

cancer plan minnesota  2011-2016



A Framework for Action
for policymakers, planners, providers, and advocates

Members

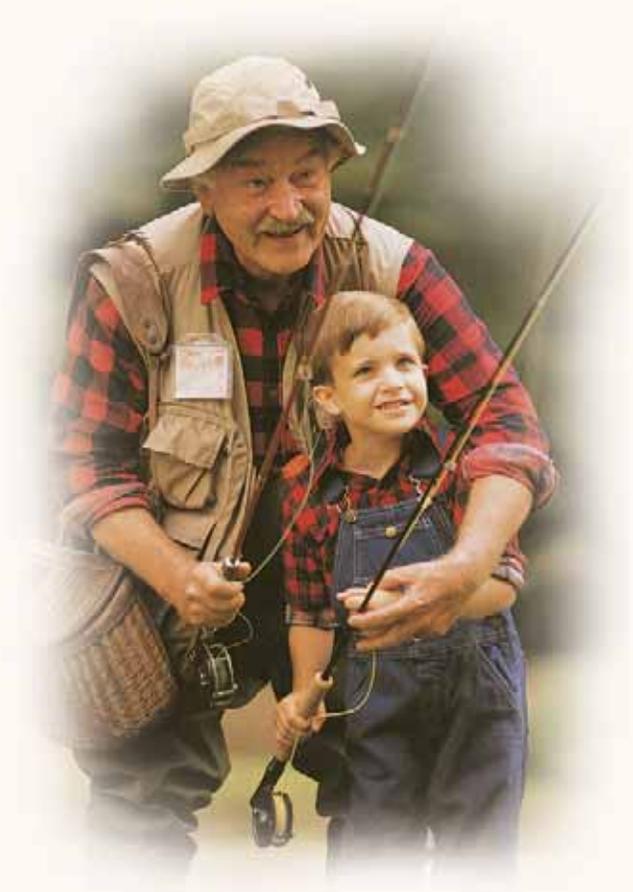
The Minnesota Cancer Alliance is a coalition of health organizations, community groups and volunteers that evolved from collaborative efforts to create Cancer Plan Minnesota. The Alliance was founded in 2005 to support and implement the plan.

For more information on the **Minnesota Cancer Alliance**, visit www.mncanceralliance.org.



African Community Services
American Cancer Society, Midwest Division
American Indian Cancer Foundation
American Lung Association, Minnesota
Angel Foundation
Association for Non-Smokers- Minnesota
Association for the Advancement of Hmong Women in Minnesota
Be The Match Registry
Bemidji Area Indian Health Service
Beyond Diagnosis Counseling
Blair's Tree of Hope
Blue Cross and Blue Shield of Minnesota
Cancer Legal Line
Cancer Project
CaringBridge
Carlson Media
Center for Africans New to America
Circle in the Field: Peer Support for Breast Cancer
ClearWay Minnesota
Coborn Cancer Center, St. Cloud Hospital
Colon & Rectal Surgery Associates
Colon Cancer Coalition
Community Clinical Oncology Program - Metro Minnesota
Community Health Foundation of Wright County
Community Safety Programs
Comunidades Latinas Unidas En Servicio (CLUES)
Confederation of Somali Community in Minnesota
Fairview Health Services
Fairview Southdale Hospital
Family Opportunities for Living Collaboration
Genentech
Gilda's Club Twin Cities
HealthPartners
HealthPartners Research Foundation
Hennepin County Medical Center
Hope Chest for Breast Cancer
Humphrey Cancer Center
Integral Visions
Itasca County Health and Human Services
"It's Still Me" Wig Studio
Kidney Cancer Association
Leukemia and Lymphoma Society
Lily Wellness
Masonic Cancer Center, University of Minnesota
Mayo Clinic Cancer Center
Medica
Mid-Minnesota Family Medicine Center
Minnesota Academy of Family Physicians
Minnesota Black Nurses Association
Minnesota Breast Cancer Coalition
Minnesota Colon and Rectal Foundation
Minnesota Community Measurement
Minnesota Council of Health Plans
Minnesota Department of Health
Minnesota Gastroenterology, P.A.
Minnesota Hospital Association
Minnesota Institute of Public Health
Minnesota Medical Association
Minnesota Network of Hospice and Palliative Care
Minnesota Oncology Hematology, PA
Minnesota Ovarian Cancer Alliance
Minnesota Physician Publishing
Minnesota Physicians for Palliative Care
Minnesota Public Health Association
Minnesota Society of Clinical Oncology
National Cancer Institute's Cancer Information Service
Native American Community Clinic
New American Community Services
North Memorial Health Care
NorthPoint Health & Wellness Center
Novartis
Olmsted County Public Health Services
Oncology Nursing Society, Metro Minnesota Chapter
Oncology Nursing Society, Southeast Minnesota Chapter
Open Arms of Minnesota
Park Nicollet Cancer Center
Pathways Health Crisis Resource Center
Pfizer
Qiagen
Rice Memorial Hospital
Ridgeview Medical Center
Sanford Health
Somali Parent Teacher Association
Somali Women of Minnesota of East Side Neighborhood Services
Southeast Asian Community Council
St. Luke's Hospital of Duluth
St. Mary's Duluth Clinic Health System
St. Stephen's Human Services
Stairstep Foundation
Stratis Health
Sub-Saharan African Youth and Family Services in Minnesota
Survivors' Training
Susan G. Komen for the Cure - Minnesota Affiliate
United Cambodia Association of Minnesota
United Hospital
Unity Hospital
Vietnamese Social Services of Minnesota
Virginia Piper Cancer Institute
Well Within
Wellshare International
Willmar Regional Cancer Center

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Introduction

Purpose Approximately 70 people are newly diagnosed with cancer each day in Minnesota and another 25 people lose their lives to this disease. Cancer Plan Minnesota 2011-2016 is an updated framework for action created by the partners of the Minnesota Cancer Alliance to address the substantial burden of cancer in Minnesota.

