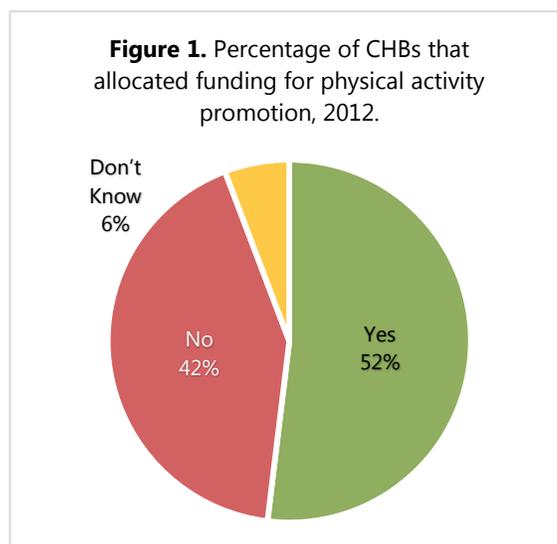


# A Snapshot of Findings for 2012 Developmental Measures



**Minnesota capitalized on existing data and data collection systems (PPMRS) to advance the national agenda for public health systems and services research through the Multi-network Practice and Outcome Examination (MPROVE) Study.**

This brief highlights Minnesota-specific findings on measures reported into the Healthy Communities/Healthy Behaviors area of PPMRS (the Planning and Performance Measurement Reporting System) in 2013 as part of a multi-state study to examine levels of variation in public health services, and explore the relationship between public health services and population health. Minnesota contributed to measure development and selection through the Research to Action Network steering committee and the Performance Improvement Steering Committee. For more information, refer to: [Research to Action Network: Publications and Presentations](#),<sup>1</sup> or contact Beth Gyllstrom ([beth.gyllstrom@state.mn.us](mailto:beth.gyllstrom@state.mn.us)) or Kim Gearin ([kim.gearin@state.mn.us](mailto:kim.gearin@state.mn.us)).



## Physical Activity

More than half of CHBs (54%) reported involvement in an initiative to increase access to free or low cost recreational opportunities for physical activity. A similar percentage (52%) reported that the CHB allocated funding to promote physical activity. Estimated allocations ranged from \$500 to \$1,000,000. Per capita funding for physical activity promotion ranged from less than \$0.01 to \$18.70.

Most CHBs reported that some community-wide physical activity initiatives were underway within the jurisdiction(s) served by the CHB. (See **Table 1**).

Table 1. Community-wide physical activity initiative	% underway within CHB
Initiatives to Create or Enhance Opportunities for Physical Activity (Policy, Systems and Environmental change approach [PSE]: increase access to trails, worksite interventions)	92.3%
Community-Level Urban Design Initiatives (PSE approach: increase green space, Safe Streets, developments to increase % of residents living within walking distance of shopping, work and school)	69.2%
Social Support Interventions in Community (e.g., focus on changing physical activity behavior through creating, strengthening and maintaining social networks that provide supportive relationships for behavior change)	66.7%
Community-Wide Health Education Campaigns (e.g., large-scale, highly visible messages directed to large audiences through media typically combined with other approaches including support or self-help groups, community events or screenings)	62.7%
Individually-Adapted Health Behavior Change Programs (e.g., teaching goal setting/self-monitoring of progress, structured problem solving and relapse prevention)	57.7%
School-Based PE Programs (e.g., programs to increase time students spend in PE class)	40.0%
Community-Wide Stair Use Campaigns (e.g., signs by elevators/escalators)	21.2%

<sup>1</sup> <http://www.health.state.mn.us/divs/opi/pm/ran/publications.html>

## Nutrition Promotion

Most CHBs (81%) reported being involved in an initiative to increase access to healthy foods in the community. Twenty percent of CHBs reported that they did not dedicate any staff full-time equivalent (FTE) hours to increasing healthy foods during 2012, though eight CHBs (15%) reported two or more FTE. The median FTE dedicated to increasing healthy foods was 0.50.

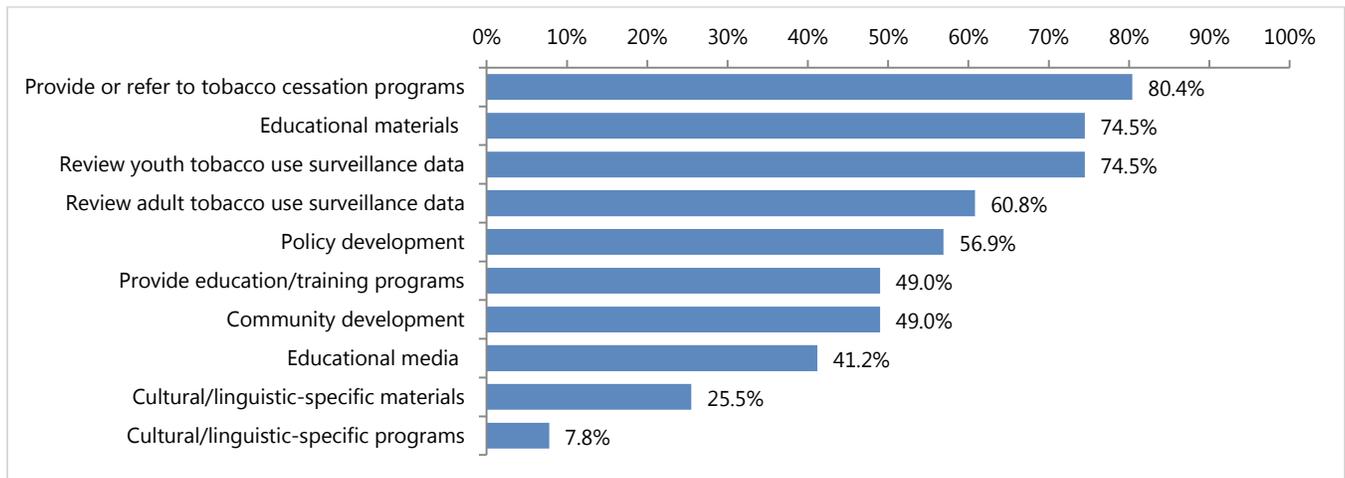
## Oral Health

The clear majority of CHBs (75%) provided oral health prevention and promotion services (including dental screening). Of the 13 CHBs that did not provide oral health prevention and promotion, almost all of them (n=11) indicated there is a need for the services. The estimated number of screenings provided for dental/oral health conditions varied widely, from fewer than 10 to more than 2,000.

## Tobacco Prevention and Clean Indoor Air

More than 70 percent of CHBs reported that they provided or referred to tobacco cessation programs, provided educational materials, and reviewed youth tobacco use surveillance data. Substantially fewer provided cultural/linguistic-specific materials or programs.

**Figure 2. Percentage of Minnesota CHBs that participated in tobacco prevention, cessation, or control initiatives, 2012.**



Very few local case violations and compliance inspections or investigations were reported or conducted with regard to enforcing the Freedom to Breathe Act.

