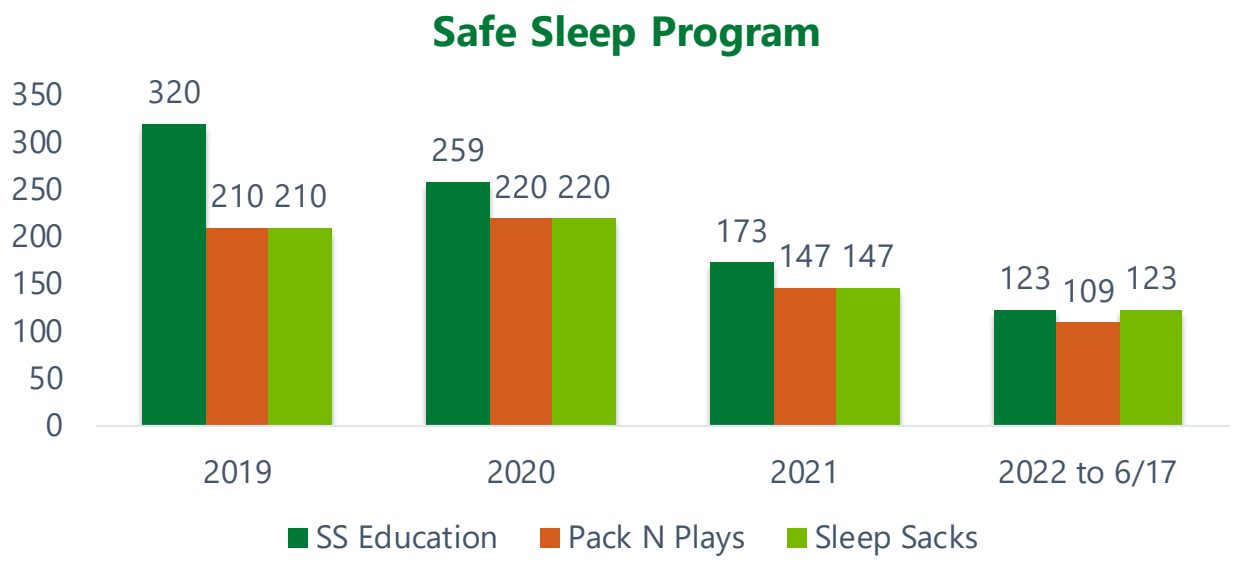

Figure 4. Safe Sleep Program Outcomes

Breastfeeding Support/Lactation Consults

Breastfeeding supports the health of infants by lowering risk of infectious disease, strengthening the immune system, and decreasing risk of sudden infant death syndrome (SIDs). Unfortunately, data shows a disparity in the rates of breastfeeding between White and African American/Black mothers. The goal of this community outreach program is to increase initiation and duration of breastfeeding among African American and low-income mothers living in south central/southeast Fort Wayne zip codes (e.g., 46803, 46805, 46806, 46807 and 46816). This program focuses on providing assistance and education to vulnerable mothers through support groups in the target zip codes listed previously. Prior to the pandemic, community nurses and lactation specialists led four to eight sessions per month. Sessions included information on the many benefits of breastfeeding, safe and effective ways to breastfeed their infants, and served as a safe space for new mothers to meet and share the joys and challenges of breastfeeding and motherhood. Support group participants are also connected to community resources as needed.

More recently the in-person support groups have been transitioned to four virtual sessions per month due to the COVID-19 pandemic. The virtual support groups have been held through a private Facebook group weekly since March 2020. Additionally, clients can receive individual breastfeeding support in-person whenever needed. These sessions may take place in a client's home or at a community location. More recently the community nursing team has returned to A Baby's Closet on a weekly basis to allow mothers to be seen for breastfeeding questions and weigh their infant. In-person options will become available again for group sessions when it has been approved and considered safe for clients and their children.

In conjunction with our produce distribution/food insecurity initiative during the pandemic, our lactation consultants identified many food insecure breastfeeding. As a result, community nursing partnered with community dieticians to bring weekly boxes of produce and other food items to their

homes. Food boxes were paired with cooking videos to help families learn how to prepare healthy meals. Cooking videos were made available through the breastfeeding support Facebook page.

Outcomes in terms of social media cooking video activity (visible numbers, not included numbers from shared posts):

- Number of views - 3,642
- Reactions from social media - 494 reactions
- Comments from social media - 221 comments
- Shares from social media - 73 shares

Table 24: Breastfeeding Support Programming Outcomes

Breastfeeding Support Programming	2019	2020	2021	2022*
Total Numbers Served	559	482	280	95
Total Number of BF Encounters	698	566	345	139
Total Number of BF Phone Call Consults	113	66	52	19
Total Number of Home Visits for BF Support	26	18	13	25
Total Number of Referrals for High Score on Edinburgh PP Depression	6	4	8	2
Total Number of Referrals for Identified SDOH	-	-	-	4
# of Moms BF After 3 Months Post-Delivery	49	-	-	2020-22
# of Moms BF After 6 Months Post-Delivery	28	-	-	2020-22
# of Moms BF After 12 Months Post-Delivery	10	-	-	2020-22
% of the pregnant moms attending groups educated on importance of breastfeeding for their baby and themselves by self-report (Goal 100%)	100%	100%	100%	100%
% of the pregnant mothers attending groups educated on the benefits of breastfeeding, mechanics of breastfeeding, support with problems, and how to access this support system. (Goal 100%)	100%	100%	100%	100%

Note: * 1/1/2022 through 3/30/2022 - No Record or Not Available.

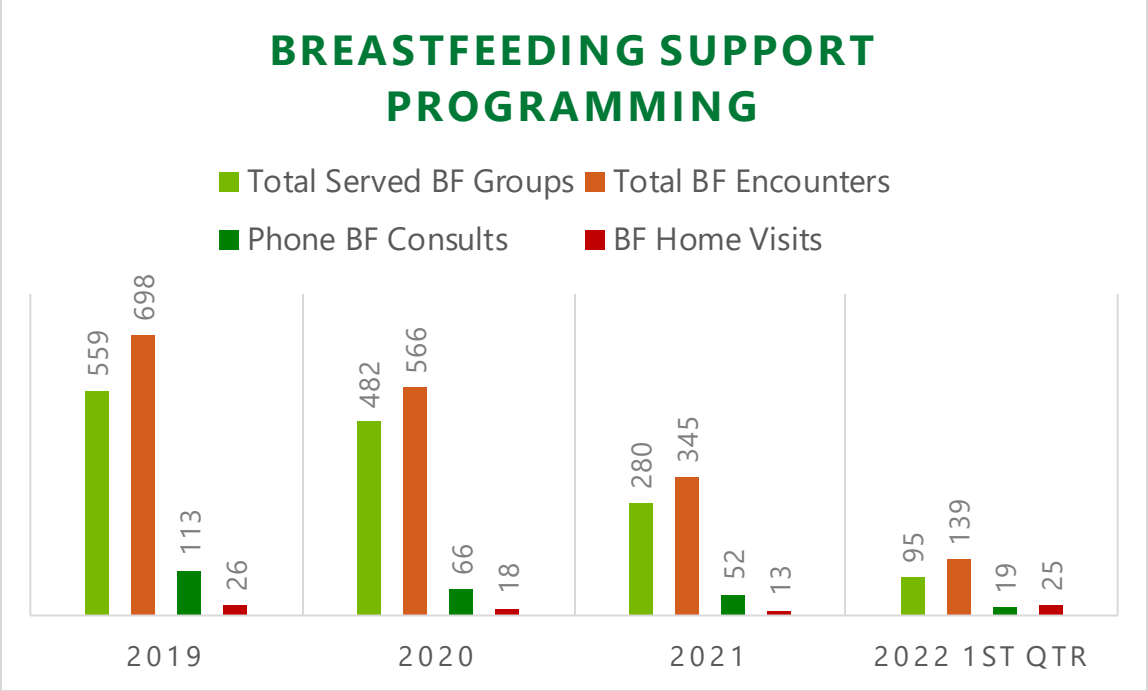

Figure 5. Breastfeeding Support Program Outcomes

Conclusion

Across PVH since 2019, we have implemented and maintained numerous initiatives to address Parkview Health's top three priorities. Though they broadly address the issues of mental health/substance use, cardiovascular disease and diabetes, and maternal and child health, the majority of these programs prioritized serving vulnerable and underserved populations This work has allowed Parkview co-workers and teams to engage and provide outreach to community members with limited access to traditional health care services or educational programming.

