

*Michigan Tobacco Control Program: Case Study Report for Tobacco
Use among Population Groups - Putting the Pieces Together to
Identify and Eliminate Disparities*

1. Overview of Disparities Project

1.1 Purpose and Goals of Project

As a grantee of the Centers for Disease Control and Prevention (CDC) pilot tobacco-related disparities project, the Michigan Department Of Community Health (MDCH) was charged with the task of convening a workgroup of individuals representing population groups in Michigan disparately affected by tobacco. The workgroup's goal was to develop a strategic plan for the identification and elimination of tobacco-related disparities. The strategies from the plan were then incorporated into the MDCH Tobacco Program's annual action plan, and lay the foundation for other initiatives that may need guidance in addressing this topic.

For the purpose of this project, it was necessary to distinguish between the terms "disparity" and "diversity" and to develop a working definition. While the terms are sometimes interchangeable, "disparity" and "diversity" had distinct meanings for the workgroup. The term "disparity" is understood to mean "tobacco-related gaps among populations". These gaps are determined by factors such as lack of tobacco use prevalence rates and morbidity and mortality rates, increased exposure to SHS, heavy industry targeting of specific groups, lack of access to health care, etc. The term diversity refers to the "inclusion and involvement of various groups" in the planning process.

Another term used throughout the project is "disparately-affected." Used interchangeably with the phrase "disparate population" the term "disparately-affected population" was favored by the workgroup to be the more accurate expression in describing a group that is disproportionately affected by tobacco use. There was further concern that "disparate population" had a pejorative connotation.

1.2 Overview of Tobacco Control Efforts and Target Populations in Michigan

Michigan is unique among the states as it consists of two peninsulas completely separated by water. Michigan has a population of 9.9 million people residing in a landmass of 56,804 square miles. According to the 2000 census, whites constituted 80.2 percent of the population, blacks 14.2 percent, Asians 1.8 percent, Native Americans 0.6 percent, and those of mixed heritage or not reporting a race 3.2 percent. Hispanics, who may be of any race, were 3.3 percent of the population.

In 2002, the Michigan labor force was comprised of over 5 million people. The largest percentage of people, 35 percent, were employed in the broad services

industry sector, 23 percent were employed in wholesale or retail trades and 21 percent were employed in manufacturing. Although Michigan has a diversified economy, it is primarily an industrial state, ranking fifth in the U.S. in value-added by manufacturing in 1996. Manufacturing and construction dominate in the southern one-third of the state while in the northern two-thirds the leading sources of income are government, services, retail trade and small-scale manufacturing. In 2002, over 21 percent of Michigan's workers were unionized, compared to a national average of 14 percent.

State per capita income in 1999 was \$22,168, slightly higher than the national average of \$21,587. Also, during that year, 10.5 percent of Michigan's population was living below poverty, compared to the national average of 12.4 percent.

The MDCH Tobacco Control Program operates through collaboration with state and local partners, including 60 local tobacco reduction coalitions, 14 Communities of Color agencies and 4 statewide tobacco reduction projects. During FY 2002 - 2003, the Tobacco Control Program increased collaborative efforts with the MDCH Cancer Section, Maternal and Child Health (MCH) Section and added partnerships from 13 regional asthma coalitions throughout the state.

Currently, state government is undergoing a re-organization. This means the Tobacco Control Section will likely be included with the Chronic Disease & Injury Control Division. For FY 2004 (October 1, 2003 - September 30, 2004), the tobacco control budget is likely facing a \$700,000 budget cut that may force reduction in some program projects. We continue to seek collaborative opportunities with other state department programs to develop low-cost ways of data collection and integrating tobacco-related activities into mutually beneficial program plans.

1.3 Disparities Project Team: Leaders and Other Members

Two staff members from the Michigan Department of Community Health, Tobacco Section participated in the project. Sophia Tyler, MDCH Communities of Color (COC) Public Health Consultant acted as Project Director, with general oversight of the project and supervisor for the Project Coordinator. James Loree, Project Coordinator was hired to oversee the convening and maintenance of the workgroup. Todd E. Bradley, Program Manager for Insight Recovery Center, was hired as the facilitator for the workgroup meetings. Kathie Boynton, Statistician for the MDCH Tobacco Program, served as project evaluator.

1.4 Roles / Responsibilities of Disparities Project Team Members

MDCH was responsible for forming the workgroup, clarifying the project vision and mission, setting the direction of the meetings, providing relevant data, hosting the meetings, and reimbursing the participants' travel expenses (as requested or needed). There were four members of the Disparities Project Team with specific responsibilities to ensure that the meeting process and project objects were met. The Project Director was responsible for ensuring the completion of the project, supervising the Project Coordinator, and preparing the

final report. The Project Coordinator was hired to act as a liaison between workgroup members and MDCH staff. He was responsible for determining the direction of the meetings and preparing the necessary materials for meetings. He collaborated with Team members to ensure a work product that reflected group requests. The Statistician was responsible for researching and collecting pertinent state data related to the identified population groups. She also helped workgroup members to understand what information was available and to interpret findings for members. She submitted the mid-term progress report to CDC and compiled the Case Study Report. The Facilitator was responsible for maximizing workgroup discussions, and keeping the group focused on the agenda and described tasks.

2. Evaluating Strategic Planning Processes

2.1 Purpose and Goals of Evaluation

The purpose of our evaluation is to describe how the workgroup was formed and how the strategic plan was developed. Goals necessary to achieve this purpose included:

- ❖ Document the main activities throughout the process
- ❖ Identify challenges that were encountered both in forming the workgroup and also challenges that the workgroup encountered
- ❖ Document milestones achieved throughout the process
- ❖ Document lessons learned during the process of workgroup formation and during the strategic planning process
- ❖ Monitor the workgroup's progress toward achieving their planning goals
- ❖ Recommend enhancements based on lessons learned

2.2 Process Evaluation Design

The process evaluation involved collection and analysis of descriptive information that allowed the workgroup to answer the following questions:

- ❖ What methods are used to form the workgroup? Who has the lead responsibility for ensuring that the workgroup is formed and representative of the broadest number of population groups disparately affected by tobacco?
- ❖ What milestones in forming the workgroup have been reached through these efforts?
- ❖ What methods are being used to form the strategic plan? What players are at the table?
- ❖ What milestones have been reached in completing the strategic plan?
- ❖ What critical lessons have been learned during these processes and how will these insights help enhance future efforts to eliminate disparities?

2.3 Evaluation Methods

Information regarding the processes of forming the workgroup and developing the strategic plan was gathered using a number of methods. The Project Team Members (with the exception of the Facilitator) diligently reviewed meeting notes and materials and discussed outcomes of each meeting. This was a very

effective method for keeping Team members involved and focused on the time-lines and objectives for subsequent meetings.

Project team members consciously observed workgroup meetings to determine how workgroup members interacted, how conflicts were resolved, and how consensus was reached on various issues and topics. Team members used this information to encourage individual strengths and diffuse those less helpful to the group dynamic.

Individuals on the Project Team also had discussions with individual workgroup members after the meetings. This allowed Project Team members to gather feedback regarding the process and progress of the meetings, and to elicit suggestions for problems or concerns that they identified.

After four of the seven meetings, workgroup members were asked to complete an evaluation form designed to evaluate outcomes and the strategic planning process for the meetings. This allowed some workgroup members who might not be comfortable in a face-to-face conversation to express valuable opinions.

