Ohio's Cross-Cultural Tobacco Control Alliance

Empowering cross-cultural communities to take action to overcome tobacco – related health disparities

Building Infrastructure 2006-2008

Executive Summary

Action Plan

"Since forming the Alliance, the members have worked on a strategic plan, developed a vision and mission statement, and identified critical issues. These activities are only the beginning of a partnership to eliminate tobacco health disparities in Ohio."

Gabrielle Brett-Sullivan
Alliance Development, Co-Chairperson

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August 2006

A Message from the Director of Health

Dear Ohioans:

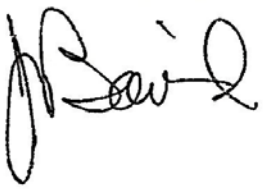
With great pleasure I would like to present an action plan to address tobacco-related health disparities among at-risk, culturally diverse, and underserved populations called *Empowering cross-cultural communities to take action to overcome tobacco-related health disparities.* The Cross-Cultural Tobacco Control Alliance is a newly-formed statewide partnership consisting of various communities that has emerged to enhance our state's ability to improve adverse health outcomes related to tobacco use and secondhand smoke exposure.

We are very proud of the diverse agencies that have come together to create a common mission and vision to lay the foundation for building infrastructure necessary for communities to develop leadership, programs, and other resources to address their own unique health challenges, while simultaneously working together to achieve common goals.

With funding support from the Centers for Disease Control and Prevention (CDC) Office on Smoking and Health, and the in-kind contributions from the Ohio Tobacco Prevention Foundation, the strategic and action planning process created a new level of local community engagement that deserves replication in other public health areas and sustainability to improve health outcomes among underserved populations.

We invite you to learn more about the strategic planning process and the action plan by visiting the Ohio Department of Health Website.

Sincerely,



J. Nick Baird, MD
Director of Health

Background

National Adult and Youth Smoking Prevalence Rates

Tobacco use is the nation's leading preventable cause of premature death (National Institute of Health [NIH], 2006). Tobacco use accounts for one in every five deaths in the United States (NIH, 2006). Currently, 21 percent of adults and 22 percent of high school students smoke cigarettes in the United States (NIH, 2006). Over the period 1995 through 1999, the estimated costs for providing direct medial care to smokers totaled $75.5 billion for adults and there was an estimated $81.9 billion associated with lost productivity as a result of tobacco-use (NIH, 2006). The estimated prevalence of current smokers in Ohio is 22.4% in comparison to 20.5% for the United States (Ohio Department of Health [ODH], 2006).

Adult Smoking Prevalence Rates in Ohio

Although 15 percent of Ohio's population consists of communities of color, their adult smoking prevalence rates within and across these communities were generally higher than their Caucasian counterparts (see Table 1 and 2). In 2005 Ohio ranked 16th in comparison to other states with regard to adult smoking prevalence (ODH 2006). According to Centers for Disease Control and Prevention (CDC) (2005) estimates for 2003, the smoking prevalence rate for African Americans was 25.1%, American Indians/Alaskan Natives was 43.2%, Asian American/Pacific Islander was 10.9%, and Hispanics/Latinos was 21.8%. Additionally, Table 1 below provides information on the estimated smoking prevalence by race and ethnicity in 2003.

TABLE 1. OHIO ESTIMATED ADULT SMOKING PREVALENCE RATES BY RACE AND ETHNICITY IN 2003

Race/Ethnicity	Population	Estimated Smoking Rates	Number of Estimated Smokers
African American/ Black	1,305,611	25.1%	327, 708
American Indian/ Alaska Native	22,706	43.2%	9,809
Asian American	136,238	10.9%	14,850
Caucasian	9,650,169	22.5%	2,171,288
Hispanic/Latino	215,710	21.8%	47,025

Sources: U.S. Census Bureau, Census 2000 Summary File 1, Matrix P8, ODH 2006, and CDC 2005.

Approximately 22.2% of the African American adult population were current smokers, 20.4% of the Hispanics/Latinos were current smokers as compared to 22.5% of the Caucasian population in Ohio (ODH, 2006).[1] However, limited studies in Ohio reveal high smoking prevalence among Vietnamese (23%) and Korean (22%) adult males (Adhikari 2002; Katsuyama 2005). Table 2 below lists the estimated smoking prevalence rates of various populations in Ohio.

"… we have proposed progressive strategies that will address the lack of research [in comparison to mainstream] in the African American community, as well as other unique needs multiple communities face."
Pam Brackett
CCTCA Member and Mentor

[1]CDC Tobacco Control Highlights 2005 data were used to estimate tobacco prevalence rates for American Indians/Alaskan Natives, Hispanic/Latino Americans and Asian Americans in 2003 for the state of Ohio since these data were not available from BRFSS 2004 or 2005.

