Health Care at a Glance

About this strategy

The goal of this strategy is to increase clinic-community linkages for equitable access to health care prevention services that address tobacco cessation, pediatric and/or adult obesity, breastfeeding support, falls prevention, and dementia awareness and support. This strategy is founded on effective collaboration between health care settings, local public health agencies and community-based organizations.

What does the evidence say?

Research has shown that patients are more likely to check out a resource referred by their health care provider. SHIP is dedicated to encouraging medical professionals to be proactive about sharing the harmful health effects of obesity and tobacco and offering ways to encourage healthy living. Early referral and intervention allows for patients to integrate into “prevention” care, which over time will alleviate the need for costly restorative care delivery. SHIP encourages health care providers and community leaders to develop a structured and well-organized strategy for communication, which will lead health care providers and community leaders to an effective system of referral of patients.

Activities

Identify clinic partners to assess gaps and barriers, then support enhancing screen, counsel, refer and follow-up protocols for evidence-based programs, including:

- National Diabetes Prevention Program
- Call it Quits Tobacco Referral Program
- A Matter of Balance
- Chronic Disease Self-Management Program
- Tai Ji Quan Moving for Better Balance
- Dementia-Friendly Communities
- MDH Breastfeeding-Friendly Maternity Centers

Priority populations

All activities that take place in the health care strategy should be using a health equity lens. Grantees should work to learn about, reach out to and engage populations that are experiencing health inequities within their communities so that all people have access and the

opportunity to live a healthy life. Populations that may be experiencing health inequities can include low income, uninsured or underinsured, older adults, racial or ethnic minorities, etc.

Requirements

Grantees are expected to:

- Identify and cultivate strong relationships with health care setting partners (e.g., clinics, hospitals, pharmacies) and community-based partners (e.g., YMCA, Area Agency on Aging, faith-based groups, community centers)
- Assess the needs of the community and health care settings that serve it; determine priorities to work on together
- Understand the health care setting work flow and the roles represented
- Build a network of community resources for prioritized work, and determine how partners will use these resources and communicate with each other
- Monitor impact of revised clinic workflows including follow-up to referrals

Important events

Look for upcoming events and webinars in the Making it Better log and on Basecamp.

Resources

- National Diabetes Prevention Program (http://www.cdc.gov/diabetes/prevention/index.htm)
- Call it Quits (https://www.health.state.mn.us/communities/tobacco/initiatives/mnquitlines/index.html)
- MDH Breastfeeding Friendly Maternity Centers (https://www.health.state.mn.us/people/breastfeeding/matcntrs.html)
- ACT on Alzheimer's (http://actonalz.org/)

Minnesota Department of Health
Office of Statewide Health Improvement Initiatives
85 E. 7th Place, Suite 220
PO Box 64882
St. Paul, MN 55164-0882
651-201-5443
Health.OSHII@state.mn.us
www.health.state.mn.us

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