Case Study – Wisconsin

1. OVERVIEW OF DISPARITIES PROJECT

1.1 Purpose and Goals of the Project

In 2001 Wisconsin and 12 other states and one territory successfully competed to be part of the federal Centers for Disease Control and Prevention (CDC) pilot project to develop a strategic plan for addressing disparities related to tobacco. The workgroup began the strategic planning process in September 2001. The project goals were:

1. Provide an example for the Centers of Disease Control and Prevention's (CDC) national strategic planning project.
2. Create a strategic plan for Wisconsin's efforts to identify and eliminate tobacco-related disparities.

The case study provides a narrative description of the strategic planning process in Wisconsin.

1.2 Overview of Tobacco Control Efforts and Target Populations in Wisconsin

Geographically, Wisconsin is largely a rural state. In 2000, twenty-one of its 72 counties had populations of less than 20,000[1] and only three counties had populations over 250,000. These three together constitute 32% of the total population[2]. According to the 2000 census, the total population of Wisconsin is 5,363,675 and comprised of: 89% Caucasians, 6 % African Americans, 2% Asians, 1% Native Americans and 4% Hispanics (up 107% since 1990)[3]. Similar to the US as a whole, 24% of adults in Wisconsin are smokers. There has been almost no decline in adult tobacco use during the past 15 years[4], due perhaps to the failure to address disparities.

With Project ASSIST funding from the National Cancer Institute, Wisconsin was one of the earliest states to be involved in tobacco programs. Project ASSIST, a partnership between the Division of Public Health (DPH) and the American Cancer Society, developed state and local tobacco control coalitions thereby forming a basis for future tobacco control successes. The Wisconsin ASSIST program evolved into the DPH Tobacco Control Program; part of CDC's National Tobacco Control Program.

In the 99-01 biennial budget, the Wisconsin State Legislature allocated $21.2 million for tobacco control programs and created the Wisconsin Tobacco Control Board to administer the funds. Many governmental, business, voluntary, and community organizations are now active in tobacco prevention and control in Wisconsin.

1.3 Project Team

The director of the DPH Tobacco Control Program served as project coordinator. Other project team members included the facilitator, a private consultant from Health Care Education and Training; the evaluator, an independent consultant contracted by UW-Extension; and a DPH project assistant.

1.4 Roles and Responsibilities of Project Team Members

The project coordinator wrote the proposal, organized the project, provided needed materials to the workgroup and worked to maintain member attendance. She tended to be a participant observer during the meetings rather than actively participate in discussions.

The facilitator kept the workgroup on track and the momentum moving forward. At the meetings she reviewed the results of the previous session, explained the meetings' tasks or goals to the group and determined when to split the group into two or three discussion groups. When the groups reconvened, she worked with them to integrate their findings. She also maintained group documents on her company's web site.

The evaluator carried out process evaluation of the work group sessions. She observed workgroup behavior and discussion, maintained field notes, developed and conducted in-depth telephone interviews and a focus group with workgroup members and the project team, and administered exit surveys and reviewed project documents.

The project assistant provided backup to the coordinator, facilitator and evaluator. She originally came to the meetings to observe and learn but quickly started to fill in for anyone and everyone.

The project team collectively created meeting agendas during pre-meeting discussions. The project coordinator and assistant refined documents between meetings and wrote reports.

2. EVALUATING STRATEGIC PLANNING PROCESSES

2.1 Purpose and goals of the evaluation

The case study will provide a guide for other states that go through this process in the future.

2.2 Evaluation design

A complete assessment of the strategic planning process included what transpired, who was involved, and the strengths and weaknesses of the process. The CDC case study outline structures the report.

2.3 Evaluation methods

The evaluator attended 7 (of 8) meetings to observe and document the participation, process and productivity of the workgroup.

Exit surveys were administered at six (of 8) sessions. The surveys for four sessions (February, March, April and June 2002) used the same format, allowing a comparison of the results. The questionnaire, (adapted from one developed by Taylor-Powell, Rossing and Geran, 1998, University of WI Extension) appears in *Appendix A.* There are ten questions that assess goals, leadership, cohesiveness and working procedures of the group using a 5-point scale; comments were encouraged.

