ARKANSAS

Case Study Report

Tobacco Use Among Special Populations:

"Putting the Pieces Together to

Identify and Eliminate Disparities"

Center for Disease Control Pilot Project
in conjunction with the
Arkansas Tobacco Prevention and Education Program

ARKANSAS DEPARTMENT OF HEALTH
ELIMINATING TOBACCO DISPARITIES STRATEGIC PLANNING WORKGROUP: CASE STUDY REPORT

1. OVERVIEW OF THE ARKANSAS TOBACCO DISPARITIES WORKGROUP PROJECT

1.1. Purpose and Goals of Project

The Arkansas Department of Health Tobacco Prevention and Education Program (ADH-TPEP) requested and received funding from the Center for Disease Control and Prevention's Office on Smoking and Health (OSH) for a project to identify and eliminate disparities in tobacco use among population groups. These funds, allocated in addition to awards from the Center for Disease Control's Comprehensive State-Based Tobacco Use Prevention and Control Programs, were to be used by the States and Territories for a strategic planning process that would result in a comprehensive plan to address disparities related to tobacco use and its affect among different population groups. In order to effectuate a statewide strategic plan inclusive of as many strata and populations as possible, the TPEP staff assembled a workgroup that could represent the various strata and populations across Arkansas that are disparately affected by tobacco use.

Arkansas was a particularly salient state for a workgroup developing a strategic plan to address tobacco use among populations disparately affected by tobacco for a number of reasons: 1) the state has a disproportionately high rate of poverty; 2) a large segment of the population has achieved only a moderate to low educational level; 3) many rural communities make the state's population difficult to reach with tobacco prevention and cessation messages; and, 4) there is a lack of community-based infrastructure to assist with tobacco prevention, cessation and education programs. The goal of the program was to develop a comprehensive strategic plan working through community groups and various organizations to target and reach various populations and strata across Arkansas to eliminate disparities related to tobacco use and its effects.

1.2 Overview of Tobacco Control Efforts and Target Populations in Arkansas

The second meeting of the Workgroup, Dr. David Bourne, Chief Physician Specialist for the Arkansas Department of Health, provided a brief history of the tobacco control initiatives in the State of Arkansas. Dr. Bourne covered the tobacco industry's influence and the ways in which it has made its presence known without most members of the general public being aware of it. He gave a perspective that allowed the Workgroup to understand how their efforts would expand all across the state.

1.3 Roles/Responsibilities of Project Team Members

The ADH Tobacco Prevention and Education staff adopted specific roles and responsibilities for the strategic planning process. Lynda Lehing, TPEP Team Leader, was responsible for

supervising the overall implementation of the strategic planning process. Staci Croom, Federal Program Support Manager served as coordinator of the pilot project. Tamika Walls, Eliminating Disparities Health Program Analyst, served as the assistant coordinator of the pilot project and day-to-day operations manager for the Arkansas Tobacco Disparities Workgroup project. Lakhiva Blann - Staff Development Coordinator, Braley Braddock - Secondhand Smoke Health Program Analyst, Cassandra Miller - Cessation Health Program Analyst, and Mitchell Simpson, Schools & Youth Health Program Analyst all contributed to their specialized expertise to the Workgroup's efforts. ADH-TPEP Epidemiologist, Matthew Quick, provided a variety of statistical presentations on the prevalence of tobacco use as well as tobacco related disease and mortality rates among populations disparately affected that were requested by the Workgroup. Judy Sopenski, consultant, served as group facilitator guiding the Workgroup through the strategic planning process. T. Gregory Barrett, project evaluator, served as consultant for developing and implementing the formative and summative evaluation components of the strategic planning process (See Appendix I for the Tobacco Disparities Workgroup Project Organizational Chart).

2. EVALUATING STRATEGIC PROCESSES

2.1 Purpose and Goals of Evaluation

The primary purpose of the Arkansas Tobacco Disparities Workgroup evaluation was to describe the formation and development of the Workgroup and the process by which the strategic plan was developed. The overall goals of the evaluation were to document the Workgroup activities, describe the challenges the group faced and how they were overcome, and chronicle milestones reached by the Workgroup and lessons learned through the strategic planning process. Formative evaluation goals were to monitor the Workgroup's strategic planning process providing ongoing feedback to the Project Team and reporting on the progress toward the planning goals. Summative evaluation goals were to discuss implications of the evaluation results and to recommend measures that might be implemented by future state planning Workgroups undertaken to eliminate the disparate affects on populations related to tobacco (Herman, Morris, and Fitz-Gibbon, 1987).

2.2 Evaluation Design

The evaluation employed a qualitative case study design. Following Yin (1994), key components incorporated into the case study research design include: the study's questions; the unit of analysis; the logic linking the data to the study's questions; and the criteria for interpreting the findings. Three general questions guided the process evaluation:

1) What is being done, how it is being done, and by whom (including the main activities, efforts involved, and key players)?
2) What milestones have been reached through the Workgroup's efforts (e.g., establishment and effectiveness of the Workgroup, identification of communities,

populations and strata disparately affected by tobacco, development of strategic planning goals and objectives)?

3) What critical lessons have been learned during the Workgroup processes and how will the insights help enhance future efforts to eliminate disparities?

The unit of analysis for the case study was the Workgroup (along with the ADH Project Team and the process facilitator) as they progressed through the process of developing a strategic plan for identifying and eliminating tobacco related health disparities among communities, populations, and strata in Arkansas. The logic linking the data to the study's questions follows a five step process evaluating each stage: 1) organizing the Workgroup; 2) identifying and taking stock of the populations disparately affected by tobacco in Arkansas; 3) developing the strategic plan; 4) adopting and refining the strategic plan; and, 5) developing the plan of action for implementation including translating it into action items for inclusion in the National Tobacco Control Program's Annual Action Plan.

Criteria for interpreting the findings was construct validity (using multiple sources of evidence to ensure the utility of the findings, establishing a chain of evidence to establish the feasibility of implementing the plan, and having key informants review the draft case study report to ensure the accuracy of the evaluation and to provide feedback to the stakeholders) and reliability (using the case study protocol and developing the case study database) (Yin, 1994; Stake, 1995).