Many of our initiatives are grant funded by local, state, and federal grants, and we continually seek new opportunities to support the health and wellness of individuals in our 16-county service area. This funding allows us to extend our reach and develop new initiatives that complement the traditional health care services provided by Parkview.

Overall, our patient and client outcomes have been extremely favorable, even with the many challenges resulting from the COVID-19 pandemic. The impact of Parkview's community health investments and outreach programs have been far reaching, and we plan to continue to build upon this work in upcoming years.

Appendix B - Community and Provider Surveys

Invitation to take the Parkview Community Health Needs Survey

Dear Community Member,

We need your help! We all know the importance of a strong community and strong community services. Parkview Health is working to identify community health needs so we can provide better services.

Your Answers Count! Your responses are completely confidential. We do not ask for your name anywhere on the survey. You must be 18 years of age or older to take this survey. The questions will take only about 5-10 minutes of your time.

If you have any questions or need any help with the survey, please call U.S. at 260-266-7765.

You can also take the survey online: https://www.research.net/r/CHNA6E or

Thank you for helping U.S. build a stronger community!

Sincerely,

Sarah GiaQuinta, MD

Sarah GiaQuinta, MD, MPH
Vice President of Community Health
Parkview Health

Parkview Community Health Needs Survey

These questions should only take about 5 - 10 minutes to complete. Your answers are confidential and will only be reported in combination with the answers of others. Your participation is voluntary; you may stop answering at any time, or skip questions you do not wish to answer.

1. **In which county do you live?**

   ☐ Adams ☐ Allen ☐ DeKalb ☐ Huntington ☐ Kosciusko ☐ LaGrange ☐ Noble

   ☐ Wabash ☐ Wells ☐ Whitley

2. **What is the zip code of your residence?** _____

3. **How many adults (18 years or older) live in your household, INCLUDING YOURSELF?** _____
   - INCLUDE all adults who are living or staying here for more than 2 months
   - DO NOT INCLUDE anyone who is living somewhere else for more than 2 months, such as a college student living away or someone in the Armed Forces on deployment

4. **How many children younger than 18 years of age live in your household?** _____

5. **How would you describe your gender? (select only one)**

   ☐ Male ☐ Other_____

   ☐ Female ☐ Prefer not to answer

   ☐ Transgender

6. **In what year were you born?** _____

7. **Are you of Hispanic or Latino origin?**

   ☐ Yes ☐ No ☐ Prefer not to answer

8. **Do you identify as Amish?**

   ☐ Yes ☐ No ☐ Prefer not to answer

9. **How would you describe your race? (select all that apply)**

☐ White ☐ Asian

☐ Black or African-American ☐ Native Hawaiian or Pacific Islander

☐ American Indian or Alaska Native ☐ Prefer not to answer

☐ Other: _____

10. **Below are some health issues present in many communities. Please pick FIVE that you think pose the greatest concern for people who live in your community. (select only five)**

☐ Tobacco/vaping use

☐ Substance use or abuse

☐ Alcohol use or abuse

☐ Assault and violent crime (including domestic violence)

☐ Child abuse or neglect

☐ Sexual violence (including assault, rape or human trafficking)

☐ Obesity (health problems due to being overweight or obese)

☐ Chronic disease (diabetes, cancer, heart disease, etc.)

☐ Suicide

☐ Infectious disease (HIV, syphilis, hepatitis, COVID-19, or other infections)

☐ Reproductive health (birth control, women's and men's reproductive health issues)

☐ Infant death

☐ Injuries (car accidents, falls, workplace injuries)

☐ Mental health

☐ Aging and older adult needs

☐ Dental Care

☐ Disability needs

11. **Below is a list of programs or services that exist in many communities. Thinking about the biggest needs in your community, please rank the importance of each with 5 being the most important and 1 being the least important.**

Category	1 Least Important	2	3	4	5 Most Important
Access to Food (such as food pantries, farmers markets, food stamps)	☐	☐	☐	☐	☐
Assistance with finding housing	☐	☐	☐	☐	☐
Financial assistance	☐	☐	☐	☐	☐
Legal assistance	☐	☐	☐	☐	☐
Assistance with getting health insurance	☐	☐	☐	☐	☐
Job training or assistance with finding a job	☐	☐	☐	☐	☐
Assistance with transportation	☐	☐	☐	☐	☐
Free or emergency childcare	☐	☐	☐	☐	☐
Nutrition education programs like healthy cooking classes	☐	☐	☐	☐	☐
Substance abuse services (prevention or treatment)	☐	☐	☐	☐	☐
Needle exchange programs	☐	☐	☐	☐	☐
Mental health counseling and support programs	☐	☐	☐	☐	☐
Gun safety education programs	☐	☐	☐	☐	☐
Access to birth control	☐	☐	☐	☐	☐
Walking trails, bike trails, and other outdoor recreation spaces	☐	☐	☐	☐	☐
Quick access primary care (like clinics in a local drug store or grocery store)	☐	☐	☐	☐	☐
Aging and older adult programs	☐	☐	☐	☐	☐
Assistance with filling a prescription	☐	☐	☐	☐	☐

12. **Considering all sources, which of the following best describes your total household income before taxes for 2020? (select only one)**

☐ Less than $15,000
☐ $15,000 - $24,999
☐ $25,000 - $34,999
☐ $35,000 - $49,999
☐ $50,000 - $74,999
☐ $75,000 - $99,999
☐ $100,000 - $149,999
☐ $150,000 or More
☐ Prefer not to answer

Invitación a participar en la encuesta sobre las necesidades de salud de la comunidad de Parkview Health

Estimado miembro de la comunidad:

¡Necesitamos su ayuda! Todos conocemos la importancia de una comunidad fuerte y de servicios comunitarios sólidos. Parkview Health está trabajando para identificar las necesidades de salud de la comunidad para poder ofrecer mejores servicios.

¡Sus respuestas son importantes! Sus respuestas son completamente confidenciales. No le pedimos su nombre en ninguna parte de la encuesta. Debe tener 18 años o más para participar en esta encuesta. Las preguntas le tomarán solo entre 5 y 10 minutos de su tiempo.

Si tiene alguna pregunta o necesita ayuda con la encuesta, llámenos al 260-266-7765.

También puede participar en la encuesta en línea:

https://es.research.net/r/CHNA7S o

¡Gracias por ayudarnos a construir una comunidad más fuerte!

Cordialmente,

Sarah GiaQuinta, MD

Sarah GiaQuinta, MD, MPH
Vicepresidente de Communidad Salud
Parkview Health

Encuesta sobre las necesidades de salud de la comunidad de Parkview Health

Debería llevarle solo entre 5 y 10 minutos responder esta encuesta. Sus respuestas son confidenciales y solo se informarán en combinación con las respuestas de otras personas. Su participación es voluntaria; puede dejar de responder en cualquier momento u omitir las

preguntas que no desee contestar.

