

**Comprehensive Statewide Health Promotion Plan Detail
November 15, 2007**

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INTRODUCTION

The 2007 Minnesota State Legislature passed legislation requiring the development of a plan for comprehensive statewide health promotion:

The commissioner of health, in consultation with the State Community Health Services Advisory Committee established in Minnesota Statutes, section 145A.10, subdivision 10, shall develop a plan to fund and implement an ongoing comprehensive health promotion program that can effect change more effectively and at lower cost at a community level rather than through individual counseling and change promotion. The program shall use proven public health strategies to promote healthy lifestyles and behaviors in order to establish a sustainable, long-term approach to reducing preventable disability, chronic health conditions, and disease. The focus shall be on community based initiatives that address childhood and adult obesity, tobacco and substance abuse, improved activity levels among senior citizens, and other lifestyle issues that impact health and health care costs. Because of its population health focus, funding shall be related to the size of the population to be served. The plan shall be completed by October 1, 2007, and shared with the Legislative Health Care Access Commission.

The Plan addresses premature and preventable deaths, decreased quality of life and financial costs resulting from chronic diseases. It utilizes proven techniques to improve population health and reduce chronic disease incidence and prevalence.

1. The Plan takes knowledge collected from existing state plans for specific chronic disease programs (e.g. diabetes, cancer and heart disease), identifies evidence-based strategies learned from programs such as Steps to a HealthierMN and state plans, and synthesizes and translates the prioritized recommendations into outcomes.
2. The Plan addresses the burden of chronic diseases and the fact that chronic disease can be reduced by addressing four significant risk factors – physical inactivity, unhealthy eating, alcohol abuse and tobacco use and exposure.
3. The Plan recommends providing local public health with funding and assistance to conduct health promotion in collaboration with local communities, schools, worksites and health care providers.

This document contains materials requested by the Health Care Transformation Task Force in an effort to provide additional depth and cost savings information in relation to the Comprehensive Statewide Health Promotion Plan. This includes statewide goals, objectives and evidence-based approaches; state-level policy efforts needed to support the Plan; accountability; and potential cost savings information.

THE BUSINESS CASE FOR HEALTH PROMOTION INTERVENTIONS

Placing greater emphasis on prevention has considerable potential for lowering health care expenditures. And while many prevention efforts make important contributions to health and wellness, changing unhealthy behaviors that are known risk factors for chronic disease can have some of the largest cost saving potential.

Table 1 shows the annual direct medical costs of tobacco use, physical inactivity and obesity in Minnesota and the U.S. These costs are high and account for significant percentages of overall health spending. For example, in Minnesota, medical costs associated with obesity in 2000 were estimated to represent about 5% of all health care spending in the state.ⁱ It is important to note that the costs for these risk factors are not mutually exclusive; physical inactivity obviously contributes to the cost of obesity and tobacco use is probably highly correlated with the other risk factors as well. In other words, there may be substantial overlap in these cost estimates.

Table 1: Estimated Annual Direct Medical Cost of Modifiable Health Risks

Risk Factor	Minnesota	U.S.
Tobacco ⁱⁱ	\$1.98 billion	\$75 billion
Physical Inactivity ⁱⁱⁱ	\$495 million	<i>Not available</i>
Obesity ^{iv}	\$1.31 billion	\$75 billion

Cost Impact of Unhealthy Behaviors

Several studies have shown that risk factors such as tobacco use, obesity and physical inactivity significantly increase health care costs. For example:

- A HealthPartners study of over 5,000 adult enrollees in 1995-1996 found that:^v
 - Each additional unit of Body Mass Index (BMI) increased medical charges by 1.9%.
 - A history of tobacco use was associated with 25.8% higher medical charges.
 - Each additional day of physical activity per week reduced medical charges by 4.7%.
- A national study found that 27% of health care charges for adults over age 40 are associated with people being physically inactive, overweight and/or obese.^{vi}
- Per capita private health insurance expenditures for obese adults were \$1272 higher than those for normal weight adults in 2002; this represents a 56% increase in the gap in spending between obese and normal weight adults from 1998 to 2002.^{vii}
- From 1987 to 2001, obesity-related health spending accounted for an estimated 27% of the increase in inflation-adjusted per capita health spending.^{viii}

Impact of Prevention and Wellness Initiatives

While the association between certain risk factors and increased health care costs is well established, there is less information about the cost effectiveness of specific interventions to change people's health behaviors. Much of the available research comes from evaluations of employer-sponsored wellness initiatives. Some of the findings from this research include:

- A preliminary study of *Fit Choices*, which subsidized gym memberships for Minnesota Medica enrollees, showed that participants had lower health care costs than a control group.^{ix}
- Preliminary analysis of the HealthPartners 10,000 Steps program shows that participants increased their daily steps by an average of 21% and 42% of them lost at least four pounds.^x
- A recent review of health promotion and disease management programs found a significant return on investment, with benefit-to-cost ratios ranging from \$1.49 to \$4.91 in benefits for every dollar spent.^{xi}
- Johnson & Johnson's *Health&Wellness Program* showed a \$225 reduction in average annual medical costs per employee over a four year period. The program is designed to integrate occupational health, wellness and medical benefits.^{xii}
- Participation in Motorola's *Wellness Initiatives* resulted in a \$3.93 return on investment (ROI).^{xiii}

Cost Benefit and Cost Savings of the Comprehensive Statewide Health Promotion Plan

Potential cost savings of reaching obesity goals by 2020 grow to just over 3.5% of the Minnesota estimate for total health care spending and equal (in millions) \$14,607.80.