2.3 Evaluation Methods

Data collection involved mixed methods (qualitative and quantitative) and was designed to achieve triangulation. The methods employed in the study included: participant observation; notes from Workgroup meetings; informal conversations with Workgroup members; focus group debriefing sessions with Project Team members; formative evaluation instruments implemented at Workgroup meetings; documentary analysis of agendas, minutes, and handouts, and evaluation of presentations; regular meetings with Project Team leaders; participation in two CDC Sponsored national training meetings; regular participation in national conference calls with CDC program officers, the13 participating states and one territory; drafting the case study report; and, reflection on both process and outcomes (Miles and Huberman, 1994, Merriam, 1998).

3. STRATEGIC PLANNING PROCESSES AND MILESTONES

3.1 Step 1: Forming the Strategic Planning Workgroup

- The Workgroup and its members (general characteristics)

Formation of the Workgroup was a three-stage process. Initially three ADH-TPEP staff members, Staci Croom, Mitchell Simpson, and Matthew Quick, attended a training session in Atlanta, Georgia sponsored by CDC's Office on Smoking and Health. Upon their return, the group sent out letters requesting nominations for prospective participants on the Workgroup.

The ADH Office of Minority Health was of great assistance in identifying people in the community who could represent many of the diverse populations disparately affected by tobacco.

The Tobacco Prevention and Education Program (TPEP) staff assembled a planning committee which met on January 5, 2002. The planning committee was comprised of TPEP staff, Hometown Health Improvement representatives (largely from the Southeastern region of the state), one ADH staff member from the Northwest Region, along with staff from the ADH Office of Minority Health to discuss how inclusive they wanted the Workgroup to be. Additional participants in the initial meeting were representatives of the Hispanic community, the University of Arkansas for Medical Services, and the African American community in Little Rock.

The first official meeting of the Workgroup was held on March 27, 2002. Workgroup members attending represented the following communities and populations: Youth K-12; African Americans; Hispanic Americans; rural populations; state healthcare professionals; social workers; marketing and development; women, ages 25 and up; urban populations; civic, state and local healthcare; racial and ethnic minority organizations; and, maternal and child health. Other representation of the group included: former smokers, frontline providers, consumers, network access members, experts in tobacco prevention, and risk reduction activists. Native American representation was added after the first Workgroup meeting (see Appendix IV & V for a complete list of Workgroup participants).

The second meeting of the Workgroup held on April 17, 2002, four gaps in representation of communities and populations disparately affected by tobacco were identified. These were the voices of the Gay, Lesbian, Bisexual and Transgender (GLBT) community; the predominantly white voices of the Ozark region of North and Northwest Arkansas; the predominantly Black voices of the Delta region of Southeast Arkansas; and the voices of the K-12 population. Though efforts were continually made throughout the strategic planning process to identify and secure the participation of representatives from these groups, no progress was made.

- Workgroup role and responsibilities

The ADH Tobacco Prevention and Education Program staff members identified their role in the Workgroup as providing data about the tobacco related disparities within the state and providing the means for this discussion to take place, but not to tell the work group what to do. They described the Workgroup's job as being to create initiatives to advise ADH on how to proceed in eliminating disparities. The TPEP staff noted that Workgroup participants should all work together and that participants on the Workgroup would be representatives but not necessarily advocates for their communities. The staff noted that the Workgroup's responsibility was to review the needs of all the communities in Arkansas and to select those populations that are "ready" to make an implementation of a proposed intervention. The staff stated that five measurable goals were a realistic number for the Workgroup to develop.

- Recruiting members and keeping them involved

TPEP staff encouraged those in attendance at the planning committee meeting to participate in the Workgroup and to nominate prospective members who could represent communities and specific populations disparately affected by tobacco for membership in the Workgroup. Planning committee members noted several groups that were missing in current representation including: faith communities, youths age 18 to 24 years, community coalitions already working for the cause, and senior citizen groups.

During the first official meeting, Workgroup membership was discussed. It was determined that the membership was heavily weighted with individuals from the Department of Health's Tobacco Prevention Program. The central region of Arkansas was also disproportionately represented among the group members. The goals of the work group were discussed and the group agreed that a diverse group was needed in order to achieve those goals. The members were asked to make suggestions for members who would provide a wider representation of the northwest, southwest, northeast and southeast regions of Arkansas.

The third meeting of the Workgroup on May 8, 2002 opened with a discussion of differences between diversity and disparity (see Appendix II for Definitions). The group discussed the need to keep issues of race, class and socio-economic status in mind. They also discussed the need to identify differences in the needs among all the disparate groups that they represent. After nearly five hours of discussion of tobacco related data, the group was still so engaged by the topic that one member was prompted to say, "I can't believe we are so into it (the data) that here it is 3:00 p.m. and we're asking for more data."

During the May 28, 2002 Workgroup meeting, group members discussed which of their fellow members were not present and why. They noted the populations that were not currently represented and brainstormed who might be able to represent them. The facilitator closed the meeting by giving the Workgroup a homework assignment to: 1) fill out the community profile for the groups they represent; and 2) develop a tobacco checklist for others to fill out that includes demographic information.

- Conduct of workgroup meetings (decision-making, other processes)

Based on discussions between the ADH-TPEP staff and the group facilitator, a strategy was developed for the early Workgroup meetings in which emphasis was placed on teambuilding activities and on group members talking to each other rather than through the facilitator. Discussions and group activities were designed to facilitate teambuilding, use of appropriate language and communication, participatory involvement, risk taking and openness, decision-making, and moving beyond disagreement. An important part of the first Workgroup meeting was a group discussion regarding operating procedures in which it was decided to utilize informal group decision-making procedures.

3.2 Step 2: Identifying/Prioritizing Tobacco-related Disparities and Assessing Capacity

- Collection and analysis of data on disparities in populations

At the first meeting of the Workgroup on March 27, 2002, TPEP staff Epidemiologist, Matthew Quick, reviewed available data that would be used to derive target populations. These data included: Behavioral Risk Factor Surveillance Survey (BRFSS), Arkansas Youth Tobacco Survey (AYTS), and the Pregnancy Risk Assessment Monitoring System (PRAMS). He suggested that one of the Workgroup's goals might be to identify ways to get more data for a particular population rather than simply rule them out as a disparate group because the Health Department does not have sufficient data to consider them a disparate population.

During the second meeting on April 17, 2002, three presentations were made to the Workgroup by Matthew Quick. The first presentation, entitled "Around the State with Data," provided an intensive review of general tobacco data for Arkansas. The second presentation was entitled simply "Tobacco Use and Mortality Data." The third presentation was one that documented "Youth tobacco usage in Arkansas". The Project Team's idea of providing three separate data presentations during the second meeting of the Workgroup was not to inundate Workgroup members with statistical information, but rather to help them start thinking about the scope of the tobacco issues in Arkansas and what these statistics mean to the communities and populations the members represented.