3. Strategic Planning Processes and Milestones

3.1 Step 1: Forming the Strategic Planning Workgroup

General Characteristics of the workgroup. The workgroup consisted of 35 individuals each representing a population disparately affected by tobacco or an organization that works with a disparately affected population. There were 16 women and 19 men in the workgroup. The level of participation defined terms to describe the workgroup members. Twelve (12) core members were those able to attend at least six of the seven meetings. They also made significant contributions to the discussions. Thirteen (13) participating members were not able to attend all the meetings, but contributed actively when they were present. The remaining members were considered silent partners. Team members were in contact with them if there were questions or concerns regarding their population group. These members did not attend any meetings, but were forwarded all meeting minutes and accompanying materials.

Roles and Responsibilities. During the first meeting workgroup members were introduced to the purpose and scope of the project. Members agreed on the following roles and responsibilities for the group:

- ❖ Attend all workgroup meetings (Send a substitute if necessary)
- ❖ Review and share relevant information about the population you work with or represent, in terms of infrastructure and environment
- ❖ Come prepared
- ❖ Participate consistently, especially during the environmental scan phase
- ❖ Listen wholeheartedly
- ❖ Respect one another during and after the meeting, including maintaining confidentiality
- ❖ Identify individuals and agencies that can help with the plan
- ❖ Participate in the priority setting process

- ❖ Help draft goals and strategies for the plan
- ❖ Garner community support for the plan
- ❖ Review the strategic plan
- ❖ Monitor the implementation of the plan
- ❖ Work as a team, not individually
- ❖ Act in the interest of all disparate groups, not just his/her own

After the discussion, the following ground rules for the workgroup were established and adopted:

- ❖ Everyone be honest with others and one's self
- ❖ Respect all members, especially their time, effort and points-of-view
- ❖ Listen (without sidebar conversation). No monopolizing the conversation or forcing one's own agenda
- ❖ Have the self-discipline to act appropriately in all interactions
- ❖ Attend all meetings or at least have someone fill in if necessary
- ❖ Use good judgment regarding confidentiality.

Some items were repeated in each of the above lists based on their importance as expressed by workgroup members.

Recruitment. Members for the workgroup were recruited using a variety of methods. MDCH Project Team members initially identified various populations as disparately affected by tobacco. The statistician conducted data searches and literature reviews to justify (or disprove) the need for the population group to be included in the project. Once disparately affected populations were identified, Project team members used phone books to locate and identify organizations associated with a particular population. The Project Director sent a questionnaire to local tobacco reduction coalitions and Communities of Color agencies asking them for any contact information they might have for specified populations within their areas. Once a complete list of organizations representing the identified disparately affected populations was compiled, letters were mailed inviting the organizations to participate in the disparities workgroup. The letter was followed up with a phone call, and personal visits were arranged for organizations that requested further information about the project.

Care and maintenance. The purpose and content of the meetings and the project was often absorbing and interesting to participants, but numerous methods were used to enhance members' involvement and participation over time. Members received gift certificates to local restaurants, door prizes, hot lunches and mileage reimbursement as requested or needed. There was an effort to highlight aspects of the many cultural heritages represented in the group. For example, Lorenzo Lopez taught a Mexican Salsa Dance during a lunch break, and George Anziano performed a Native American opening and closing ceremony during one of the meetings.

Group process. Meetings were conducted openly. Written agendas provided focus for topics of discussion. Decisions, when a consensus or unanimous agreement was not possible, were made by a majority vote. The facilitator was responsible for facilitating the topic of discussion and keeping the discussion focused and purposeful. Many times the whole group would divide into smaller groups to expedite the discussion process, and then reassemble. The large group would then compile the results and begin the decision-making process.

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

Collection and analysis of data. In preparation of the first workgroup meeting, MDCH staff members identified disparately affected populations within Michigan. Internet data searches and literature reviews were performed to determine if the population was accurately described and identified. The statistician compiled the data and prioritized the identified populations according to their tobacco prevalence rates. If the disparately affected population was represented in the workgroup, the group was also ranked higher. The statistician presented the data to the workgroup during the first disparities meeting in a PowerPoint presentation (See Attachment 1). The major finding recognized by the workgroup members was that much of the data presented was not Michigan-specific, but national data.

The list of identified population groups/communities were presented to the group members. They were asked to identify populations that they felt were missing or not represented at the table. Contact information was sought where feasible and invitations extended to participate in the disparities workgroup. Participation at the second meeting was greatly increased as a result of this request.

Population assessments. Population assessments were conducted during the second meeting. The large group was divided into six smaller groups so that more attention could be given to each identified population. Each group was given a list of questions developed by the CDC and slightly modified (See Attachment 2). Each person was asked to identify within their population the following: communication channels, social norms, knowledge and attitudes regarding tobacco, assets that the population/group has that support tobacco prevention and control efforts, and existing barriers that make reaching this specific population group/community challenging. Upon completion, the groups reconvened and discussed the results.

Developing a comprehensive profile of disparities statewide. In reviewing the Tobacco Use Matrix (Attachment 1) as well as the information gathered during the population assessments, the workgroup began to visualize a rich, complex profile of Michigan populations disparately affected by tobacco. Perhaps the most obvious finding was the gap in information that made a truly comprehensive profile incomplete.

Some important highlights of the comprehensive profile include the following findings:

- ❖ There are over 40 populations or groups in Michigan disproportionately affected by tobacco.
- ❖ Despite its reputation for being a highly industrial state with Detroit at the hub, much of the state is rural, with many isolated and underserved populations.
- ❖ The Upper Peninsula is largely rural and geographically isolated from the rest of the state.
- ❖ Michigan is home to 12 federally recognized Native American tribes. Many of these sovereign nations remain secluded; and tobacco as a traditional ceremonial use remains a strong part of their culture.

- ❖ Southeast Michigan is very urban with most of the identified disparate populations residing there. All five major ethnic groups - African American (14.2%), Hispanic/Latino, Asian American (1.8%), Arab American and Native American (0.6%), are heavily represented in southeast Michigan.
- ❖ The auto industry and many supporting industries in southeast Michigan give rise to a large blue-collar population, and groups identified as low socioeconomic status.
- ❖ There is growing awareness and growth in the gay-lesbian-bisexual-transgender population.
- ❖ The largest Arab/Chaldean American population outside of the Middle East resides in southeast Michigan.
- ❖ Asian Americans are a growing population in mid Michigan.
- ❖ The Hispanic/Latino population is the fastest growing ethnic group and is present in rural areas as seasonal migrant workers, and as long time residents in urban centers.

See Attachment 1 for more detailed information about other groups identified as disparately affected by tobacco.

SWOT Analysis: Methods and results. The SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis was started during the second meeting and finished during the fourth meeting. The strengths and weaknesses portion of the SWOT was conducted during the second meeting, and allowed members the opportunity to look at their own strengths and weaknesses in the strategic planning process. Several workgroup members had to leave early, so the Strengths and Weaknesses portion was reviewed at meeting #4 and the Opportunities and Threats portion was completed at that time. The SWOT was conducted in a large group, led by the facilitator. (See Attachment 3). The SWOT was used during the construction of the goals and strategies and again during the Marketing Analysis process to discuss political considerations.