TABLE 2 ESTIMATED ADULT SMOKING PREVALENCE BY POPULATION IN OHIO YEAR 2005	
Population	**Estimated Smoking Prevalence**
Uninsured[2]	55%
Medicaid[3]	50.1%
Unemployed Caucasians	45.2%
American Indians/Alaskan Natives[4]	43.2%
Caucasians with less than a High School Diploma	42.4%
Individual earning less than $15,000	35.9%
African American Males ages 35-54 years	30.7%
African American Females ages 35-54 years	30.4%
Vietnamese[5]	23%
Caucasians	22.5%
African Americans	22.2%
Koreans[6]	22%
Asian Americans[7]	10.9%

Sources: ODH, 2006; CDC, 2005; Adhikari, 2002; Katsuyama, 2005; Ohio Comprehensive Tobacco Use Prevention Strategic Plan, 2004-2008.

When gender, age, income, employment status, and education of the race/ethnicity are taken into account, some of the populations with the largest estimated smoking rates in Ohio include: uninsured individuals, Medicaid participants, unemployed Caucasians, American Indians/Alaskan Natives, Caucasians with less than a high school diploma, African American males and African American females ages 35-54 years old. (ODH, 2006; Ohio Comprehensive Tobacco Use Prevention Strategic Plan, 2004-2008).

Adult Regional Smoking Prevalence Rates in Ohio

At the regional level, the estimated smoking prevalence data show that the groups with the highest smoking rates include: the population with less than a high school diploma in the Northwestern region, the unemployed population in the Southeastern region, the low income population in the Northwestern region, females ages 35-54 years in the Southeastern region, and the 18 – 24 year old population in the Northwestern region (see Table 3). Table 3 below provides estimates of the smoking prevalence for various populations across the five regions in Ohio.

[2]Ohio Comprehensive Tobacco Use Prevention Strategic Plan 2004 – 2008:2006 Update. The year for this statistic is not reported.
[3]Ibid.
[4]State level data were not available for American Indians/Alaskan Natives. This is a national estimate obtained from 2003 data (CDC, 2005).
[5]This data was collected 2000-20001 and is not based on a random sample; therefore it cannot be generalized to the population (Adhikari, 2002).
[6]This data was collected in 2004 and is not based on a random sample; therefore it cannot be generalized to the population (Katsuyama, 2005).
[7]State level data were not available for American Indians/Alaskan Natives. This is a national estimate obtained from 2003 data (CDC, 2005).

TABLE 3 ESTIMATED ADULT SMOKING PREVALENCE BY POPULATION ACROSS THE FIVE REGIONS IN OHIO YEARS 2000-2004	
Population	**Estimated Smoking Prevalence**
Less than High School Diploma in the Northwestern Region	56%
Unemployed in the Southeastern Region	55.3%
Low Income in the Northwestern Region	46.6%
Females ages 35-54 years in the Southeastern Region	39%
Individuals ages 18-24 years in the Northwestern Region	37.2%
Appalachians	26.9%

Sources: Bennett, 2006; ODH, 2005.

Based on the regional estimates in Table 3 above, it appears that the less than high school diploma in the Northwestern region, unemployed in the Southeastern region, low income in the Northwestern region, females ages 35-54 years in the Southeastern region, and individuals ages 18-24 years in the Northwestern region had the highest smoking prevalence rates in Ohio.

TABLE 4. LUNG AND BRONCHUS CANCER RATES BY POPULATION IN OHIO, 1997-2000[8]	
Population	**Estimated Incidence Rates**
African Americans	88.1/100,000
Caucasians	75.1/100,000
African American Males	124.3/100,000
Caucasian Males	100.6/100,000
African American Females	63.8/100,000
Caucasian Females	57/100,000

Source: The Comprehensive Cancer Program, Community Health Assessments, and the Ohio Cancer Incidence Surveillance System at the ODH and The Arthur G. James Cancer Hospital and Richard J. Slove Research Institute at the Ohio State University. Ohio Cancer Facts & Figures 2003.

Table 4 above lists the incidence rates of lung and Bronchus cancer for African Americans and Caucasians.[9] The incidence rate of African Americans with bronchus cancer was 88.1/100,000 in comparison to 75.1/100,000 for Caucasians over the period 1997 through 2000 in Ohio (ODH, 2004). Similarly, the incidence rate of lung and bronchus cancer cases was 124.3/100,000 for African American males as compared to 100.6/100,000 for Caucasian males over the period 1997 through 2000 (ODH, 2004). During that same period, the incidence rate of lung and bronchus cancer cases for African American females was 63.8/100,000 in comparison to 57/100,000 for Caucasian females (ODH, 2004).

[8]Average Annual rate per 100,000 age-adjusted to the 2000 U.S. standard populations.
[9]Data for American Indians/Alaskan Natives, Asian Americans, and Hispanics/Latinos were not available.