- Population assessments: Methods and results

Population assessments began May 8, 2002 at the third Workgroup meeting. Matthew Quick presented review questions on the BRFSS data he had presented at the previous meeting noting the weakness of the survey is that it is a telephone-administered survey and therefore may not completely capture the populations disparately affected by tobacco. Taniesha Richardson presented information about Environmentally Transmitted Smoke and the means by which the tobacco industry markets its products and lobbies the legislature to fight anti-smoking legislation. Mr. Quick returned toward the end of the meeting to give a PowerPoint presentation on the Arkansas Youth Tobacco Survey. Based on what had been presented thus far, the Workgroup requested the following additional data: a map with racial breakdown, education, and unemployment figures; breakdowns by region; survey data on all tobacco products and their usage; a map showing healthcare facilities statewide that are available (or lacking) for underserved populations; a map depicting existing prevention resource centers from previous grants; and data on the state's overall health status.

During the May 8 post-meeting debriefing, the Project Team agreed that today the Workgroup took ownership of the meeting. The team discussed how to weight the various populations disparately effected. They noted the importance of focusing on groups where you can make a "win" but asked: What is a "win?" The Team discussed how you differentially weight qualitative versus quantitative data. They also noted that CDC had warned that the Workgroup could get "stuck in the data." The Team members said they needed to come up with a way to compare the individual environmental scans thus creating some sense of progression without taking away the decision power of the Workgroup.

The May 28, 2002 meeting of the Workgroup was preceded by a second CDC sponsored training workshop in Atlanta, Georgia. ADH-TPEP staff members Staci Croom and Tamika Walls attended the training along with the Workgroup facilitator, Judy Sopenski and evaluator T. Gregory Barrett.

To assist the Workgroup with its focus, Facilitator Judy Sopenski presented material from the training workshop and noted that the tobacco industry spent $8.25 billion to promote tobacco use in 1999 up from $4 billion when the tobacco settlement was made. She presented tobacco control objectives and strategies and discussed strata as opposed to population groups. She continued by presenting the four-pronged Tobacco Logic Model designed to: prevent initiation of tobacco use; eliminate environmentally transmitted smoke; teach cessation techniques; and, eliminate disparities.

Following Ms. Sopenski's presentation, guest presenter Paul Austin of the American Indian Center of Arkansas, provided an overview of Native American presence and culture in Arkansas. He discussed ceremonial use of tobacco and the importance of Smoke Shops to tribal economies in Oklahoma. Workgroup member Lois Bethards, who is Native American, noted that during the last census only 30,000 Native Americans were recorded as living in Arkansas, some Native American were counted as being Hispanic or White in the Arkansas counties bordering Oklahoma.

Workgroup member Maura Lozano-Yancy provided a demographic and cultural profile of the Hispanic population in Arkansas. She indicated there had been a 337 percent growth in the number of Hispanics living in Arkansas between the 1990 and the 2000 Censuses. She stated that Hispanics are a very young group, often poorly educated, with a strong family orientation encouraged by their Catholic religion. The Catholic Church would be the best vehicle to reach this widely dispersed population.

The main topic of discussion during the debriefing meeting with Project Team members centered largely on the relatively low turnout of Workgroup members. Possible causes included the long holiday weekend and the move of the meeting place from the ADH 4th Floor Conference Room to St. John Catholic Center.

The June 24, 2002 Workgroup meeting included two data presentations. Mitchell Simpson, ADH-TPEP staff member, gave a PowerPoint presentation on Youth and Tobacco Prevention “What Works and What Tobacco Prevention and Education Program is Doing”. The presentation highlighted ten leading health indicators, trends and objectives of the Youth Tobacco prevention effort, and Arkansas versus National data. The presentation emphasized the vision, goals, objectives, and activities that the Tobacco Prevention and Education Program were then implementing. These included: community grants, youth initiatives, school RFP’s, and the S.O.S. (Stamp Out Smoking) Campaign. Braley Braddock, ADH-TPEP staff member, gave a PowerPoint presentation entitled “Secondhand Smoke: Clearing the Air”. Ms. Braddock briefly explained what is in tobacco smoke, what comprises secondhand smoke, and who is at risk. She discussed the benefits of clean indoor air ordinances, policy options for securing such ordinances, how ventilation systems cannot eliminate health risks, and federal, state, and local

actions to date. Ms. Braddock concluded by sharing the Tobacco Prevention and Education Program's goal for reducing secondhand smoke.

During the July 29, 2002 Workgroup meeting, preliminary results from the Community/ Population Assessment Survey were presented, newly available Arkansas data was reviewed, and Robert Easter, a counselor at the Arkansas Rehabilitation Center, presented an overview of tobacco use among the state's disabled populations.

- Developing a comprehensive profile of disparities statewide

The first activity directed toward developing a comprehensive profile of disparities statewide was conducted during the June 24, 2002 Workgroup meeting. The Selecting Priority Population exercise was designed for participants to focus on ways to select a community and to see whether there had been prior attention placed on the community, what impact it would make if the community were targeted, and whether it would be operationally and politically feasible to make a difference in the identified community. The exercise was structured to occur in two parts with the second half to be conducted at the next Workgroup meeting. Meantime, Workgroup members were asked to assist in implementing the "Eliminating Disparities Workgroup: Community/Population Assessment Survey."

The July 29, 2002 Workgroup meeting opened with a review of the ways the Arkansas Department of Health has tried to reach communities and populations disparately affected by tobacco. Judy Sopenski reviewed tobacco prevention and tobacco control treatment approaches and the key ingredient for eliminating disparities – comprehensive prevention. She discussed the communities, strata, and populations that are disparately affected by tobacco in Arkansas. She distributed handouts on the American Cancer Society's Communities of Excellence in Tobacco Control: Community Indicators, for the Workgroup to review.

The Workgroup decided that in order for the members to get a better handle on strategies for eliciting community support they would attend the Arkansas Minority Health Summit on Tobacco on August 29, 2002 at the University of Arkansas at Pine Bluff rather than holding its regularly scheduled August meeting. The Workgroup requested a private meeting with Dr. Robert G. Robinson, Associate Director for Program Development, Centers for Disease Control and Prevention to get ideas on community infrastructure development. Dr. Robinson had a strong recommendation for the Workgroup both with regard to data and to representation. He recommended to the Workgroup to figure ways on collecting data and representation among un-represented groups. He said the Workgroup should invite a spirit of inclusiveness.
His idea was formulated from the Workgroup having 50% information on disparate groups, and 50% of disparate groups do not have information.