Taped telephone interviews were conducted with members of the workgroup after meetings one and two and interviews with the project coordinator and the facilitator were held after meetings three and six. At session eight, a focus group session was held. Project documents were collected and reviewed. A more detailed description of the evaluation methods is included in *Appendix B* and *Appendix C* has the minutes from all sessions.

3. STRATEGIC PLANNING PROCESSES AND MILESTONES

3.1 Forming the Strategic Planning Workgroup

3.1.1 Workgroup Members

The workgroup members (*Appendix D*) represent Wisconsin's major racial/ethnic groups, rural and urban groups, Medicaid, low socio-economic groups, and organizations within the tobacco control community. Organizations on the workgroup:

American Cancer Society
Black Health Coalition of Wisconsin, Inc.
Bad River Tribe, Family Preservation Program
Center for Tobacco Research and Intervention
Department of Health and Family Services, Minority Health Program
Great Lakes Inter-Tribal Council
Innovative Resource Group – (for the Wisconsin Medicaid population)
Madison Area Technical College
Milwaukee Area Health Education Center
United Migrant Opportunity Service
Wisconsin Office of Rural Health
Wisconsin Tobacco Control Board
Wisconsin United Coalition of Mutual Assistance Associations

3.1.2 Workgroup roles and responsibilities

The workgroup members were asked to commit to six all-day meetings and work together to create a strategic plan for addressing tobacco-related disparities among population groups in Wisconsin. Most of the work was accomplished at the meetings but volunteers were asked to analyze data outside of the meeting time. Volunteers also shared information about the project at the statewide Tobacco Control Conference held in April 2002. Everyone was asked to contribute additional time to complete the population assessments.

Workgroup members agreed to additional meetings and will share the responsibility of marketing and implementing the plan.

3.1.3 Recruiting members and keeping them involved

Recruitment: The federal *Healthy People 2010* plan lists population groups that commonly experience disparities. This listing was used as selection criteria of which groups to invite to the strategic planning process. Names of individuals who could represent these groups emerged in a series of DPH meetings held in-house to prepare for the strategic planning grant.

The preliminary list included 25 agencies or experts associated with health inequities based on age, gender, education, income, occupation, race/ethnicity, geographic location and sexual orientation (*Appendix E*). These agencies received a letter giving information about the project and asking them to indicate their level of interest in the issue. Telephone contacts were used to follow-up and new names emerged from this contact.

Organizations that work specifically in tobacco control, like the Tobacco Control Board (the organization that oversees the tobacco settlement monies), the Center for Tobacco Research and Intervention, and the American Cancer Society were contacted by phone and/or email.

All interested parties were given additional information about the goals and responsibilities of the workgroup and invited to attend a statewide videoconference on September 25, 2001 (*Appendix F* and *Appendix G*). The videoconference announced the strategic planning effort, solicited input for the workgroup, and requested names for workgroup participants (*Appendix H*). All local health departments and local tobacco control coalitions where invited.

The project coordinator's goal was to recruit:

1. people interested in the topic of disparities,
2. people willing to work hard (in terms of giving ideas, testing ideas with others and seeking input from others),
3. people who could commit to attending all meetings (total of six planned) and work cooperatively with others.
4. people who represented diversity and inclusivity.

Names of individuals who met these criteria emerged from responses to the letters, from the statewide videoconference and a roundtable discussion (*Appendix I*), and from "word-of-mouth" messages. The majority of the members came from Wisconsin's two largest metropolitan areas (Milwaukee and Madison).

The original 9-month timeline for concluding the strategic planning process impacted the composition of the workgroup because there wasn't time to develop the relationships necessary to find representation for all groups. For example, the contacted labor unions declined and the coordinator did not have time to pursue the contact.