Goal #4 Workgroup for Addressing Tobacco-related Disparities in Ohio

Given the high smoking prevalence, morbidity, and mortality rates among communities of color and other at-risk underserved populations, the Centers for Disease Control and Prevention Office on Smoking and Health (CDC/OSH) provides funding to state coalitions to address tobacco-related disparities. In 2005, the Goal #4 Workgroup received funding from the CDC/OSH to build infrastructure to create an strategic and action plan to address tobacco-related disparities in Ohio. The Goal #4 Workgroup was formed in March 2004 as one of five workgroups for the Ohio Comprehensive Tobacco Use Prevention Strategic Plan 2004-2008 to address eliminating disparities in tobacco and to focus on tobacco-related disparities among at-risk, culturally diverse, underserved populations in Ohio. Nationally, this has been one of the most challenging areas to address for state-level tobacco prevention and control programs. Despite the challenges, high tobacco-related morbidity and mortality rates among communities of color and various at-risk, underserved populations call for culturally-competent, practice-based evidence, innovative approaches that can facilitate reducing and eliminating tobacco-related heath disparities among these populations. The term "practice-based evidence" is used because oftentimes in underserved populations, there is a lack of evaluated "gold standard" interventions to confirm what works. That is, practice-based evidence approaches allow us to conduct interventions and evaluate them to "show evidence" of what did and did not work.

The purpose of the Goal #4 Workgroup (which has now emerged into the *Cross-Cultural Tobacco Control [CCTC] Alliance*) was to develop their own strategic and action plans for the identification, reduction, and elimination of tobacco-related disparities. The strategic plan was used to develop an action and marketing plan in order to lay the foundation for undertaking sustainable initiatives that will help to accomplish the goals and objectives of the Ohio Comprehensive Tobacco Use Prevention Strategic Plan (2004-2008) overall. Funding from CDC/OSH allowed the CCTC Alliance to build infrastructure for the community strategic planning and implementation processes by hiring a meeting facilitator for four meetings, a case study evaluator, and a focus group contractor to help us look more closely into at-risk populations to learn about their specific needs for tobacco control and prevention.

The ***vision*** of the CCTC Alliance is to eliminate tobacco-related health disparities across the state of Ohio.

The ***mission*** is to identify and systematically eradicate tobacco-related health disparities by using innovative approaches to: build networks, alliances, infrastructure, and capacity; identify gaps in data collection; provide culturally-competent education; advocate for tobacco-control legislation; and develop and support culturally-competent best practices for at-risk, culturally diverse, underserved populations that are disproportionately affected by tobacco use.

The thirteen populations the CCTC Alliance identified for assessing their tobacco control and prevention needs included:
1) African Americans, 2) Amish, 3) Appalachians, 4) Asian Americans,5) Chemically Dependent, 6) the Deaf Community, 7) Hispanics/Latinos, 8) Immigrants/Refugees, 9) Lesbian-Gay-Bisexual-Transgender, 10) Medicaid Eligible, 11) Mentally/Physically Challenged, 12) American Indians/Alaskan Natives, and 13) Veterans/Active Duty Military Personnel.
Two populations have since been added: Persons Affected by HIV/AIDS and Blue Collar/ Union. The Ohio Tobacco Prevention Foundation provided a data analyst as in-kind support to assess data availability and to identify gaps in data information on the identified special populations/groups.

Workgroup Leadership and Roles

The most important asset of the community strategic and action planning processes has been the community membership. There were three leadership levels.

Foundational Workgroup Membership Leaders: These leaders volunteered their time to contribute input based upon the community they were working on behalf of, participated in the strategic planning and evaluation process, or established relationships with new members who may have benefited from or contributed to the process.

Deborah Chambers, Ohio Department of Alcohol and Drug Addiction Services
Dr. Leroy Cothran, United Missionary Baptist Church, Dayton, Ohio
Anna Cruz and Dawn Emmons, DeafLink
Icilda Dickerson, Ohio Tobacco Prevention Foundation
Marian Ghedi, United Somali Refugee Women
Amy Hopping, National Cancer Institute, Cancer Information Service, Columbus
Reina Sims, Ohio Tobacco Prevention Foundation
Alberto Uribe, Ohio Hispanic Coalition
Grayce Villa-Shaw, Adelante'
Victoria Wilder-Crews, The C.E.A.S.E. Project

Goal/Objective Team Chairperson Leadership: These leaders chaired each objective (which later turned into goals for the final Action Plan), advocated for funding and infrastructure for the plan, contributed input based upon the community they were working on behalf of, participated in the strategic planning and evaluation process as requested, and invited or established relationships with new members who may have benefited from or contributed to the process. An extra responsibility was to complete tasks that would advance their particular objective or the alliance as a whole.

Dr. Surendra Bir Adhikari: Data Availability
Emily Lee and Gabrielle Brett: Alliance Development
Kathryn Grayson, Gayden Fite, Cheryl Owens, & Michael Byun: Network Development
Najeebah Shine, Justin Henderson, and Grayce Villa-Shaw: Tobacco-Free Workplaces
Jennifer Brindle and Dr. Lucinda M. Deason: Youth Programs
Bonnie Kirsch and Gothai Jayaraj: Cessation and Associated Support

CDC/OSH Disparities Supplemental Grant Leadership: These leaders were either funded by CDC/OSH or gave their in-kind support to analyze relevant data to determine current prevalence rates and identify gaps, lead the workgroup meetings to accomplish tasks, evaluate the community strategic planning and implementation process, coordinate the movement of the workgroup, and/or collect focus group data from the 13 populations.