3.3 Step 3: Developing the Strategic Plan

Identification and prioritization of critical issues. At the end of the second meeting the workgroup members were given a homework assignment to submit at least six critical issues regarding their population to the project coordinator before the third meeting. Workgroup members returned with a total of 60 critical issues that would then be condensed into six priority issues.

The 60 critical issues were compiled into a master list and posted on the conference room walls using large Post-It notes. The workgroup divided up into six smaller groups to determine their group's top six critical issues from the master list. This process reduced the original list to 25 critical issues. One of the smaller groups identified six issues that seemed to encompass the majority of the 25 remaining ones. The facilitator pointed this out to the group and after further discussion the workgroup was able to reach a consensus on those six issues. They are:

- ❖ Collaboration among existing tobacco control advocates
- ❖ Prioritize awareness of disparately affected populations within state and local governments

- ❖ Create a maximally effective marketing campaign, targeting many disparate populations
- ❖ Increase funding from state, local and community foundation sources to address needs in disparately affected population throughout Michigan
- ❖ Reduce health consequences in disparately affected communities
- ❖ Prevent, reduce and eliminate tobacco use among youth

Converting critical issues to planning goals and strategies. The focus of the fourth meeting was to develop the goals and strategies that would become the strategic plan. During this time, it became apparent that workgroup members were afraid of offending populations by not including them or their community in the strategic plan. The result was that the goals and strategies were very broad and too vague. The strategies did not link with the goals, and they were neither attainable nor measurable.

At the fifth workgroup meeting, the MDCH Disparities Project Team members presented a condensed version of the Tobacco Section Annual Action Plan. This enabled workgroup members to visualize a format that linked goals and strategies, and that also demonstrated attainability and measurability. As a result, the workgroup was able to narrow the scope of the statements and to prioritize 2 – 3 populations. Workgroup members were comfortable with this process when they understood that as progress is made in one area, programs would be expanded into other communities and populations.

MDCH Disparities Project team members made some changes in the goal statements and workgroup plan while keeping the essence of the workgroup's efforts intact. The final results were presented to the workgroup at the beginning of the sixth meeting and the changes were unanimously approved. The final goal statements are the following:

1. Identify and reduce gaps in prevalence and morbidity/mortality data for disparate populations in Michigan
2. Educate local policy makers and community leaders about the burden of tobacco-related disparities in Michigan
3. Increase quit attempts among African American, Latino/Hispanic American, Arab/Chaldean American and White WIC participants in Mid and Southeast Michigan
4. Modify the social environment in Michigan to reduce initiation of tobacco use among youth, grades 6-12, especially Native American and white youth
5. Increase participation by disparate populations in tobacco control efforts
6. Promote secondhand smoke awareness within three (3) automobile assembly plants in Southeast Michigan

Assessing clarity and feasibility of planning goals. In order to assess the feasibility of the workgroup's goals and strategies, the tool sheet developed by the CDC was disseminated to and reviewed by the workgroup members. This tool sheet focused on answering questions related to the parties responsible for implementing the strategies, appropriate time lines for goals and strategies, as well as oversight and reporting issues.

Examining the feasibility of the strategic plan was not completed within a single meeting, rather it was interwoven into workgroup meetings 5-7 during which the audience assessment, marketing analysis, political considerations and “What’s in it for me?” exercises were conducted. The workgroup members and MDCH staff identified organizations that seemed most appropriate to adopt each of the strategies. For example, as previously mentioned, MDCH was designated as the entity best suited to accomplish goals #1 and #5. Please see Attachment 4 for the list of other potential partners.

Regarding the feasibility of time lines for the goals and strategies, the Facilitator instructed workgroup members to think realistically about the time and effort needed for each strategy. Following in-depth discussion, the workgroup members reached consensus on what they believed to be the most appropriate time lines for completion of the strategies.

In order to assure completion of objectives and project time lines, it was agreed that workgroup members would maintain involvement in the process once partners began to adopt selected strategies. MDCH staff would act as the liaison between these partners and the workgroup members through reports, conference calls or meetings. In some cases the organizations represented by workgroup members agreed to incorporate selected strategies into their current efforts.

Assignment to implement the strategic plan. The MDCH Tobacco Section will incorporate the workgroup’s recommended strategies from each of the six goal areas into its Annual Action Plan. The primary goals for which MDCH will take the lead include:

Goal 1: Identify and reduce the gaps in prevalence and mortality/morbidity data
Goal 5: Increase participation by representatives from disparately affected populations in tobacco control.

The remaining four goals will be incorporated into the activities/action plans of local tobacco control partners, community agencies and other partners. For example, goal #3- Educate local policy makers and community leaders about the burden of tobacco-related disparities in Michigan, will be incorporated in a work plan to initiate and implement a smoke-free regulation or ordinance. Goal #6 - Promote secondhand smoke awareness within three (3) automobile assembly plants in Southeast Michigan, is finding concrete strategies and activities in a work plan that several contract agencies in Southeast Michigan will commit to undertaking.

Safeguarding the plan: Monitoring, oversight, and feedback. Feedback from local community contracts will be provided every four months through performance indicators for the strategies and objectives identified under each goal area. Tracking progress of performance indicators will provide much needed time-specific and measurable information. Progress on performance indicators that are specific to the six goals will be compiled for periodic progress reports. These will be presented to workgroup members at future meetings, to be determined. The same periodic progress report will be sent to the Michigan Multi-Cultural Network (MCN).

Finding partners to help implement the plan. During the audience assessment workgroup members identified potential partner organizations or communities and attempted to match specific plan strategies with perceived strengths and interests of that potential partner. For example, Tobacco-Free Michigan (TFM) is an advocacy organization with special skills and interests that suggest a good match for goal #3 - educate local policy makers and community leaders about the burden of tobacco-related disparities in Michigan. Other potential partners identified include the Michigan High School Athletic Association that has been supportive of tobacco prevention interventions. They may be engaged in supporting modification of school rules restricting tobacco use among athletes. The United Auto Worker's Union was identified to help target and educate plant workers about the health and economic benefits of a smoke-free work-site.

3.4 Step 4: Adopting and Refining the Plan

Identification of audiences for the strategic plan. In addition to the audience assessment that generated a list of potential partners (see Attachment 5) workgroup members also discussed political considerations that could impact on the success of engaging partners in adopting the strategic plan and performed a marketing analysis to discern methods and incentives for approaching and engaging potential partners in the plan.

Political issues addressed. During discussion about the political realities and issues several important items were identified. Members acknowledged 'traditional' political opposition to components of the strategic plan and expressed the need to learn how to diffuse opposition without derailing the plan. Another point was that it is important to work at the community level while developing relationships and building trust of elected officials and other community leaders with influence. Everyone agreed to an excellent point made that legislators and other elected officials usually have numerous agendas, and they may need educating about the importance of adding tobacco control issues to their list of concerns. Workgroup members agreed that language demonstrating respect, honesty and good will are important in developing relationships. Further discussion revealed that many state or local organizations are still "out-of-loop" with regard to tobacco control issues. Members expressed the need to find creative ways of identifying and activating tobacco-free advocates, especially in populations disparately affected by tobacco.

Internal workgroup assessment and external marketing analysis. In considering how to promote the strategic plan and engage partners regarding tobacco-related disparities, the members first needed to assess themselves as a workgroup. Afterwards, they also had to consider the factors that might encourage or discourage potential partners from collaboration.