As a framework, the five-year cancer-specific plan delivers to planners, providers, policymakers, the public health community and other stakeholders a common set of objectives and strategies that are designed to keep partners moving in the same direction. It is not a detailed action plan. This framework is consistent with national priorities released in 2010 by the Centers for Disease Control and Prevention (CDC) and by Healthy People 2020. (Note: Detailed, coordinated action plans are developed by Cancer Alliance partners in focus areas selected every two years by the Minnesota Cancer Alliance Steering Committee. Companion action plans for the 2011 to 2013 cycle are available at www.mncanceralliance.org.)

Key objectives and strategies are identified across the continuum of cancer control, ranging from prevention, early detection and treatment to survivorship and end of life. To the extent possible, updated plan strategies draw from existing, evidence-based guidelines and best practices and are linked to specific and measurable objectives.

How the Cancer Plan was updated

Ad hoc groups comprising Minnesota Cancer Alliance members and invited content experts met beginning in 2009 to review objectives and strategies in Cancer Plan Minnesota 2005-2010. Recommended updates, formulated through an iterative process, were forwarded to the Alliance steering committee for review and approval. In all discussions, a premium was placed on objectives that could be measured using available data sources and strategies based in best practices and evidence of effectiveness.



The steering committee elected to weave strategies addressing cancer-related health disparities throughout the document and, where appropriate, to include strategies particular to priority populations based on disease burden. Suggested content revisions were posted online for review by and comment from all Alliance members.

Objectives pertinent to obesity prevention and tobacco control were adopted from the Minnesota Plan to Reduce Obesity and Obesity-Related Chronic Disease and from planning documents developed by state tobacco control partners. The Alliance Data Review Committee worked through the proposed objectives to refine proposed indicators, help establish targets and identify additional sources of measurement data.

Evaluation

Measuring the outcomes of specific initiatives and tracking progress in meeting targets in Cancer Plan Minnesota 2011-2016 is essential to achieving the goals of the Minnesota Cancer Alliance. Without evaluation, time and resources may be misspent and more successful strategies may be overlooked. Evaluation also extends to assessing success in engaging partner organizations and in their satisfaction with Alliance structure and activities. A Minnesota Cancer Alliance Evaluation Committee, comprising individual and member organization volunteers, oversees these components of evaluation in close collaboration with the Alliance steering committee.

Forty-eight measures are supplied in Cancer Plan Minnesota 2011-2016 to track progress in achieving 23 plan objectives. The majority of these measures provide baselines from the most recent data available and for 2016 targets. Measures are drawn from a wide variety of sources, as footnoted. Selection of targets is based on such considerations as the existing baseline and trends, goals that other states have proved achievable and the desire to attain health equity. Each year, the Alliance publishes a report that tracks progress in meeting plan objectives.





Minnesota Cancer Facts and Figures

Cancer became a reportable disease in Minnesota in 1988. Minnesota Cancer Alliance objectives related to cancer occurrence rely on data from the Minnesota Cancer Surveillance System (MCSS), which is part of the Minnesota Department of Health.

Since 1995, CDC has provided additional funds through the National Program of Cancer Registries that enables MCSS to collect information on stage at diagnosis, treatment and race. Because of the investment of Minnesota citizens in MCSS, it is possible to compare cancer rates and trends in specific types of cancers in Minnesota with those in the nation and to see how those rates and trends vary by region, age, gender, race and ethnicity.

Minnesota Cancer Facts and Figures was first published in 2003 to assist the development of the first state cancer plan. It is published collaboratively every two years by the MCSS, the American Cancer Society and the Alliance (www.mncanceralliance.org/Cancer_Data_Sources.html).

Integration across chronic disease program areas

Public health departments and community partners across the country are working to better integrate efforts across a variety of chronic disease prevention programs. At the federal level, the CDC is also emphasizing the need to work across its own program “silos” to limit duplication, improve coordination and maximize the use of program resources.

Many of the leading causes of chronic disease in the United States share common risk factors –obesity and tobacco use and exposure, for example. This accentuates the need to purposefully work in a coordinated way across programs and partnerships to promote sustainable, healthy lifestyles through common messaging, chronic disease surveillance and support for implementing evidence-based policy, systems and environmental strategies that inspire change.

Cancer Plan Minnesota incorporates common objectives, strategies and measures from plans developed by partners statewide working on obesity and tobacco control. As state chronic disease prevention programs and partnerships implement an increasing number of disease-focused activities, opportunities abound for cross-program

integration through commonalities in venue (e.g., worksites); approaches (e.g., the use and/or training of community health workers); audiences (e.g., particular communities) and partners (e.g., health plans). Identifying and leveraging these opportunities should enable the Alliance to more effectively and efficiently reduce the burden of chronic diseases in Minnesota and to help people live longer, healthier lives.

Focus on Policy, Systems and Environmental Change

Cancer Plan Minnesota includes strategies and interventions that are intended to encourage public health efforts in Minnesota to move toward a focus on policy, systems and environmental changes that will provide a foundation for population-wide change. Long-lasting and sustainable change to tobacco use, physical activity and nutrition requires systems change driven by new and improved policies.¹ Policy, systems and environmental changes make it inherently easier for individuals to adopt healthier choices than to choose unhealthy options.