Dr. Surendra Bir Adhikari, Data Analyst
Wendy Berry-West, Workgroup Facilitator
Tracy Clopton, Project Coordinator
Dr. Lucinda M. Deason, Case Study Evaluator
Dr. Barry Oches, Qualitative Data - Focus Group Contractor

"Somalis, as other refugee populations, need to have ownership of their program to respond to their community's needs. … and we have resources to share to support the larger alliance with special needs."
Marian Ghedi
CCTCA Member and Mentor

Involving Communities in the Process

During the CDC/OSH nine-month funding cycle, the CCTC Alliance convened five formal meetings on October 3, 2005, December 16, 2005, February 15, 2006, April 25, 2006, June 14, 2006 and a conference call on June 28, 2006. The five formal meetings were held in Columbus, Ohio at various locations. Approximately 15 - 20 workgroup members participated in each meeting. Much of the preliminary groundwork had been completed before the funding arrived such as, preliminary objectives were established, various communities provided input regarding the formation of a workgroup, a Power Analysis was conducted, and twelve populations were identified. A summary of each meeting is provided below:

Meeting 1: October 3, 2005: The Chairperson Leadership was formally introduced, persons worked in their respective objective teams to determine how to further develop their action plan objectives, focus group questions and themes were reviewed, and future meeting dates were scheduled for the remaining grant cycle.

Meeting 2: December 16, 2005: Roles and responsibilities for leadership were reviewed and clarified, training needs and future presenters for leadership development were solicited from workgroup members, the vision and mission statements were finalized, and the Critical Issues tool from CDC/OSH was reviewed and used to determine the priority of all objectives for each goal.

Meeting 3: February 15, 2006: Workgroup members received leadership training on a topic called "Human Resources: People are Your Most Valuable Asset" given by Heard Management. The information focused on agency staff recruitment, training, and retention, along with overall agency development. Members provided ideas for the next grant cycle to sustain the process. Updates on focus group progress were given, and the group went through the Critical Issues process for the Youth Programs goal.

Meeting 4: April 25, 2006: The United Way of Greater Cleveland provided insight on securing funding from their agency. Results of the Power Analysis were reviewed, a SWOT analysis was conducted on the action plan goals, and the Wisconsin Strategic Plan was reviewed for Ohio's action plan structure and format. Workgroup members from four of the five different regions agreed to host regional meetings to secure more input before the final action plan was developed.

Meeting 5: June 14, 2006: The meeting was facilitated by Rod Lew of Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL) and David Nakashima of Nakashima and Associates. Workgroup members participated in a "Cover Story Vision Activity" to think about goals and objectives that could be achieved in five years. A Tinker Toy exercise was conducted to gain an understanding of the factors that can facilitate and impede effective communication between individuals and/or groups. Lastly, the group discussed tasks that could be done to sustain momentum and foster leadership development in various communities.

Meeting 6: June 28, 2006 (Conference Call): Workgroup members voted to be called the Cross-Cultural Tobacco Control Alliance and the theme for the action plan became "Empowering cross-cultural communities to take action to overcome tobacco-related health disparities." Some of the group members volunteered to serve as Chairpersons and others as team members for the next funding cycle. The group also received a preliminary marketing plan matrix in preparation for the fall 2006 meeting.

Goals and Strategies

Long-term Goal. Identify and eliminate the disparities related to tobacco use and its effects among population groups disproportionately affected by tobacco use.

Populations:

- African Americans
- Amish
- Appalachians
- Asian Americans
- Blue Collar/Union
- Chemically Dependent
- Deaf/Hard of Hearing
- Hispanics/Latinos
- Immigrants/Refugees
- Lesbian, Gay, Bisexual, Transgender
- Medicaid Eligible
- Mentally/Physically Challenged
- American Indians/Alaskan Natives
- Persons Affected by HIV/AIDS
- Veterans/Active Duty Military Personnel

"The Ohio Cross-Cultural Tobacco Control Alliance can positively affect a variety of underserved populations in the state when it comes to tobacco control, including the Appalachian population."

Bonnie Kirsch
Cessation & Associated Support, Co-Chairperson

Sustaining the Alliance

During two CDC/OSH grant cycles (June 2006 to June 2008), the CCTC Alliance will receive $120,000 per year to hold community-specific forums, collect additional data, distribute mini-grants to engage communities currently not addressing tobacco for various specifically identified populations, advocate for state-wide community-appropriate policies, continue leadership and regional meetings, provide leadership development trainings, advocate for funding from national, state and local grant-making agencies, hire a project assistant to coordinate responsibilities, and expand the overall movement to improve adverse health outcomes related to tobacco use and secondhand smoke exposure until it is institutionalized in Ohio.