1. **En qué condado vive?**
   ☐ Adams ☐ Allen ☐ DeKalb ☐ Huntington ☐ Kosciusko ☐ LaGrange ☐ Noble
   ☐ Wabash ☐ Wells ☐ Whitley

2. **Cuál es el código postal de su residencia? _____**

   ¿Cuántos adultos (mayores de 18 años) viven en su hogar, INCLUYÉNDOSE A USTED MISMO? _____
   - INCLUYA a todos los adultos que vivan o estén viviendo aquí por más de 2 meses
   - NO INCLUYA a nadie que haya vivido en otro lugar por más de 2 meses, como un estudiante universitario que viva fuera o alguien de las fuerzas armadas en misión

3. **Cuántos menores de 18 años viven en su hogar? _____**

4. **Cómo describiría su género? (seleccione solo uno)**
   ☐ Hombre ☐ Otro_____
   ☐ Mujer ☐ Prefiero no contestar
   ☐ Transgénero

5. **En qué año nació? _____**

6. **Es U.S.ted de origen hispano o latino?**
   ☐ Sí ☐ No ☐ Prefiero no contestar

7. **Se identifica como Amish?**
   ☐ Sí ☐ No ☐ Prefiero no contestar

8. **¿ómo describiría su raza? (seleccione todo lo que corresponda)**

☐ Blanco
☐ Negro o afroamericano
☐ Indio americano o nativo de Alaska
☐ Otros: _____
☐ Asiático
☐ Nativo de Hawái o de las islas del Pacífico
☐ Prefiero no contestar

9. **A continuación se presentan algunos problemas de salud presentes en muchas comunidades. Por favor, elija CINCO que en su opinión sean los que más les preocupan a las personas que viven en su comunidad. (seleccione solo cinco)**

☐ Consumo de tabaco/vapeo

☐ Uso o abuso de sustancias

☐ Uso o abuso del alcohol

☐ Agresión y delitos violentos (incluida la violencia doméstica)

☐ Abuso o negligencia infantil

☐ Violencia sexual (incluido el abuso, la violación o la trata de seres humanos)

☐ Obesidad (problemas de salud debidos al sobrepeso o la obesidad)

☐ Enfermedades crónicas (diabetes, cáncer, enfermedades del corazón, etc.)

☐ Suicidio

☐ Enfermedades infecciosas (VIH, sífilis, hepatitis, COVID-19 u otras infecciones)

☐ Salud reproductiva (anticonceptivos, cuestiones de salud reproductiva de mujeres y hombres)

☐ Muerte infantil

☐ Lesiones (accidentes de tráfico, caídas, lesiones en el lugar de trabajo)

☐ Salud mental

☐ Envejecimiento y necesidades de los adultos mayores

☐ Atención odontológica

☐ Necesidades de las personas con discapacidades

10. **A continuación se presenta una lista de programas o servicios que existen en muchas comunidades. Pensando en las mayores necesidades de su comunidad, clasifique la importancia de cada una de ellas, siendo 5 la más importante y 1 la menos importante.**

Categoría	1 Menos importante	2	3	4	5 Más importante
Acceso a alimentos (como las despensas, los mercados de agricultores, los cupones de alimentos)	☐	☐	☐	☐	☐
Asistencia en la búsqueda de vivienda	☐	☐	☐	☐	☐
Asistencia financiera	☐	☐	☐	☐	☐
Asistencia jurídica	☐	☐	☐	☐	☐
Asistencia para conseguir un seguro médico	☐	☐	☐	☐	☐
Capacitación laboral o ayuda para encontrar un trabajo	☐	☐	☐	☐	☐
Asistencia para el transporte	☐	☐	☐	☐	☐
Cuidado de niños/as gratuito o de emergencia	☐	☐	☐	☐	☐
Programas de educación nutricional como clases de cocina saludable	☐	☐	☐	☐	☐
Servicios de abuso de sustancias (prevención o tratamiento)	☐	☐	☐	☐	☐
Programas de intercambio de jeringas	☐	☐	☐	☐	☐
Programas de terapia y apoyo en materia de salud mental	☐	☐	☐	☐	☐
Programas de educación sobre la seguridad de las armas	☐	☐	☐	☐	☐
Acceso a anticonceptivos	☐	☐	☐	☐	☐
Rutas de senderismo, carriles para bicicletas y otros espacios recreativos al aire libre	☐	☐	☐	☐	☐
Acceso rápido a la atención primaria (como clínicas en una farmacia o un supermercado local)	☐	☐	☐	☐	☐
Programas para adultos mayores y envejecimiento	☐	☐	☐	☐	☐
Asistencia para surtir una receta	☐	☐	☐	☐	☐

11. **Teniendo en cuenta todas las fuentes, ¿cuál de las siguientes opciones describe mejor los ingresos totales de su hogar antes de impuestos para 2020? (seleccione solo uno)**

☐ Menos de $15,000
☐ $15,000 - $24,999
☐ $25,000 - $34,999
☐ $35,000 - $49,999
☐ $50,000 - $74,999
☐ $75,000 - $99,999
☐ $100,000 - $149,999
☐ $150,000 o más
☐ Prefiero no contestar

ရပ်ရွာကျန်းမာရေး လိုအပ်ချက်များ Parkview's စစ်တမ်းတွင် ပါဝင်ရန် ဖိတ်ကြားခြင်း။

ချစ်ခင်လေးစားရပါသော ရပ်ရွာအတွင်း နေထိုင်သူများခင်ဗျာ၊

ကျွန်ုပ်တို့မှ သင်တို့အကူအညီလိုအပ်နေပါသည်။ ခိုင်မာကောင်းမွန်သည့် ရပ်ရွာ နှင့် ခိုင်မာကောင်းမွန်သည့် ရပ်ရွာဝန်ဆောင်မှုများ၏ အရေးပါပုံကို ကျွန်ုပ်တို့အားလုံး သိရှိထားပြီးဖြစ်ပါသည်။

Parkview ကျန်းမာရေးမှ ရပ်ရွာကျန်းမာရေးဆိုင်ရာများအတွက် လိုအပ်သည်များကို စိစစ်သတ်မှတ်နိုင်ရန် လုပ်ဆောင်လျက်ရှိနေပြီး သို့မှသာ ပိုမိုကောင်းမွန်သည့် ဝန်ဆောင်မှုများကို ပေးအပ်နိုင်မည် ဖြစ်ပါသည်။

သင်၏ထည့်သွင်းမှုသည် အထောက်အကူဖြစ်စေပါသည်။ သင့်အဖြေများကို 100% လျှို့ဝှက်ထားပါမည်။ ဤစစ်တမ်းတွင် သင့်အမည်ကို မည်သည့်နေရာတွင်မှ ပေးဆောင်ရန် မလိုအပ်ပါ။ စစ်တမ်းဖြေဆိုရန် သင်သည် အသက် 18 နှစ်နှင့်အထက် ဖြစ်ရမည်။ ဤမေးခွန်းများကိုဖြေဆိုရန် 5-10 မိနစ်ခန့် လိုအပ်ပါသည်။

သင့်တွင် မေးခွန်းများ သို့မဟုတ် ဤစစ်တမ်းအတွက် အကူအညီ လိုအပ်ပါက ကျွန်ုပ်တို့ထံ ကျေးဇူးပြု၍ ဖုန်းခေါ်ဆိုပါ 260-266-7765

မြန်မာဘာသာစကားဖြင့် စစ်တမ်းကောက်ယူပြီးစီးရန် ကျေးဇူးပြု၍ ဒီကိုသွားပါ

https://www.research.net/r/CHNA10B သို့မဟုတ်

ပို၍ ခိုင်မာကောင်းမွန်သည့် ရပ်ရွာတည်ဆောက်ရာတွင် ပါဝင်ကူညီပေးသည့်အတွက် ကျေးဇူးအထူးတင်ရှိပါသည်။