Potential cost savings of reducing smoking prevalence to 12% by 2020 would result in a total savings (in millions) between 2008-2020 of \$6,629.00.

Cost savings data for reducing the misuse of alcohol is not available.

IDENTIFICATION OF EVIDENCE-BASED INTERVENTIONS FOR THE COMPREHENSIVE STATEWIDE HEALTH PROMOTION PLAN

Scientifically sound strategies and approaches are critical for the Comprehensive Statewide Health Promotion Plan implementation. To be successful in improving the quality of life for Minnesotans and reducing health care costs, the Minnesota Department of Health will utilize the RE-AIM tool to monitor, course correct and ensure the strategies and interventions being implemented across the state at the community level will provide the expected and required health saving results.

RE-AIM is a systematic way for researchers, practitioners and policy makers to evaluate health behavior interventions; it can be used to estimate the potential impact of interventions on public health. RE-AIM is an acronym that consists of five elements, or dimensions, that relate to health behavior interventions:

- Reach the target population
- Efficacy or effectiveness
- Adoption by target settings or institution
- Implementation - consistency of delivery of intervention
- Maintenance of intervention effects in individuals and populations over time.

(See separate article titled “Evaluating the impact of health promotion programs: using the RE AIM framework to form summary measures for decision making involving complex issues.”)

STATEWIDE POLICY INITIATIVES AND LOCAL GOALS, OBJECTIVES AND STRATEGIES OF THE COMPREHENSIVE STATEWIDE HEALTH PROMOTION PLAN

Many of the most prevalent and costly illnesses today are preventable, but the unhealthy behaviors contributing to these illnesses are rising. To change this, Minnesota needs to make health promotion a higher priority and invest in programs that demonstrate results in helping individuals as well as whole communities become healthier.

Statewide Policy Initiatives Needed to Produce Systems Change

As indicated by the CDC, “The next major step forward in chronic disease prevention and health promotion will come through the increasing and widespread use of policy and environmental change interventions that can impact large segments of the population simultaneously.” The following seven policies are critical in the success of systems wide health maintenance and improvement. These policies need support at both the state and local level for the proposed goals, objectives and strategies to be most cost effective and reduce the burden of chronic disease.

1. *Enhance Physical Education in Schools*

Physical education programs within the school setting can set the stage for how children view physical fitness, activity levels and future health. The school setting provides a structured atmosphere in which to incorporate physical activities and ideally develop healthy habits for life. Studies indicate that promotion of a healthy lifestyle taught in physical education classes can influence long-term health benefits such as reduced rates of obesity, heart disease, high cholesterol, diabetes and high blood pressure.

The evidence is strong that physical education (PE) in school increases levels of physical activity and fitness. The Institute of Medicine recommends at least 30 minutes of physical activity at school since that is where children spend half their day. Strategies include

adding new PE classes, lengthening existing classes, and increasing physical activity levels. There is no evidence that increased PE time impairs academic performance.

2. *Increase Access to Places for Physical Activity*

Communities play a large role in providing and developing venues where all citizens can be physically active in a safe and healthy environment. Creating or enhancing access to places for physical activity, combined with informational outreach, is effective at increasing levels of physical activity. In addition to increasing fitness, and decreasing body fat, increasing physical activity can reduce medical costs. Scientific evidence increasingly indicates that physical activity can extend years of active independent life, reduce disability and improve the quality of life for older persons.

3. *Promote Healthy Foods in Schools*

Interventions within schools to increase the availability and promotion of healthy foods have increased the purchase of these foods by adolescents. Schools can reach almost all children and adolescents. Schools can provide opportunities to practice healthy eating as approximately 1 million children attending school daily in Minnesota, making the school setting an ideal environment to provide healthy foods.

4. *Increase Access to Healthy Foods in Communities*

Introducing a wider range of healthy food and beverage options to convenience stores is essential to providing access to all populations for healthy fruit and vegetable consumption. Other successful interventions include creating accessible farmers markets, establishing food-buying cooperatives, and establishing community gardens, which are currently being implemented in all Steps communities.

5. *Make Public Places and Workplaces Smoke-free*

Smoke-free policies are effective at reducing exposure to secondhand smoke. They reduce exposure to the components of secondhand smoke by an average of 72%. Studies have observed reductions in the number of cigarettes smoked by people covered by smoke free policies. Freedom to Breathe is an example of such a policy that will impact the health of Minnesotans related to tobacco use and exposure.

6. *Increase the Price of Tobacco Products*

Price increases reduce the number of people who start using tobacco and increase the number who quit. National research shows that a 10% increase in tobacco prices has led to a 3.7% reduction in adolescent use and a 4.1% reduction in adult use. Raising the excise tax on tobacco products has historically resulted in equivalent or larger increases in tobacco product price. Tobacco taxes and fee increases can be used to fund tobacco prevention and other chronic disease prevention efforts, thus increasing the beneficial impact on health.

7. *Ensure Access to Clinical Preventive Services*

Clinical preventive services include screening, counseling and follow-up treatment for conditions such as high blood pressure, high blood glucose, high cholesterol and tobacco use. While insurance coverage does not guarantee that services will be delivered, adults are more likely to receive services such as blood pressure and cholesterol tests when those services are covered by insurance. Treatment for high cholesterol reduces death from heart disease by 23% and from stroke by approximately 24%.

(See separate attachment for article titled “Impact of Energy Intake, Physical Activity, and Population-wide Weight Loss on Cardiovascular Disease and Diabetes Mortality in Cuba, 1980–2005.”)

