Helping Hoosiers Address Obesity

Healthcare systems have a role to play in addressing obesity in Indiana, which is a contributing factor to several chronic health conditions including diabetes, cardiovascular disease, cancer and asthma. Use these resources from the IDOH Division of Nutrition and Physical Activity to create an action plan.

Patients

- Food insecurity screening and referral to food resource services
    - Example: Parkview Health's FAST program
- Food is Medicine Programming – Eskenazi has a robust FIM suite of programming
    - Produce Prescription Programs
        - Clinicians provide "prescriptions" for fresh produce for patients who have or are at risk for certain chronic conditions (hypertension, type 2 diabetes, obesity); usually includes a nutrition education component and requires a partnership with community org for provision of food (and sometimes education).
        - Example: Marion County Public Health Department's Produce Rx Program - multiple health care partners, including Eskenazi, Community Health Network, and several local FQHCs.
        - The DNPA oversees a Produce Prescription program with around 15 funded partners statewide. Reach out to Michelle Shippy (mshippy@health,in.gov) for more information.
    - Medically Tailored Meals (MTMs) - make these meals available in the hospital cafeterias
        - MTMs are delivered to individuals living with severe, complex and chronic illness through a referral from a medical professional or healthcare plan. Meal plans are tailored to the medical needs of the recipient by a Registered Dietician Nutritionist (RDN), and are designed to improve health outcomes, lower cost of care and increase patient satisfaction.
        - Eskenazi is the only program in Indiana I know about offhand, but we are working on a mapping project with some IU students that will map all FIM (including MTMs) across the state. Can share more information about other local examples of MTM once we gather it.
        - Here is an example from Michigan.
    - Nutrition Supports for Health Clinics Toolkit
- Wraparound Referral Services
    - In-house navigators to connect at-risk patients with appropriate support services and programming (SNAP, WIC, Medicaid, SNAP-Ed, TANF, etc.).
    - Make available to all patients a current resource list of what's around them (i.e. food pantries, SNAP/WIC retail outlets, sidewalks, trails, fitness centers) to support wellness and health weight management. This could be

done/created in partnership with Community Wellness Coordinators (CWCs) and/or local health coalitions.
        - The Community Compass app is a great tool. Referral services also at Eskenazi
- Implement food service guidelines and/or food purchasing policies in cafeterias
    - Eskenazi has a scratch-cooking model and purchases 70% of their food from local producers
    - Roadmap for Comprehensive Food Service Guidelines
    - CDC Food Service Guidelines Implementation Toolkit
- Include fruits and vegetables with every meal and make fresh produce readily available for snacks.
- Onsite food pantries and/or "food pharmacies"

Employees

- Have an employee wellness program that incentivizes screenings, healthy biometrics, etc.
    - Hancock Regional resources for employees and community members
- Follow food service guidelines in cafeterias
    - Eskenazi has a scratch-cooking model and purchases 70% of their food from local producers
    - Roadmap for Comprehensive Food Service Guidelines
    - CDC Food Service Guidelines Implementation Toolkit
- Include fresh fruits and vegetables with every meal
- Have a garden on-site
    - Eskenazi Sky Farm

Collaborate with LHDs/broader community

- Provide grants to the community based on CHNA priorities
    - IU Health
- Participate in Healthy Community Initiatives
    - Hancock Regional and the Healthy365 Program
- Host Farmers markets, mobile markets, or mobile pantries
    - Reid Health and Richmond Farmers Market
- Host or sponsor community events:
    - Resource/health fairs
    - Food drives or distribution events
    - Fun runs or other events in outdoor spaces
- Convene/create or identify a staff person to participate in existing local health coalitions and/or food policy councils
    - Example: Schneck Medical and Healthy Jackson County
- Examples of hospitals already working on collaborative projects with LHDs (can get more detailed examples of these partnerships upon request):
    - Marion County Public Health Department and Eskenazi
    - Monroe County Health Department and IU Health Bloomington

- Montgomery County Health Department and Franciscan Health
- Boone County Health Department and Witham Health
- Pulaski Health Department and Pulaski Memorial Hospital (in Winamac)
- Fulton County Health Department and Woodlawn Hospital
- Jackson County Health Department and Schneck Medical Center
- St. Joseph County Department of Health and Saint Joseph Health System

(they partner on obesity prevention AND infant mortality)

- Consider Community-Based Participatory Methods when performing community needs assessments