Sarah GiaQuinta, MD

Sarah GiaQuinta, MD, MPH

Senior Vice President of Community Health & Equity
Parkview Health

Parkview ရုပ်ရှင်ကျန်းမာရေးလိုအပ်ချက်စစ်တမ်း

ဤမေးခွန်းအားလုံးကို ဖြေရန် 5-10 မိနစ်ခန့် ကြာပါမည်။ သင့်အဖြေများကို တင်းကြပ်စွာလျှို့ဝှက်ထားမည်ဖြစ်ပြီး အခြားသူများ၏အဖြေများနှင့်အတူသာ တင်သွင်းမည်ဖြစ်သည်။ သင်၏ပါဝင်မှုသည် ဆန္ဒအလျောက်ဖြစ်သည်။ မေးခွန်းများကို အချိန်မရွေးဖြေဆိုခြင်းကို ရပ်နိုင်သည် သို့မဟုတ် သင်မဖြေလိုသောမေးခွန်းများကို ကျော်သွားနိုင်သည်။

1. မည်သည့် ကောင်တီတွင် သင်နေထိုင်ပါသလဲ။

   ☐ Adams ☐ Allen ☐ DeKalb ☐ Huntington ☐ Kosciusko ☐ LaGrange ☐ Noble

   ☐ Wabash ☐ Wells ☐ Whitley

2. သင်နေထိုင်သည့်နေရာ၏ စာပို့သင်္ကေတ ကုဒ်မှာ မည်သို့နည်း။_____

3. သင့်အိမ်တွင် သင်အပါအဝင်၊ အသက်ရွယ်ပြည့်ပြီးသူ (အသက် ၁၈နှစ်နှင့်အထက်) မည်မျှ နေထိုင်ကြပါသလဲ။

   ☐ ၎င်းအသက်ရွယ်ပြည့်ပြီးသူများထဲတွင် ဤနေရာ၌ နေထိုင်လာခဲ့သည်မှာ ၂ လအထက်ရှိသူများကို ထည့်သွင်းပါ။

   • ၎င်းသူများထဲတွင် အဝေးရောက် ကော်လိပ်ကျောင်းသား သို့မဟုတ် စစ်တပ်တွင် တာဝန်ထမ်းဆောင်နေသူကဲ့သို့သော အခြားနေရာတွင် နေထိုင်သည်မှာ ၂ လထက်ပိုနေသူများကို မထည့်သွ

4. သင်၏ အိမ်တွင် အသက် ၁၈ နှစ်မပြည့်သေးသည့် ကလေးမည်မျှ နေထိုင်ကြပါသလဲ။_____

5. သင်၏ လိင်ကို ဘယ်လိုဖော်ပြလိုပါသလဲ။ (တစ်ခုသာ ရွေးချယ်ပါ)

   ☐ အထီး ☐ အခြား_____)ကျေးဇူးပြု၍ မှတ်ချက်တစ်ခုထည့်ပါ။ (

   ☐ အမျိုးသမီး ☐ မဖြေဆိုလိုပါ

   ☐ လိင်ပြောင်းသူ

6. မည်သည့်ခုနှစ်တွင် သင့်ကိုမွေးဖွားခဲ့ပါသလဲ။ _____

7. သင်သည် ဟစ်စပန်းနစ် သို့မဟုတ် နဂိုမူလ လာတီနို ဖြစ်ပါသလား။

☐ ဟုတ်တယ် ☐ မှား ☐ မဖြေဆိုလိုပါ

8. သင့်ကိုယ်သင် Amish အဖြစ် သတ်မှတ်ပါသလား။

☐ ဟုတ်တယ် ☐ မရှိ ☐ မဖြေဆိုလိုပါ

9. သင်၏ လူမျိုးအကြောင်း ဘယ်လို ဖော်ပြမှာလဲ။ (ဖြစ်နိုင်သည်များအားလုံးကို ရွေးချယ်ပါ)

☐ လူဖြူ

☐ လူမည်း သို့မဟုတ် အာဖရိကန် အမေရိကန်

☐ အမေရိကန် အိန္ဒိယန် သို့မဟုတ် အလက်စကာတွင် မူလနေထိုင်သူ

☐ အာရှသား

☐ ဟာဝိုင်ရီတွင် မူလနေထိုင်သူ သို့မဟုတ် ပစိဖိတ်ကျွန်းသား

☐ မဖြေဆိုလိုပါ

☐ အခြား _____) ကျေးဇူးပြု၍ မှတ်ချက်တစ်ခုထည့်ပါ။ (

10. အောက်တွင် ဖော်ပြထားသည့် ကျန်းမာရေးဆိုင်ရာများသည် ရပ်ရွာအများစုတွင် ရှိနေသည့် အရာများဖြစ်သည်။ သင်၏ ရပ်ရွာတွင် နေထိုင်သည့်လူအများထဲ အဖြစ်အများဆုံးဟု ယူဆရသည့် အရာ ငါးခုကို ကျေးဇူးပြု၍ ရွေးချယ်ပါ။ (ငါးခုသာ ရွေးချယ်ရန်)

☐ ဆေးရွက်ကြီး/vaping အသုံးပြုခြင်း

☐ တရားမဝင် မူးယစ်ဆေးဝါး သုံးစွဲမှု သို့မဟုတ် အလွဲသုံးစားမှု

☐ အရက်သေစာသောက်စားခြင်း သို့မဟုတ် အလွဲသုံးစားလုပ်ခြင်း။

☐ ထိမှန်ခြင်းနှင့် အကြမ်းဖက်ရာဇဝတ်မှုများ (အိမ်တွင်းအကြမ်းဖက်မှု အပါအဝင်)၊

- ☐ ကလေးအား မတရားပြုကျင့်ခြင်း သို့မဟုတ် လျစ်လျူရှုခြင်း
- ☐ လိင်ပိုင်းအကြမ်းဖက်ခြင်း (လိင်ပိုင်းဆိုင်ရာ တိုက်ခိုက်ခြင်း၊ အဓမ္မပြုကျင့်ခြင်း သို့မဟုတ် လူကုန်ကူးခြင်း)
- ☐ အဝလွန်ခြင်း (ကိုယ်အလေးချိန်များလွန်းခြင်း သို့မဟုတ် အဝလွန်ခြင်းကြောင့် ကျန်းမာရေးပြဿနာများ)
- ☐ နာတာရှည်ရောဂါများ (ဆီးချို၊ ကင်ဆာ၊ နှလုံးရောဂါ စသည်)
- ☐ ကိုယ့်ကိုယ်ကိုသတ်သေ
- ☐ ကူးစက်ရောဂါ (HIV၊ ဆစ်ဖလစ်၊ အသည်းရောင်ရောဂါ၊ COVID-19၊ သို့မဟုတ် အခြားရောဂါကူးစက်မှု)
- ☐ မျိုးဆက်ပွားကျန်းမာရေး (သန္ဓေတားဆေး၊ အမျိုးသမီးနှင့် အမျိုးသား မျိုးဆက်ပွားကျန်းမာရေး ပြဿနာများ)
- ☐ မွေးကင်းစ ကလေး သေဆုံးခြင်း
- ☐ ဒဏ်ရာများ (ကားတိုက်မှု၊ ပြုတ်ကျ၊ အလုပ်ခွင် ဒဏ်ရာများ)
- ☐ စိတ်ကျန်းမာရေးဆိုင်ရာများ
- ☐ အိုမင်းရင့်ရော်ခြင်း နှင့် အသက်ရွယ်ကြီးသူများ၏ လိုအပ်မှုများ
- ☐ သွားကျန်းမာရေး စောင့်ရှောက်ခြင်း
- ☐ မသန်စွမ်းသူများ၏ လိုအပ်ချက်များ

11. အောက်ပါပရိဂရမ်များ သို့မဟုတ် ဝန်ဆောင်မှုများကို အသိုင်းအဝိုင်းအများစုတွင် ရနိုင်သည်-သင့်အသိုင်းအဝိုင်း၏ အကြီးမားဆုံးလိုအပ်ချက်များကို စဉ်းစားပါ။ တစ်ခုချင်းစီရဲ့အရေးပါမှုကို အဆင့်သတ်မှတ်ပါ။ 5 က အရေးကြီးဆုံးပါ။ 1 က နည်းနည်း အရေးကြီးတယ်။