In reviewing the internal workgroup environment, the members acknowledged factors that may influence their involvement in the execution of planned strategies. First, they recognized that they are representatives of individual organizations with competing priorities other than tobacco control and prevention issues. For instance, some organizations may focus on illicit drug use or education. While these issues may be impacted by or interrelated to tobacco use,

tobacco might rank lower in terms of priorities. Second, the issue of funding was a major concern. The members were disappointed that no additional funding would be available to carry out the strategies outlined in the strategic plan. Many expressed hesitancy to adding more work to their jobs without a financial incentive. Furthermore, workgroup members were aware that they would have to present these ideas to the organization supervisors and/or decision-makers. These decision-makers would also be reluctant to work on a project without additional resources. Third, time and availability were concerns. Many of the workgroup members felt that they already had numerous responsibilities at their jobs. It would be difficult and unrealistic to expect them to add more responsibilities to their current workloads. Despite these challenges, the workgroup members also discussed the positive factors that may affect the Disparities Project.

The individual members agreed that their commitment to reducing and eliminating tobacco-related disparities was genuine. This was a major motivating factor demonstrated in their regular attendance at the meetings. Also, they felt that they had expertise in working with those groups that were identified as disparately affected. Since many of the identified populations experienced disparities in other areas such as health care, financial resources, etc., members understood the need to collaborate with traditional tobacco control partners, as well as non-traditional partners.

With regard to external marketing analysis, some of the same concerns emerged from the internal marketing analysis. These included: Competing priorities in that tobacco reduction and prevention is not a high priority among organization agendas; lack of additional funding to dedicate staff time and energy to tobacco control issues; the time and energy and perhaps money needed to cultivate relationships with new partners; the politics within each agency that often drive agency priorities. Workgroup members participated in an exercise called "What's in it for me?" This allowed the members to consider the perspective of a potential partnering group or agency – that the agency may also need to get something in return for their participation or support. Workgroup members determined that providing positive media attention, help in educating their target populations, and realization that their participation could bring health and or economic benefits could enhance participation. For example, the United Auto Workers might be engaged if they are convinced that support for an on-site education campaign on the benefits of smoke-free environments would bring a decrease in health care costs.

Writing the strategic plan. The Project Director wrote the strategic plan based on input and feedback by workgroup members. Final edits to the plan were made after the last formal meeting of the workgroup, which required conference calls, fax and e-mail communication to ensure inclusiveness and consensus.

Workgroup adoption of the plan. Once the strategic plan was complete the Project director distributed it to workgroup members via e-mail and fax asking them to review the document and provide feedback. The workgroup members unanimously approved the final document.

State Health Department approval for the plan. Specific strategies have been incorporated in to the MDCH Tobacco Program Annual Action Plan. In the intervening months since the completion of the plan a more supportive health department administration has emerged. This new reality will enhance the opportunity for getting the plan formally approved and bringing attention to its components.

3.5 Step 5: Preparing for Action

Marketing the plan: Strategies and results. Key findings from the marketing analysis were incorporated into a marketing plan. Members agreed that promoting the plan requires the need to cultivate new relationships and actively seek out potential partners for collaboration. In raising awareness about the tobacco burden in disparately affected groups there will likely be a need to defuse potential opposition – economic and political. It is no secret that disparately affected populations are frequently supported in part by tobacco industry grants. Such a reality may cause resistance and even opposition to the strategic plan.

Next steps. There continues to be discussions with Tobacco-Free Michigan to partner with MDCH in co-sponsoring a Disparities Conference, hopefully within the next year. More immediately, the disparities strategic plan will be incorporated into Michigan's Five Year Strategic Plan for Comprehensive Tobacco Use Reduction and Prevention. The Five Year Strategic Plan will be completed in the Fall 2003. MDCH will continue to engage local coalition contracts and communities of color agencies to commit to strategies and activities in their work plans that will promote the disparities agenda.

Effective marketing strategies.

Workgroup members agreed that the most effective means of reaching disparately affected populations is to provide and disseminate materials that are language appropriate, culturally sensitive, and geographically specific. As noted above, the group recommended incorporation of various strategies into MDCH Annual Action Plan. For example, the multi-cultural Smoke-Free Home Pledge initiative will be promoted through various ethnic community venues and WIC clinics.

Obstacles to marketing efforts. While lack of support from the health department administration no longer poses an obstacle, the significant budget cuts do present a challenge for effective implementation of parts of the plan. Although MDCH staff is committed to convening a Disparities Conference, current funding levels require delaying it until funds are available.

Impact of marketing on development of action plans. Workgroup members acknowledged the importance of creating opportunities to market and promote the disparities strategic plan in order for it to be fully implemented and to be successful. As noted earlier, there was understanding that competing priorities in fiscally stressed organizations and groups could diminish proactive and fully supportive acceptance of the plan.

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

The MDCH Project Team will continue to be in active communication with workgroup members, seeking their participation and involvement in all aspects of the strategic plan marketing and implementation.

4. Major Assets For Strategic Planning

4.1 Factors Facilitating Planning Processes

Step 1: Forming the strategic planning workgroup. The workgroup members were truly committed to the expressed goal. Most were willing to market the process to other communities/populations to get their involvement and commitment.

Step 2: Identifying/prioritizing tobacco-related disparities and assessing capacity. Many of the workgroup members had first-hand knowledge and great insight regarding their population's strengths and challenges. They were able to provide detailed methods for approaching and engaging them. They also had knowledge about strategies that would be effective in their communities and key leaders able to support implementation.

Step 3: Developing the strategic plan. The perceptions and experience of workgroup participants uniquely qualified them to develop a strategic plan that is realistic, attainable and relevant to their communities.

Step 4: Adopting and refining the plan. After consultation with the CDC, the workgroup members they revisited the original work plan to ensure that goal statements were more specific, measurable and attainable.

Step 5: Preparing for Action. During the market analysis, workgroup members assessed their own organizational resources and assets, identified other potential partners and their resources, and evaluated how the political climate may effect the implementation of the plan.

4.2 Maximizing Planning Assets

There were numerous assets that enhanced potential success of the project. Many of these were related to the quality of the workgroup participants. They include:

- ❖ The workgroup was diverse, ethnically, geographically and culturally.
- ❖ The group enjoyed broad diversity in work experience ranging from a college student to a high school counselor to a public housing commissioner to an attorney.
- ❖ Some participants were influential within their communities.
- ❖ Members were enthusiastic about the project and worked well together.
- ❖ The group learned a lot from its own individual members. It was a community-based workgroup with much to share and teach each other.

5. Challenges to Strategic Planning

5.1 Challenges to successful planning

5.2

Step 1: Forming the strategic planning workgroup: Challenges in recruitment and maintenance of the disparities workgroup. Once the disparately affected populations were identified it was difficult in some cases to get a commitment to participate in the workgroup process. Initially there was skepticism that their participation was vital. For others it was competing priorities, and in some cases no recognition that they would be involved in a mutually beneficial relationship. On occasion, there was some disagreement between individuals within a population regarding their perspectives. There was inconsistency in regular attendance by some individuals and decreasing participation at some meetings. Finally, it was challenging to keep a strong and representative attendance by workgroup members. Michigan is geographically large, making participation from the Upper Peninsula difficult. Some groups that were invited and wanted to participate, had to decline due to time and/or scheduling constraints.