- Policy interventions may be laws, resolutions, mandates, regulations or rules. Examples are laws and regulations that restrict smoking in public buildings and organizational rules that promote healthy food choices in a worksite. Policy change refers not only to the enactment of new policies, but also to a change in or enforcement of existing policies.
- Systems interventions are changes that impact all elements of an organization, institution or system; they may include a policy or environmental change strategy. Two examples include a school district providing healthy lunch menu options in all school cafeterias in the district and a health plan adopting a health reminder intervention system wide. As the Kellogg Foundation states, “the school system, the transportation system, parks and recreation and community design/land use influence the built and physical environment. All of these interdependent systems influence the presence or absence of opportunities to be healthy.”²
- Environmental interventions involve physical or material changes to the economic, social or physical environment. Examples are incorporating sidewalks, walking paths and recreation areas into community development design or a high school making healthy snacks and beverages available in all of its vending machines. There is growing recognition that the built environment — the physical structures and infrastructure of communities — plays a significant role in shaping health. The designated use, layout and design of a community’s physical structures, including its housing, businesses, transportation systems and recreational resources, affect patterns of living (behaviors) that, in turn, influence health.³



- 1 *W.K. Kellogg Foundation. Policy and Systems Change, 2008:* www.wkkf.org/knowledge-center/resources/2008/12/Policy-And-Systems-Change-Webcast-1.aspx.
- 2 *W.K. Kellogg Foundation. Policy and Systems Change, 2008:* www.wkkf.org/knowledge-center/resources/2008/12/Policy-And-Systems-Change-Webcast-1.aspx.
- 3 *Prevention Institute. The Built Environment and Health: 11 Profiles of Neighborhood Transformation, 2004:* http://preventioninstitute.org/index.php?option=com_jlibrary&view=article&id=114&Itemid=288



* *The power of social determinants and social inequalities to influence health outcomes over a lifetime is shown dramatically in the report: **The Unequal Distribution of Health in the Twin Cities**, Wilder Research, Oct., 2010.*

Health Equity and Social Determinants of Health

Reducing cancer and its impact cannot be achieved through health education strategies or traditional skills-based behavior change alone. These approaches, when relied on exclusively, focus too heavily on the individual's responsibility for maintaining a health-conscious lifestyle and on the health care provider's responsibility to treat the patient without accounting for external, community and environmental forces, including access to health care; income distribution; educational opportunities; racism, and the characteristics of neighborhood or community. These and other forces influence the prevalence of major risk factors for cancer, diabetes, heart disease and stroke, yet they are often unseen or unacknowledged.

A more complete model of health promotion must be adopted through policy and environmental change to address these environmental forces, including direct intervention on the social environment and influencing health-related behaviors that affect disability and disease.* Additionally, data from the CDC Behavioral Risk Factor Surveillance Systems survey clearly shows a strong inverse relationship in Minnesota between income and education and risk factors for chronic diseases).

Planning Definitions used in this Plan

Goals *A limited number of critical ends toward which the plan is directed. Goals address broad, fundamental components of success. They represent a general focus area, without specifications about how to achieve them.*

Objectives *Specific, measurable outcomes that will lead to achieving a goal. Objectives must be "SMART": Specific, Measureable, Attainable, Relevant and Timed. Objectives indicate what will be done, not how to make it happen.*

Measures *Provide information to gauge progress toward an intended outcome or objective.*

Strategies *Specific processes or steps undertaken to achieve objectives. To the extent possible, strategies are evidence-based.*



Goals

across the cancer care continuum

Cancer Plan Minnesota 2011-2016 is based on five overarching goals that are unchanged from 2005.

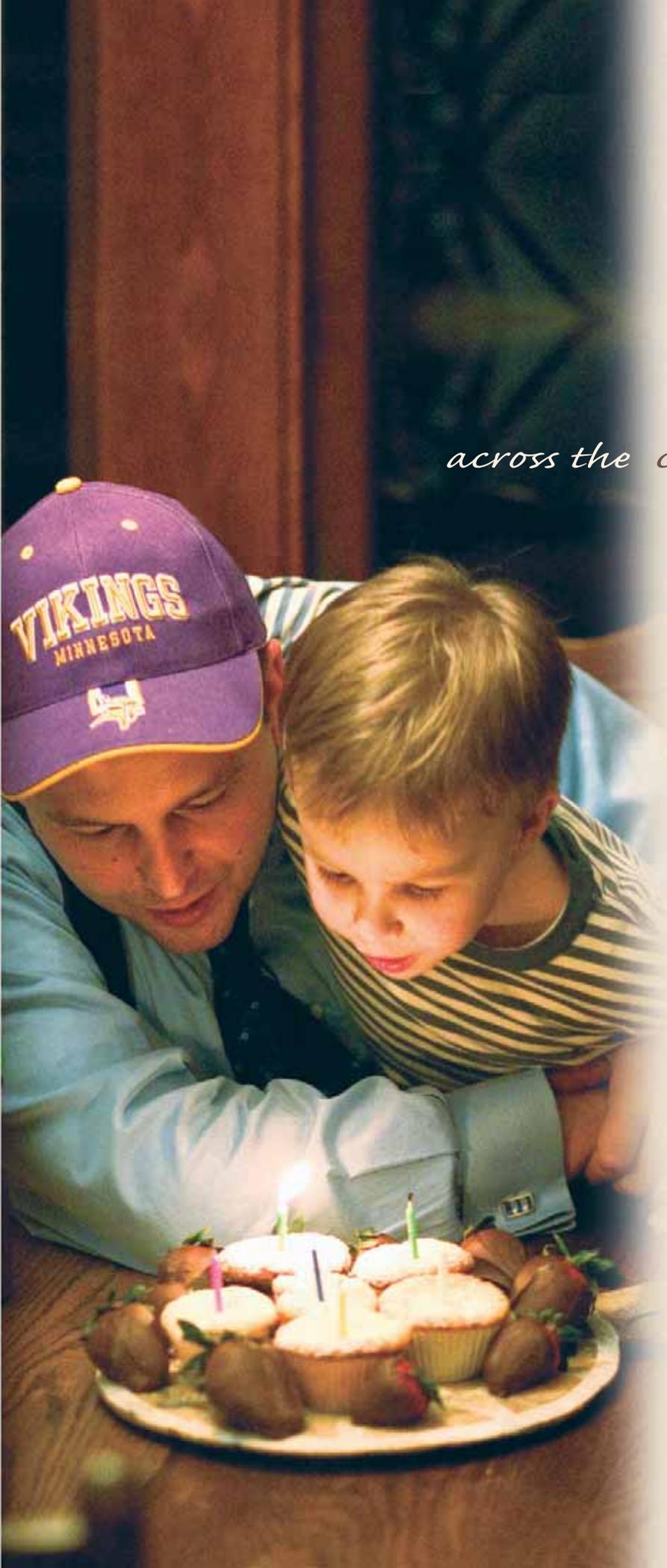
- **Prevent** cancer from occurring.