Keeping members involved: The group coalesced gradually, over the course of the meetings the average score (5-point scale) from the exit questionnaires gradually increased. In February, the mean score for the measure (10 respondents) was 3.58; the average increased incrementally each subsequent meeting (3.9 in February, 4.2 March; 4.3 in April, and 4.4 in June). The modal response for all questions in the June survey was a 5 (very good), reflecting what the evaluator and other staff members feel about the internal functioning of the workgroup. The facilitator commented, "A high percentage of the group is committed. When they come, they work hard and I think that is pretty impressive." The coordinator in an early interview stated: "I think there has been real progress in the group's coming together. I think we are building consensus in terms of the focus of the group". The only category that has been low on this measure across time was attendance.

The facilitator fostered and maintained participation. She used small task groups to work through the assignments. Keeping workgroup members involved by using their input and feedback – actually listening to them – appeared critical.

Participation in the strategic planning meeting was totally voluntary. No incentives were provided. The core group of seven reported that their level of involvement was due to their commitment to eliminating disparities as well as the cohesion, the level of discussion, the group's diversity and the organization provided by DPH that kept them involved in the process. One member, who did not miss a single meeting, said this about the meetings: "The core group that emerged was committed. It was a benefit to me to be involved."

For the peripherally involved members, those who have attended fewer than three meetings, the project coordinator and the facilitator tried several approaches to engage them. These included: individual messages and phone calls before meetings reiterating how much their participation would enrich the group, requesting help in the population assessments, and continuing to include them in all minutes and messages that went out to the core group.

Making it possible for members to attend the CDC training appeared to contribute to commitment and involvement. Several members took advantage of the CDC training. One of them said this about the two training sessions he attended: " The training has allowed me to better articulate my point of view to my colleagues (in the workgroup)."

3.1.4 Conduct of workgroup meetings

The organizational structure of Wisconsin's workgroup was horizontal and egalitarian. The work group was relatively small (normally eight members and four project staff were present). After the first two meetings, members in exit surveys rated group cohesiveness and communication to be very good to excellent. A committee system was not adopted as members felt that that it would not be useful or necessary. To facilitate the accomplishment of tasks, the project coordinator asked members with access to needed data or with a particular skill to work on assigned tasks between sessions and present their findings to the entire group at a the next meeting. For instance, one member conducted a data analysis of vendor density in urban low-income neighborhoods using census tract data (*Appendix J*).

No one member or agency was in the forefront or controlled discussions. When the project coordinator was asked if she believed any leader had emerged in the group, she asserted that, "I don't think there is any dominant member. Let me put it this way. There are a number of leaders." Independently the facilitator concurred: "I think that there is a lot of shared leadership in the group.… Right across the board, everyone is participating and pitching in and serving a role." The project facilitator expressed satisfaction about the interaction between group members: "I think what is wonderful about our group is they are talking to each other. They aren't addressing everything to the staff." Although members cited attendance as a problem, the core group functioned well —disagreements were worked out in discussions that generally led to compromise. When the facilitator was asked how she saw disagreements being resolved she commented: " I can't remember specifically but my impression is that when they have disagreed they sit at the table and ask the questions." The project coordinator felt it had a lot to do with the facilitator's style: " It kind of feels like the way Karen facilitates lends itself to that (resolution) too. She tries to bring them collectively together."

To assess the level of participation of members, the evaluator used an informal technique at two meetings (third and fourth) to chart when each member talked, for how long, and who took over when s/he finished talking. In small group sessions, everyone talked, though some members elaborated for longer periods than others did. Even in the full group sessions, there was no one person who did not participate in the discussions. The members were engaged and worked hard during the sessions. Several said they gained significant information and experience from their effort. One member gave a brief explanation of her participation in the project to her colleagues at a staff meeting and told them: "It has been difficult and often draining work but well worth it. I have learned so much personally and I feel privileged to be part of the group."