Step 2: Identifying/prioritizing tobacco-related disparities and assessing capacity. It was a challenge to identify some disparately affected populations due to the lack of Michigan specific data. Project staff had to rely on empirical evidence from workgroup members that an identified population should be included as disparately affected by tobacco. At the time, MDCH administration was not wholly supportive of including certain population groups (GLBT) in the pilot study.

Step 3: Developing a strategic plan: Workgroup members had difficulty in developing a plan that was specific and measurable. Participants were reluctant to exclude specific population groups and specific regions of the state. It was therefore necessary to edit the original plan so that it met CDC requirements for specificity, measurability, and attainability.

Step 4: Adopting and refining the plan. Since it took more meeting time than anticipated to develop an acceptable strategic plan, workgroup members were asked to review plan elements long after the last formal meeting, and to provide comments and feedback through e-mail and fax. The long time lag made final edits and approval of the plan a laborious and inefficient process that was not as inclusive and participatory as we would have desired.

Step 5: Preparing for Action. As a result of budget constraints the disparity conference that was seen as a key marketing strategy for releasing the disparities strategic plan has been postponed for the near future. As a result the workgroup will rely on other venues to market and promote the plan.

5.2 Strategies to Overcome Challenges

Described below are some key strategies for overcoming various challenges:

- ❖ Overcoming apprehension or reluctance about the project. When invitees expressed concerns or questions about their involvement, personal visits were made to discuss the project in depth. This approach seemed very effective in garnering support to join the workgroup.

- ❖ Improving communication. A lot of information was collected at meetings, yet workgroup meetings were spaced at fairly long intervals. In order to capture information and keep everyone equally engaged between meetings, the Project Team often used e-mail and fax to keep workgroup members updated and to request feedback and comments. This extra communication promoted continuity of the process and contributed to members' sense of active involvement.
- ❖ Delays in marketing. The disparities conference has been postponed, but MDCH staff members continue to look for innovative methods for marketing the strategic plan, as well as for opportunities to collaborate with potential new partners in implementing the plan strategies. Project team members have drafted a 'highlights' sheet to provide information on the strategic plan to tobacco control partners and potential partners.

6. Conclusions

6.1 Major Planning accomplishments

- ❖ The workgroup was able to identify over forty populations in Michigan that are disparately affected by tobacco. The comprehensive profiles helped to conceptualize and identify gaps in data collection for many disparate populations.
- ❖ Workgroup members made valuable contributions and were key to the successful process and outcome of the project. They were dedicated people, willing to commit their precious time, energy, experiences and talents to the project. The group members worked very well together – they were focused on the long-range goals and able to sublimate personal agendas and egos.
- ❖ Workgroup members produced a plan that is concise, concrete and measurable. The plan is equally relevant to a community, a group or a population.
- ❖ Many of the priorities agreed upon by the workgroup have been incorporated into the Tobacco Section's Annual Action Plan and into the local coalition and local agency contracts as strategies and activities to be accomplished.
- ❖ The highly visible efforts of the disparities workgroup enabled and empowered the Michigan Multi-cultural Network to spearhead an initiative to get permanent representation on the Board of Directors of Tobacco-Free Michigan, the statewide advocacy organization. This is an important achievement for Michigan's major ethnic populations to gain parity and recognition for their advocacy efforts in tobacco control and to bring awareness to the greater Michigan population regarding the disproportionately negative impact of tobacco use on numerous populations.

6.2 Lessons learned during the planning process

- ❖ All Project team members agreed that everyone would have benefited by reviewing the workgroup member evaluations at the end of each meeting. In some cases requests from participants were not responded to in a timely manner.
- ❖ Communication is truly an art form – definition of terms is crucial to full and robust interaction. Even though many of our workgroup participants were professionals they were not familiar with our terminology. Some members

may have been reluctant to ask questions or to give their opinions because they did not understand terms or concepts being used.

- ❖ All Project team members would have benefited from better communication and planning among themselves. There were occasions when confusion among team members produced confusion among workgroup members and impeded progress in completing the agenda.
- ❖ Stronger content support for the facilitator. While the group facilitator was very good at monitoring and encouraging discussion, there were times when the workgroup would get off-track and it was difficult for the facilitator to know when to re-focus the discussion to keep the process moving forward. The MDCH team needed to include the facilitator in planning the agenda and discussing work products for each meeting.
- ❖ Prepare workgroup members for the needed outcomes for each meeting. Since meeting times were limited, it would have been to everyone's advantage to distribute agendas and materials before the meetings. This practice would encourage members to preview the materials and increase the probability that more participants would be better prepared at meeting time.
- ❖ Food is very important. Workgroup members were not adequately included in the decision-making process for the menus. This would have been an easy way to validate and acknowledge the importance of their time and effort.
- ❖ Closely monitor group adherence to the roles and responsibilities agreed upon in the first meeting. This would ensure that all members continue to feel valued. On occasion some members tried to monopolize the conversation resulting in frustration and decreased participation by other workgroup members.

6.3 Recommendations to enhance future strategic planning

As a result of the evaluation of the group process and outcomes, there are numerous recommendations that will be helpful for future endeavors. Project team members agreed on the following key points:

- ❖ Allocate more money in the budget for participants' travel costs -lodging, meals, and travel. While such expenditures aren't sufficient to insure a successful workgroup process, it is necessary in a state of the size of Michigan to ensure that resources don't create yet another disparity.
- ❖ Project team members agreed that better communication and collaboration among themselves would have improved and enhanced workgroup meetings and outcomes.
- ❖ Be more diligent about appropriate materials that support and improve understanding rather than impede it. There were occasions when good participation was held hostage by information overload and confusion regarding work direction.
- ❖ Meet with the facilitator on a regular basis, so that he has an understanding of what the objectives of the meetings are and he is able to divert unproductive discussion at the appropriate time.

6.4 Final Comments

The Disparities Strategic Planning project and process has been a great opportunity for the Michigan Tobacco Program to expand and deepen its long-

time commitment to reaching populations disparately affected by tobacco use. The experience of working with the Disparities Workgroup has afforded the program staff to learn important lessons and create new strategies as it implements plans for future involvement on behalf of disparately affected populations. The project has encouraged the MDCH staff to think creatively about ways to reach a larger percentage of disparately affected populations, such as offering grants that encourage work with less obvious population groups. While stretching the state tobacco program budget to focus on identified populations, we will continue to look for opportunities and resources to devote to disparities.

Through the planning process for the Michigan Five Year Plan Strategic Plan for Comprehensive Tobacco Use, the Tobacco program has a venue through which to actively involve workgroup members in marketing, educating and promoting integration of the Disparities strategic plan into the Five Year Comprehensive Plan. This involvement will help to involve and engage a diverse and invested group of stakeholders that represent many facets of the Michigan population. It is one of numerous forums and opportunities we will seek to bring attention to the issue of disparately affected populations and to break down barriers, especially lack of information that may prevent awareness and lack of outreach to disparately affected populations.

As noted above, one of the major findings in the Disparities project was the dearth of information surrounding disparately affected populations and the need to fill gaps in accurately describing and defining these population groups. The MDCH staff is committed to continue to research data and work to disseminate more and better information regarding all Michigan populations disparately affected by tobacco. We will actively seeking venues to gather new data and share information with other states regarding our findings. Michigan will be involved in conducting the Adult Tobacco Survey, and we propose to over-sample in some disparately affected population groups to get data that are statistically significant. We will also look for opportunities to disseminate information in peer reviewed journals and scientific publications.