- **Detect** cancer at its earliest stages.

- **Treat** all cancer patients with the most appropriate and effective therapy.

- **Optimize** the quality of life for every person affected by cancer.

- **Eliminate** disparities in the burden of cancer.





OBJECTIVE 1 Reduce tobacco use among youth and young adults.



STRATEGIES

- 1.1 Increase the tax on cigarettes and other tobacco products.
- 1.2 Change social norms around tobacco use and exposure.
- 1.3 Enforce/expand policies that limit visibility of and access to tobacco products.
- 1.4 Conduct a statewide youth-focused counter-marketing campaign.

MEASURES

Young adults who currently smoke cigarettes ⁴ (ages 18-24)	TARGET	17.0 %
	BASELINE	21.8 %
Adolescents who currently smoke cigarettes ⁵ (grades 9-12)	TARGET	11.3 %
	BASELINE	19.1 %
Pre-adolescents who currently smoke cigarettes ⁵ (grades 6-8)	TARGET	1.3 %
	BASELINE	3.4 %
Young adults who use other tobacco products ⁴	TARGET	12.7 %
	BASELINE	17.0 %
Adolescents who use other tobacco products ⁵	TARGET	16.8 %
	BASELINE	18.8 %
Pre-adolescents who use other tobacco products ⁵	TARGET	4.0 %
	BASELINE	5.4 %

⁴ Minnesota Department of Health (MDH), ClearWay Minnesota. Tobacco Use in Minnesota: 2010 Update, February 2011.

⁵ MDH, Division of Health Policy, Center for Health Statistics. *Teens and Tobacco in Minnesota, the View from 2008, 2008*: <www.health.state.mn.us/divs/chs/tobacco/teens_tobacco08.pdf>.

OBJECTIVE 2 Reduce exposure to secondhand smoke.



STRATEGIES

- 2.1 Advance policies that reduce exposure to secondhand smoke.
- 2.2 Conduct messaging campaigns about the dangers of secondhand smoke.

MEASURES

Adults exposed to secondhand smoke ⁴	TARGET	32.7 %
	BASELINE	45.6 %
Young adults exposed to secondhand smoke ⁴	TARGET	67.6 %
	BASELINE	73.8 %
Adolescents in grades 9-12 exposed to secondhand smoke ⁵	TARGET	40.5 %
	BASELINE	55.4 %
Pre-adolescents in grades 6-8 exposed to secondhand smoke ⁵	TARGET	27.0 %
	BASELINE	39.6 %

⁴ Minnesota Department of Health (MDH), ClearWay Minnesota. Tobacco Use in Minnesota: 2010 Update, February 2011.

⁵ MDH, Division of Health Policy, Center for Health Statistics. *Teens and Tobacco in Minnesota, the View from 2008, 2008*: <www.health.state.mn.us/divs/chs/tobacco/teens_tobacco08.pdf>.



OBJECTIVE 3

Increase the number of tobacco users that quit.



STRATEGIES

- 3.1 Expand comprehensive tobacco cessation benefits to all Minnesotans.
- 3.2 Promote utilization of comprehensive smoking cessation services.
- 3.3 Deliver cessation services for population groups with higher prevalence rates of tobacco use.
- 3.4 Leverage policy changes that promote quitting.

MEASURES

Smokers who successfully quit in the last year⁶

TARGET	15.1 %
BASELINE	12.8 %

⁶ Minnesota Department of Health (MDH), ClearWay Minnesota. Tobacco Use in Minnesota: 2010 Update, February 2011.

OBJECTIVE 4

Establish consistent and reliable funding for tobacco control in Minnesota at the level recommended by CDC.



STRATEGIES

- 4.1 Educate the public and policymakers regarding the current allocation of tobacco settlement dollars in Minnesota and about tobacco still serving as a leading cause of preventable death and disease in the state.
- 4.2 Dedicate funding to tobacco control.