The following agencies support the work of this Action Plan:

- Adelante, Inc.
- American Lung Association of Ohio (Southwest and Northeast)
- Asian American Community Services
- Asian Services in Action, Inc.
- Athens City-County Health Department
- Case Western Reserve University, Tobacco Reduction Advocacy & Innovation Lab (T.R.A.I.L.)
- City of Cleveland Department of Public Health
- Cuyahoga County Board of Health
- DeafLink
- District Board of Health-Mahoning County
- Division of Adolescents Health, CASE
- Emancipation Celebration Committee
- Erie-Huron Counties Community Action Commission, Inc.
- Greene County Combined Health District
- Guernsey, Noble, Monroe Tobacco Project
- Hamilton County Tobacco-Free Partnership
- Holzer Tobacco Prevention Center
- Institute for Local Government Administration and Rural Development (ILGARD)
- Lesbian, Gay, Bisexual, & Transgender Community Center of Greater Cleveland (LGBT)
- National Center Institute-Cancer Information Services (Cleveland and Columbus) (N.C.I.)
- Ohio African American Communities for Optimum Health (OAACOH)
- Ohio Commission on African American Males (OCAAM)
- Ohio Department of Alcohol and Drug Addiction Services (ODADAS)
- ODH; Tobacco Risk Reduction Program
- Ohio Department of Mental Health
- Ohio Hispanic Coalition
- Ohio Sickle Cell and Health Association
- Ohio Tobacco Prevention Foundation
- Premier Community Health
- Recovery Resources
- Somali Senior & Family Services
- The C.E.A.S.E. Project
- The University of Akron Department of Public Administration and Urban Studies
- UMADAOP of Lucas County
- United Missionary Baptist Church
- United Somali Refugee Women
- US Together
- Wright State University; Substance Abuse Resources and Disability Issues (SARDI)
- Your Human Resource Center
- Zanesville-Muskingum County Health Department

Goal 1

Increase the availability of tobacco-specific baseline and continuity of collecting data related to at-risk, culturally diverse, underserved populations to reverse adverse health outcomes.

Agencies interested in this goal:

- Asian American Community Services
- Asian Services in Action, Inc.
- Cuyahoga County Board of Health
- DeafLink
- Division of Adolescents Health, CASE
- Erie-Huron CCAC
- Greene County Combined Health District
- I.L.G.A.R.D.
- LGBT Center for Greater Cleveland
- N.C.I.
- OAACOH
- OCAAM
- ODH; Tobacco Risk Reduction Program
- Ohio Sickle Cell and Health Association
- Ohio Tobacco Prevention Foundation
- Premier Community Health
- Somali Senior & Family Services
- United Missionary Baptist Church
- United Somali Refugee Women
- The University of Akron, Dept. of Public Admin & Urban Studies
- Your Human Resource Center

Strategy 1.1: Review and identify tobacco, geographical, health-outcome disparity, and chronic disease-related data that are available and needed to identify gaps in information and interventions for at-risk, culturally diverse, underserved populations.

Action Steps:

- Compile a comprehensive listing of data sources.
- Review multiple data sources to identify and document prevalence, health outcome and intervention gaps.
- Conduct on-going assessments of populations currently assessed.
- Sponsor and conduct primary research on populations that have not been assessed.
- Provide input to state entities that design tobacco related instruments to collect data on at-risk, culturally diverse, underserved populations.
- Compile samples of survey tools used by local communities in convenience assessments among sub-populations.
- Create public access to the data by developing a website.

Strategy 1.2: Make data user-friendly and accessible to the public to influence policies that decrease smoking prevalence, and secondhand smoke exposure to improve health outcomes among at-risk, culturally diverse, underserved populations.

Actions Steps:

- Determine the adverse policies that need to be changed.
- Determine where policies are lacking and need to be developed.
- Disseminate data to key stakeholders.
- Develop a white paper.
- Share and create dialogue on the developed white concept paper with policymakers and the communities.
- Seek funding for and engage communities in appropriate policy specific initiatives.

Goal 2

Establish an adequately funded and fully operational tobacco education and advocacy alliance among statewide at-risk, culturally diverse, underserved populations to build public health influence, capacity and infrastructure.

Agencies interested in this goal:

- American Lung Association of Ohio
- Asian American Community Services
- Asian Services in Action, Inc.
- Athens City-County Health Department
- Case Western Reserve University, T.R.A.I.L.
- Cuyahoga County Board of Health
- DeafLink
- District Board of Health-Mahoning County
- Division of Adolescents Health, CASE
- Emancipation Celebration Committee
- Green County Combined Health District
- LGBT Center for Greater Cleveland
- N.C.I.
- OAACOH
- ODH; Tobacco Risk Reduction Program
- Ohio Hispanic Coalition
- Premier Community Health
- Somali Senior & Family Services
- The C.E.A.S.E. Project
- UMADAOP of Lucas County
- United Missionary Baptist Church
- United Somali Refugee Women
- US Together
- The University of Akron, Dept. of Public Admin & Urban Studies
- Your Human Resource Center
- Zanesville-Muskingum County Health Department

Strategy 2.1: Identify key organizations that serve at-risk, culturally diverse, underserved populations to increase their capacity to address tobacco-related disparities and adverse health outcomes.

Action Steps:

- Develop a list of organizations for each identified population.
- Develop and disseminate a resource directory.
- Maintain the resource directory.
- Upload the directory onto various established websites.

Strategy 2.2: Develop partnerships and collaborative opportunities among agencies serving at-risk, culturally diverse, underserved populations to build alliance relationships.