အဖြို းအစား	၁ အရေး ကီ်ြးမ အနည်း ငယ် သာ ရှိ	၂	၃	၄	၅ အရေး ကီ်ြး ဆုံး
စား နပ်ရိက္ခာရရှိရန်ဌမ (အရေး ယူ အစား အစာ၊ လယ်သမား စွဲ မှီး၊ အစား အသောက် ကဘောက် ကချာများ)	☐	☐	☐	☐	☐
အိမ်မရာ ရှာဖွေ ထောင်ကွယ် ဆောင်ရွက်ပေး ခြင်း	☐	☐	☐	☐	☐
ွေ့ ဆက်သွယ်ခိုင်ရာ အကူအညီ	☐	☐	☐	☐	☐
ဥပဒေရေး ရာခိုင်ရာ အကူအညီ	☐	☐	☐	☐	☐
ကျွန်းမာ ရေး အာ မံခရိုရိုရန် ကူညီဆောင်ရွက်ပေး ခြင်း	☐	☐	☐	☐	☐
အလုပ်အကိုင်ရှာဖွေ ဆေး့နွှေးအကူ အလုပ်သင်တန်းဦ့မဟုတ် အကူအညီများ	☐	☐	☐	☐	☐
သယ်ယူပို့ဆောင်ရေး ခိုင်ရာ အကူအညီ	☐	☐	☐	☐	☐
အခွဲ့မဦ့မဟုတ် အရေး ယူ ကလေး ထိန်း	☐	☐	☐	☐	☐
ကျွန်းမာ ရေး့နှင်ညီညွတ်သော ဟင်းချက်သင်တန်းများကဲ့ဦ့ အာ ဟာ ရိခိုင်ရာ ပညာ ပေး အစီအစဉ်များ	☐	☐	☐	☐	☐
ဆေး ဝါး အလွဲသုံးစား့မ ဝန်ဆောင်ဌမများ (ကာ ကွယ်ခြင်းဦ့မဟုတ် ကုသခြင်း)	☐	☐	☐	☐	☐
ဆေး ထိုးအပ်လဲလှယ်ရေး အစီအစဉ်များ	☐	☐	☐	☐	☐
စိတ်ကျွန်းမာ ရေး ခိုင်ရာ အကဲြ်ဖြတ်ပေး ခြင်းနှင့် ပံ့ပိုး ကူညီမ အစီအစဉ်များ	☐	☐	☐	☐	☐

12.ရင်းမြစ်များအားလုံးမှ ၂၀၂၀ ခုနှစ်အတွက် အခွန်မဆောင်ခင် သင့်အိမ်၏ ဝင်ငွေစုစုပေါင်းမှာ ဖော်ပြပါများထဲမှ မည်သည့်ကိန်းကဏ္ဍန်းသည် အနီးစပ်ဆုံးဖြစ်ပါသလဲ။ (တစ်ခုသာ ရွေးချယ်ပါ)

☐ $၁၅,၀၀၀ ထက်နည်းသည်
☐ $၁၅,၀၀၀ - $၂၄,၉၉၉
☐ $၂၅,၀၀၀ - $၃၄,၉၉၉
☐ $၃၅,၀၀၀ - $၄၉,၉၉၉
☐ $၅၀,၀၀၀ - $၇၄,၉၉၉
☐ $၇၅,၀၀၀ - $၉၉,၉၉၉
☐ $၁၀၀,၀၀၀ - $၁၄၉,၉၉၉
☐ $၁၅၀,၀၀၀ သို့မဟုတ် ထို့ထက်ပိုသည်
☐ မဖြေဆိုလိုပါ

Welcome!

The purpose of this survey is to help meet the Internal Revenue Service (IRS) requirement from the Affordable Care Act that non-profit hospitals conduct a community health needs assessment every three years.

This survey includes 12 questions and will require approximately 5-10 minutes of your time. It asks questions about your practice setting and the primary community health issues, social service needs, barriers to healthcare access, and problems in providing service in the county(ies) you serve. Your responses will not be connected back to you as an individual and will only be used and published in aggregated format.

This survey is being conducted as part of Parkview Health's 2022 Community Health Needs Assessment (CHNA).

Thank you in advance for completing this survey!

YOUR PRACTICE SETTING

1. **In which county is your primary practice or service located?**
   ♦ Adams ♦ Allen ♦ DeKalb ♦ Huntington ♦ Kosciusko ♦ LaGrange ♦ Noble
   ♦ Wabash ♦ Wells ♦ Whitley

2. **How long have you practiced/provided service in this area?**
   ♦ Less than 1 year ♦ 1-5 years ♦ 6-10 years ♦ 11-15 years ♦ 16-20 years
   ♦ More than 20 years

3. **What type of healthcare or service provider are you?**
   - ○ Physician
   - ○ Physician's Assistant
   - ○ Nurse Practitioner
   - ○ Registered Nurse
   - ○ Mental/Behavioral Health
   - ○ Nutritionist
   - ○ Wellness Practitioner
   - ○ Public Health/Community Health Practitioner
   - ○ Social Worker/Case Management
   - ○ Other, please specify

4. **In which type of setting do you provide your services?**
   - ○ Outpatient Primary Care Clinic
   - ○ Outpatient Specialized Care Clinic
   - ○ Immediate/Urgent Care Clinic
   - ○ Community Health Center
   - ○ County Health Department
   - ○ Hospital - Specialized Care
   - ○ Hospital - Emergency Care

- Long-Term Care Facility
- Hospice/Palliative Care Facility
- School
- In-Home
- Other, please specify

COMMUNITY HEALTH NEEDS

5. Below are some health issues present in many communities. Please pick FIVE that you think pose the greatest concern for people who live in your community. (Select only five)

- Tobacco/vaping use
- Substance use or abuse
- Alcohol use or abuse
- Assault and violent crime (including domestic violence)
- Child abuse or neglect
- Sexual violence (including assault, rape or human trafficking)
- Obesity (health problems due to being overweight or obese)
- Chronic disease (diabetes, cancer, heart disease, etc.)
- Suicide
- Infectious disease (HIV, syphilis, hepatitis, COVID-19, or other infections)
- Reproductive health (birth control, women's and men's reproductive health issues)
- Infant death
- Injuries (car accidents, falls, workplace injuries)
- Mental health
- Aging and older adult needs
- Dental care
- Disability needs

6. Which of the following are the <u>top three</u> barrier(s) to accessing care/services in your county?

- Costs
- Lack of Insurance
- Access/Insufficient Healthcare Resources (i.e. shortage of providers)
- Transportation
- Education/Health Literacy
- Childcare
- Language
- Housing
- Other; please specify

SERVICE NEEDS

7. **Below is a list of programs or services that exist in many communities. Thinking about the biggest needs in your community, please rank each by importance with 5 being the most important and 1 being the least important.**

Category	1 Least Important	2	3	4	5 Most Important
Access to Food (such as food pantries, farmers markets, food stamps)	♦	♦	♦	♦	♦
Assistance with finding housing	♦	♦	♦	♦	♦
Financial assistance	♦	♦	♦	♦	♦
Legal assistance	♦	♦	♦	♦	♦
Assistance with getting health insurance	♦	♦	♦	♦	♦
Job training or assistance with finding a job	♦	♦	♦	♦	♦
Assistance with transportation	♦	♦	♦	♦	♦
Free or emergency childcare	♦	♦	♦	♦	♦
Nutrition education programs like healthy cooking classes	♦	♦	♦	♦	♦
Substance abuse services (prevention or treatment)	♦	♦	♦	♦	♦
Needle exchange programs	♦	♦	♦	♦	♦
Mental health counseling and support programs	♦	♦	♦	♦	♦
Gun safety education programs	♦	♦	♦	♦	♦
Access to birth control	♦	♦	♦	♦	♦
Walking trails, bike trails, and other outdoor recreation spaces	♦	♦	♦	♦	♦
Quick access primary care (like clinics in a local drug store or grocery store)	♦	♦	♦	♦	♦
Aging and older adult programs	♦	♦	♦	♦	♦
Assistance with filling a prescription	♦	♦	♦	♦	♦