MEASURES

IN MILLIONS

Spending on tobacco prevention⁷

TARGET	\$ 58.4
BASELINE	\$ 20.3

⁷ Campaign for Tobacco-Free Kids, American Heart Association, American Cancer Society Cancer Action Network, American Lung Association and the Robert Wood Johnson Foundation. *A Broken Promise to our Children: The 1998 State Tobacco Settlement 12 Years Later*, 2010: <www.tobaccofreekids.org/reports/settlements/print.php?StateID=MN>.



OBJECTIVE 5 Increase healthy eating among people in Minnesota.



See also the [Minnesota Obesity Plan, www.health.state.mn.us/cdr/r/obesity/index.html](http://www.health.state.mn.us/cdr/r/obesity/index.html).

STRATEGIES

- 5.1** Advocate for sustained funding for local and statewide health improvement programs.
- 5.2** Implement policy, system and environmental interventions that promote healthy eating.

MEASURES

Adults who consume fruits and vegetables five or more times/day ⁸	TARGET	42.0 %
	BASELINE	22.0 %
6th Graders who report consuming at least five fruits, fruit juices or vegetables the previous day ⁹	TARGET	37.0 %
	BASELINE	20.6 %
9th Graders who report consuming at least five fruits, fruit juices or vegetables the previous day ⁹	TARGET	26.0 %
	BASELINE	18.1 %
12th Graders who report consuming at least five fruits, fruit juices or vegetables the previous day ⁹	TARGET	23.0 %
	BASELINE	17.3 %

⁸ U.S. Department of Health and Human Services (HHS), CDC; MDH, Minnesota Center for Health Statistics (MCHS) and Behavioral Risk Factor Surveillance System (BRFSS). Prevalence and trends data, 2009: <http://apps.nccd.cdc.gov/brfss/display.asp?cat=FV&yr=2009&qkey=4415&state=MN>.

⁹ MDH, MCHS. Minnesota student survey statewide tables, 2010: <http://education.state.mn.us/mdeprod/groups/SafeHealthy/documents/Report/019009.pdf>.

OBJECTIVE 6 Increase physical activity among people in Minnesota.



See also the [Minnesota Obesity Plan, www.health.state.mn.us/cdr/r/obesity/index.html](http://www.health.state.mn.us/cdr/r/obesity/index.html).

STRATEGIES

- 6.1** Advocate for sustained funding for local and statewide health improvement programs.
- 6.2** Implement policy, system and environmental interventions that increase physical activity.

MEASURES

Adults age 18+ who are physically inactive ^{10,11}	TARGET	9.0 %
	BASELINE	15.7 %
Adults who meet CDC requirements for physical activity ¹²	TARGET	67.0 %
	BASELINE	52.7 %
Boys/girls who say they have exercised or participated in sports that made them sweat or breathe hard for at least 20 minutes at least three of the last seven days ¹³	6th Grade Boys/Girls	TARGET 85.0 / 89.0% BASELINE 70.9 / 66.9%
	9th Grade Boys/Girls	TARGET 88.0 / 86.0% BASELINE 73.7 / 68.0%
	12th Grade Boys/Girls	TARGET 77.0 / 68.0% BASELINE 66.9 / 53.4%
Boys/girls who say they have been physically active for a combined total of at least 30 minutes at least five of the past seven days ¹³	6th Grade Boys/Girls	TARGET 60.0 / 54.0% BASELINE 53.7 / 42.0%
	9th Grade Boys/Girls	TARGET 68.0 / 60.0% BASELINE 62.9 / 50.1%
	12th Grade Boys/Girls	TARGET 55.0 / 42.0% BASELINE 54.7 / 34.0%

¹⁰ CDC and BRFSS. Prevalence and trends data, 2009: <http://apps.nccd.cdc.gov/brfss/display.asp?cat=EX&yr=2009&qkey=4347&state=MN>.

¹¹ People are considered physically inactive if they report they have not participated in any physical activity in the past month.

¹² CDC and BRFSS. Prevalence and trends data, 2009. CDC recommends 30 minutes of moderate activity five or more times a week or 20 minutes of vigorous activity three or more times a week. Physical Activity Guidelines for Americans, 2008: <www.cdc.gov/physicalactivity/everyone/guidelines/index.html>.

¹³ MDH, MCHS. Minnesota student survey statewide tables, 2010: <http://education.state.mn.us/mdeprod/groups/SafeHealthy/documents/Report/019009.pdf>.



OBJECTIVE 7

Increase the number of people with healthy weight in Minnesota.



STRATEGIES

7.1 Advocate for sustained funding for local and statewide health improvement programs.

7.2 Implement policy, system and environmental interventions that promote healthy weight.

See also the *Minnesota Obesity Plan*, www.health.state.mn.us/cdr/obesity/index.html.

MEASURES

Adults classified as obese ¹⁰	TARGET	19.0 %
	BASELINE	25.3 %
Adults classified as healthy weight ¹⁰	TARGET	45.0 %
	BASELINE	36.7 %
9th and 12th graders who are classified as obese. ¹⁴ (BMI > 95th percentile)	9th Grade Boys/Girls	
	TARGET	11.0 / 5.5 %
9th and 12th graders who are classified as healthy weight ¹⁵	12th Grade Boys/Girls	
	TARGET	11.9 / 4.6 %
Children age 2-5 in "women, infants and children" population classified as obese ¹⁶	9th Grade Boys/Girls	
	TARGET	81.0 / 90.0 %
	12th Grade Boys/Girls	
	TARGET	82.0 / 91.0 %
	TARGET	12.1 %
	BASELINE	13.4 %

¹⁰ CDC and BRFSS. Prevalence and trends data, 2009: <<http://apps.nccd.cdc.gov/brfss/display.asp?cal=EX&yr=2009&qkey=4347&state=MN>>