Local-Level Goals, Objectives and Suggested Strategies in Four Settings

This plan will engage the following goals and objectives to work toward reducing the prevalence of chronic disease risk factors in Minnesota and decrease overall health care costs.

The Comprehensive Statewide Health Promotion Plan aims to:

I. Decrease the rates of obesity in Minnesota

- A. Reduce the prevalence of obesity to 15% by 2020;
- B. Reduce the prevalence of overweight to 35% by 2020;
- C. Increase the percentage of healthy weight Minnesotans to 50% by 2020.

Community strategies:

- 1) Increase the physical activity environmental and policy supports in Minnesota.

Possible activities: Work with schools and communities to implement Safe Routes to School infrastructure and non-infrastructure projects funded through the Minnesota Department of Transportation; implement walkable community workshops.

- 2) Improve access to and affordability of fruits and vegetables for low income populations through supermarkets, farmers’ markets and community gardens.

Possible activities: Work with local farmers’ markets to do coupon exchange programs; work with local community gardens to get fruits and vegetables donated to local food shelves.

School strategies:

- 1) Promote quality K-12 physical education in Minnesota schools.

Possible activities: Require the recommended amount of physical education (National Association of Sports and Physical Education: 150 minutes/week for students in elementary school and 225 minutes/week for students in middle and high school); assist schools in adopting Standards, Benchmarks, and Activities in Physical Education developed by the Quality Teaching Network in Health Education and Physical Education in partnership with the Minnesota Department of Education.

- 2) Improve the nutritional environment in schools.

Possible activities: Provide technical support to schools to implement policies that develop or adopt nutrition standards for all food and beverages available on school campuses, including vending, school lunch and breakfast programs, school stores, concessions, classroom parties and fundraising.

Worksite strategies:

- 1) Implement point-of-decision prompts (e.g., stairwell campaigns, steps or mileage signs, walking route maps, etc.) in Minnesota worksites.

Possible activities: Provide technical assistance to local worksites to create and post signage and maps for various point-of-decision opportunities for physical activity; promote implementation of point-of-decision programs such as the do Campaign and programs offered by the American Heart Association and American Cancer Society in local worksites.

- 2) Implement worksite interventions that combine nutrition and physical activity (e.g., “multi-component interventions”).

Possible activities: Encourage worksites to work with their insurance providers to increase the nutrition and physical activity resources available to staff; promote the use of lactation rooms in worksites.

Health care strategies:

- 1) Implement physical activity counseling by health care providers.

Possible activities: Promote patient counseling guidelines on physical activity from Institute for Clinical Systems Improvement (ICSI), U.S. Clinical Preventive Services, American Medical Association and American College of Sports Medicine to health care providers; map community opportunities for physical

activity and share with local health care providers so they may refer patients to the opportunities.

- 2) Offer culturally sensitive programs that focus on reducing obesity prevalence, improving dietary behaviors, increasing physical activity levels and reducing sedentary behaviors in high risk populations.

Possible activities: Work with healthcare industry to increase the proportion of healthcare providers who offer culturally sensitive counseling patients and families on the prevention and risks associated with overweight and obesity.

II. Decrease the rates of tobacco use in Minnesota

- A. Have no increase in the percentage of Minnesotans who smoke in 2008 and 2009;
- B. From 2010-2013 reduce the percentage of Minnesotans who smoke by 2% per year, so that the percentage who smoke is cut in half by 2013;
- C. Continue reducing the percentage of Minnesotans who smoke after 2013.

Community strategies:

- 1) Mobilize communities to identify and reduce the commercial availability of tobacco products to youth, using combined interventions (stronger local laws directed at retailers, active enforcement of retailer sales laws and retailer education with reinforcement.)

Possible activities: Write stronger laws directed at retailers, actively enforce retailer sales laws and educate retailers about reducing commercial availability of tobacco products to youth.

- 2) Increase the number of tobacco-free environments in the community by adopting comprehensive tobacco-free parks, playgrounds, beaches and other recreation area policies.

Possible activities: Support community assessment and build policy support.

School strategies:

- 1) Advocate for the development, implementation, promotion and enforcement of smoke-free tobacco policies at all public and private facilities.

Possible activities: Prohibit tobacco use at all school facilities and events and encourage and help students and staff to quit using tobacco.

- 2) Implement CDC's "Guidelines for School Health Programs to Prevent Tobacco Use and Addiction," including tobacco free policies, teacher training, parental involvement and cessation services.

Possible activities: Provide developmentally appropriate instruction in grades K-12 that addresses the social and psychological causes of tobacco use; aim for a coordinated school health program in which everyone delivers consistent messages about tobacco use.

Worksite strategies:

- 1) Work with local communities to enforce Freedom to Breathe provisions in workplaces.

Possible activities: Create a business kit that includes letters, brochures or signage that explains ordinance compliance to businesses and their patrons. Translate materials into a variety of languages, as deemed appropriate for each community

- 2) Consult with employers to increase cessation resources offered at workplaces.

Possible activities: Market 'Quitplan at Work' no cost on-site cessation classes (One or two groups offered free per year per employer by Park Nicollet Occupational Health Source). Promote Quitplan telephone counseling, web services to uninsured and underinsured. Work with Clearway Minnesota to intensify the mass media campaign to promote Quitplan.

Health care strategies:

- 1) Reduce or eliminate client out of pocket cost for effective cessation therapies.

Possible activities: Promote local public health staff understanding and utilization of mandated tobacco cessation benefits for Minnesota Medicaid-eligible persons. Increase information disseminated through MN DHS website and toll free phone line for health care providers (MHCP program) about current reimbursement rates and levels for effective tobacco cessation interventions/therapies.