Break-out groups were used at all workgroup meetings and proved to be very effective. The subgroup composition changed at each session. In interviews conducted after the early meetings, several members felt it was a good way of getting everyone to participate and to get a wider range of opinions on the table. Their comments included: "The small groups made it easier for a more in-depth discussion of looking at what [population] groups and

subgroups need to be further looked at." And, "Splitting up into smaller groups gives everyone time to talk and listen to each other. I would continue using that method**."**

In sum, decisions were typically negotiated in the smaller groups and then consensus was sought for a position in the full group. When members reconvened in the larger group, they had to defend their issues before the group, which served to stimulate discussion and understanding. It was at this point that the values of the group members became clear. Group leadership was shared and decisions were made through discussion and consensus building.

3.2 Step 2: Identifying/prioritizing disparities and assessing capacity

3.2.1 Collection and analysis of data on disparities in populations

DPH Tobacco Control Program staff held meetings with a Bureau epidemiologist prior, during and after the application for funding. Students at the University of Wisconsin provided help in gathering and presenting relevant data. An epidemiologist was available to help the workgroup but was not a part of the workgroup. The deliberate decision to not have an epidemiologist as a workgroup member helped avoid what the CDC training referred as "getting face down in the data".

The DPH Tobacco Control Program organized data relevant to tobacco disparities in Wisconsin while preparing the proposal for CDC. The information, organized in a report entitled *Selected Tobacco Control Information* (*Appendix K*), formed the base of information that the group used to carry out the data assessment. The issuance of the Wisconsin Medical Journal (2001) devoted to tobacco was timely and helpful.

One complexity was deciding what data, beyond prevalence of tobacco use, was needed. The workgroup decided to include lung cancer and heart disease rates, degree of industry targeting, level of access to services, relapse rates, exposure to secondhand smoke and access to product as needed data. The workgroup devised a tool, subsequently adopted by other states (*Appendix L*), that helped workgroup members keep track of the data and visualize what tobacco related data are available in Wisconsin and where gaps exist. The matrix positioned disparately affected groups on the vertical axis and types of data along the horizontal axis. To discuss the data, the facilitator broke the workgroup into two smaller groups to examine the data and fill in the matrix. They later reconvened to discuss and integrate their findings. Members reported that the process of working in smaller groups and then discussing their findings in the larger group encouraged everyone's participation and permitted a more complete assessment of the data. One member created a three-dimensional graph, which helped the group visualize the factors that go into prioritizing risk groups (*Appendix M*).

The integrated critical issues based on the data analysis are listed in *Appendix N*.

3.2.2 Population assessments: Methods and Results

Population assessments were completed to provide background information for the determination of critical issues. Workgroup members felt that they had the best understanding of the tobacco situation in their communities and were best equipped to conduct the population assessment. In addition, they felt others in the community would not be able to answer many of the technical questions in the CDC adopted outline. Therefore, each workgroup member volunteered to prepare a report using the CDC tool.

The degree of preparation and depth of analysis varied from person to person but all reports except rural and Native Americans were completed. *Appendix O* includes the full reports for African Americans, 18-24 year olds, Hmong, Latinos, low income and urban residents.

3.2.3 Identifying Critical Issues from population assessments

In two break-out groups, workgroup members identified issues that were most important based on the population assessments. Each subgroup (with 3 or 4 members) came up with 10 issues. A full group session then developed the final 10 issues from the combined list of 20. Many of the issues identified by the two groups were similar and thus were easy to combine or integrate. For instance, in one group 'Educate community leaders' was identified. In the other group an issue was 'How do we make community leaders better aware that disparities exist?' The two variations were discussed and the group agreed on the following formulation: 'Educate and influence policy makers about disparities.'

The integrated critical issues based on population assessments are listed in *Appendix N*.

3.2.4 SWOT analysis: Methods and Results

At the session when the SWOT analysis was conducted, there were four group members present. Normally eight members were present, though not always the same ones. The method adopted for the SWOT analysis followed the CDC model. The group listed strengths and weaknesses of: the workgroup, the health department and collaborators in the field of tobacco control. The group itemized the opportunities and threats. They then split into two groups to analyze and prioritize the SWOT data. Because so few members were present, the coordinator and another staff member participated in the breakout groups, something they normally did not do. The two small group reports were later combined into a single list of critical issues and accepted by the larger workgroup at a later meeting.