Action Steps:

- Determine common concerns and goals among multiple communities to affect mutually beneficial change.
- Create or improve communication channels between multiple organizations.
- Offer networking and leadership development opportunities by providing information at forums, conferences and meetings.
- Develop memoranda of understanding for alliance participation among agencies.
- Reach out to new partners with one-on-one visits to agencies serving each identified population.

Goal 2 (cont.)

Strategy 2.3: Develop resources to support and implement mutually beneficial strategies to increase multiple populations' capacity to address tobacco-related disparities and adverse health outcomes through the alliance.

Action Steps:

- Seek funding for the alliance to be established as a staffed entity.
- Create a cross-population/community alliance that has the minimum standards of mutually agreed upon goals/ objectives, a multiple community-competent staff, list-serve management, training and technical assistance abilities, diversified funding sources, fundraising and sustainability, practice-based evidence interventions, community-competent media outreach, and strategic marketing capabilities.
- Create a virtual resource center to disseminate information to the users.
- Identify existing population-specific materials about tobacco control strategies.
- Create new or retrieve existing population-specific informational material about tobacco control strategies and tools.
- Create training and technical assistance modules about tobacco control strategies for each identified population.
- Provide population-specific training and technical assistance to address tobacco use prevention.

Strategy 2.4: Create community-specific agency networks to increase the number of statewide entities addressing tobacco use and adverse health outcomes in a community-competent manner.

Action Steps:

- For each community, create an interest group of local and regional governmental and non-governmental social service, health, educational, faith-based, SES, occupational, etc. agencies that serve at-risk, culturally diverse, underserved populations.
- Assess readiness levels of each community to address tobacco and adverse health outcomes.
- Based upon the readiness level assessment, develop a specific plan and monitor the movement of communities along the continuum of community-network development.
- Create community-specific networks that have the minimum standards of community-specific goals/ objectives, a community-competent staff, list-serve management, training and technical assistance abilities, diversified funding sources, fundraising and sustainability, practice-based evidence interventions, community-competent media outreach, and strategic marketing capabilities.
- Seek funding for the establishment of a staffed community-specific network entity for communities as they demonstrate readiness.
- Create community-specific plans to acquire replacement funding to decrease the tobacco industry influence in media, cultural arts and non-profit social service programs.

Goal 3

Establish baseline data and increase by five percent the number of tobacco free workplaces (restaurants and bars included) who employ or serve at-risk, culturally diverse, underserved populations.

Smoke Free Ohio Passed November 7, 2006!

Agencies interested in this goal:

- Adelante, Inc.
- Asian American Community Services
- Asian Services in Action, Inc.
- Cuyahoga County Board of Health
- DeafLink
- Greene County Combined Health District
- LGBT Center for Greater Cleveland
- ODADAS
- ODH; Tobacco Risk Reduction Program
- Ohio Hispanic Coalition
- Premier Community Health
- Somali Senior & Family Services
- United Somali Refugee Women
- Your Human Resource Center
- Zanesville-Muskingum County Health Department

Strategy 3.1: Expand comprehensive assessment of workplaces to determine baseline data. Suspended

Action Steps:

- Compile local data sources.
- Complete report by adding new workplaces to the current listing.

Strategy 3.2: Compile resources currently available to support tobacco free workplaces.

Action Steps:

- Identify existing or new tobacco free ordinances. Suspended
- Review existing resources to assist workplaces in establishing new tobacco free policies and make resources competent for each community.
- Identify existing enforcement policies and procedures from communities with comprehensive clean indoor air policies (Columbus, Dublin, etc.) Suspended

Strategy 3.3: Provide training and technical assistance to assist workplaces in establishing tobacco free policies.

Action Steps:

- Create regional strategies to reach employers based upon the data currently collected.
- Collaborate with any local or statewide initiatives to ensure compliance with existing or new clean indoor air ordinances.
- Create community and occupation competent training, mentoring, technical assistance modules, and services to assist businesses in establishing tobacco free workplaces for each identified population.
- Conduct trainings to educate employers.
- Make training information available through the website.

Strategy 3.4: Implement recognition program for worksites that comply with ordinances and complete training.

Action Steps:

- Schedule recognition ceremonies.
- Contact community specific media representatives to report the success.

Goal 4

Increase the number of practice-based evidence tobacco-use prevention programs that are culturally competent for at-risk population youth that also address age group and socioeconomic influences.

Agencies interested in this goal:

- American Lung Association of Ohio
- Asian American Community Services
- Asian Services in Action, Inc.
- Case Western Reserve University, T.R.A.I.L.
- DeafLink
- Division of Adolescents Health, CASE
- Emancipation Celebration Committee
- LGBT Center for Greater Cleveland
- OAACOH
- ODADAS
- ODH; Tobacco Risk Reduction Program
- Ohio Hispanic Coalition
- Somali Senior & Family Services
- The C.E.A.S.E. Project
- The University of Akron, Dept. of Public Admin & Urban Studies
- UMADAOP of Lucas County
- United Missionary Baptist Church
- United Somali Refugee Women
- Your Human Resource Center
- Zanesville-Muskingum County Health Department

Strategy 4.1: Search for national models and best practices to be replicated and evaluated in Ohio.

