



## Health Care and Public Health Partnering for Prevention

The Minneapolis SHIP Health Care Projects help clinics implement obesity and chronic disease prevention best practices, including linking patients to resources to help them eat better, be more active and quit smoking.

### Impact

"After seeing people suffer from chronic diseases from the inside of a hospital, it feels so wonderful to be a part of trying to help upstream, outside of the hospital, before people get sick. This is a dream come true and should be for many Minnesotans." Courtney Jordan, MD, SHIP Project Physician Consultant, and chair of the project's Health Care Work Group.

### Issue

The *Hennepin County SHAPE 2006-Adult Survey* indicated that:

- 54% of Hennepin County adults were either obese or overweight
- 43% of Hennepin County adults had one or more risk factors for chronic diseases (diabetes, heart disease, hypertension, or high cholesterol)
- 23% of obese Hennepin County adults who had complete physicals within the past year reported receiving weight loss advice from their health care provider
- 63.3% of overweight adults had never received weight loss advice from their health care provider.

### Intervention

The Minneapolis SHIP Health Care Projects capitalize on this missed opportunity, and give providers the tools and resources they need to maximize their influence on their patients' behavior changes. Using Institute for Clinical Systems Improvement (ICSI) evidence-based clinical practice guidelines, the project helps providers:

- Assess patients' chronic disease risk factors (nutrition, physical activity, tobacco use and exposure, and alcohol use)
- Talk to and set goals with patients about minimizing their risks
- Make referrals to community resources to help patients reach these goals



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**Creating a Healthier Minneapolis**  
**healthy eating + physical activity + smoke-free living**

Minneapolis Department of Health and Family Support (MDHFS)  
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## Key Strategies

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- Partner with multi-disciplinary clinic and clinic system teams to assess current practices, develop and implement clinic-specific action plans and evaluate results.
- Develop a referral system for providers to refer patients to clinic- and community-based programs and services for obesity and tobacco cessation.
- Assist clinics in identifying population specific resources and pursuing third-party reimbursement for obesity and tobacco cessation services.
- Collaborate with other local public health agencies, community agencies, clinics, ICSI, Minnesota health plans and other stakeholders, including receiving guidance from an advisory Health Care Work Group.

## Current Participating Clinics and Clinic Systems

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- AXIS Medical Center
- Bloomington Lake Clinics (Minneapolis and Bloomington)
- Broadway Family Medicine
- Fremont Community Health Services (Fremont, Central and Sheridan Clinics)
- Neighborhood Involvement Program
- Park Nicollet clinic system
- Phillips Neighborhood Clinic
- Southside Community Health Services
- The People's Center Medical Clinic

## Contact Information

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