The integrated critical issues based on the SWOT analysis are listed in *Appendix N*.

3.3 Developing the strategic plan

3.3.1 Identification and prioritization of critical issues

Following the data analysis, population assessment analysis and the SWOT analysis, the group had a list of 28 issues (8 critical issues from data analysis, 10 population assessment issues and 10 issues from the SWOT analysis). These 28 were reduced to 12 by a member vote on the priority of each. Then each of the two break-out groups took half of the issues (6) to discuss and refine. After reconvening to the full group each subgroup shared it's refined six statements. A second vote was taken and each member voted for six of the twelve statements. The highest-ranking statements were discussed and consensus was reached on the six statements that become the goals for the plan.

Goals for the strategic plan:

1. Eliminate (reduce) gaps in the data that limit the identification of tobacco-related disparities
2. Make tobacco a high priority by creating partnerships that maximize resources related to tobacco control
3. Increase the number of tobacco control strategies that include an emphasis on elimination of disparities
4. Educate and influence policy makers and community opinion leaders about tobacco disparities
5. Execute effective ETS strategies tailored to disparately affected populations
6. Develop "Best Practice Models" for Wisconsin's disparately affected groups

After agreement on the goals was reached, the group again split into two subgroups. Each subgroup developed strategies for three goals.

3.3.2 Conversion of planning goals into strategies

Three strategies were identified for each goal statement. Each subgroup took three statements and identified three or more strategies for each one. The wording was revised in the full group and then two group members and the project coordinator tested the goals and strategies on their colleagues to obtain feedback. The testing was most useful and the feedback helped clarify the goals. When the group met again, the suggested changes that were deemed relevant by the members were incorporated. Most of these were changes in the wording of the goals and strategies, though one minor change in focus was also adopted. *Appendix P* contains the full list of strategies for each goal.

Considerably more time was given to the identification of critical issues to select the goals than to determining strategies. Due to meeting time constraints, DPH staff refined the strategies between meetings. All strategies were revisited at later meetings.

3.3.3 Assessing clarity and feasibility of planning goals

The workgroup went through the feasibility exercise provided by the CDC to assess whether the final six goals were feasible and well defined. More specifically, the exercise addressed whether there were potential partners to carry out the goals, and whether feasible time lines could be established. Other issues included oversight, reporting and feedback processes. The feasibility questions were considered by the full workgroup in a discussion session.

3.3.4 Assignment of persons to implement the strategic plan

It is the expectation of the Workgroup, as stated in the Strategic Plan, that workgroup members, the Division of Public Health, and statewide tobacco control partners will assist in implementing the different components of the strategic plan. The Division of Public Health's Tobacco Control Plan will develop ways to weave recommended strategies into its annual action plan.

3.3.5 Safeguarding the plan: Monitoring, oversight, and feedback

To ensure implementation of the strategic plan, it was decided that members of the workgroup would meet twice a year to monitor progress. The workgroup recommended that a statewide manager be hired to supervise implementation. Job responsibilities for the position were identified. DPH will explore possibilities to fund the position.

To assess the implementation of the Strategic Plan, a comprehensive evaluation is planned that includes a mix of quantitative and qualitative methods to answer two principal questions: (1) To what extent is the plan implemented as planned; (2) To what extent are the desired outcomes achieved? Logic models for each goal describe the underlying expected action and clarify the evaluation information needs. Simple checklists will be used to monitor the achievement of planned activities for each goal. Outcomes for each goal are delineated and will be assessed using a variety of data collection methods including key informant interviews, telephone surveys, document review, structured observations and testimonials. The proposed evaluation is ambitious; final implementation will depend upon resources available and intended use of resulting data.

An evaluation specialist from the University of Wisconsin Extension developed the evaluation plan (*Appendix Q*), after completion of the strategic plan. While it would have been beneficial to include the workgroup in the creation of the evaluation plan, there was simply not enough time for this process. The evaluation plan will be shared with interested workgroup members. It will also be used when reporting back to the group if funding for a statewide manager is found.