Action Steps:

- Contact other states and national organizations that have youth programs serving at-risk, culturally diverse, underserved populations.
- Create awareness of appropriate currently existing programs to the community.
- Develop collaborations with existing youth initiatives.
- Tailor culturally-specific interventions into mainstream programs.
- Evaluate the effectiveness of culturally-specific interventions.

"The LGBT population is only one of numerous underserved populations whose voices need to be heard in the realm of tobacco control in Ohio."

Sue Doerfer
CCTCA Mini-Grant Recipient

Goal 5

Increase the availability of adult practice-based evidence cessation programs, pharmaceutical support, interventions, and awareness campaigns/information among at-risk, culturally diverse, underserved populations to reduce smoking prevalence and social acceptance of smoking.

Agencies interested in this goal:

- Adelante, Inc.
- Asian American Community Services
- Asian Services in Action, Inc.
- Cleveland Department of Public Health
- Cuyahoga County Board of Health
- DeafLink
- Greene County Combined Health District
- LGBT Center for Greater Cleveland
- N.C.I.
- OAACOH
- ODH; Tobacco Risk
- Ohio Hispanic Coalition
- Premier Community Health
- Somali Senior & Family Services
- The C.E.A.S.E. Project
- United Missionary Baptist Church
- United Somali Refugee Women
- Your Human Resource Center
- Zanesville-Muskingum County Health Department

Strategy 5.1: Identify groups that currently do not access the Ohio Tobacco Quit Line to support cessation.

Action Steps:

- Review quit line call center data and compare this to community-specific smoking prevalence and/or tobacco-related adverse health outcome data.
- Based upon prevalence and health outcome data, determine missing community-specific data collection within the call center and add assessment questions.
- Identify key organizations that serve specific communities to conduct direct assessments of their clients regarding knowledge, level of trust, appropriate campaigns, and barriers to quit line use.
- Review other statewide and local quit line programs within the nation to learn how they have successfully reached specific communities.
- Make recommendations to the Ohio Tobacco Prevention Foundation regarding specific community quit line use.

Strategy 5.2: Search for national program models and best practices to be replicated and evaluated in Ohio.

Action Steps:

- Contact other states and national organizations that have adult programs serving at-risk, culturally diverse, underserved populations.
- Create awareness of appropriate currently existing programs to the community.
- Develop collaborations with existing chronic disease and other initiatives addressing adverse health outcomes.
- Tailor culturally-specific interventions into mainstream programs.
- In program development, give particular attention to free or reduce cost interventions and pharmaceutical support.
- In program development, give particular attention to cessation maintenance.
- Seek funding through pharmaceutical companies that develop cessation products to support programs and interventions in the community.
- Create culturally-appropriate media campaigns with the community.
- Evaluate the effectiveness of culturally-specific programs and media campaigns.

Goal 5 (cont.)

Strategy 5.3: Increase the number of certified community-competent trained tobacco specialist to implement cessation programs in their own community.

Action Steps:

- Identify existing mainstream training programs.
- Work with mainstream program providers to locate community-competent leaders to be trained.
- Identify and develop a data base listing of the current community-competent certified tobacco specialist. Make the community aware of the listing through website and other appropriate means.

Strategy 5.4: Increase the medical and health care community's involvement in culturally specific cessation-related support to expand the ability to reduce smoking prevalence or tobacco-related adverse health outcomes among at-risk, culturally diverse, underserved populations.

Action Steps:

- Assess, monitor and document the amount of medical research studies being conducted to address the adverse physiological affects of tobacco use on various communities (i.e. menthol tobacco and metabolism, HIV and smoking).
- Make knowledge of the research studies available to the medical community and various agencies serving affected populations.
- Establish national, state and local partnerships with research institutions, medical societies, professional medical and social organizations, hospitals and universities to promote the enhancement of funding for community-specific medical research related to the adverse physiological affects of tobacco use.
- Integrate smoking cessation into the educational curriculum of health care, medical social work, and other cross-disciplinary graduate and professional training programs.
- Incorporate the 5A's, or other community-appropriate stages of change cessation support into clinical and private practices that disproportionately serve at-risk, culturally diverse, underserved populations.
- Evaluate the effectiveness of the cessation interventions implemented by the providers.

The following agencies support this Action Plan:

- Hamilton County Tobacco-Free Partnership
- Recovery Resources
- Guernsey, Noble, Monroe Tobacco Project
- Holzer Tobacco Prevention Center
- Wright State University ISARDI
- Ohio Department of Mental Health

Before the action plan was released, 71 Ohioans from local health departments, government agencies, community-based agencies and universities attended one of five regional meetings to review the plan and provide final input.

Evaluating the Alliance's Progress

The Ohio Department of Health's Tobacco Risk Reduction Program will evaluate the progress of the CCTC Alliance through an outside evaluator for the entire program. Also, the program will incorporate the evaluation of the CCTC Alliance activities into the cooperative agreement's formal electronic reporting system which focuses on such infrastructure objectives as collaboration with partners, communication and information exchange, strategic planning, training and technical assistance..

