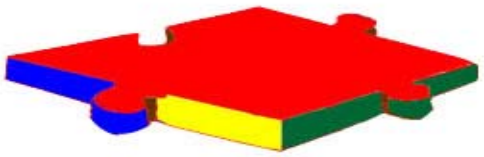
North Carolina Tobacco-related Health Disparities
Strategic Planning Case Study



North Carolina Tobacco Prevention and Control Branch
NC Department of Health and Human Services
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1. Overview of Disparities Project

1.1 Purpose and Goals of Project

North Carolina's history as a tobacco growing and manufacturing state presents unique challenges in addressing tobacco related health disparities. Rural white, African American and Native American farmers grow tobacco as a cash crop. Tobacco farmers employ many Hispanic migrant farm workers. The tobacco industry provides jobs and subsidizes cultural events to urban African American communities. This economic and cultural dependence makes change slow in North Carolina and disproportionately affects the poor, the rural and the disenfranchised. Nevertheless, the socio-economic face of North Carolina is now changing. The purpose of this project was to bring together individuals working in state government and in minority communities on tobacco prevention and control, jointly identify tobacco-related health disparities, set collective priorities for action, and develop a shared strategic plan to address those disparities.

1.2 Overview of Tobacco Control Efforts and Target Populations in North Carolina

North Carolina is a racially and ethically diverse population, with a large percentage of persons in poverty and living in rural areas. In addition, North Carolinians are more likely to smoke than their national counterparts (25.7% vs. 22.8%, 2001).[1] While African American (24.7%, 2000) and white (25.5%, 2000) populations in NC have similarly high rates of smoking, Native Americans (31.6%) are higher.[2] Middle school students ever smoking show an even more striking disparity by race: White (31.4%); African American (30.4%); American Indian (54.8%); Asian (18.8%); Multiple Race (43.0%).[3]

The NC Tobacco Prevention and Control Branch has the primary responsibility for coordinating tobacco control activities across the state. But it also has established strong, long-term ties with many other agencies interested in both

[1] BRFSS, 2001
[2] BRFSS combined data for 1999 and 2000
[3] NC Middle School Asthma Study, UNC School of Public Health, 1999-2000

tobacco prevention and minority health issues. From its inception, this project has aimed to include as many diverse community partners as possible, in order to obtain their perspective on tobacco use and be guided by their expertise. The other purpose is to get good information about what others are doing in the area of tobacco prevention and cessation and to make sure the resultant plan includes their vision for the future.

1.3 Implementation Team

The project was managed by Laurie Mettam-Rude. The Project Manager (PM) was assisted by an Implementation Team composed of Felicia Snipes Dixon (NC Tobacco Prevention and Control Branch), Leslie Brown (NC Office of Minority Health and Health Disparities), and Andrew Sachs (Dispute Settlement Center of Orange County). Clerical Support was provided by Deborah Givens of the NC Tobacco Prevention and Control Branch (NCTPCB). Evaluation was conducted by Kathy Blue (NCTPCNB), with the meeting evaluation processes evaluated by Sheri Scott (Scott Consulting) and Felicia Snipes Dixon (NCTPCB).

1.4 Roles/Responsibilities of Diversity Workgroup Members

The Diversity Workgroup was composed of the organizations and individuals on the attached membership list (Attachment 7.1). Organizations were represented by the individuals indicated on the list, unless the representative or the organization made permanent changes. In those cases where more than 1 member was from the same organization, there was one designated as the voting member for the organization.

People were added to the workgroup membership through a workgroup decision. It was decided the total number of the Diversity Workgroup would not exceed 30 members (including resource persons). New members were selected based on the following criteria. The potential member:

- Represents a group likely to be affected by tobacco-related disparities who are not currently at the table
- Understands and can articulate tobacco control needs of the constituency they represent

- Bring experience and resources to the group
- Does not represent a tobacco company's interest.
- Demonstrates willingness and commitment to group member roles and guidelines

Any workgroup member could designate a permanent or temporary substitute for him or herself for any reason. While in service as a substitute, that person was considered a workgroup member. The workgroup member was responsible for educating the substitute about the history, roles and responsibilities, and current status of the strategic planning process.