3.3.6 Finding partners to help implement the plan

Finding partners to help implement the plan will depend on the success of the marketing plan.

3.4 Adopt and Refine the Plan

3.4.1 Identification of audiences for the plan

In order to tailor the plan to appeal to different audiences, the workgroup identified organizations that serve the target population, a partial list includes: employers, insurers, medical providers, programs already serving disparately affected populations such at the Ethnic Collaborative (Black Health Coalition, Hispanic, American Indian, SE Asian), local public health departments, and local tobacco control coalitions. This is not to be considered an exhaustive list. Partnerships among these organizations are to be promoted. Also, marketing messages designed to appeal to different groups were discussed and will be developed.

3.4.2 Political issues addressed

The Wisconsin State government is facing a budget crisis. The Master Settlement Agreement dollars were securitized and used to help balance the State's 2002-2003 budget. The loss of endowment is critical and ensures a continuing struggle for funds to address this issue. Other issues touched on in the course of the meetings:

- Is there sufficient political leverage for tobacco control efforts.
- The tobacco industry is a strong player.
- There are increasingly more people without health insurance as the economy worsens and the cost of coverage rises.

3.4.3 Internal and external market analyses: Methods and results

The group met with two market analysts from a multicultural communications firm in Milwaukee (G Communications) who participated in the eighth workgroup session (and an additional meeting to complete the marketing plan) when they were developing the original market plan. The consultants suggested a number of strategies for the marketing plan. None of the members had experience in this area, therefore, the suggestions made by the marketing experts were of considerable value. For the internal plan, the group used a grid that asked for identification of audiences, what action should be taken, the benefits accrued and what the message and messenger should be.

An external analysis was conducted at the next meeting which reviewed the marketing steps planned or already adopted and added others. A member of G Communications staff was present. The Division of Public Health agreed to continue working on the marketing plan. Everyone in the workgroup will help implement the marketing plan.

3.4.5 Writing the strategic plan/ workgroup adoption of the plan

Working in small groups, the workgroup discussed and wrote each of the goals and strategies. Usually half of the tasks were assigned to one group and the other half to the second group. The facilitator later copied the output on large sheets of paper for the entire group to revise. The draft was sent out to members between meetings and reviewed at the

subsequent meeting. DPH edited between sessions but the content was not changed in any way. Since the plan was written by the group and had gone through a number of revisions (always with the consensual approval of the group), it was not necessary to formally adopt the plan. It was understood that the plan was ready to go.

3.4.6 Getting State Department of Health & Family Services/DPH approval of the plan

The project coordinator's position as Director of the DPH Tobacco Control Program helped facilitate the approval of the plan. However, midway through the approval process, a complete administration change following the election of a new governor slowed the process considerably. Internal marketing of the plan will be an ongoing effort.

3.5 Preparing for Action

3.5.1 Marketing the plan: Strategies and results

Using the CDC training, manuals, and tools for marketing the plan, the Wisconsin DPH created a tool (*Appendix R*) for the workgroup to use in planing the marketing approach.

The main strategies identified for the marketing plan are:

- Have multiple messages – streamlined for different groups
- Create a white paper
- There should be a call to action specific to each group addressed
- Develop specific informational packets for each audience incorporating the values of the group
- Look to larger groups for assistance in marketing the plan
- Collapse some audiences and consider three general themes for each: benefits, message, and action
- Go back to the data to create fact sheets on the population groups targeted.
- Submit abstracts for the 2003 Tobacco Control Conference
- Go to the groups and ask for their input in terms of what it would take to get their 'buy-in' for the plan
- Develop new stakeholders
- Create power-point presentations

3.5.2 Obstacles to marketing efforts

The main obstacles to the marketing efforts:

- Lack of funds
- Lack of personnel
- Lack of staff time
- Competing priorities/interests/initiatives
- Lack of experience in developing marketing plans

3.5.3 Impact of marketing on development of action plans

The marketing has not occurred yet but it is anticipated that once organizations and individuals start to embrace and implement the strategic plan, changes might need to be made by the workgroup when it reassembles in the future.