8. **Are you aware of resources available to the community to address the following issues? (Answer Yes, No, or Don't Know for each)**

Category	Yes	No	Don't Know
Access to Food (such as food pantries, farmers markets, food stamps)	♦	♦	♦

Assistance with finding housing	♦	♦	♦
Financial assistance	♦	♦	♦
Legal assistance	♦	♦	♦
Assistance with getting health insurance	♦	♦	♦
Job training or assistance with finding a job	♦	♦	♦
Assistance with transportation	♦	♦	♦
Free or emergency childcare	♦	♦	♦
Nutrition education programs like healthy cooking classes	♦	♦	♦
Substance abuse services (prevention or treatment)	♦	♦	♦
Needle exchange programs	♦	♦	♦
Mental health counseling and support programs	♦	♦	♦
Gun safety education programs	♦	♦	♦
Access to birth control	♦	♦	♦
Walking trails, bike trails, and other outdoor recreation spaces	♦	♦	♦
Quick access primary care (like clinics in a local drug store or grocery store)	♦	♦	♦
Aging and older adult programs	♦	♦	♦
Assistance with filling a prescription	♦	♦	♦

9. **What problems and barriers do you face in providing health-related services (please check all that apply)?**

- Collaboration/communication with other provider/coordinated care
- Effective quality improvement strategies
- Electronic medical records/electronic health records
- Access to timely data
- Relationship with insurers/reimbursement levels
- Insufficient healthcare resources (i.e. shortage of providers)
- Language barriers
- Other, please specify

DEMOGRAPHICS

10. How would you describe your gender?

- Male
- Female
- Transgender
- Other:
- Prefer not to answer

11. Are you of Hispanic or Latino origin?

- Yes
- No
- Prefer not to answer

12. How would you describe your race? (Select all that apply)

- White
- Black or African American
- Asian
- Native Hawaiian or other Pacific Islander
- American Indian or Alaskan Native
- Other:
- Prefer not to answer

Appendix C - Hanlon Score Calculation

(A) Size		(B) Seriousness				(C) Effectiveness of Intervention	
Score	% of Population	Score	Community (B1) and Provider (B2) % endorsed	Score	Urgency (B3)	Score	Evidence-based intervention
10	≥ 50%	2	≥ 80%	2	Significantly worsening	Yes	1
9	25 to < 50%	1.5	60 to < 80%	1.5	Worsening	No	0
8	17.5 to < 25%	1	40 to < 60%	1	No trend		
7	10 to 17.5%	0.5	20 to < 40%	0.5	Improving		
6	5 to < 10%	0	0 to < 20%	0	Significantly improving		
5	1 to < 5%						
4	0.50 to < 1%						
3	0.10 to < 0.50%						
2	0.05 to < 0.10%						
1	0.01 to < 0.05%						
0	0 to < 0.01%						

Priority Score D = [A + 4.167 * (B1 + B2 + B3)] * C

Appendix D - Prioritization Tool

2022 Allen County CHNA: Scorecard to Prioritize Top Health Needs

Please review this scorecard and accompanying data in advance of the Prioritization Session. During the session, information and instructions will be provided that will help to contextualize the health problems and ranking scores presented in the table below and the data provided in the subsequent pages. You will be asked to consider both your professional and personal perspectives when you rate each health problem as we work to prioritize Allen County's top health needs.

Prioritization Criteria

- **Significance** of the health problem -> How many people are affected?
- **Severity** of the health problem -> How likely is it to limit length and quality of life?
- **Suitability** for a strategic intervention-> is Parkview in a good position to address the problem?
- **SDOH** -> Do social determinants of health (SDOH) drive health disparities in rates and outcomes for the health problem?

	Priority Rank by Hanlon for Allen Co.	Priority Rank by Community & Provider Survey in Allen Co.	Significance of the Issue	Severity of the Problem	Suitability for Intervention	SDOH – Impact of Health Disparity
Health Problem	1= top priority	* Chronic disease was a single question in our survey	**1-10**	**1-10**	**1-10**	**1-10**
Obesity	**1**	**1**				
Mental Health	**2**	**3**	ALREADY SELECTED	ALREADY SELECTED	ALREADY SELECTED	ALREADY SELECTED
Chronic Obstructive Pulmonary Disease (COPD)	**3**	***2**				
Asthma	**4**	***2**				
Chronic Kidney Disease	**5**	***2**				
Cardiovascular Disease	**6**	***2**				
Substance Use/ Abuse	**7**	**4**				

Note: for voting you will be asked to use the following scale: 1=Very Little, 10=Very Much

Appendix E - Prioritization Participating Organizations

Prioritization session attendees represented several organizations in Allen County:

Organization/Department
Parkview Board
Parkview Home Health and Hospice
Parkview Administration
Parkview Quality Department
Parkview Community Health Improvement
Parkview Behavioral Health
Parkview Women's and Children's Hospital
Parkview Endocrinology
Alliance Health Centers of Allen County

Appendix F - Community Resources

Findhelp.org is an online to that allows the end user to search and connect to support, including financial assistance, food pantries, medical care, and other free or reduced-cost help.

https://www.findhelp.org/

Name	City	ZIP Code	Service
OBESITY			
Turnstone	Fort Wayne	46805	Fitness Center
Central Branch YMCA	Fort Wayne	46802	Recreational Club
Cole Center Family YMCA	Kendallville	46755	Recreational Club
Jackson R Lehman YMCA	Fort Wayne	46835	Recreational Club
Jorgensen Family YMCA	Fort Wayne	46804	Recreational Club
Kosciusko Community YMCA	Warsaw	46582	Recreational Club
Kosciusko Community YMCA - North Webster Branch	N. Webster	46555	Recreational Club
Parkview Family YMCA	Fort Wayne	46825	Recreational Club
Renaissance Pointe YMCA	Fort Wayne	46803	Recreational Club
Skyline YMCA	Fort Wayne	46802	Recreational Club
Wabash County YMCA	Wabash	46992	Recreational Club
Parkview Huntington Family YMCA	Huntington	46750	Recreational Club
Parkview Center for Healthy Living	Kendallville	46755	Wellness Program
Parkview Center for Healthy Living - FW	Fort Wayne	46816	Wellness Program
Parkview Center for Healthy Living - FW	Fort Wayne	46845	Wellness Program
Lakeland Youth Center	Syracuse	46567	Youth Center
TOBACCO USE			
Healthier Moms and Babies	Fort Wayne	46807	Baby & Me Tobacco Free
Kosciusko Cares Youth Services	Warsaw	46580	Baby & Me Tobacco Free
Parkview Hospital Randallia	Fort Wayne	46805	Baby & Me Tobacco Free
SCAN	Fort Wayne	46802	Baby & Me Tobacco Free
Wabash County Tobacco Free Coalition	Wabash	46992	Baby & Me Tobacco Free
Wabash County Tobacco Free Coalition	Wabash	46993	Smoking Cessation

