Developing the Minnesota Cancer Plan
Step 2: Recommend Objectives and Strategies

Workgroup: Prevention Group B **Date: June 23, 2016**

Objective: Eliminate inequities in nicotine dependence in Minnesota

Rationale: There are inequities in nicotine dependence in Minnesota. For instance, the smoking rate for American Indians living in urban Minnesota is nearly 60% (Forster, et al., 2016), versus an overall state prevalence rate of 14.4% (ClearWay Minnesota, 2015). Minnesotans who are LGBTQ (Rainbow Health Initiative, 2015), young adults, individuals with lower education levels, lower household income levels, men, and African Americans are also likely to smoke at higher rates (Boyle, et al., 2015). The problem isn't just that disparities among the populations most impacted by nicotine dependence aren't decreasing at the rate of the general population – there is evidence that smoking prevalence is actually increasing among the lowest education groups in Minnesota – thereby widening disparities (Boyle, et al., in press). As the field of tobacco control advances, addressing tobacco-related health disparities is becoming increasingly important.

Strategies to address inequities are likely to be more effective if they are culturally relevant and the communities themselves are actively engaged in developing and implementing them. Many communities that suffer from inequities in nicotine dependence are already working on this issue. However, as indicated by the MDH Community Voices report (2016), there are barriers to engagement and more work needs to be done. The Community Voices report indicated that many racial/ethnic minority members in Minnesota don't find conventional quit aids relevant and wish to use culturally-tailored services provided through their own communities. However, the resources to provide culturally-relevant quit assistance is often not available and community-based organizations face many barriers to traditional granting practices.

One important barrier to community engagement and evaluation of change is a lack of community-specific data that is accepted as creditable. Current data collection efforts, such as the Minnesota Adult Tobacco Survey (MATS) and the Youth Tobacco Survey (YTS), are important but they typically collect high-level data that cannot be broken down sufficiently by subgroup; more granular data is needed. In addition, funding for data collection is not reliable. For instance, the future of MATS is currently being debated as ClearWay Minnesota, the organization that sponsors this effort, winds down; and one major source of funding just ended for the Rainbow Health Initiative's Voices of Health data collection.

The establishment of consistent and reliable funding for tobacco control in Minnesota is central to addressing inequities. Funding for tobacco control in Minnesota faces significant decreases in the near future. Impending funding decreases include the following:

- ClearWay Minnesota, funded through an endowment established from tobacco settlement dollars, currently contributes $20 million per year to tobacco control funding. Clearway's funding will sunset in 2023.
- Since ClearWay currently funds the statewide quitline and the Minnesota Adult Tobacco Survey (MATS), funds will be required to continue these resources.
- An estimated $1,000,000 is currently devoted to tobacco control from the Statewide Health Improvement Program (SHIP). SHIP funding needs to be reauthorized by the legislature and governor every two years. The current round of funding ends in 2019

Funding for tobacco control in Minnesota has never risen to the level recommended by CDC, which is $52.9 million for 2015.

A number of groups are working on the issue of establishing consistent and reliable funding for tobacco control. Notably, it is one of four goals of MN for a Smoke-Free Generation, a coalition of organizations interested in tobacco control. The Cancer Alliance could play an important support role in this effort and it could also lead an effort to insure that funding addresses inequities.

Please note that Strategies 1 and 2 go hand-in-hand. Therefore most of the details provided for these strategies are the same and they are given the same priority level. In terms of timing and relative importance, the combination of Strategies 1 and 2 were given a higher rating than was Strategy 3 by the members of the subgroup that worked on this objective.

Desired Outcome:

At the end of five years, what would you like to accomplish? If you do not expect to achieve the objective by the end of five years, what would success look like?

More communities that suffer from inequities in nicotine dependence are engaged in decreasing nicotine dependence and have the resources to effect change. These communities are also more involved in Cancer Alliance activities. The ultimate desired outcome is a decrease in prevalence of nicotine dependence in these communities.

Alignment:

Partners currently working on this objective and type of activity:

Organization	Activity (such as PSE change, education, programmatic)
Association for non-smokers Rights	PSE change, education, programmatic
AICAF	PSE change, education, programmatic
ClearWay	PSE change, education, programmatic, data collection
ANSR-MN	PSE change
Leadership Advancing and Mobilizing Minnesota's Priority Populations for Parity (LAMPP)	PSE change, education, programmatic
BCBS Center for Prevention	PSE change, education, programmatic
American Lung Association	PSE change, education, programmatic
HealthPartners	PSE change, education, programmatic
Allina	PSE change, education, programmatic
American Cancer Society –Cancer Action Network	PSE change, education
American Cancer Society	PSE change, education, programmatic
Minnesota Department of Health	PSE change, education, programmatic
University of Minnesota School of Public Health	Education, research
U of M Program in Health Disparities Research	Education, research
Rainbow Health Initiative	PSE change, education, programmatic
Public Health Law Center	PSE change, education, legal analysis
FQHCs	Type and extent of activity varies – have to look at what each FQHC is doing
Minnesota legislature	PSE change
Minnesota for a Smoke-Free Generation	PSE change
American Heart Association	PSE change

MPHA (member of Minnesota for a Smoke-free Generation)	PSE change
MMA (member of Minnesota for a Smoke-free Generation)	PSE change
Twin Cities Medical Society ((member of Minnesota for a Smoke-free Generation)	PSE change

Stakeholders for this issue not currently working on it and potential role:

Organization	**Potential role (PSE change, education, programmatic)**
Health Systems	PSE change, education, programmatic
Community based organizations	PSE change, education, programmatic
Foundations	PSE change, education, programmatic
Minnesota Public Health Association	PSE change, education
Employers	PSE change, education, programmatic
Center for Health Promotion	
NOTE: Organizations we want to identify for this list are probably those that are working on or interested in increasing health equity, but haven't traditionally been involved in tobacco control work.	