The "needs piece" of the report, according to Dr. Robinson, should focus on what is needed to develop better data and to get the absent people to the table. "The vision should be informed by and grounded in the voice of the community. The process cannot be conducted from the top down. It must be from the bottom up," he told the Workgroup. Dr. Robinson noted that an historical problem with funding has been that programs fund services, but they do not develop community and infrastructure. "If you are going to deal with disparities, you need to deal with it

in its complexity," Dr. Robinson urged the Workgroup. Though only three Workgroup members along with the Workgroup facilitator, the ADH program analyst and the Workgroup evaluator were in attendance at this meeting, the discussion with Dr. Robinson seemed to have a substantial impact on them.

- SWOT analysis: Methods and results

The first real attempt at an analysis of the Workgroup's strengths, weaknesses, opportunities and threats (SWOT Analysis), came at the July 29, 2002 Workgroup meeting. This was achieved by asking a series of questions including: 1) Have we achieved a diverse group representing our identified populations? 2) Have we achieved statewide representation? The answers to these questions were followed by a discussion of possible recruitment strategies; a review of what participation in the Workgroup requires; a discussion of needs to identify priority groups; a delineation of the reasons for disparate health consequences related to tobacco; a discussion as to why tobacco needs to be addressed as an environmental issue; and an assessment of how to analyze populations and assess priorities.

- Presenting results of these investigations to the workgroup

The answers to the questions posed to the Workgroup at the July 29, 2002 Workgroup meeting and the discussion of the five key issues were recorded on flipcharts and reported back to the members for their review. Although somewhat intuitive, key findings from discussion of the questions regarding achievement of a diverse group representing identified populations and achieving statewide representation included: Groups working with identified populations have limited time to devote to meetings/workgroups, and rotating meetings around the state might have encouraged additional participation from representatives of the geographic areas in which the meetings would have been held.

Key strategies for recruitment were to recruit: within spiritual/faith communities; influential people and groups; economically affluent and powerful people, recognizable people; and present the group as an influential voice. Keys to ongoing participation in the Workgroup included: displaying success or making noticeable progress; making time requirements conflict less with job demands; increasing capacity – both people and funding; regionalizing the meeting locations; identifying a vested interest in the participants; targeting specific groups/forums; identifying community leadership; and training through skill building. Needed resources and approaches for identifying priority groups were: hiring a research specialist (epidemiologist); securing data on specific groups and specific uses of tobacco; ensuring that data is specific to geographic areas of the state; focusing the search for data on the missing groups; securing data from other sources/organizations; allocating funds to securing data on missing groups; and connecting the "priority" issue to the economic costs and not simply to the prevalence of smoking/tobacco use. Ways to create understanding of the reasons for disparate health consequences of tobacco use among disparately affected populations were: providing access to new sources of healthcare to communities; targeting awareness; targeting population specific research; building trust; acknowledging racial biases; providing funding targeted to specific communities/populations. Ideas on how to create understanding of why tobacco needs to be addressed as an environmental issue included: highlighting the opportunity to impact a greater number of individuals; and

developing a message from a respected credible source targeted to a specific environment. A final discussion centered on analyzing populations and assessing priorities. Workgroup members identified key elements of the analysis and assessment process as: knowing the political influence of the issue; looking for the economic impact to the community/state from tobacco use; and establishing a clearinghouse of sources/resources in the state for tobacco control.

3.3 Step 3: Developing the Strategic Plan

- Identification and prioritization of critical issues

Prior to the September 30, 2002 Workgroup meeting, Project Team members Staci Croom and Tamika Walls along with Workgroup evaluator T. Gregory Barrett attended the third and final CDC sponsored training in Atlanta, Georgia to learn more about the strategic planning process, the evaluation process and to share with the other thirteen states and one territory the successes and challenges of the process to date. Unfortunately Workgroup participation reached a low point at the September 30th meeting with only two members attending.

The meeting opened with a discussion of an article from the October, 2001 issue of *American Journal of Community Psychology* entitled "Value-Based Praxis in Community Psychology: Moving Toward Social Justice and Social Action." The Project Team then presented the Workgroup a list of Tobacco grantees in Arkansas and the updated results of the Tobacco Disparities Survey. To set-up the beginning of the development of the strategic plan, the Project Team next presented an overview of the history of Arkansas public health. The Hometown Health program is only two years old. The Arkansas Department of Health is recognized as the leader in conducting scientific research on public health issues across the state but due to funding constraints it has limited capacity to address issues like tobacco disparities. A discussion ensued concerning two major issues in developing the strategic plan: funding and volunteer infrastructure. It was suggested that Workgroup members or the Health Department may need to hold one-on-one meetings with stakeholders across the state and with other people like the absent Workgroup members in order to develop an effective plan.

At this point Judy Sopenski, the facilitator, turned the topic to what the Workgroup needed to succeed with the strategic plan. First was more participation in planning and participation in researching the issues. To effectuate this, ADH needs to develop more community capacity and infrastructure by developing more leaders and building new organizations among the populations that are disparately affected. This would entail more training both about the effects of tobacco in the state and on how to build effective community-based organizations. The plan should include a 50-50 balance between securing information on disparities that is lacking and on actions needed to address the disparities problem based on what we know. There needs to be a praxis combining theory and action. The philosophical context must come first followed by a quest for social justice. The Workgroup must make visible the invisible.

At this point in the meeting, the strategic planning process began in earnest with a presentation of a list of twenty-three critical issues that the Project Team had distilled from earlier Workgroup discussions (see Appendix III: Critical Issues). These critical issues were encapsulated in six

categories: 1) why we have not achieved our goals as a diverse group; 2) statewide representation; 3) lack of data to identify priority groups; 4) understanding the reasons for disparate health consequences; 5) understanding why tobacco needs to be addressed as an environmental issue; and, 6) how to analyze populations and assess priorities.