Despite fiscal constraints, our program will seek opportunities to train other organizations in Michigan to work more effectively with disparately affected populations. We will keep focus on this issue by finding national forums for sharing lessons learned in other states. The Disparities Project process ignited enthusiastic and inspiring interest in this important goal area of tobacco control. The MDCH program will continue to be a leader in striving for social justice, tobacco-free behaviors and environments in all population groups. We are grateful for the grant opportunity afforded by the Centers for Disease Control.

5/16/03

Attachment 1-Quantitative Data-Tobacco Use Matrix

	General Population	Male > 18 yrs old	Female > 18 yrs old	Youth < 18 yrs old	Pregnant Women	Morbidity Data	Mortality Data	Population Addressed
Native American	42.0% *	45.4%	34.2%	20.0%	39.0%			Minimally
Arab American	38.9% *	40.6%	38.2%	23.0%				Minimally
African American	30.9% *	31.4%	22.7%	16.4%				Minimally
Asian American	29.4% *	29.4%	5.8%	Male - 25% Female - 14%				Minimally
High School High School Students	27.6% *	25.8% (grades 9-12)	29.5% (grades 9-12)					Minimally
Hispanic / Latino	26.4% *	22.9%	15.1%	31.6%				Minimally
Caucasian	22.8% *	26.4%	21.9%	28.9%				Minimally
Pregnant Women	15.6% *	N/A		23.3%				Minimally
Middle School Students	9.3% *	9.8% (grades 6-8)	8.7% (grades 6-8)					Minimally
Mentally Ill	92.0%							No
Substance Abusers	85.0%							No
Alcohol Abusers	80.0%							No
LGBT	48.0%							No
Migrant Workers	43.0%							Minimally
Armed Services	43.0%							No
Athletes	40.0%							No
Blue Collar Workers	39.0%							No
College Students	35.5%							Minimally
Rural Population	not available							No
Correction Institutes	not available							No
Low SES	not available							No
Homeless Population	not available							No

* Michigan data

Sources Cited for Quantitative Data

Native American

1999-2000 Behavioral Risk Factor Survey (BRFSS), Inter-Tribal Council of Michigan, Inc. & The Center for Social Gerontology (TCSG)

Arab-Americans

1999-2000 BRFSS & TCSG

African-Americans

1999-2000 BRFSS, TCSG & American Lung Association (ALA)

Asian-Americans

1999-2000 BRFSS, TCSG, & ALA

High School Students

2001 Michigan Youth Tobacco Survey (MI YTS)

Hispanic/Latinos

1999-2000 BRFSS, TCSG & ALA

Whites

2000 BRFSS & 2001 MI YTS

Pregnant Women

1999 MDCH Vital Records (Birth Certificates)

Middle School Students

2001 MI YTS

Diagnosed Mentally Ill

<http://papers.nber.org/papers/W8699>
www.archgenpsychiatry.com
Schizophr Res 1998 Sep 7;33 (1-2):113-18

Substance Users and Alcohol Abusers

LBGT

Am J Prev Med 2001 Aug;21(2):142-9
Am J Public Health 1999 Dec;89(12):1875-8
J Drug Alcohol Depend 2001 Jan 1;61(2):105-12

Migrant Workers

American Journal of Industrial Medicine 29:23-32 (1996)
Chest-Abstracts: Gamsky et al. 101(5):1361
JAMA, May 16, 1990 v263 n19 p2565(2)

Armed Services Personnel

Tobacco Control 1998;7::219-21 (Autumn)
Tobacco Control 1998;7:236-40 (Autumn)
Tobacco Control 2001;10:43-47 (Spring)

Athletes

Tobacco Control 2000;9(Suppl II):ii32-39 (Summer)
J Calif Dent Assoc 1998 May;26(5):365-72, 376
Tobacco Control 1998;7:443-444 (Winter)

Blue Collar Workers

J Occup Environ Med 1998 May;40(5):441-44
Br J Ind Med 1989 Jan;46(1):12-5
Am J Ind Med 40:233-239, 2001

College Students

Core Institute Statistics on Alcohol and other Drug Abuse

J Subst Abuse 1993;5(2):175-81 J Subst Abuse Treat 1993 Mar- Apr;10(2):221-27 J Subst Abuse 1996;8(4):445-52	
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Attachment 2

Population Assessment Qualitative Data Details

Conducting the population assessment is not meant to be comprehensive. The intent is to become more informed about the issues related to disparities. To accomplish this task, the workgroup divided into small groups of four or five and classified information of the populations represented by the workgroup members under various headings, including: population type, communication patterns, social norms, knowledge & attitudes, assets, and barriers. Through this exercise we found that every population has unique characteristics, yet they still share similar basic needs, such as the need for community health, the need to fund their own infrastructure, the need to feel appreciated and worthwhile. We can confidently address these needs as we address the issue of disparities related to tobacco. The highlights from the small groups about the population assessment are as follows:

THE CHEW GUM GROUP

POPULATION:

- Latino/Chicano, Arab-Americans, Urban Youth, Women-bearing children, GLBT, mentally ill, substance users

COMMUNICATION:

- URBAN YOUTH: through music, fashion, attitudes & relations (prevention tactics low when targeting GLBT, women bearing children, & mentally ill)
- LATINO: language, social, religion, educational, media, cultural
- ARAB: *Religion, language, social, & media
- Barriers to communication: Lack of knowledge and understanding, e.g. cultural competency

SOCIAL NORMS:

- Latino: tobacco as a VICE, not an ADDICTION
- Tim says-shame & guilt; Arab-not a big deal
- Youth: image, peer pressure, "Fitting-in", ignorance of long-term effects

KNOWLEDGE and ATTITUDES:

- Major issue: Attitude (knowledge accessible but often ignored)
- Tim: environmental influences & rituals

ASSETS:

- Latino: Community & family based & national organizations, religious groups
- Youth: community agencies & internal organizations, preventions & cessation services, youth groups
- Arab: family ties, religion

BARRIERS:

- lack of understanding & cultural sensitivity to needs of population (GLBT, mentally ill, women)
- Arab: events of 9/11/01 sparking intense emotions=Negativity, prejudice, stereotyping
- Chicano/Latino: cultural competency, media & educational programming; not enough tobacco control programs

KICK BUTTS GANG

POPULATION:

African American Youth (H.S., M.S., special education, ADHD), Women, MSM

COMMUNICATION:

Language; Interference; Open/Closed Discussion; Distribution channels

SOCIAL NORMS:

N/A

KNOWLEDGE & ATTITUDES:

N/A

ASSETS:

N/A

BARRIERS:

Generational; Sub group nuances; Health vs. Morality/Spirituality; Immediacy of Youth; Marketing; Family modeling

THEMES:

- ***Focus on frailties, omit morality***
- Sing in harmony
- How do we come together

SMOKING SLASHERS

POPULATION GROUPS:

- Youth, including HS & college aged
- Prisoners
- Those who have no health care access/no insurance
- People who work in bars, restaurants, and casinos where smoking is promoted

COMMUNICATION:

- Teaching youth about choices with peers. They have alternatives. Visuals and marketing influence them (party stores). College-aged youth are targeted by tobacco marketing in bars, etc. Socially influenced by smoking, drinking, parties, etc.