Diabetes, Prediabetes, Heart Disease and other Cardiovascular Diseases

- Diabetes Self Management Education and Support Programs (DSMES) - are geared to people with pre-existing or newly diagnosed diabetes. (Must have a physician's referral.) Teaches not only how to manage diabetes and medication, but covers food and physical activity also.
  - https://www.in.gov/health/cdpc/diabetes/#Programs_for_Citizens
  - https://www.adces.org/practice/diabetes-education-accreditation-program
  - https://professional.diabetes.org/education-recognition-program
- National Diabetes Prevention Program – for people who are at-risk for diabetes or who have been diagnosed with prediabetes. This program assists in losing weight, eating healthy foods, increasing activities. Evidence has shown that individuals who lost 5-7% of their current weight and who do at least 150 minutes per week of physical activity, can prevent diabetes or delay the onset of diabetes for 7 to 10 years.
  - https://www.cdc.gov/diabetes/prevention/index.html
  - https://www.in.gov/health/cdpc/diabetes/prevention/
- Provide the National DPP for employees as either a wellness benefit or a covered health benefit. https://www.cdc.gov/diabetes/prevention/employers-insurers.htm
- For people with high blood pressure or diagnosed hypertension, assist them in controlling their blood pressure by encouraging them to eat healthy, lower their salt/sodium intake and increase their physical activity level. https://millionhearts.hhs.gov/
- Help employees manage their blood pressure and make the DSMES program available for employees with diabetes. https://www.cdc.gov/dhdsp/pubs/toolkits/index.htm
- Refer individuals with diabetes to Purdue Extension's Dining with Diabetes to learn better eating and cooking tips. https://www.purdue.edu/hhs/extension/programs-food-0/#dining-with-diabetes or contact your local county extension educator.
- Refer individuals to TOPS, Weight Watchers, other evidence-based weight loss programs

Cancer: What can hospitals do? What is the connection to LHDs?

- Support policies which involve walkability and bicycle safety to increase daily physical activity.
- Emphasize health literacy efforts through outreach, support of community health workers, patient navigation and partnerships with LHDs, employers and community based organizations.
- Participate in the Indiana Breast and Cervical Cancer Program to enroll clients for breast and cervical cancer screening. Indiana Breast and Cervical Cancer Program
- Promote model efforts related to colorectal and lung cancer screening such as expanded hours, removing structural barriers such as transportation and lack of health literacy as well as innovative ideas such as participation in National Lung Cancer Screening day, FIT/FLU clinics and other outreach. The CDC Community Guide, Indiana Cancer Consortium Resources and Cancer Control at IDOH
- Participate in quality improvement activities to assure that clients are receiving regular care and supports to reduce obesity, increase activity and engage in cancer early detection activities. The CDC Community Guide
- Participate in the Indiana Cancer Consortium to shape cancer control activities for the state of Indiana. Indiana Cancer Consortium: Get Involved

Asthma

What can hospitals do? What is the connection to LHDs?

- EXHALE Guide for Healthcare System Executive Leaders – this guide has detailed steps and examples for how hospitals/healthcare systems can address asthma, which results in not only improved health outcomes but also cost savings
    - **Example: Parkview Health** is considered a "gold star" program by CDC and is noted in this guide (p. 9 of 17) as an example of a health system addressing asthma via a patient call-back system. *Through Parkview's partnership with the IDOH Asthma Program*, any patient seen in the 9 Parkview EDs for asthma receive a follow-up from a RN or RT with their program to address all elements of EXHALE. More details about Parkview's program are available in the guide and in the CDC's EXHALE Technical Package (p. 25 of 56).
        - The ROI of Parkview's program is greater than $1 per $1 spent
- Involve staff and community
    - Provide education on asthma symptoms, triggers, and treatment (1 in 10 Indiana adults have a diagnosis of asthma)
    - Commit to monitoring and improving indoor air quality and addressing identified asthma triggers (helps all staff, patients, and visitors)
    - Use existing internal and external communication channels to promote awareness of symptoms, triggers, and resources
        - Recognize World Asthma Day, Asthma & Allergy Awareness month, etc.

- Use CHWs, social workers, navigators, et al to connect patients to resources (for ex. addressing SDOH, medication access, referrals to primary care including CHCs/FQHCs, asthma trigger mitigation supplies, etc.)

- Partner with LHDs for asthma home trigger assessments and make referrals for patients whose asthma is poorly controlled (defined as visit to the ED for asthma, in-patient hospital stay for asthma, or frequent use of rescue medications)
    - IDOH Asthma Program trainings for LHDs to complete asthma home trigger assessments
        - Using EPA/HUD/CDC checklist: https://www.epa.gov/sites/default/files/2018-05/documents/asthma_home_environment_checklist.pdf
    - IDOH Asthma Program home assessment referral program provides support to LHDs to establish their own referral program or will provide in home assessments for those w/out internal capacity
    - **Example**: The **Marion County Public Health Department**, through its partnership with the IDOH asthma program, has successfully established a referral program to provide in home asthma trigger assessments and education. MCPHD has established a formal, bi-directional referral system with Riley Hospital for Children High Rish Asthma Clinic (and other community-based organizations and clinics). Patients/clients who complete the program report improved asthma symptoms and health outcomes.