Strategies

Strategy #1: Identify and implement community-driven solutions to eliminate nicotine dependence

Indicator to measure progress (such as increased number of engaged stakeholders, increased media events, increased number of local jurisdictions that pass policy): Number of engaged stakeholders; equitable environment where these community-driven solutions are given priority and funding; number of specific community-driven tobacco-related strategies have been identified and are being implemented.

Rationale: Interventions are more effective when they come from the community and authentic partnerships result in more equity. Communities know their own needs and barriers, and community-based organizations already have established relationships with members. It is also important to recognize the work that communities have already done on these issues in order to understand the work that needs to be done: we don't want to re-invent the wheel.

This is an _x__ evidence-based practice __x__ promising practice ____ other. Please explain.
We believe that this approach is evidence-based since the literature on community-based public health work indicates effectiveness. This approach is promising because it is the equitable and ethical way to go about this work.

Does this strategy promote health equity by addressing a racial, economic, geographic or other barrier? If yes, explain.
Yes, it will be culturally relevant. It will address cultural and ethnic barriers since communities will be active in developing and implementing solutions for their communities. Because it is coming from within communities, it will probably also address geographic barriers.

Rank this strategy for the greatest potential for traditional and non-traditional partners working together.
Rank __1_ of _4__ strategies

Strategy #2: Engage in authentic partnership with communities disproportionately impacted by nicotine dependence.

Indicator to measure progress (such as increased number of engaged stakeholders, increased media events, increased number of local jurisdictions that pass policy): Number of engaged stakeholders; increased representation from a wide range of communities in nicotine-related initiatives and in Cancer Alliance activities.

Rationale: Interventions are more effective when they come from the community and authentic partnerships result in more equity. Communities know their own needs and barriers, and community-based organizations already have established relationships with members. It is also important to recognize the work that communities have already done on these issues in order to understand the work that needs to be done: we don't want to re-invent the wheel.

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Rank _1__ of _4__ strategies

Strategy #3: Provide meaningful community level-data that are collected periodically.

Indicator to measure progress (such as increased number of engaged stakeholders, increased media events, increased number of local jurisdictions that pass policy): Credible data on subgroups is available. Data are collected periodically so that change can be identified. The availability of credible community-level data should result in the involvement of more communities and an increased level of engagement.

Rationale
Current data collection efforts, such as the Minnesota Adult Tobacco Survey (MATS) does not have the sampling strategy and sample size to provide information about subgroups; more granular data are needed. It is very difficult to get funders for this type of information and the funding that does exist is unreliable. For instance, one major source of funding just ended on Voices for Health survey and the future of MATS is uncertain.

This is an ____ evidence-based practice __x__ promising practice ____ other. Please explain. Data are necessary to identify populations that need intervention. Relevant information from communities can be used to develop effective programs and policies.

Does this strategy promote health equity by addressing a racial, economic, geographic or other barrier? If yes, explain.
Yes, data collection will identify inequities and inform the development of programs and policies to address inequities.

Rank this strategy for the greatest potential for traditional and non-traditional partners working together.
Rank _3__ of _4__ strategies

Strategy #4: Establish consistent and reliable funding for tobacco control at a level recommended by CDC that can be used to fund the following CDC-recommended activities: (1) state and community interventions; (2) mass-reach health communication interventions; (3) cessation interventions; (4) surveillance and evaluation; (5) infrastructure, administration and management. Care should be taken to deploy these funds in a way that would address inequities.
Indicator to measure progress (such as increased number of engaged stakeholders, increased media events, increased number of local jurisdictions that pass policy): Consistent and reliable sources of funding for tobacco control are identified and secured. Stakeholders from communities that suffer nicotine inequities are engaged.
Rationale: Adequate funding is necessary to implement evidence-based tobacco control strategies.
This is an __x__ evidence-based practice ____ promising practice ____ other. Please explain. There is strong evidence that consistent and adequate funding is needed to implement effective tobacco control activities, including (1) state and community interventions; (2) mass-reach health communication interventions; (3) cessation interventions; (4) surveillance and evaluation; (5) infrastructure, administration and management. The CDC are listed and justified on the following website: http://www.cdc.gov/tobacco/stateandcommunity/best_practices/
Does this strategy promote health equity by addressing a racial, economic, geographic or other barrier? If yes, explain. Not in itself, but the resulting funds are necessary to promote health equity.
Rank this strategy for the greatest potential for traditional and non-traditional partners working together. **Rank _2_ of _4_ strategies**