- 2) Implement multi-component tobacco use cessation interventions that include client telephone support (quit lines).

Possible activities: Disseminate information on cessation resources and current treatments; what they are, how they work, and how to access them. LPH agencies participate in the "Call It Quits" program; statewide referral of smokers to quitlines by fax after an agency registers with the program.

III. Decrease the misuse of alcohol among Minnesota youth and adults

Youth

1. Have no increases in the percentage of Minnesota youth who report underage drinking in 2008 and 2009;
2. From 2010-2013 reduce the percentage of Minnesota youth who report underage drinking by 1% per year, so fewer than 25% of 9th graders and 45% of 12th graders report underage drinking by 2013;
3. Continue reducing the percentage of Minnesotan youth who report underage drinking after 2013.

Adults

1. Have no increases in the percentage of Minnesota adults who report binge drinking in 2008 and 2009;
2. From 2010-2013 reduce the percentage of Minnesota adults who report binge drinking at least 1% per year, so fewer than 15% of Minnesota adults report binge drinking by 2013;
3. Continue reducing the percentage of Minnesota adults who report binge drinking after 2013.

Community strategies:

- 1) Implement and enforce policies that reduce youth access to alcohol.

Possible activities: Work with local law enforcement to implement and enforce alcohol compliance checks; work with communities to develop strong social host ordinances which make it illegal for adults to allow minors to consume alcohol, other than their own children, in their homes.

- 2) Implement and enforce policies that discourage both youth and adult misuse of alcohol.

Possible activities: Work with local governments and business organizations to develop policies to limit or eliminate drink specials; work with local governments to limit alcohol beverage outlet density through zoning ordinances.

School strategies:

- 1) Provide education for students, staff and parents about alcohol use and misuse.

Possible activities: Implement an evidence based curriculum for students including a parental component; facilitate a parent program to educate them about alcohol use and to increase their communications with the school and with each other.

- 2) Implement and enforce policies for students, staff and parents about alcohol use during school hours.

Possible activities: Enforce a no use policy on school property; enforce a no use policy during school sponsored events for staff and parents.

Worksite strategies:

- 1) Implement and enforce rules about alcohol use during work time.

Possible activities: Implement no use policies during work sponsored events such as holiday parties; implement no use policies while engaged in offsite work activities including use of company vehicles.

- 2) Provide employee assistance programs for those who are having problems with their alcohol use.

Possible activities: Publicize the program so employees can easily access the program; encourage use of the program and provide support to employees who use it.

Health care strategies:

- 1) Work with healthcare providers to address patient alcohol use.

Possible activities: Implement policies requiring providers to screen patients for alcohol use; implement policies to provide brief intervention or referrals for patients who are having problems with their alcohol use.

- 2) Work with healthcare providers to address employee alcohol use.

Possible activities: Implement and enforce rules about alcohol use during work time; provide employee assistance programs for those who are having problems with their alcohol use.

IDENTIFY BARRIERS AND DEVELOP STRATEGIES RELATING TO THE COMPREHENSIVE STATEWIDE HEALTH PROMOTION PLAN

Health costs are rising largely due to chronic diseases and conditions that can be prevented with healthier lifestyles. Despite the potential for greater health at lesser cost, prevention receives

little financial support or merely sporadic funding in Minnesota; efforts for health promotion tend to be small and piecemeal and focused on one disease at a time. In addition, many federal programs that have helped support health promotion have been reduced or eliminated, making health promotion resources scarce for the Minnesota Department of Health and our local community partners.

As in the case with the four communities of the Steps to a HealthierMN program, continual assessment and evaluation of interventions will take place while implementing the Comprehensive Statewide Health promotion Program to ensure that interventions are working with the highest risk populations and that the programs are tailored to be culturally specific in order to achieve maximum effect.

All interventions proven to be ineffective will be immediately modified to improve impact or discontinued.

IMPLEMENTATION OF THE COMPREHENSIVE STATEWIDE HEALTH PROMOTION PLAN

Local Public Health Roles, Responsibilities and Accountability

The community health board (CHB) roles defined in the Plan are consistent with the essential local activities (ELAs), or the minimum standards that all local health departments are expected to be able to perform. All local health departments in Minnesota are required to report annually what they have done to meet the ELAs, including what they have done to promote physical activity and nutrition and prevent alcohol, tobacco and other drug use in their jurisdictions. This data is collected using the Local Public Health Planning and Performance Measurement Reporting System (LPH PPMRS).

To the extent possible, this existing system will be used to track local accountability and document successes of the Plan. This includes providing additional (yet to be developed) Plan tracking questions as necessary. Furthermore, state staff monitoring the implementation and success of the Plan will have access to LPH PPMRS data for analysis and evaluation purposes. Data and reports from this reporting system will be made available to policy and decision makers as requested.

The eight ELAs relevant to this Plan are outlined below. Examples of work done by local health departments to meet these standards during CY2006 are listed under each ELA. These examples provide a snapshot of the breadth of activities being undertaken around the state, but also illustrate the piecemeal way in which health promotion is currently undertaken in Minnesota. To review all examples submitted by local public health departments for 2006, please visit: <http://www.health.state.mn.us/ppmrs>.

To comprehensively address chronic diseases, a statewide plan and additional funding are needed. The Goal Matrix (see Appendix) outlines additional, evidence-based strategies and

activities that local public health departments could implement (with help from partners) in their communities with additional funding.