The Workgroup then developed a vision for Arkansas over the next five years. The first vision was to develop organizational capacity to see tobacco related problems and to be able to act on them. It was suggested that a step in that direction would be to send community representatives to the National Conference on Tobacco. The second vision was to create responsiveness within communities across the state. This could be achieved by two means: 1) developing leadership across Arkansas with the capacity to respond to tobacco issues in a means that is specific to their own community; and, 2) secure the buy-in of health organizations across the state which deals with tobacco related issues. The third vision was to identify the funding that will be needed to implement a comprehensive strategic plan and find the means by which the plan can be funded.

- Conversion of critical issues to planning goals and strategies

The September 30, 2002 meeting closed with the Workgroup identifying five goals for the strategic plan: funding, partnerships, data, capacity and infrastructure, and politics. Under each goal the Workgroup identified several preliminary strategies for achieving the goal (see Appendix IV: Preliminary Strategic Plan Goals and Strategies).

- Assessing clarity and feasibility of planning goals

Between the September 30 meeting and the next Workgroup meeting on October 30, 2002, the facilitator, Judy Sopenski, individually, and the remainder of the Project Team, as a group, separately took the preliminary goals and strategies developed by the Workgroup and created two sample strategic plans for the Workgroup members' review. The substantive differences between the two plans arose over whether the goals of the plan should be people oriented such as communities, populations and groups or whether the goals of the plan should be action oriented such as funding, partnerships, data, capacity and infrastructure, politics, and materials and resources.

After reviewing and comparing the two strategic plans, the Workgroup decided to adopt the format with goals being represented by actions and settled on seven rather than the original five goal areas: 1) funding; 2) partnerships; 3) data and research; 4) capacity and infrastructure; 5) policy and advocacy; 6) materials and resources; and, 7) media/counter marketing. The Workgroup also opted to list the priority populations it had identified in tabular form and to incorporate a vision, mission and values statement into the strategic plan.

- Assignment of persons to implement the strategic plan

The strategic plan will not be implemented until after the Workgroup has moved to a monitoring, oversight and feedback stage of its responsibilities. Therefore both the funding and implementation of the strategic plan will be left in the hands of the ADH Project Team and additional volunteers as they are identified and brought on-board.

- Safeguarding the plan: Monitoring, oversight, and feedback

Workgroup members, at the last meeting on December 4, 2002, agreed to continue serving on the committee to help monitor, oversee and provide feedback on the strategic plan to identify and eliminate tobacco related disparities in Arkansas for one year after which they agreed to evaluate the need for the Workgroup's ongoing monitoring efforts.

- Finding partners to help implement the plan

One of the major discussions during the October 30, 2002 Workgroup meeting centered on how partners could be found to help implement the strategic plan. Ideas included: placing tobacco as a higher priority for the Hometown Health programs; building partnerships with advocacy based organizations across the state; developing relationships with interfaith groups and individual churches, synagogues, and mosques; securing the support of the Racial and Cultural Diversity Commission and other such groups across the state that work with populations disparately affected by tobacco; and working with local coalitions that can work with the more formal advocacy organizations in local communities around Arkansas.

3.4 Step 4: Adopting and Refining the Plan

- Identification of audiences for the strategic plan

The Workgroup identified several primary audiences for the strategic plan. The first audience is the Workgroup itself to secure their endorsement of the plan. The second audience is the Arkansas Department of Health to ensure approval of the plan. The third audience is the Center for Disease Control Office on Smoking and Health for the purpose of the grant. Additional audiences, include: 1) the Arkansas State Legislature to secure their support for the plan; 2) various Arkansas State administrative departments; 3) healthcare providers across the state; 4) community organizers and activists across Arkansas; 5) the general public through the various elements of the strategic plan.

- Political issues addressed

One political issue that the Workgroup addressed was related to the goal names for the strategic plan. The goal originally entitled "Politics" was changed to "Policy and Advocacy" to eliminate the possibility that anyone might mistake the purpose of the Workgroup or of the strategic plan to be lobbying the State Legislature rather than to be advocating for better health on behalf of the citizens of Arkansas.

- Internal and external marketing analyses: Methods and results

The internal and external marketing analyses – both methods and results will depend on feedback received from the ADH Strategic Subcommittee (Please see the description of the ADH approval process below).

- Writing the strategic plan

The basic goals and strategies included in the strategic plan were formulated by the Workgroup and the Project Team with the assistance of the group facilitator during the regularly scheduled meetings. Details of the plan, including refinement of the strategies, objectives and action items, were developed by the Project Team, then reviewed and approved by the Workgroup.

- Workgroup adoption of the plan

The plan was reviewed and adopted by the Workgroup during its December 4, 2002 meeting.

- Getting State Health Department approval of the plan

The Arkansas strategic plan "Putting the Pieces Together to Identify and Eliminate Disparities Related to Tobacco Use Among Special Populations" will be submitted to the Strategic Subcommittee of the Arkansas Department of Health. They will review the plan and submit their recommendations to the Agency Leadership Team. Upon their approval, the Agency's marketing contractor Cranford Johnson Robinson Woods will develop the marketing plan.

3.5 Step 5: Preparing for Action

- Marketing the plan: Strategies and results

The marketing plan will be contingent on funding and upon the plan to be developed by the Agency's marketing contractor.

- Effective marketing strategies

The marketing contractor will determine effective marketing strategies for the strategic plan after the ADH Leadership Team approves a final version of the plan. The marketing strategies will be contingent on funding constraints.

- Obstacles to marketing efforts

Funding

- Impact of marketing on development of action plans

The action plan has been developed (please see the appendices to the Arkansas Strategic Plan included in Appendix III). The tentative action plan is contingent on what the ADH Leadership Team ultimately approves, on the plan developed by the marketing contractor and on the availability of funding to support the plan.

- Next steps

The final ADH approved version of the Arkansas strategic plan "Putting the Pieces Together to Identify and Eliminate Disparities Related to Tobacco Use Among Special Populations" will be formally announced at the Arkansas Summit on Cancer & Health Disparities in October 2003.

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

The Workgroup strategic planning process: From the outset, Project Team members and the facilitator agreed to establish a strategy which emphasized teambuilding activities and group members talking to each other rather than through the facilitator. Throughout the process, discussions and group activities were designed to facilitate teambuilding, use of appropriate language and communication, participatory involvement, risk taking and openness, decision-making, and moving beyond disagreement. During the very first Workgroup meeting, group consensus was achieved on operating procedures for the Workgroup meetings. It was decided that there would be no formal hierarchy established (no officers elected or committees formed) and that informal group decision-making procedures would be utilized. Additionally, discussions regarding how the Workgroup could recruit representatives to the meetings from populations disparately affected by tobacco, so the voices of people missing from the Workgroup could be heard, occurred repeatedly.