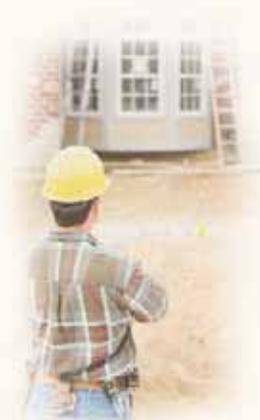
¹⁴ MDH, MCHS. Minnesota student survey statewide tables, 2010: <<http://education.state.mn.us/mdeprod/groups/SafeHealthy/documents/Report/019009.pdf>>

¹⁵ MDH, MCHS. Minnesota student survey statewide tables, 2010: <<http://education.state.mn.us/mdeprod/groups/SafeHealthy/documents/Report/019009.pdf>>

¹⁶ Pediatric and Pregnancy Nutrition Surveillance System (PedNSS). *Health Status: Minnesota children enrolled in WIC 1999 to 2008*, 2010: <www.health.state.mn.us/divs/ih/wic/localagency/infosystem/pednss/2010.pdf>

OBJECTIVE 8

Establish statewide policies that will result in levels of radon in new and existing homes that are as low as reasonably achievable.



STRATEGIES

8.1 Incorporate the Minnesota Department of Health Gold Standard into current requirements for radon resistant new construction.

8.2 Advocate for statewide policy requiring radon education and/or testing during residential real estate transactions.

8.3 Educate stakeholders, including legislators, home builders, real estate agents and associated nonprofit agencies, about radon safety.



OBJECTIVE 9

Reduce the use of artificial UV light for tanning.



STRATEGIES

- 9.1** Advocate for a state tax on tanning bed use.

- 9.2** Ban the use of tanning beds by minors.

- 9.3** Strengthen and enforce existing regulations to require that adults receive health warnings and sign consent forms for tanning bed use.

MEASURES

Adults age 18 and older who report using tanning beds ¹⁷	TARGET	33.0 %
	BASELINE	37.0 %

Adolescents in grades 9-12 who report using tanning beds	No Data Available
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¹⁷ Armson, Rossana. University of Minnesota, Center for Survey Research. 2010 Minnesota State Survey: Results and Technical Report #11-1, 2010.

OBJECTIVE 10

Reduce the prevalence of sunburn among adults, adolescents and children.



STRATEGIES

- 10.1** Implement sun protection policy and environmental changes in settings where outdoor activities occur, such as park and recreation centers, schools, day care centers and worksites.

MEASURES

Adults age 18 and older who report sunburn within the last twelve months ¹⁸	TARGET	20.0 %
	BASELINE	23.0 %

Adolescents in grades 9-12 who report sunburn	No Data Available
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¹⁸ Armson, Rossana. University of Minnesota, Center for Survey Research. 2010 Minnesota State Survey: Results and Technical Report #11-1, 2010.



OBJECTIVE 11

Increase vaccination rate for vaccines shown to reduce the risk of cancer.



STRATEGIES

- 11.1** Promote a comprehensive health care visit (including vaccination) for all adolescents age 11-12.

- 11.2** Collaborate with partners to raise awareness of human papillomavirus (HPV) vaccine and hepatitis B vaccine and their benefits.

- 11.3** Increase provider participation and improve completion of vaccination protocol in Minnesota's statewide immunization registry (Minnesota Immunization Information Connection).

MEASURES

Girls age 13-17 who receive at least one dose of HPV vaccine ¹⁹	TARGET	90.0 %
	BASELINE	44.9 %
Girls age 13-17 who receive three doses of HPV vaccine ²⁰	TARGET	75.0 %
	BASELINE	27.0 %
Newborns receiving one birth dose of hepatitis B vaccine (0 to 3 days between birth date and date of vaccination) ²¹	TARGET	85.0 %
	BASELINE	66.9 %

¹⁹ CDC. National, state and local area vaccination coverage among adolescents aged 13-17 years – United States, 2009: *MMWR Morb Mortal Wkly Rep.* 2010 Aug 20; 59(32):1018-23.

²⁰ CDC. National, state and local area vaccination coverage among adolescents aged 13-17 years – United States, 2009: *MMWR Morb Mortal Wkly Rep.* 2010 Aug 20; 59(32):1018-23.

²¹ MDH, Minnesota Immunization Information Connection. Analyses conducted by Perinatal Hepatitis B Program, 2010.



OBJECTIVE 12 Increase risk-appropriate screening for colorectal cancer.



STRATEGIES

- 12.1** Implement changes within health systems that increase risk-appropriate screening.
- 12.2** Increase consumer demand for colorectal cancer screening.
- 12.3** Conduct targeted outreach using client reminders and small media²⁴ campaigns to increase demand for screening among groups that experience high mortality rates from colorectal cancer.
- 12.4** Reduce financial barriers to colorectal cancer screening.

MEASURES

Adults age 50 and older who have had a fecal occult blood test within the previous 12 months or colonoscopy within the previous 10 years or sigmoidoscopy within the previous five years²²

TARGET	80.0 %
BASELINE	68.0 %

Adults age 51-75 who have had a fecal occult blood test within the previous 12 months or colonoscopy within the previous 10 years or sigmoidoscopy within the previous five years²³

TARGET	80.0 %
BASELINE	66.0 %

²² CDC and BRFSS. Chronic disease indicators, 2008: <<http://apps.nccd.cdc.gov/cdi->

²³ Minnesota Community Measurement. 2010 Health Care Quality Report, measurement year 2009: <<http://mncm.org/site/upload/files/HCCRFinal2010.pdf>>.