Essential Local Activities with Examples

1. Engage community partners through (a) collaborative assessment and prioritization, (b) coalition building, (c) community readiness, (d) empowerment and (e) decision making.
 - *Tobacco*: Anoka worked with community residents to build a locally driven effort that advocated for adopting tobacco-free policies for city parks and youth organizations.
2. Based on a community assessment, develop community health action plans to address physical activity, nutrition, tobacco, alcohol and other drug use.
 - All community health boards in Minnesota are required to submit community health action plans. These plans are based on their community assessment and prioritization process (as described in the Local Public Health Act legislation) and are due to MDH by December 31, 2009. Specific local examples are not available at this time.
3. Conduct evidence-based, culturally sensitive programs, and disseminate information on services and resources to promote healthy behaviors and communities.
 - *Physical activity*: Dakota County has targeted WIC participant families as being at high risk for obesity and is promoting physical activity to this population (parents and children) through the Fit WIC program. Fit WIC uses music and movement classes, educational materials and individual counseling strategies.
4. Inform and educate different audiences, e.g., general public, providers and policy leaders, about healthy communities and population health status.
 - *Nutrition*: Kandiyohi County collaborated with the Steps to a Healthier Willmar program and the YMCA to enhance a summer garden project by incorporating a nutrition education unit (based on the 5 A Day campaign) for children and parents; awareness and behavior changes were noted.
5. Support the development and enforcement of policies, and encourage cultural norms that promote healthy communities.
 - *Alcohol*: Carver County's Safe Communities Coalition worked to support the creation of local ordinances that require liquor license holders to attend annual trainings.
6. Participate in decisions about community improvement and development to promote healthy behaviors and communities.

- *Physical activity*: The Northeast MN Active Community Assessment and Engagement project, a coalition comprised of four MN counties and two reservations are engaging strategic groups and developing active living principles to guide regional planning.
7. Promote the optimum quality of life, e.g., healthy growth, development, aging, and management of chronic diseases across the lifespan.
- *Nutrition*: Dakota County participated in a community collaborative to promote breastfeeding. Their activities included promoting breastfeeding at the county fair by offering lactation rooms and providing educational materials as well as publicity.
8. Identify and address the needs of vulnerable populations and those experiencing health disparities.
- *Tobacco*: Meeker County worked with the Litchfield school district to promote tobacco prevention to Latino youth by offering two Tobacco Free Latino Hip Hop Dances, reaching over 350 middle and high school students. The events featured music, food, prizes and tobacco education materials and displays.

The CHBs will participate in establishing a common set of core performance measures to track the number and types of persons served by various intervention strategies and the achievement of related short-term, intermediate, and long-term outcomes. As a component of the local public health PPMRS, CHBs should agree to collect and report on core performance measures using standardized methodology to document how intervention strategies are being implemented and are successfully addressing priorities of the initiative.

Minnesota Department of Health Roles and Responsibilities

MDH provides administrative and program support for local public health departments and plays an important role in promoting the adoption or application of research findings into their programs and practices. This is both critical to and consistent with Minnesota's state-local public health partnership model. In this regard, MDH has a long history of involvement in health promotion and the prevention of chronic diseases.

MDH would provide state-level oversight and guidance of the Comprehensive Statewide Health Promotion Plan. In addition, MDH would serve a role in implementing statewide policies discussed on page 5 to ensure these policies support local program efforts to improve the health of Minnesotans.

MDH would provide the following services to CHBs as they implement the Plan:

- Content expertise - MDH has content experts in health promotion, chronic disease prevention and disease management.
- Technical expertise - MDH staff has provided similar technical expertise for Steps to a HealthierMN communities on all aspects of program administration and evaluation.
- Training - MDH staff experts will work with CHBs to train program staff on implementing and evaluating interventions.

- Overall assessment and evaluation - MDH will be responsible for coordinating the overall assessment and evaluation activities at the state-level and assist on local evaluations.
- Responsibility for RE-AIM framework - MDH will be responsible for the RE-AIM framework used to ensure the strategies and interventions being implemented across the state of Minnesota at the community level will provide the expected and required health saving results.
- Reporting and accountability back to the Minnesota State Legislature - MDH will prepare comprehensive reports for the state legislature detailing accomplishments.

MDH will ensure the Plan meets and addresses all outlined short, mid and long-term objectives by coordinating the statewide evaluation and assisting CHBs with local evaluation technical assistance.

MONITORING AND EVALUATION OF THE COMPREHENSIVE STATEWIDE HEALTH PROMOTION PLAN

Comprehensive Evaluation of the Comprehensive Statewide Health Promotion program will be coordinated by MDH. This evaluation will include both statewide and local evaluation and will occur continuously beginning with program planning. The Centers for Disease Control and Prevention's *Framework for Evaluation of Public Health Programs* and Michael Patton's (1996) *Utilization-Focused Evaluation* will be used to guide evaluation activities. Progress towards intended goals and objectives will be monitored by reporting and collecting data on Comprehensive Statewide Health Promotion Core Performance Measures.

Specifically, statewide evaluation activities will include:

- Facilitating the process to identify Comprehensive Statewide Health Promotion Core Performance Measures.
- Providing guidance and assistance to local public health staff in developing local evaluation plans.
- Development of reporting mechanisms to be integrated with current local public health reporting, demonstrating accountability that:
 - Interventions address the key elements of the Comprehensive Statewide Health Promotion Plan
 - Community input into planning, implementation, and evaluation process
 - Adherence to the socio-ecological model
 - Health promotion through four settings: community, schools, worksites, health care
 - Program staff to champion health promotion efforts locally
 - Interventions are informed by evidence-base
 - Integration across chronic disease programs
 - Local evaluation is extensive and comprehensive and linked to program planning
 - Interventions primarily rely on policy, systems and environmental change that supports healthy behaviors

- Local level accountability and oversight of partner organizations
 - Appropriate data is collected that measures progress towards Comprehensive Statewide Health Promotion Core Performance Measures
- Coordinate the implementation of surveys to measure outcomes at the local level (Expand the BRFSS to sample size that allows data analysis at the CHB level).
- Work with the Minnesota Student Survey team to ensure all questions necessary to evaluate student process and outcomes measures are included on the survey.
- Identify and utilize existing secondary data bases to measure progress toward program goals and objectives.