SOCIAL NORMS:

N/A

KNOWLEDGE & ATTITUDES:

N/A

ASSETS:

- Youth-Future orientation/opportunities. This may be a barrier to prisoners, yet being captive may be an asset to Health intervention.

BARRIERS:

- Youth-Belief in invincibility. Social norm of smoking (college aged). Prisoners-choice about health care/cessation is nearly non-existent. Self worth is low. Literacy is a problem. Perception is present that tobacco abuse is not a problem because it is readily available.
- People are afraid to question their health care practitioner. Smokers continue the habit within social norms.
- Youth see athletes chewing. Racing directly affiliated with tobacco, as are rodeos and cowboy image. Youth see and imitate the images.

Why do we have NO SMOKING signs instead of the reverse, SMOKING ALLOWED?

DON'T PLAY THE SECOND HAND

POPULATIONS:

- Women
- Youth

CHARACTERISTICS OF DISPARATE POPULATIONS:

- Part of a community
- Comes from different histories and cultures
- Urban & rural; all social & economic classes

COMMUNICATION CHANNELS:

- School peer groups
- Social setting; at home; in neighborhood
- Community events
- At work

BARRIERS TO COMMUNICATION:

- Accessibility!!!! It is a legal drug to adults.
- Peers, parents, TV, advertising, life stresses all reflect a lack of respect for a spiritual base.

SOCIAL NORM CHANNELS:

- Peers
- Ads
- Movies
- Cultures
- Parents
- Spirituality

KNOWLEDGE & ATTITUDES:

N/A

ASSETS:

N/A

BARRIERS:

N/A

THE HANDS-FREE SMALL GROUP

POPULATIONS:

N/A

COMMUNICATION :

N/A

TOBACCO-RELATED NORMS:

- **It's okay to smoke**
- It's legal
- It's stylish

ATTITUDES:

- Ignore our problems
- I can always quit /I'm invincible

ASSETS:

- *Prevention programs*
- Community awareness
- Tobacco coalitions
- Political awareness

BARRIERS:

- Inadequate funding
- Overwhelming tobacco industry advertising & promotion
- Lack of support from community & political leaders
- Need more smoke-free ordinances
- Power of addiction
- Youth-local store displays, magazine ads, sporting events

THE SMOKE-FREE ZONE OF LANSING SMALL GROUP

POPULATION

- Rural, Gay/Lesbian, Native American, Latino/Hispanic

COMMUNICATION:

- Culture of modeling
- Cultural conflict (bedroom communication)
- Alternative newspapers
- Community centers
- Gay/Lesbian High School Gay/Straight Alliance
- Common language, different dialects

SOCIAL NORMS:

- Lack of alternative activities
- Out of the "Normal" culture
- Outreach in bars and clubs
- Dispersed
- Identity issues
- Spiritual use of tobacco
- Prejudice issue

- Tribal affiliation issue
- Many subgroups
- Spirituality
- Extended family influence, including palomilla and comoradazo, folk healer

KNOWLEDGE AND ATTITUDES:

- Strong family (extended)
- Kinship
- Traditional programs not reaching
- Subgroups
- 3% receive casino money
- Descendents are a subgroup
- Obvious targeting (sponsors of Fiesta)

ASSETS:

- Peer groups
- Some stigma is disappearing
- Extremely multilingual people

BARRIERS:

- No one to communicate with
- Cultural/linguistic competencies, yet translation problems
- Self-esteem issues in youth

Attachment 3

S.W.O.T. Analysis Details

The purpose of the SWOT is to collect information rather than define solutions. It is a tool to inform the strategic planning process. While the *strengths and weaknesses* components target internal areas over which the workgroup and Michigan Department of Community Health have some control (themselves), the *opportunities and threats* components target external areas where the workgroup and MDCH have less control (such as the political arena and educational system.) Workgroup members broke into small groups to share personal impressions, and then they shared with the large group.

What are the greatest strengths of the workgroup that will support the process to develop a strategic plan that addresses identified tobacco-related disparities?

- Respect for differences
- Fact-based message
- Passion for making things better in tobacco control
- Diverse experience of workgroup members
- Strong commitment of group

What are the weaknesses or barriers in the workgroup that might hinder the development of a strategic plan to identify and eliminate tobacco-related disparities?

- **Lack of community forums about how tobacco companies target marketing to groups**
- Inconsistent participation due to contractual obligations

What tobacco prevention and control successes have we had in our Michigan? What have we learned from those successes?

- **Community-based and national organizations**
- **Tobacco-free policy supporters at the national, state, and local levels**
- Agencies and internal organizations strongly supporting tobacco-free policies
- Existing community prevention and cessation services
- Existing youth groups/ youth leaders giving strong tobacco free messages
- Increase of 50 cents of tobacco tax
- DOCS- list of Tobacco-free magazines
- Junior high/High school students are claiming responsibility to spread tobacco-free messages
- Prevention Network Efforts

What failures have we experienced in tobacco prevention and control? What did we learn from those failures?

- **Prosecuting vendors for selling to minors is ineffective**
- **Health insurance should pay for tobacco cessation**
- **Not targeting the gay populations, women, women bearing children, & the diagnosed mentally ill**
- **More venues needed to create cessation**
- **Lack of cultural knowledge, understanding, and sensitivity throughout state; Need for more cultural competency, especially in the media and in educational programming**
- **Lack of culturally specific tobacco control programs**
- **The mindset of segregation often supercedes the value of integration**
- **Tobacco is still normalized within the culture and promoted by various segments of society (i.e. restaurants & movies)**
- **Smoke-free workplace ordinances-WIC, Head Start, Child Care Coord. Councils**
- **Take cessations programs to youth. Nicotine replacements are not marketed to youth**
- **Youth needs to be subject to tougher laws**
- **Vendors must be licensed to sell tobacco products**

What threats might exist in the State that would impact the identification and elimination of disparities?

- **Lack of Michigan specific data for disparately-affected populations.**
- **Impact of tobacco cartel \$\$\$ and how they are being funneled into disparate populations. Educate about other sources of funding.**
- **The detailed knowledge that the tobacco cartel has of our populations. We need to have knowledge about diverse cultures and solid cultural competence.**
- **Tobacco cartels ability to get their product placed in movies.**
- **Lack of a reliable vendor list for tobacco retailers.**
- **Pre-emptive clause that Michigan has for CIA in restaurants and tobacco retail licensing. We are not able to get regulation in our state to help with issues of youth access.**
- **Election upcoming in November and the scare tactics being used regarding the scholarship funds.**
- **Change in state administration and Legislature.**
- **Immediate response that the tobacco cartel has when we make strides in tobacco control.**
- **Tobacco tax-that in order to balance our state budget we have to have a certain number of people addicted.**
- **Internet sales.**

What threats might the workshop experience during the strategic planning process?

- **Huge geographic wealth of our state makes it difficult to collect information.**
- **Restrictions of the agenda- it doesn't allow the group to focus on what it feels needs to be addressed**
- \$\$\$
- Less money leads to more infighting
- If there is too narrow of a scope, some populations will not be represented right away.
- Lack of attendance by members
- Keeping the group focused and together
- Keeping a clear direction and clear focus at the meetings
- Possibly revisit the meeting schedule

What current opportunities might be available in the State that could aid the workgroup's efforts to identify and eliminate tobacco- related disparities?