²⁴ CDC. Guide to Community Preventive Services. Small media include videos and printed materials such as letters, brochures, and newsletters. These materials can be used to inform and motivate people to be screened for cancer. They can provide information tailored to specific individuals or targeted to general audiences. 2010: <www.thecommunityguide.org/cancer/screening/client-oriented/SmallMedia.html>.

Minnesota Colorectal Cancers Diagnosed at Late Stage, 2003-2007



- African American
- American Indian/Alaskan Native Statewide
- American Indian/Alaskan Native CHSDA*
- Asian/Pacific Islander
- Hispanic (all races)
- Non-Hispanic White

Source: MCSS (May 2010). Late-stage cancers have extended beyond the colon or rectum (regional or distant stage) when diagnosed. The denominator is all invasive colorectal cancers, including un-staged (5.9%).

* CHSDA=IHS Contract Health Service Delivery Area residents



OBJECTIVE 13

Increase risk-appropriate screening for breast cancer.²⁵

STRATEGIES



13.1 Provide appropriate breast cancer screening information utilizing evidenced-based interventions, focusing the message for never or rarely screened women.

13.2 Reduce financial barriers to breast cancer screening.

13.3 Conduct targeted outreach using client reminders, small media campaigns and one-on-one education to increase the rate of mammography screening among groups that experience high mortality rates from breast cancer, including African American women, American Indian women and underserved populations.

MEASURES

Women age 50 and older who have had a mammogram within the previous two years²⁶

TARGET	92.0 %
BASELINE	80.0 %

Women age 40 and older who have had a mammogram within the previous two years²⁷

TARGET	90.0 %
BASELINE	79.0 %

Women age 52-69 who have had a mammogram within the previous two years²⁸

TARGET	85.0 %
BASELINE	75.0 %

²⁵ In 2009, the U.S. Preventive Services Task Force withdrew a recommendation for routine screening mammography for women age 40 to 49. It retained a recommendation of biennial mammography screening for women age 50 to 74. As of January 2011, the American Cancer Society continued to recommend annual screening mammography for women age 40 and older.

²⁶ CDC, BRFSS. 2008. Chronic disease indicators, 2008: <<http://apps.nccd.cdc.gov/cdi>>

²⁷ CDC, BRFSS. 2008. Chronic disease indicators, 2008: <<http://apps.nccd.cdc.gov/cdi>>

²⁸ Minnesota Community Measurement. *Health Care Quality Report*, measurement year 2009: <<http://mmcm.org/site/upload/files/HCQRFinal2010.pdf>>

Minnesota Female Breast Cancers Diagnosed at Late Stage, 2003-2007



- African American
- American Indian/Alaskan Native Statewide
- American Indian/Alaskan Native CHSDA*
- Asian/Pacific Islander
- Hispanic (all races)
- Non-Hispanic White

Source: MCSS (May 2010). Late-stage cancers have extended beyond the breast (regional or distant stage) when diagnosed. The denominator is all invasive female breast cancers, including un-staged (2.2%).

* CHSDA=IHS Contract Health Service Delivery Area residents



OBJECTIVE 14

Increase risk-appropriate screening for cervical cancer.



STRATEGIES

- 14.1** Ensure appropriate follow-up for women who receive abnormal test results.

- 14.2** Promote cervical cancer screening, especially among newly arrived immigrant populations.

- 14.3** Reduce financial barriers to cervical cancer screening and follow-up testing (i.e., colposcopy).

MEASURES

Women age 21 and older who have had a Pap smear within the previous 3 years²⁹

TARGET	98.0 %
BASELINE	89.0 %

Women age 24-64 who have had a Pap smear within the previous 3 years³⁰

TARGET	85.0 %
BASELINE	77.0 %

²⁹ CDC and BRFSS. Chronic disease indicators, aggregated for 2004, 2006 and 2008: <<http://apps.nccd.cdc.gov/cdi>>.

³⁰ Minnesota Community Measurement. 2010 Health Care Quality Report, measurement year 2009: <<http://mncm.org/site/upload/files/HCCRFinal2010.pdf>>.

Minnesota Cervical Cancer Incidence 2003-2007



Source: MCSS (May 2010). Rates are age adjusted to the 2000 U.S. population.
* CHSDA=IHS Contract Health Service Delivery Area residents

OBJECTIVE 15

Promote shared decision making for prostate cancer screening and treatment.



STRATEGIES

- 15.1** Partner with providers, clinics and health systems serving populations with the highest mortality rates from prostate cancer, especially African American and American Indian men, to support shared decision making.

- 15.2** Provide targeted education that incorporates the principles of informed decision making to African American men and American Indian men.



OBJECTIVE 16



Increase the use of hereditary cancer risk assessment, including genetic counseling and appropriate genetic testing.

STRATEGIES

- 16.1 Promote a set of referral guidelines (e.g., *National Society of Genetic Counselors*) for oncologists, gynecologists, surgeons, primary care physicians and health plans for appropriate referral for genetic services, including cancer risk assessment.
- 16.2 Advocate for third-party payment of genetic counseling (and appropriate testing).
- 16.3 Conduct targeted outreach to groups at elevated risk for hereditary breast, ovarian and colorectal cancer.

OBJECTIVE 17



Increase participation in cancer treatment clinical trials.