The specific responsibilities for local evaluation include:

- Engaging stakeholders in the evaluation process at the community level and incorporating recommendations from those stakeholders in the program design and evaluation process.
- Submitting reports through the PPMR reporting system.
- Assisting MDH in coordinating the BRFSS and MSS in their communities.
- Coordinating qualitative data collection and analysis on measures for which these methods are deemed the best evaluation technique.
- Writing quarterly reports for their community.
- Communicating evaluation results to the project coordinator and local stakeholders.

Progress Publicly Reported

The Minnesota Department of Health will report annually to the State Legislature on progress toward achieving the Comprehensive Statewide Health Promotion Plan goals, objectives and outcomes. Progress measures will be disaggregated by community utilizing the BRFSS and the MSS in order to identify shortfalls enable technical assistance efforts to be appropriately targeted.

Organizations that implement priority intervention programs and/or achieve significant progress toward priority goals will receive governor’s awards and be publicly recognized.

COMPREHENSIVE STATEWIDE HEALTH PROMOTION PLAN TIME LINE

Fall 2008:	Initiate state-level program and evaluation planning
Spring 2009:	Initiate community plan and consortium development
Fall 2009 - 2010:	Initiate implementing community, worksite, school, and health care interventions
Fall 2010:	Begin first round of collecting data for evaluation at state- and local-level
Spring 2011:	Prepare first year reports

- 2011 – 2018:** Continue implementing and evaluating interventions (modifying as necessary) and preparing yearly reports
- Spring 2013:** Update community and state-level program plans
- 2009 – 2018:** Provide technical assistance (MDH and other state agencies)

NEXT STEPS

For Minnesota to make a lasting impact on the reduction of chronic diseases, we need to develop, implement and sustain focused outreach efforts. It takes targeted, disease-specific actions to eradicate disease. Reaching high risk groups and specific settings requires intensive effort. The following suggestions are key to reducing chronic diseases and health care costs for Minnesota:

1. Implement and support the essential policy suggestions at the state and local level.
2. Implement and support the nine component model addressed in the Comprehensive Statewide Health Promotion Plan.
3. Adequately finance the Comprehensive Statewide Health Promotion Plan.
4. Provide adequate state and local level staffing to assure the effective implementation and monitoring of the Plan.
5. Implement core performance measures that ensure both chronic diseases and cost savings are being documented and goals are being reached.
6. Maintain funding as a long term infrastructure investment for the state of Minnesota.

APPENDIX – GOAL MATRIX

GOAL I: To decrease rates of obesity in Minnesota		
Objectives	Indicator	Cost Benefit/Savings
<ul style="list-style-type: none"> • Reduce the prevalence of obesity to 15% by 2020 • Reduce the prevalence of overweight to 35% by 2020 • Increase the percentage of healthy weight Minnesotans to 50% by 2020 	Overweight adults: 38% Obese adults: 25% (BRFSS 2006)	Total potential savings (in millions) between 2008-2020: \$14,607.8
Setting	Strategy	Indicator
<i>Community</i>	1. Increase the physical activity environmental and policy supports in Minnesota. <ul style="list-style-type: none"> • Work with schools and communities to implement Safe Routes to School infrastructure and non-infrastructure projects funded through the Minnesota Department of Transportation. • Implement walkable community workshops. 2. Improve access to and affordability of fruits and vegetables for low income populations through supermarkets, farmers' markets and community gardens. <ul style="list-style-type: none"> • Work with local farmers' markets to do coupon exchange programs. • Work with local community gardens to get fruits and vegetables donated to local food shelves. 	1. LPH PPMRS 2. LPH PPMRS
<i>School</i>	1. Promote quality K-12 physical education in MN schools <ul style="list-style-type: none"> • Promote the recommended amount of physical education (National Association of Sports and Physical Education: 150 minutes/week for students in elementary school and 225 minutes/week for students in middle and high school). • Assist schools in adopting Standards, Benchmarks, and Activities in Physical Education developed by the Quality Teaching Network in Health Education and Physical Education in partnership with the Minnesota Department of Education. 2. Improve the nutritional environment in schools <ul style="list-style-type: none"> • Provide technical support to schools to implement policies that develop or adopt nutrition standards for all food and beverages available on school campuses, including vending, school stores, concessions, classroom parties, and fundraising. • Evaluate local implementation of school policies. 	1. School surveys such as School Health Education Profile Survey (SHEPS), SHPPS, School Health Index 2. LPH PPMRS
<i>Workplace</i>	1. Implement point-of-decision prompts (e.g., stairwell campaigns, steps or mileage signs, walking route maps, etc) in Minnesota worksites. <ul style="list-style-type: none"> • Provide technical assistance to local worksites to create and post signage and maps for various point-of-decision opportunities for physical activity. 	1. LPH PPMRS