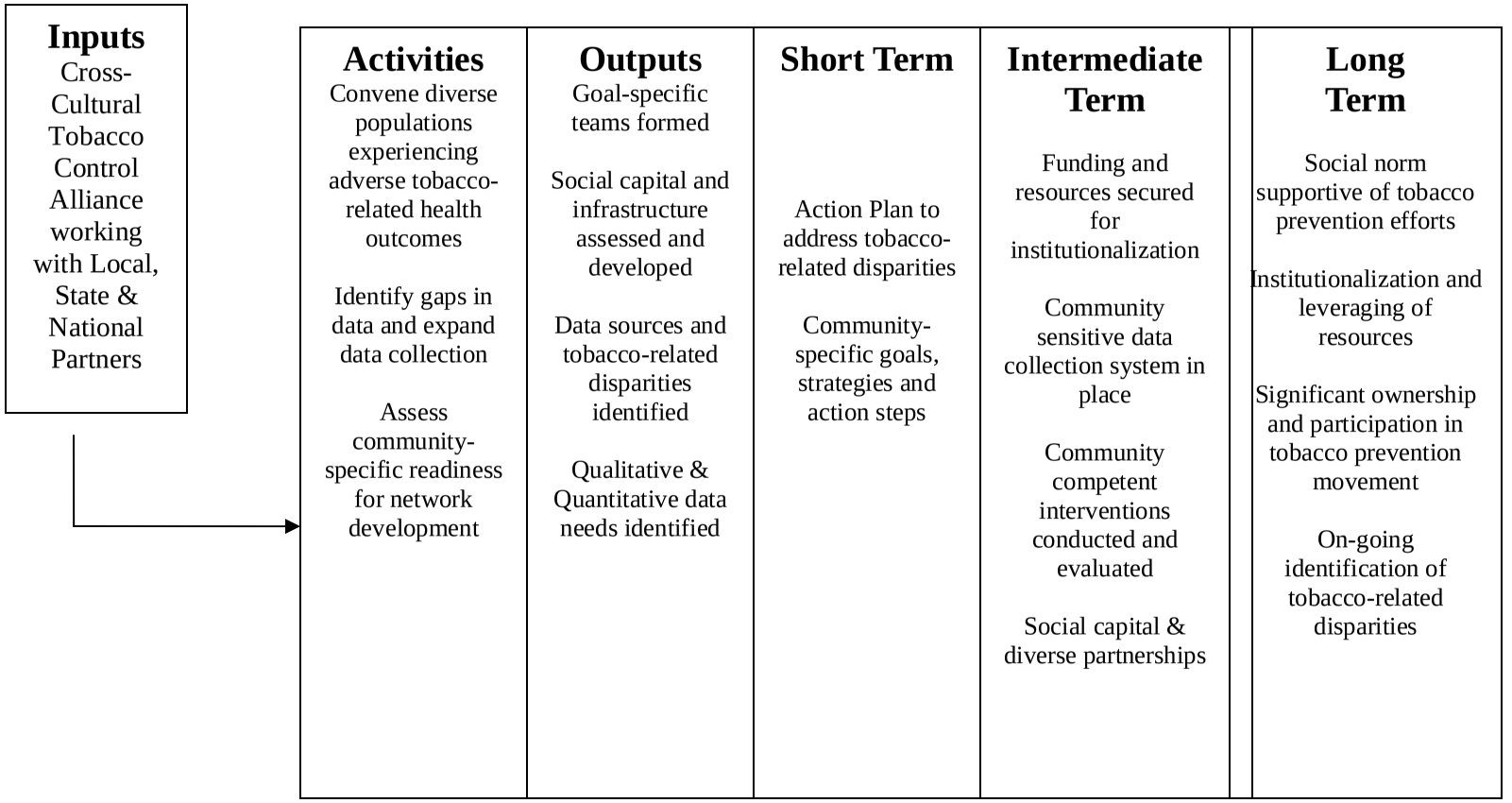
During the first year, a project assistant will be hired and the Alliance will continue to conduct internal meeting participant evaluations which look at various aspects of the group such as openness, participation and productivity after each meeting. The leadership for each of the five objectives, along with the coordinator and the project assistant will monitor the completion of action steps for their chosen strategies. The community-specific forums will be held to facilitate the establishment of networks. Leadership training will be provided to the CCTC Alliance. Focus groups will be conducted with Veterans and Active Duty Military Personnel and communities of color in southeastern Ohio. Mini-grants will be distributed to engage communities that have not been addressing tobacco. Additional funding will be sought after as well.

During the second year the CCTC Alliance hopes to have secured additional funding. There will be a plan to evaluate progress the CCTC Alliance has made in accomplishing the tasks and activities it undertook during the first year. Lastly, the CCTC Alliance will develop an action plan for the period 2008 to 2010. Figure 1(page 19) depicts a logic model that illustrates CCTC Alliance's action plan to achieve its short-, intermediate-, and long-term goals.

"As we explore the issue of tobacco control in Ohio, we must include the LGBT community in our discussions."

Jason Fallon
CCTCA Member and Mentor

Figure 1. Logic Model
Identifying and Eliminating Tobacco-Related Disparities
Cross-Cultural Tobacco Control Alliance



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