STRATEGIES

- 17.1 Train patient navigators and lay health workers to support recruitment and retention of underserved populations in clinical trials.
- 17.2 Increase public awareness regarding the benefits of participating in clinical trials.
- 17.3 Convene representatives of all Minnesota institutions offering cancer clinical trials to explore effective recruitment and retention strategies (including messaging, payment/reimbursement and employer coverage).
- 17.4 Develop promotional media campaign aimed at increasing participation in cancer clinical trials.



OBJECTIVE 18

Connect cancer patients and caregivers with non-clinical support services.



STRATEGIES

- 18.1** Promote Minnesota Cancer Resources Web portal through multiple channels.
- 18.2** Assess and address gaps in resources statewide.

MEASURES

Number of visits to www.mncancerresources.org³¹

TARGET	3,300 visits/mo
BASELINE	2,500 visits/mo

³¹ Google Analytics. Based on 2010 monthly data.

Non-clinical support services encompass resources beyond medical treatment that are essential for people experiencing a life altering health challenge. Often needed are resources to support emotional, spiritual and physical changes that impact a person's well-being, as well as resources for transportation, health insurance, day-to-day needs, long range planning and general finances.

OBJECTIVE 19

Provide cancer patients with a comprehensive care summary and follow-up plan after completing treatment.



STRATEGIES

- 19.1** Promote the use of survivor care plans by health care providers and cancer patients.
- 19.2** Build existing treatment summary templates into systems of care.
- 19.3** Establish health care teams to coordinate care.

MEASURES

Cancer patients who have ever been given a written summary of all the cancer treatments received by a doctor, nurse or other health professional³²

TARGET	50.0 %
BASELINE	40.0 %

³² CDC and BRFSS. Chronic disease indicators data, analysis conducted by MDH, 2010: <<http://apps.nccd.cdc.gov/cdi>>.



OBJECTIVE 20 Increase the use of advance care planning.



STRATEGIES

- 20.1** Promote completion of advanced care planning documents for all cancer patients near the time of diagnosis or early in treatment.
- 20.2** Use electronic medical record to prompt provider patient conversation about end of life and document completion of advanced care planning health care directive.
- 20.3** Educate clinic staff to facilitate culturally competent conversations about advance care planning.
- 20.4** Improve accessibility of advanced care planning documents within health care systems' electronic medical records.
- 20.5** Educate health professionals and first responders about physician orders for completion and use of life-sustaining treatment (POLST).

MEASURES

Patients up to age 65 with documentation in their medical record of a surrogate decision maker or advance care plan. **No data available**

Patients age 65 and older with documentation in their medical record of a surrogate decision maker or advance care plan.³³ **Available in 2011**

³³ National Committee for Quality Assurance. *Healthcare Effectiveness Data and Information Set, Appendix 1 – HEDIS 2009 Summary Table of Measures, Product Lines and Changes, 2009*. <http://www.ncqa.org/Portals/0/HEDISGM/HEDIS2009/2009_Measures.pdf>.

OBJECTIVE 21 Improve availability of palliative care services.



STRATEGIES

- 21.1** Support collaborative learning ventures among partners that help establish new palliative care programs.
- 21.2** Increase the number of health professionals who are trained in palliative care.
- 21.3** Promote systems change to integrate palliative care practice guidelines (such as the Institute for Clinical Systems Improvement or National Comprehensive Cancer Network) into routine cancer care.
- 21.4** Increase the number of health professionals who are trained in pediatric palliative care.

MEASURES

Number of nurses who report palliative care as a specialty³⁴ **TARGET 75**
BASELINE 53

Number of board certified palliative medicine physicians³⁵ **TARGET 30**
BASELINE 23

Number of pediatricians who are board certified in hospice and palliative medicine³⁶ **TARGET 2**
BASELINE 1

³⁴ MDH, Office of Rural Health and Primary Care. Workforces Analyses Program, analyses by Minnesota Department of Health, 2010.

³⁵ MDH, Office of Rural Health and Primary Care and the Minnesota Board of Medical Practices. Analyses by MDH, 2010.

³⁶ MDH, Office of Rural Health and Primary Care and the Minnesota Board of Medical Practices. Analyses by MDH, 2010.



OBJECTIVE 22

Increase utilization of hospice care.



STRATEGIES

- 22.1** Increase education and training of health care providers on end-of-life care.

- 22.2** Increase the number of primary care providers receiving continuing medical education about hospice care.

- 22.3** Increase percentage of nurses (APN, RN, LPN, etc.) receiving hospice training.

- 22.4** Work with member organizations to do targeted outreach and education about the benefits of hospice.

MEASURES

Percentage of Minnesota Medicare recipients with a cancer diagnosis who die in hospice ³⁷	TARGET	85.0 %
	BASELINE	79.0 %
Median length of stay in hospice care among cancer patients ³⁷	TARGET	27 days
	BASELINE	23 days
Percentage of hospice stays that are seven days or less among cancer patients ³⁷	TARGET	20.0 %
	BASELINE	25.0 %

³⁷ Kassner, Cordt. Unpublished data. Hospice analytics, 2009: <<http://hospiceanalytics.com/>>.

OBJECTIVE 23

Increase number of hospice care providers who accept pediatric patients.



STRATEGIES

- 23.1** Increase education and training of health care providers on pediatric hospice care.

- 23.2** Increase number of home-based program health professional staff completing training in pediatric hospice care.

MEASURES

Number of hospice care providers who report acceptance of pediatric patients ³⁸	TARGET	68
	BASELINE	59 / 68
Number of health professional teams trained in pediatric palliative care by the Center to Advance Palliative Care	TARGET	3
	BASELINE	2

³⁸ Special survey conducted by the Children's Hospitals and Clinics of Minnesota and Network of Hospice and Palliative Care, 2010.

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