	<ul style="list-style-type: none"> Promote implementation of point-of-decision programs such as the do Campaign and programs offered by the American Heart Association and American Cancer Society in local worksites. <p>2. Implement worksite interventions that combine nutrition and physical activity (e.g., “multi-component interventions”).</p> <ul style="list-style-type: none"> Encourage worksites to work with their insurance providers to increase the nutrition and physical activity resources available to staff. Promote the use of lactation rooms in worksites. 	2. Worksite survey
<i>Health care</i>	<p>1. Implement physical activity counseling by health care providers.</p> <ul style="list-style-type: none"> Promote patient counseling guidelines on physical activity from Institute for Clinical Systems Improvement (ICSI), U.S. Clinical Preventive Services, American Medical Association and American College of Sports Medicine to health care providers. Map community opportunities for physical activity and share with local health care providers so they may refer patients to the opportunities. <p>2. Offer culturally sensitive programs that focus on reducing obesity prevalence, improving dietary behaviors, increasing physical activity levels and reducing sedentary behaviors in high risk populations.</p> <ul style="list-style-type: none"> Work with healthcare industry to increase the proportion of healthcare providers who offer culturally sensitive counseling patients and families on the prevention and risks associated with overweight and obesity. Implement the Fit WIC model program, which promotes physical activity (through music and movement classes, educational materials, counseling, and take home support materials) to WIC participant children and parents. 	<p>1. MN Physical Activity Survey being conducted by BCBS in partnership with MDH; could also be tracked using LPH PPMRS</p> <p>2. LPH PPMRS</p>

GOAL II: Decrease the rates of tobacco use in Minnesota		
Objectives	Indicator	Cost Benefit/Savings
<ul style="list-style-type: none"> Have no increase in the percentage of Minnesotans who smoke in 2008 From 2010-2013 reduce the percentage of Minnesotans who smoke by 2% per year, so that the percentage who smoke is cut in half by 2013* (see below) Continue reducing the percentage of Minnesotans who smoke after 2013 	<p>Adults (ages 18 and older) who currently smoke cigarettes: 18.3% (MBRFSS 2006)</p> <p>Young adults (ages 18-24) who currently smoke cigarettes: 39.0% (MATS 2003)</p>	<p>A less aggressive goal of reducing smoking prevalence to 12% by 2020 would result in a total savings (in millions) between 2008-2020 of: \$6,629.0</p>

	<p>Adolescents who currently smoke cigarettes as measured in grades 9-12: 22.4% (MYTS 2005)</p> <p>Pre-adolescents who currently smoke cigarettes as measured in grades 6-8: 5.2% (MYTS 2005)</p>	
Setting	Strategy	Indicator
<i>Community</i>	<ol style="list-style-type: none"> 1. Increase the unit price for tobacco products through state or federal tobacco tax increase. 2. Fund and implement long-term, high-intensity statewide mass media campaigns using paid broadcast times and media messages developed through formative research. <ul style="list-style-type: none"> * Consider MN contribution to American Legacy Foundation X-Smoker national media campaign, focus tested in 2006 and 2007, found to increase calls to quitlines eleven-fold, resulting in counseling enrollment increases of 16% 3. Mobilize communities to identify and reduce the commercial availability of tobacco products to youth, using combined interventions (stronger local laws directed at retailers, active enforcement of retailer sales laws, and retailer education with reinforcement.) <ul style="list-style-type: none"> • Write stronger laws directed at retailers • Actively enforce retailer sales laws • Educate retailers about reducing commercial availability of tobacco products to youth 4. Increase the number of tobacco-free environments in the community by adopting comprehensive tobacco-free parks, playgrounds, beaches and other recreation area policies. <ul style="list-style-type: none"> • Support community assessment • Build policy support 5. Increase the number of smoke-free homes (including multi-unit housing) and cars. <ul style="list-style-type: none"> • Hold a community event to highlight the health risks of ETS and to promote Smoke-Free Homes program • Create an Environmental Tobacco Smoke educational activities for children 	
<i>School</i>	<ol style="list-style-type: none"> 1. Advocate for the development, implementation, promotion and enforcement of smoke-free tobacco policies at all public and private facilities. <ul style="list-style-type: none"> • Prohibit tobacco use at all school facilities and events. 	<ol style="list-style-type: none"> 1. School health policies and programs study (SHPPS)

	<ul style="list-style-type: none"> • Encourage and help students and staff to quit using tobacco. <p>2. Implement CDC’s ‘Guidelines for School Health Programs to Prevent Tobacco Use and Addiction,’ including tobacco-free policies, teacher training, parental involvement and cessation services.</p> <ul style="list-style-type: none"> • Provide developmentally appropriate instruction in grades K-12 that addresses the social and psychological causes of tobacco use • Aim for a coordinated school health program in which everyone delivers consistent messages about tobacco use <p>3. Facilitate student/school integration with statewide Catalyst youth involvement project</p> <ul style="list-style-type: none"> • Create school and community partnerships for comprehensive youth prevention programming • Undertake school based education about tobacco industry manipulation of young people. 	2. Local Public Health Planning and Performance Measurement and Reporting System (LPH PPMRS)
<i>Workplace</i>	<p>1. Work with local communities to enforce Freedom to Breathe provisions in workplaces</p> <ul style="list-style-type: none"> • Create a business kit that includes letters, brochures or signage that explains ordinance compliance to businesses and their patrons. • Translate materials into a variety of languages, as deemed appropriate for each community <p>2. Consult with employers to increase cessation resources offered at workplaces.</p> <ul style="list-style-type: none"> • Market ‘Quitplan at Work’ no cost on-site cessation classes (1 or 2 groups offered free per year per employer by Park Nicollet Occupational Health Source). • Promote Quitplan telephone counseling, web services to uninsured and underinsured • Work with Clearway Minnesota to intensify the mass media campaign to promote Quitplan. 	<p>1. LPH PPMRS</p> <p>2. Worksite survey</p>
<i>Health care</i>	<p>1. Reduce or eliminate client out-of-pocket cost for effective cessation therapies.</p> <ul style="list-style-type: none"> • Promote local public health staff understanding and utilization of mandated tobacco cessation benefits for Minnesota Medicaid-eligible persons. • Increase information disseminated through MN DHS website and toll free phone line for health care providers (MHCP program) about current reimbursement rates and levels for effective tobacco cessation interventions/therapies. • Increase consumer demand for cessation services that are a covered benefit among Medicare populations (Eff. July 2005, 2 quit attempts in max. of 8 office visits/year reimbursable by Medicare, cessation meds reimbursable under Medicare part D) <p>2. Implement healthcare provider reminder systems for tobacco use cessation.</p> <ul style="list-style-type: none"> • Screen LPH agency caseloads for tobacco use in each of the following program areas; WIC, Child and Teen Check Up, MCH block grant projects, TANF home visiting, family planning • Develop a process to offer cessation interventions to all tobacco-using persons and families, 	