The Workgroup evaluation process: Throughout the evaluation process, the evaluator collaborated with the Project Team, the facilitator, and Workgroup members to provide ongoing guidance and feedback in setting goals, group progress, identification of problems and issues the Workgroup encountered, and assistance in finding solutions to those problems and issues. Prior to submission to the Centers for Disease Control, the final report was distributed to Project Team members and Workgroup members to secure stakeholder feedback regarding the accuracy of the representations, analyses, and conclusions of the report.

4. MAJOR ASSETS FOR STRATEGIC PLANNING

4.1 Factors Facilitating Planning Processes: Steps 1-5

A number of factors helped facilitate the planning processes. Statewide recognition of the leading role the Arkansas Department of Health plays in conducting research on public health issues across the state was a major asset for the Workgroup. Assistance from the ADH Office of Minority Health in identifying prospective Workgroup members at the outset of the Workgroup project was critically important. The existence of the ADH Hometown Health program to assist with volunteer recruitment and implementation of the plan was also a major plus. The small but committed core of the Workgroup was also critical to the success of the strategic planning effort. The skilled facilitator, who was able to emphasize teambuilding at the outset and communication, participatory involvement, risk taking and openness, group decision-making, and moving beyond disagreement, was essential to the process. The non-hierarchical

organization of the group and the informal group decision-making processes it adopted were also essential to the effective functioning of the group.

A major asset during the early data analysis portion of the Workgroup process was the presence of Matthew Quick, ADH staff Epidemiologist. His presentations and honest evaluation of the quality of the data for the Workgroup's purposes was critical. Another data related asset was the range of service providers who were willing to educate the Workgroup on their particular community, population or strata.

Throughout the strategic planning process, having Tamika Walls, Eliminating Disparities Health Program Analyst and Assistant Coordinator of Pilot Project, available to dedicate nearly all her time to the program was a tremendous asset to the planning effort. Another factor that facilitated the planning process was having T. Gregory Barrett, the evaluator, present at the Workgroup meetings to provide formative evaluations of the strategic planning process.

Two major assets for the strategic planning effort were the Arkansas Minority Summit on Tobacco, held August 29, 2002 in Pine Bluff, and the private meeting of the Workgroup during the conference with Dr. Robert G. Robinson, Associate Director for Program Development, Centers for Disease Control and Prevention to get input on community infrastructure development. Additionally, the three CDC sponsored training workshops for Project Team members were exceptionally helpful as was Suzanne Bowler's assistance on the evaluation component of the project.

4.2 Maximizing Planning Assets

The Project Team maximized its planning assets in four ways, through: 1) continuous project coordination, made possible by Tamika Walls, the Eliminating Disparities Health Program Analyst, dedicating nearly 100 percent of her time to the strategic planning effort; 2) data presentations by Matthew Quick, ADH staff Epidemiologist, that provided the Workgroup with entry level tobacco surveillance and mortality data; 3) Workgroup facilitation by Judy Sopenski, Project Facilitator, who brought to bear her extensive, twenty-year plus background in grassroots tobacco control efforts; and, 4) immediate adjustments to the strategic planning process based on formative evaluation measures made possible by the presence of T. Gregory Barrett, Project Evaluator, at Workgroup meetings and at Project Team debriefing meetings immediately following Workgroup meetings.

5. CHALLENGES TO STRATEGIC PLANNING

5.1 Challenges to Successful Planning: Steps 1-5

Several challenges to successful planning existed in Arkansas. First was the ongoing problem of securing the involvement on the Workgroup of individuals representing the Gay, Lesbian, Bisexual and Transgender community; the predominantly white voices of the Ozark region of North and Northwest Arkansas; and the predominantly Black voices of the Delta region of

Southeast Arkansas. Lack of existing data on certain populations and the telephone administration of survey data were limitations on effectively presenting data on the populations disparately affected by tobacco in Arkansas. The Health Department was unable to fill the vacant Epidemiologist position after the departure of Matthew Quick, was another challenge to successful planning. A major challenge to the Workgroup's functioning as a voice for all of the populations disparately affected was at times the low turn-out of the Workgroup members for the planning meetings.

Two major challenges to the implementation of the strategic plan are the ongoing lack of state funding being experienced by the Arkansas Department of Health and the lack of an effective volunteer community-based infrastructure to support efforts among local communities.

Another major challenge is lack of access to National and State Surveys. Examples include: 1) National Health Interview Survey (NHIS) conducted by the National Center for Health Statistics, Centers for Disease Control which provides longitudinal data periodically beginning in 1965 and annually from 1990 to the present; over sampling for Hispanic and African American adults; and provides data on cigarette, cigar, pipe, bidi's, smokeless tobacco use, age of initiation, cessation behavior, ETS policies, and exposure; and, 2) Current Population Survey (CPS) conducted by the National Cancer Institute and the U.S. Census Bureau which provides periodic longitudinal data beginning in 1992-93 for individuals aged 15 or older on cigarette, pipe, cigar and smokeless tobacco use, age of initiation, ETS exposure, and cessation behavior. Lack of access to data such as these caused the Workgroup to guess and possibly overestimate the prevalence and impact of tobacco use among certain populations and strata, and to be possibly over-inclusive in determining the number of populations disparately affected by tobacco use in Arkansas that were included in the strategic plan.

5.2 Strategies to Overcome Challenges

ADH-TPEP has funded coalitions in all 75 Arkansas counties to create community infrastructure. Disparities has been recognized as a programmatic area in the overall Tobacco Prevention and Education Program which should ensure funding for the strategic plan. Eliminating Disparities is being incorporated into other TPEP goals, examples include: cessation, pregnant women, second hand smoke for blue collar workers.

6. CONCLUSIONS

6.1 Major Planning Accomplishments

The strategic planning process introduced people to viewing tobacco control from a different perspective by breaking down communities into smaller population groups that could be targeted more effectively. A complete strategic plan was developed including goals, strategies, objectives and action items. Also, securing the commitment of the Workgroup to monitor, oversee and provide feedback on the strategic plan to identify and eliminate tobacco related disparities in Arkansas, was a major accomplishment.