3.5.4 Next steps

Members of the workgroup have agreed to become an advisory board and have pledged to work toward implementing actions to eliminate disparities within their organizations.

3.6 Adherence to CDC/OSH Principles/characteristics of Participatory Planning

4. MAJOR ASSETS FOR STRATEGIC PLANNING

4.1 Factors facilitating planning processes: Steps 1-5

Preparatory steps: Writing the application for funding helped begin the necessary collection of available data. While the data available was inadequate for the task of identifying disparities, Wisconsin does have a history of collecting tobacco-related data and has a foundation to build on.

Dedicated individuals: Wisconsin is fortunate in having a populace committed toward furthering equity. The State has a strong history and culture in this regard. Nevertheless, it is difficult for busy people to make time for a topic even when they consider it very important.

CDC training: The first CDC training was valuable in orienting the group. The training in January provided a revised "roadmap". The CDC step-by-step procedures (population assessment, SWOT analysis, narrowing down critical issues, etc.) made the next steps of the process transparent and clarified the roles of the group members.

Members of the workgroup stated the following items facilitated the planning process:

- Skills in the group helped broaden scope and understanding
- Workgroup members have access to disparately affected populations
- Excellent participation from some members
- Members who attend are engaged
- The group has the capacity for strategic thinking
- The group communicates well with each other
- The population assessments were excellent, especially the Hmong assessment
- The use of small groups has been effective
- The facilitation has been good; the facilitator and project director kept the group on track, yet allowed flexibility
- The minority health officer was very helpful in the process
- The workgroup members are all advocates for this topic
- Having the Tobacco Control Board staff on this planning committee was a plus

4.2 Maximizing Planning Assets

5. CHALLENGES TO STRATEGIC PLANNING

5.1 Challenges to successful planning: Steps 1-5

A major obstacle was lack of staff. Without dedicated staffing, special projects become add-ons to already full schedules. Up-front contracting for a facilitator and an evaluator who were experienced was critical. However, lack of staff time continued to be a problem. The flip side was that lack of staff time made the process more dependent on the workgroup which is the purpose in having a diverse workgroup.

Another obstacle was getting the appropriate people on the task force and keeping them committed to the process. Available time for meetings was always an issue but the core group made time for the meetings. The core workgroup had several things in common—educational level (high), expertise in an area of tobacco control or desire to learn this, and residency in the southern and southeastern part of the State. Attendance of the peripheral members may have been enhanced if the meeting sites were rotated around the state. This strategy was mentioned in the exit evaluation of the group members. On the other hand, some of the faithful members may have missed meetings held elsewhere.

Keeping the group a manageable size and yet large enough to have an adequate number of core participants was a challenge. The intent was to limit the group to around 12-15 members, as this is the ideal size for group work. Thirteen organizations were selected. Starting with a larger group because there is always some attrition might maintain participation levels.

Achieving total inclusivity was a challenge. There was no representation from the gay/lesbian community, current smokers, unions, or the business community. Inclusion in some of these areas would have added other perspectives.

One frustration with being in a "pilot program" was that the approach was in development and required flexibility. Wisconsin began meeting before the CDC training provided in January. The Wisconsin approach, language and format (developed in the application) needed to be changed after the first meetings as CDC's direction became more focused following development of the training. One member said, "We need a better roadmap of expected results and the steps needed to get there" in an exit survey after the second meeting. In this sense it was an obstacle to be one or two steps ahead of the CDC training. On the other hand, it allowed Wisconsin to really utilize the training to the utmost since they were already in the "thick of it". Having an experienced facilitator flexible enough (and previously familiar with the methods put forward at the CDC training) helped the workgroup overcome this obstacle.

The workgroup recognized that marketing is a critical component. With no marketing experts on the team, the evaluator thought it prudent that leadership seek outside help and invited marketing consultants to the final two meetings.