	<p>and follow up with those who request help in quitting</p> <p>3. Implement healthcare provider reminder systems with provider education, with or without patient education.</p> <ul style="list-style-type: none"> • Instruct LPH staffs in how they can monitor rates of tobacco use and trends in their agency caseloads (WIC, Child-Teen Check Up databases,) and in their respective counties (MN vital statistic county profiles on MDH website) • Obtain periodic training and consultation in methods of behavior change, including motivational interviewing, and in effective health promotion and education concepts • Support attendance at tobacco treatment clinical conferences, in-services, conference calls and webinars <p>4. Implement multi-component tobacco use cessation interventions that include client telephone support (quit lines).</p> <ul style="list-style-type: none"> • Disseminate information on cessation resources and current treatments; what they are, how they work, and how to access them • LPH agency participation in the “Call It Quits” program; statewide referral of smokers to quitlines by fax after an agency registers with the program 	
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GOAL III: To decrease the misuse of alcohol among Minnesotan youth and adults		
Objectives	Indicator	Cost Benefit/Savings
<p>Adult</p> <ul style="list-style-type: none"> • Have no increases in percentages of Minnesotan adults who report binge drinking in 2008 and 2009 • From 2010 – 2013, reduce the percentage of Minnesotan adults who report binge drinking by at least 1% per year, so fewer than 15% of Minnesotans report binge drinking by 2013 • Continue reducing the percentages of Minnesotan adults who report binge drinking after 2013 	<p>Adult Binge drinkers¹: 17.6% (BRFSS 2006)</p>	<p>Data is not available</p>

<p>Youth</p> <ul style="list-style-type: none"> • Have no increases in percentages of Minnesotan youth who report underage drinking in 2008 and 2009 • From 2010- 2013, reduce the percentage of Minnesotan youth who report underage drinking by 1% per year, so fewer than 25% of 9th graders and 45% of 12th graders report underage drinking by 2013 • Continue reducing the percentages of Minnesotan youth who report underage drinking after 2013 	<p>Underage drinking²:</p> <p>9th grade 28%</p> <p>12th grade 48%</p> <p>(Minnesota Student Survey, 2004)</p>	
Setting	Strategy	Indicator
<i>Community</i>	<ol style="list-style-type: none"> 1. Implement and enforce policies that reduce youth access to alcohol. <ul style="list-style-type: none"> • Work with local law enforcement to implement and enforce alcohol compliance checks. • Work with communities to develop strong social host ordinances which make it illegal for adults to allow minors to consume alcohol, other than their own children, in their homes. 2. Implement and enforce policies that discourage both youth and adult misuse of alcohol. <ul style="list-style-type: none"> • Work with local governments and business organizations to develop policies to limit or eliminate drink specials. • Work with local governments to limit alcohol beverage outlet density through zoning ordinances. 	
<i>School</i>	<ol style="list-style-type: none"> 1. Provide education for students, staff and parents about alcohol use and misuse. <ul style="list-style-type: none"> • Implement an evidence based curriculum for students including a parental component. • Facilitate a parent program to educate them about alcohol use and to increase their communications with the school and with each other. 2. Implement and enforce policies for students, staff and parents about alcohol use during school hours. <ul style="list-style-type: none"> • Enforce a no use policy on school property. • Enforce a no use policy during school sponsored events for staff and parents. 	
<i>Workplace</i>	<ol style="list-style-type: none"> 1. Implement and enforce rules about alcohol use during work time. <ul style="list-style-type: none"> • Implement no use policies during work sponsored events such as holiday parties. • Implement no use policies while engaged in offsite work activities including use of company vehicles. 2. Provide employee assistance programs for those who are having problems with their alcohol use. <ul style="list-style-type: none"> • Publicize the program so employees can easily access the program. • Encourage use of the program and provide support to employees who use it. 	

<i>Health care</i>	<ol style="list-style-type: none"> 1. Work with healthcare providers to address patient alcohol use. <ul style="list-style-type: none"> • Implement policies requiring providers to screen patients for alcohol use. • Implement policies to provide brief intervention or referrals for patients who are having problems with their alcohol use. 2. Work with healthcare providers to address employee alcohol use. <ul style="list-style-type: none"> • Implement and enforce rules about alcohol use during work time. • Provide employee assistance programs for those who are having problems with their alcohol use. 	
NOTES 1. Males having five or more drinks on one occasion, females having four or more drinks on one occasion 2. male or female youth having an alcoholic beverage at least one day in the past 30 days		

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