6.2 Lessons Learned Throughout the Planning Process

Groups working with identified populations have limited time to devote to meetings or workgroups. Invite a large number of people at the outset of the strategic planning process so when they begin dropping off there will still be enough people to allow for effective representation of the populations disparately affected thus allowing the Workgroup to continue functioning effectively. Rotating meetings around the state might have facilitated participation by communities, groups, or populations geographically dispersed across the state that were not represented on the Workgroup.

Identified the importance of carrying the message of tobacco issues to populations disparately affected through people and organizations that are credible to them. Possible examples of effective representatives include: leaders of spiritual or faith communities; influential people or leaders of credible groups; economically affluent or powerful individuals; recognizable people who can carry the message to communities that they should "look-sound-act-like me;" and developing a means by which the Workgroup may present itself to communities disparately affected as having an influential and powerful voice.

6.3 Recommendations to Enhance Future Strategic Planning

Provide funding for both the development and implementation of the strategic plan. Other more clearly delineated and easily approached elements of the overall tobacco control program (cessation, schools and youth, etc.) receive funding because proven methods exist to address those issues. New initiatives which have yet to be proven effective to the state health department will need the assistance of funding, at least until the strategic plans developed by the pilot states can be evaluated for their efficacy. Additionally, the costs of certain important components of the strategic planning process (e.g., fees for the facilitator, fees for the evaluator, travel to centralized training sessions, media, location, meals) as well as making stipends and travel reimbursements available to encourage participation from distant parts of the states are key elements in ensuring the Workgroup's success.

Provide access to national and state surveys. Breakout the data by state from the National Health Interview Survey. The processing of these and other data instruments and other materials developed by CDC and the pilot states should prove a great enhancement to group knowledge.

Make sure the states or territories selected have individuals in place who are committed to this effort and/or in position to take action with the plan.

Clearly explain the process to state agency leadership. Seek buy-in up front from individuals who have key leadership roles. Frame the disparities program as the one that can really illustrate the comprehensive structure of the overall tobacco control program. Also frame it as an important way to develop a working plan to meet the unmet needs of disparately effected

communities and populations by including input from members of the Workgroup who represent the disparately affected populations.

Establish a budget review process so monies will not be used for other than the expressed purpose of the program (this situation did not occur in Arkansas, but there is potential for a number of other interests to seek to secure the monies for their own purposes).

References

Herman, J. L., Morris, L. L., and Fitz-Gibbon, C. T. (1987). *Evaluator's Handbook*. Newbury Park, CA: Sage.

Merriam, S. B. (1998). *Qualitative Research and Case Study Applications in Education*. San Francisco, CA: Jossey-Bass.

Miles, M. B. & Huberman, A. M. (1994). *Qualitative Data Analysis: An Expanded Sourcebook* (2nd Ed.). Thousand Oaks, CA: Sage.

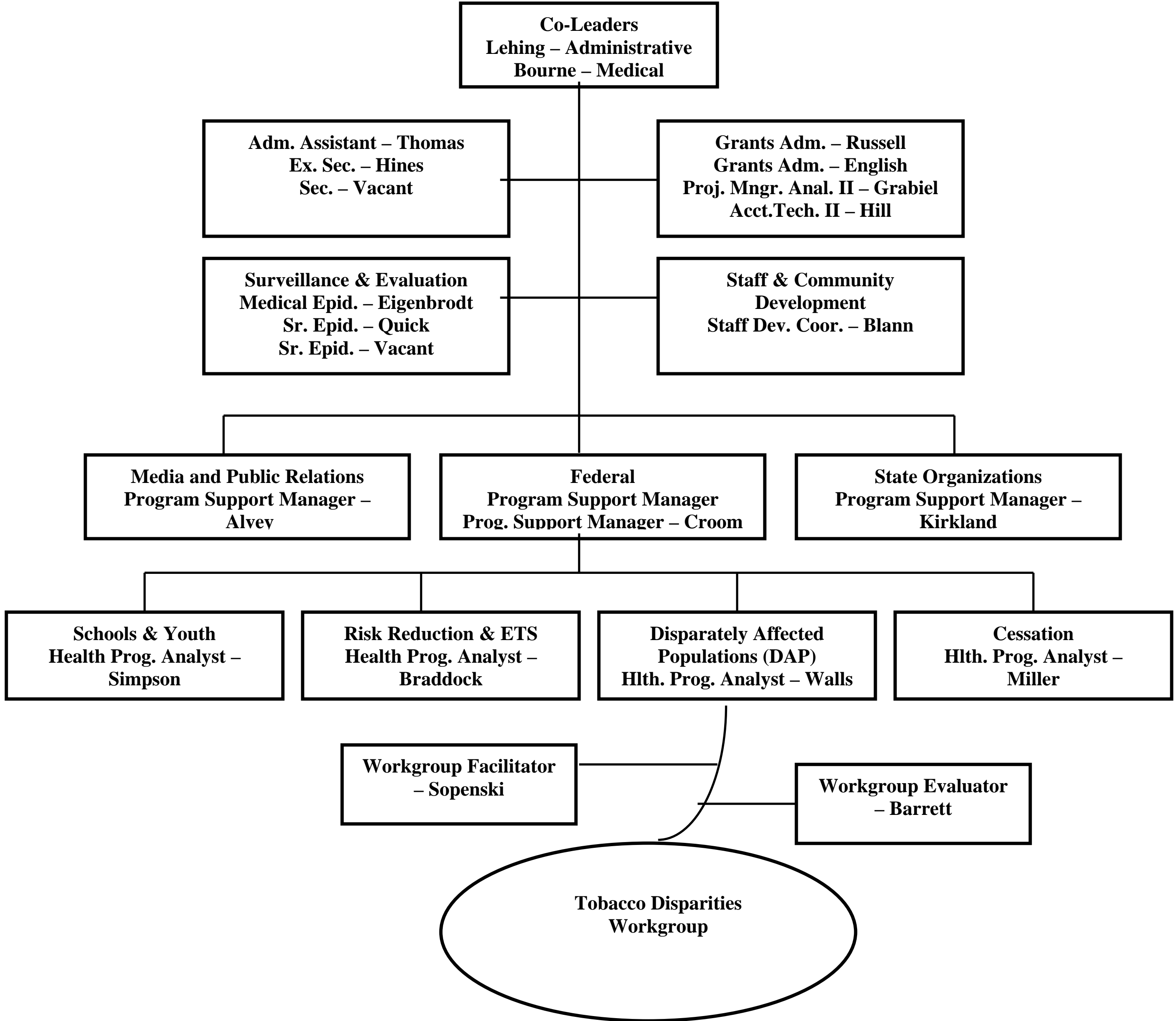
Stake, R. (1995). *The Art of Case Study Research*. Thousand Oaks, CA: Sage.