5.2 Strategies to Overcome Challenges

The CDC training and technical assistance was excellent. The workgroup members indicated that the plan to identify critical issues and then strategies helped them get through the process in an efficient and effective way. Wisconsin adapted and simplified several of the CDC tools for the State's specific needs.

Strategies for addressing attendance problem:

- Avoid long periods between meetings.
- Keep in touch with people between meetings.
- Circulate relevant materials to members between meetings.
- Call members who were absent to keep them involved.
- Rotate the meeting sites so that it is not always the same people who have to come a distance.

6. CONCLUSIONS

6.1 Major planning accomplishments

- A committed, knowledgeable and diverse workgroup was created and maintained.
- Relevant data available on disparities were identified and compiled in tables for the meetings.
- Those data were critically examined using a tool developed by the workgroup; that tool was made available to and used by other states.
- Members became fully engaged with the data; for example volunteering to analyze information on vendor density and interesting results emerged.
- Members completed thoughtful, organized population assessments, one created a power point presentation that will be useful in creating targeted messages.
- Members involved their organizations in reviewing the Strategic Plan and got commitments from them to promote the goals.
- A marketing plan was started with the help of outside consultants.
- Process evaluation instruments were adapted, developed, and administered at almost every session to provide a full description of the planning process.
- The members themselves completed every component of the plan within the allotted time frame—the team members own the product.
- A plan for addressing disparities is now available in Wisconsin. It is a plan that will serve as an example for other public health issues.

6.2 Lessons learned

Competing for time: There are many dedicated individuals but they are very busy. Most organizations have goals that include addressing disparities but there are many competing organizational priorities.

"Catch 22": Getting representatives from groups that are not yet identified is necessary but not possible. Making your strategies "data-driven" when you don't have complete data is essential but not possible. These issues need to be continually revisited.

Societal priorities: Getting public acceptance that inequities affect everyone, not just populations with disparities, is exceedingly difficult. This lack of acceptance of the essential scope of the issue makes progress difficult.

Unmet expectations: Lack of implementation resources to meet the increased expectations from the planning process may simply add to the existing problem.

Perfection vs. proceeding (or fear of failure): The enormity of the issue can create fear in proceeding and intensify the desire to have everything in place before starting. You can't wait; you have to start where you are.

The WI experience suggests that individuals who work in the field, are committed to tobacco control and perceive the activity as valuable, as well as those who have experience in and confidence in analyzing complex issues and working collaboratively are the members who participate consistently. The process is demanding and requires a high level of commitment.

6.3 Recommendations to Enhance Future Strategic Planning

1. Gather data available from resident epidemiologists prior to convening the group.
2. Hire an experienced facilitator prior to convening the group.
3. Allot sufficient time during the recruitment process to develop contacts to ensure diversity in the workgroup. But don't expect perfection the first time. This will need to be continually revisited.
4. Consider what the ideal number of individuals might be and involve more people than that number to ensure that the group will have an adequate number of core participants.
5. Have materials for the initial meeting ready before scheduling the first meeting. Provide a good description of the goals of the project, time commitment and member responsibility. Provide directions and hotel information for those who will have to stay overnight. Be at the door to welcome participants on arrival and introduce them to one another.
6. The workgroup will interact freely with one another when the project coordinator and facilitator do not impose their vision of the process and outcomes on the group.
7. Use the break-out method to increase the power and efficiency of the group.
8. Keep to a strict schedule.
9. Give the group specific tasks to accomplish both at and between meetings.
10. Adapt and streamline CDC tools for state's individual circumstances.

ENDNOTES:

[1] Census 2000 for the State of WI: State by County (http://www.census.gov/census2000/states/html)

[2] Ibid

[3] Census 2000 for the State of WI: General demographic characteristics (op. cit.)

[4] Malmstadt, J., Nordstrom D., Carty, D., Christiansen, A., Chudy, Rumm N., and Remington, P. (2001). Cigarette Smoking in Wisconsin: The influence of race, ethnicity and socioeconomics. Wisconsin Medical Journal, Special Issue "Smoke Out: Examining the Real Cost of Tobacco Use". 100: 3. p 30