Cornerstone Connections Project - New Haven	New Haven	46774	VIVA
Cornerstone Youth Center - CYC Monroeville	Monroeville	46773	VIVA
Cornerstone Connections Project - Woodlawn	Woodburn	46797	VIVA
Parkview Center for Healthy Living	Kendallville	46755	Wellness Program
Women & Children			
Parkview Regional Medical Center - Women and Children's Hospital	Fort Wayne	46845	Breastfeeding Support
Parkview Hospital Randallia	Fort Wayne	46805	Breastfeeding Support Group
Parkview Huntington Hospital	Huntington	46750	Breastfeeding Support Group
Parkview LaGrange Lactation Services	LaGrange	46761	Breastfeeding Support Group
Parkview Noble Hospital	Kendallville	46755	Breastfeeding Support Group
Parkview Regional Medical Center - Women and Children's Hospital	Fort Wayne	46845	Breastfeeding Support Group
Parkview Whitley Hospital	Columbia City	46725	Breastfeeding Support Group
Life & Family Services	Kendallville	46755	Campaign For Our Kids
Lutheran Hospital	Fort Wayne	46804	Childbirth Classes
Clinic	Warsaw	46580	Childhood Immunization
Fort Wayne-Allen County Department of Health	Fort Wayne	46802	Childhood Immunization
LaGrange County Health Department	Topeka	46571	Childhood Immunization
LaGrange County Health Department	Shipshewana	46565	Childhood Immunization
LaGrange County Health Department	LaGrange	46761	Childhood Immunization
Noble County Health Department	Albion	46701	Childhood Immunization
Super Shot	Fort Wayne	46806	Childhood Immunization
Super Shot	Fort Wayne	46845	Childhood Immunization
Super Shot	Fort Wayne	46805	Childhood Immunization
Super Shot	Grabill	46741	Childhood Immunization
Wabash County Health Department	Wabash	46992	Childhood Immunization
Whitley County Health Department	Columbia City	46725	Childhood Immunization
Safe Families for Children - Northeast Indiana	Fort Wayne	46825	Crisis Child Care
Clinic	Warsaw	46580	Early Start Prenatal Clinic/Care Coordination
Brightpoint	Fort Wayne	46802	Family Development
Neighborhood Health Clinics - South Calhoun Street	Fort Wayne	46802	Family Planning

Women's Care Center of Fort Wayne - East Wayne Street	Fort Wayne	46802	Family Planning
Women's Care Center of Fort Wayne - West Coliseum Boulevard	Fort Wayne	46808	Family Planning
Women's Care Center of Fort Wayne - West Jefferson Street	Fort Wayne	46804	Family Planning
Huntington County Division of Family Resources	Huntington	46750	Family Planning Eligibility Program
Kosciusko County Division of Family Resources	Warsaw	46580	Family Planning Eligibility Program
LaGrange County Division of Family Resources	LaGrange	46761	Family Planning Eligibility Program
Noble County Division of Family Resources	Albion	46701	Family Planning Eligibility Program
Vocational Rehabilitation Services - Areas 7 & 8	Fort Wayne	46806	Family Planning Eligibility Program
Wabash County Division of Family Resources	Wabash	46992	Family Planning Eligibility Program
Whitley County Division of Family Resources	Columbia City	46725	Family Planning Eligibility Program
McMillen Center for Health Education	Fort Wayne	46816	Human Growth and Development Education
Healthier Moms and Babies	Fort Wayne	46807	Mama Moods
Lutheran Hospital	Fort Wayne	46804	Mood Changes and Moms
Kosciusko Community Hospital	Warsaw	46580	Nursing Mothers Group
A Hope Center - Grabill	Grabill	46741	Post Abortion Healing
A Hope Center - South Calhoun	Fort Wayne	46807	Post Abortion Healing
A Hope Center Pregnancy and Relationship	Fort Wayne	46815	Pregnancy and Parenting Resource
Life & Family Services	Kendallville	46755	Pregnancy and Parenting Resource
A Hope Center - Grabill	Grabill	46741	Pregnancy Testing
A Hope Center - South Calhoun	Fort Wayne	46807	Pregnancy Testing
A Hope Center Pregnancy and Relationship	Fort Wayne	46815	Pregnancy Testing
Area Five WIC - North Manchester	N. Manchester	46962	WIC Care
Area Five WIC - Wabash	Wabash	46992	WIC Care
Huntington County (Area Five) WIC	Huntington	46750	WIC Care
Kosciusko County WIC	Warsaw	46580	WIC Care
LaGrange County WIC	LaGrange	46761	WIC Care
Lafayette Street Family Health Clinic	Fort Wayne	46806	Women's Clinic
SUBSTANCE ABUSE/ADDICTION			
Salvation Army Adult Rehab Center	Fort Wayne	46802	Adult Rehab Center

AA - FW Intergroup	Fort Wayne	46815	Al-Anon / Alateen
AA - FW Intergroup	Fort Wayne	46815	Alcoholics Anonymous
Christian Community Healthcare	Grabill	46741	Community Clinic
Friends Counseling Center - Huntington	Huntington	46750	Counseling
Friends Counseling Center - Wabash	Wabash	46992	Counseling
Northeastern Center	Kendallville	46755	Crisis Line
Otis R. Bowen Center for Human Services	Warsaw	46581	Crisis Line
Park Center - E State Boulevard	Fort Wayne	46805	Crisis Line
McMillen Center for Health Education	Fort Wayne	46816	Drug Abuse Prevention Education
YWCA of Northeast Indiana	Fort Wayne	46816	Hope and Harriet
Park Center - Carew Street	Fort Wayne	46805	Inpatient Mental Health
Connection Points Ministry - Columbia City	Columbia City	46725	Living Free Recovery and Counseling Services
Connection Points Ministry - FW	Fort Wayne	46815	Living Free Recovery and Counseling Services
Connection Points Ministry - Grabill	Grabill	46741	Living Free Recovery and Counseling Services
VA of Northern Indiana - FW	Fort Wayne	46805	Mental Healthcare, Veteran
St. Joseph Hospital	Fort Wayne	46802	Mental Health Services
FW-Allen County Dept of Health - Syringe Services	Fort Wayne	46806	Needle Exchange/Distribution Programs
Drug Free Noble County	Albion	46701	Substance Abuse Education
Bowen Center - Albion	Albion	46701	Substance Abuse Services
Bowen Center - Columbia City	Columbia City	46725	Substance Abuse Services
Bowen Center - FW	Fort Wayne	46808	Substance Abuse Services
Bowen Center - Huntington	Huntington	46750	Substance Abuse Services
Bowen Center - Syracuse	Syracuse	46567	Substance Abuse Services
Bowen Center - Wabash	Wabash	46992	Substance Abuse Services
Bowen Center - Warsaw	Warsaw	46580	Substance Abuse Services
Indiana Dream Center	Huntington	46750	Substance Abuse Services
Northeastern Center - Noble County	Albion	46701	Substance Abuse Services
Northeastern Center - Noble County Clinic	Kendallville	46755	Substance Abuse Services
Park Center - Carew Street	Fort Wayne	46805	Substance Abuse Services
Addiction Recovery Centers of Indiana - Columbia City	Columbia City	46725	Substance Use Disorder Services