Yin, R. K. (1994). *Case Study Research: Design and Methods, 2nd Ed.* Thousand Oaks, CA: Sage.

Appendices

Appendix I

Organizational Chart for Arkansas Tobacco Team and the Tobacco Disparities Workgroup



Appendix II

DIVERSITY vs. DISPARITY

Definitions Developed by Workgroup

- **Diversity**

  an inclusion of variety and difference among a former homogenous group or new affiliation to promote equal representation and involvement. Representation from populations must include members at all decision-making related to tobacco-related health issues, but not limited to only race or ethnicity. (e.g. socioeconomic status, age, gender, and sexual orientation, etc.)

- **Disparity**

  a distinct gap in access, opportunity, and/or prevention among populations or groups with significantly higher tobacco use and exposure to secondhand smoke as determined by data and/or other sources. This is a "condition" that influences a population of people by either inhibiting their ability to act or by precluding their awareness of a current condition.

Appendix III

Critical Issues
Identified by the Tobacco Disparities Workgroup
September 30, 2002

Why we have not achieved our goals and a diverse group?
- Success: show noticeable progress
- Priority conflicts with job (Time)
- Capacity limited people -- funding to support initiatives, meetings, trainings, and evaluations

Statewide representation
- Regional – move the meetings and collaborations to other areas of the state
- Vested interest – People who are already stakeholders in the issue
- Specify group targeting – public forums, town meetings, focus group
- Identify community leadership – recognize that community knows itself best
- Training – continuous skill building for the group

Data – identify priority groups
- Research specialist needed to find and interpret data
- Data missing for specific areas of the state (regional and counties)
- Approach to conducting research should focus on missing groups (data collection)
- Allocate funds specific to the groups missing from data
- Tap into other sources (Environments) for data (Hospitals – ER, Physicians visits)
- Connect the priority issue to economic costs and not simply prevalence of smoking/tobacco use

Understand reasons for disparate health consequences
- Access to healthcare is limited for disparate populations – go where community members are (provide access from new sources)
- Information not provided to specific populations (target awareness)
- Very specific research for target populations (target research)
- Building working trust relationships with populations and service providers (build trust)
- Require and demand attention for health/living risks of all populations, e.g. racial sexism, LGBT economic influence (acknowledge racial biases)
- Place funding within specific communities to address tobacco related disparities (specific funding)

Understand why tobacco needs to be addressed as an environmental issue
- Opportunity to impact greater number of individuals
- Specific environment with message from a respected, credible source

How to analyze populations and assess priorities
- Know the political influence of issue
- Look for the economic impact to community and state from tobacco use
- Establish a clearinghouse of sources and resources in the state for tobacco control

Appendix IV

Preliminary Strategic Plan Goals & Strategies
Identified by the Tobacco Disparities Workgroup
October 30, 2002

Funding
Invest funding in Departmental Staff (Epidemiologist, Statistician)
Provide funding for specific communities
Provide funding for data collection

Partnerships
Provide access to new sources/resources
Target Awareness
Build a working trust relationship with service providers
Include representation from all disparate groups (ex., GLBT, 18-24 no college)

Data
Hire staff to gather and prepare data
Gather Missing Data

Capacity and Infrastructure
Be present within community proximity
Go to community
Target Awareness
Clearinghouse of Sources/Resources
Teaching Political Implications
Develop local constituents to reach disparate groups
Training for continuous skill building

Politics
Access to healthcare
Educate Arkansas Department of Health Staff and Leadership Team
Educate local and state Government
Educate Administrative Agencies
Healthcare Providers
Research Political Influence

Teach Economic Impact
Teach Scientific Methodology for success
Human Impact

Appendix V

Workgroup Members

Lois Bethards, Assistant Program; Director American Indian Center of Arkansas

Carlette Henderson, Executive Director; Racial and Cultural Diversity Commission

Kim Wilson-Dean, Program Coordinator; Minority Health Program ADH

Brenda Howard, Family Service Supervisor; Arkansas Department of Human Services

Jackie Johnson, Community Vision Director; UAMS/CDC/Arkansas Children Hospital

Taniesha Richardson, Grants Coordinator; Arkansas Department of Health

James Jones, Coordinator/Counselor; AWCLR

Chara Stewart, Manager of Health Services; UALR Share America

Maura Lozano-Yancy, Publisher; Cross Cultural Development

T. Gregory Barrett, Evaluator

Mr. Barrett is the Assistant Professor of Higher Education at the University of Arkansas at Little Rock. He has conducted qualitative research in fund raising, organizational behavior and teaches various courses on Qualitative Research Methods.

Judy Sopenski, Facilitator

Ms. Sopenski has over 30 years of experience in the field of education and advocacy including 20 years in the field of substance abuse prevention. At the present time, she serves as a consultant and trainer on tobacco company strategies, community mobilization, and effective youth and community advocacy initiatives. She has worked with states to develop an infrastructure capable of supporting community-based youth advocacy work.

Appendix VI

Guest Speakers

Dr. David Bourne, Chief Physician Specialist
Arkansas Department of Health

Robert Easter, Counselor
Arkansas Rehabilitation Center

Dr. Robert Robinson, Associate Director of Office of Smoking Prevention
Center for Disease Control in Atlanta, GA

Presenters and Contributors

Matthew Quick, Epidemiologist
Arkansas Department of Health

Maura Lozano-Yancy, Publisher
Cross Cultural Development

Paul Austin & Lois Bethards, Program Directors
American Indian Center of Arkansas

Mitchell Simpson, Youth & Schools Health Program Analyst
Arkansas Department of Health

Braley Braddock, Secondhand Smoke Health Program Analyst
Arkansas Department of Health

Tobacco Prevention and Education Staff

Lynda Lehing, Team Leader

Staci Croom, Federal Program Support Manager; *Coordinator of Pilot Project*

LaKhiva Blann, Staff Development Coordinator; *Contributor*

Braley Braddock, Secondhand Smoke Health Program Analyst

Cassandra Miller, Cessation Health Program Analyst; *Contributor*

Mitchell Simpson, Schools & Youth Health Program Analyst

Tamika Walls, Eliminating Disparities Health Program Analyst,
Assist. Coordinator of Pilot Project