- **Shift in emphasis to focus on tobacco as an addiction and not a habit. Change public perception through word choice of marketing.**
- November's outcome.
- Candidate forums and community meetings to address the disparity between what the governor says we spend on tobacco control vs. what we actually spend on tobacco control
- A strong strategic plan and implementation plan will lay the ground work for other stakeholders and potential funders
- Resources sharing among workgroup members
- Ourselves- Collaboration of our diverse group leading to discussions that were not previously happening.
- State- Substance Abuse Prevention is now housed under the Office of Drug Control Policy, so prevention is now together under one office.

* **Bolded items currently have higher priority in Michigan.**

Attachment 4

Potential Partners from Audience Assessment

Potential Tobacco Champions

- ❖ Paul DeWeese, M.D.
- ❖ Rep. Virg Bernero
- ❖ Rep. Michael Murphy
- ❖ Rep. Kilpatrick
- ❖ Rep. Alma Stallworth
- ❖ Guillermo Lopez
- ❖ The Mayor's Drug-Free Youth Task Force

Potential Partners

- ❖ Michigan State Medical Society (MSMS)
- ❖ Michigan Health & Hospital Association
- ❖ Local County Health Departments
- ❖ Tobacco Reduction Coalitions
- ❖ Ingham County Health Department and the Ingham County Commissioners (Smoke-free Workplace Regulation)
- ❖ Tobacco-Free Michigan (TFM)
- ❖ American Heart Association (AHA), Michigan Chapters
- ❖ American Lung Association (ALA), Michigan Chapters
- ❖ American Cancer Society (ACS), Michigan Chapters
- ❖ American Association of Retired Persons (AARP), Michigan Chapter
- ❖ Michigan Nurses Association
- ❖ Michigan Association of Firefighters
- ❖ Mothers Against Drunk Driving (MADD)
- ❖ Students Against Destructive Decisions (SADD)
- ❖ American Dental Association (ADA)
- ❖ Michigan Association of Substance Abuse of Coordinating Agencies (MASACA)
- ❖ Community Action Programs (CAP)
- ❖ Michigan Association of Labor & Professional Assistance
- ❖ Unions
- ❖ Michigan Education Association (MEA)
- ❖ Michigan Public School Districts
- ❖ Michigan Prevention Association (MPA)
- ❖ Churches
- ❖ Health Insurance Providers Association
- ❖ Michigan's Surgeon General
- ❖ Office of Minority Health, Detroit
- ❖ Office of Drug Control Policy
- ❖ Communities of Color (ex. Black Caucus Foundation)
- ❖ Michigan Association of Local Public Health (MALPH)

Partners Still “Out of the Loop”

- ❖ Physical Therapists
- ❖ Occupational Therapists
- ❖ Physicians
- ❖ Dentists
- ❖ Dental Hygienists
- ❖ Psychologists
- ❖ Social Workers
- ❖ Medical Schools
- ❖ Dental Schools
- ❖ All Health Institutions
- ❖ Rural areas
- ❖ Rural Health Centers

Attachment 5

Audience Assessment Tool by Organization

Goal #1: Identify and reduce gaps in prevalence and morbidity / mortality data for disparate population in Michigan

		Political	Money	Implement	Education	Media	WIFM
Organization	Michigan Department of Community Health, Tobacco Section	X	X	X	X	X	
Key Leaders	Surveillance and Evaluation Specialist for MDCH Tobacco Section						
Mission	To improve health through identification and elimination						
Audiences	Hospitals, physician offices & clinics, other state offices and local health departments	X	X	X	X		
Services	Database development, clearinghouse & dissemination of data						
Resources	CDC & Universities	X		X	X		
	Coordination of data gathering, act as						

Role in Project	a catalyst in getting organizations to collect data						
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Goal #2: Educate local policy makers and community leaders about the burden of tobacco-related disparities in Michigan

		Political	Money	Implement	Education	Media	WIFM
Organization	City Councils & County Commissioners	X	X	X	X	X	X
Key Leaders	Mayor, Council President, Health & Human Services Committee						
Mission	Govern the cities & counties Protect the health & well-being						
Audiences	Committee Members & Individual Members	X	X	X	X	X	X
Services	Regulatory / Policies, Influence State government						
Resources	Tobacco Reduction Coalitions, Multi-purpose collective bodies	X	X	X	X	X	X
Role in Project	Change community norms, identify and target services, allocate resources & conduct a needs assessment						

Goal #3: Increase quit attempts among African American, Latino / Hispanic American, Arab / Chaldean American and White WIC participants in Mid and Southeast Michigan.

		Political	Money	Implement	Education	Media	WIFM
Organization	Health Departments and Community Health Center	X	X	X	X	X	X
Key Leaders	WIC Coordinator & Community Health Educator						
Mission	Provide information, links to resources and health services						
Audiences	WIC Participants, WIC Coordinators & Health Educators	X		X	X	X	X
Services	Educate, refer, collaborate, provide treatment						
Resources	Existing structure, direct access & consistent access			X	X		X
Role in Project	Access to target population, collect data & treatment of clients						

Goal #4: Modify the social environment in Michigan to reduce initiation of tobacco use among youth, grades 6 – 12, especially Native American and White Youth

		Political	Money	Implement	Education	Media	WIFM
Organization	Michigan High School Athletic Association	X		X	X	X	X
Key Leaders	Executive Director, School Board & Coaches Association						
Mission	Promote positive relationships, promote healthy life choices, building teamwork						
Audiences	Coaches, Referees, Parents, Athletes, School Boards, Teachers / Educators	X	X	X	X	X	X
Services	Access to target audience, political influence						
Resources	Human resources, knowledge about the community, set standards	X		X	X	X	X
Role in Project	Change social norms, change attitudes among youth and coaches, raising standards						

Goal #5: Increase participation of disparate populations in tobacco control efforts

		Political	Money	Implement	Education	Media	WIFM
Organization	Michigan Department of Community Health, Tobacco Section	X	X	X	X	X	X
Key Leaders	Tobacco Reduction Coalition Chairs, Organization Representatives						
Mission	Identifying and Eliminating Disparities						
Audiences	Tobacco Reduction Coalitions, MRC, Prevention Network, CBO	X	X	X	X	X	X
Services	Leadership trainings, education, technical assistance						
Resources	Tobacco Reduction Coalitions, Tobacco Free Michigan, DYTUR's and Prevention Network	X	X	X	X	X	X
Role in Project	Leadership, delegate and mobilize disparate populations						

Goal #6: Promote secondhand smoke awareness within three (3) automobile assembly plants in Southeast Michigan

		Political	Money	Implement	Education	Media	WIFM
Organization	United Auto Worker's Union and Community Action Program	X	X	X	X	X	X
Key Leaders	EAP & Michigan Association of Labor & Professional Asst. Coalitions						
Mission	Provide direction for Health Services, educate and promote health, connect employees to services						
Audiences	Membership & Insurance Providers	X	X	X	X	X	X
Services	Access to membership, ability to influence the policies and environment						
Resources	EAP, Voting Block – can leverage money and resources	X	X	X	X	X	X
Role in Project	Advocate for policy, help collect data, role model, create a healthy environment						