Addiction Recovery Centers of Indiana - Lagrange	Lagrange	46761	Substance Use Disorder Services
Hope Alive	Fort Wayne	46808	Support Groups
Vocational Rehabilitation Services - Areas 7	Fort Wayne	46807	Substance Abuse Treatment, Outpatient
The Thirteen Step House	Fort Wayne	46802	Substance Abuse, Residential
Freedom House	Fort Wayne	46802	Transitional Housing
Road to Recovery	Fort Wayne	46805	Transitional Housing
Shepherd's House	Fort Wayne	46805	Transitional Housing
The Rose Home	Fort Wayne	46803	Transitional Housing
The Rose Home	Syracuse	46567	Transitional Housing
MENTAL HEALTH			
Center for Nonviolence	Fort Wayne	46807	Anger Management
Drug Free Noble County	Noble	46701	Anger Management
Center for Nonviolence	Fort Wayne	46807	Batterer Intervention Program
Parkview Behavioral Health	Fort Wayne	46805	Behavioral Health Services
HealthVisions of Fort Wayne	Fort Wayne	46803	Bienvenido Program
Turnstone	Fort Wayne	46805	Caregiver Support Group
Northeastern Center - Dowling Street	Kendallville	46755	Children's Mental Health Initiative
Park Center - E State Boulevard	Fort Wayne	46805	Children's Mental Health Initiative
Friends Counseling Center - Huntington	Huntington	46750	Counseling
Friends Counseling Center - Wabash	Wabash	46992	Counseling
Vocational Rehabilitation Services - Areas 7 and 8	Fort Wayne	46807	Counseling
Northeastern Center - Main Street	Kendallville	46755	Crisis Line
Park Center-East State Boulevard	Fort Wayne	46805	Crisis Line
Park Center-East State Boulevard	Fort Wayne	46805	Dialectical Behavioral Therapy
Park Center-Carew Street	Fort Wayne	46805	Inpatient Mental Health
Mental Health America Northeast Indiana	Fort Wayne	46807	Mental Health Association
VA of Northern Indiana - FW	Fort Wayne	46805	Mental Healthcare, Veteran
St. Joseph Hospital	Fort Wayne	46802	Mental Health Services
Crossroad Child & Family Services	Fort Wayne	46805	Outpatient Mental Health Services
Crossroad Child & Family Services - Huntington	Huntington	46750	Outpatient Mental Health Services
Northeastern Center - Dowling Street	Kendallville	46755	Outpatient Mental Health Services

Northeastern Center - LaGrange County	LaGrange	46761	Outpatient Mental Health Services
Northeastern Center - Main Street	Albion	46701	Outpatient Mental Health Services
Park Center - Carew Street	Fort Wayne	46805	Outpatient Mental Health Services
Park Center - East State Boulevard	Fort Wayne	46805	Outpatient Mental Health Services
Bowen Center - Albion	Albion	46701	Outpatient Treatment Services
Bowen Center - Columbia City	Columbia City	46725	Outpatient Treatment Services
Bowen Center - Cromwell	Cromwell	46732	Outpatient Treatment Services
Bowen Center - FW	Fort Wayne	46808	Outpatient Treatment Services
Bowen Center - Huntington	Huntington	46750	Outpatient Treatment Services
Bowen Center - LaGrange	LaGrange	46761	Outpatient Treatment Services
Bowen Center - Syracuse	Syracuse	46567	Outpatient Treatment Services
Bowen Center - Wabash	Wabash	46992	Outpatient Treatment Services
Bowen Center - Warsaw	Warsaw	46580	Outpatient Treatment Services
Bowen Center - Warsaw	Warsaw	46580	Psychiatric Residential Treatment
Crossroad Child & Family Services	Fort Wayne	46805	Psychiatric Residential Treatment
Hope Alive	Fort Wayne	46808	Support Groups
We The Living	Fort Wayne	46814	Support Groups
National Alliance on Mental Illness	Fort Wayne	46805	Support Groups - Family Support
National Alliance on Mental Illness	Fort Wayne	46805	Support Groups - Peer to Peer
National Alliance on Mental Illness	Fort Wayne	46805	Support Groups - Special Spousal Support
Youth Services Bureau Huntington County	Huntington	46750	Teen Suicide Prevention
Center for Nonviolence	Fort Wayne	46807	Women's Violence Intervention Program
Bowen Center - Columbia City	Columbia City	46725	Children's Mental Health
Bowen Center - Huntington	Huntington	46750	Children's Mental Health
Bowen Center - Warsaw	Warsaw	46580	Children's Mental Health
Bowen Center- Wabash	Wabash	46992	Children's Mental Health
DIABETES			
HealthVisions of Fort Wayne	Fort Wayne	46803	Diabetes Education
St. Joseph Hospital	Fort Wayne	46802	Diabetes Support Group
Parkview Center for Healthy Living	Kendallville	46755	Diabetes Workshop
HealthVisions of Fort Wayne	Fort Wayne	46802	Health Fair - FW Rescue Mission
CANCER			
American Cancer Society	Fort Wayne	46825	Appearance Enhancement Program
American Cancer Society	Fort Wayne	46825	Cancer Information and Referral

Cancer Services of Northeast Indiana	Fort Wayne	46825	Client Services
Francine's Friends	Fort Wayne	46845	Mobile Mammography
American Cancer Society	Fort Wayne	46825	Peer to Peer Breast Cancer Support
Cancer Services of Northeast Indiana	Fort Wayne	46825	Support Groups
AGING			
Aging and In - Home Services of NE Indiana	Fort Wayne	46805	Aging and Disability Resource Center
Turnstone	Fort Wayne	46805	Caregiver Support Group
Community Center	Fort Wayne	46802	Community Center
Huntington County Council on Aging	Huntington	46750	Information and Referral
Greater Indiana Chapter - FW	Fort Wayne	46804	Mental Health Information
Wellspring Interfaith Social Services	Fort Wayne	46802	Older Adult Program
Huntington County Council on Aging	Huntington	46750	Senior Center
Kosciusko Community Senior Services	Warsaw	46580	Senior Center
LaGrange County Council on Aging	LaGrange	46761	Senior Center
Neighborhood Health Clinics - Cedar Street	Kendallville	46755	Senior Center
Whitley County Council on Aging	Columbia City	46725	Senior Center
CARDIOVASCULAR DISEASE			
Wabash County Health Department	Wabash	46992	Health Screenings
Huntington County Health Department	Huntington	46750	Heath Screenings
Living Well in Wabash County COA	Wabash	46992	Living Well Winchester Center
HEALTHCARE ACCESS			
Brightpoint	Fort Wayne	46802	Covering Kids and Families
Brightpoint	Fort Wayne	46805	Covering Kids and Families
Brightpoint	Huntington	46750	Covering Kids and Families
Brightpoint	Wabash	46992	Covering Kids and Families
Brightpoint	Warsaw	46580	Covering Kids and Families
Brightpoint	Kendallville	46755	Covering Kids and Families
Brightpoint	LaGrange	46761	Covering Kids and Families
Kosciusko Community Hospital	Warsaw	46580	Health Insurance
Neighborhood Health Clinics - South Calhoun Street	Fort Wayne	46802	Health Insurance
Parkview Center for Healthy Living	Kendallville	46755	Health Insurance
Parkview Huntington Hospital	Huntington	46750	Health Insurance
Parkview LaGrange Hospital	LaGrange	46761	Health Insurance
Parkview Wabash Hospital	Wabash	46992	Health Insurance

Huntington County Division of Family Resources	Huntington	46750	Medicaid/Hoosier Healthwise/Hoosier Care Connect
Kosciusko County Division of Family Resources	Warsaw	46580	Medicaid/Hoosier Healthwise/Hoosier Care Connect
LaGrange County Division of Family Resources	LaGrange	46761	Medicaid/Hoosier Healthwise/Hoosier Care Connect
SSA-FW Field	Fort Wayne	46819	Medicare
STD TREATMENT			
LaGrange County Health Department	Shipshewana	46565	Adult Immunizations
LaGrange County Health Department	Topeka	46571	Adult Immunizations
Super Shot	Fort Wayne	46806	Adult Immunizations
Super Shot	Grabill	46741	Adult Immunizations
Super Shot	Fort Wayne	46845	Adult Immunizations
Medical Annex	Fort Wayne	46803	Adult/Adolescent Immunizations
Medical Annex	Fort Wayne	46803	Clinic
Neighborhood Health Clinics - South Calhoun Street	Fort Wayne	46802	Family Planning
Northeast Indiana Positive Resource Connection	Fort Wayne	46806	HIV Care Coordination
Northeast Indiana Positive Resource Connection	Fort Wayne	46806	Prevention Outreach
Northeast Indiana Positive Resource Connection	Fort Wayne	46806	STD Testing