2. Evaluating Strategic Planning Processes

2.1 Purpose and Goals of Evaluation

The goals of this evaluation were to determine:

- Were the activities of the grant conducted and the products produced as required?
- How well did the meetings proceed?
- How well did the workgroup process work?
- What were the barriers to implementation and planning?
- What was learned that should be passed on to others considering this type of planning process.

2.2 Evaluation Design and Methods

The evaluation was made up of 3 processes. The first was an evaluation of the individual meetings through participant observation methods. At each meeting (except one, when Kathy Blue substituted) Sheri Scott and Felicia Snipes Dixon gathered data on the participants, the agenda and other variables around how the meeting was conducted. (See Attachment 7.6.1.) They used a standardized form based on the CDC criteria for strategic planning meetings. After each meeting, the observers would compare ratings, discuss differences and then come to consensus on how each item should be scored. They also held a "debriefing"

session with the facilitator and the Project Manager to share the results of the observation and to collect qualitative data on their perspective of what worked and what did not work during the meeting. This discussion provided an important opportunity for critical reflection by project staff to identify issues to improve the planning process.

The second process was composed of two key informant interviews. One was conducted at the conclusion of the workgroup formation period and was aimed at finding out how well people felt the Diversity Workgroup was organized, how representative it was, and how they felt it should be altered to make the process run more efficiently and effectively. This instrument can be found as Attachment 7.6.2. The second set of key informant interviews (Attachment 7.6.3) was conducted after the SWOT analysis and the Data Analysis were completed. This survey centered on the data collection processes used in the Population Assessment and the SWOT Analysis, as well as the way the synthesis processes were conducted.

The last process was a focus group of the Implementation Team and the most "faithful" of the Diversity Workgroup members – those who showed up regularly and contributed. This focus group's discussion was centered around the grant as a whole. The group discussed the barriers and advantages of the way the grant was implemented. Notes from this focus group are included as Attachment 7.6.4.

3. Strategic Planning Processes and Milestones

3.1 Forming the Strategic Planning Workgroup

The Diversity Workgroup was formed from a list that was gathered at the initial planning meeting of the Vision 2010 Taskforce, a statewide group interested in public health issues. The initial members of the Diversity Workgroup were those who had signed up as having an interest in diversity issues. The first strategic planning meeting was held in December, 2001. The purpose of the first meeting was to review the mission of the Diversity Workgroup and give an overview of the CDC grant project on Strategic Planning to Identify and Eliminate Tobacco- Related Disparities. Meeting agendas and minutes are

included in Attachment 7.2. In the second meeting, populations who were not "at the table" were identified, and additional members recruited.

The Workgroup was made up of people who represented community organizations, state programs, universities and staff members of the TPCB. A few Workgroup members were most actively involved engaged via the internet. Though they were unable to attend many meetings they offered their expertise by revising drafts, collecting community feedback and attending the smaller team meetings. Despite best intentions, Workgroup members whose agencies supported their attendance tended to be regular Workgroup meeting attendees. Workgroup members without such support, such as community-based volunteers, did not remain engaged. This tended to overload the Workgroup with State employees, contractors of the TPCB, and non-profits with a mission in tobacco or minority health. A more diverse representation would be preferable. Throughout the planning process, members were recruited, but it was constant struggle to attract and maintain community leaders.

In addition, North Carolina is a large rural state. It was difficult to engage people from outside the central area of the state because of the long drive times needed. Curiously, the money allocated by TCPB for travel was rarely used by public participants in the workgroup (state and local agency people were not allowed to use these funds). Some way beyond the allocation of travel funds needs to be found to involve people from all over the state, such as regional meetings or "road trips."

The Implementation Team decided that one approach might be to pay stipends to non-profit, community-based organizations for their time and expertise. This approach has a two-fold purpose:

1. Many of the small, community-based organizations struggle financially and have many requests by public agencies to represent their community.
2. This show of support may be one effective method for "Saying No to Industry Dollars" which is an issue in North Carolina.

3.2 Identifying/Prioritizing Tobacco-related Disparities and Assessing Capacity

The workgroup spent three meetings analyzing existing quantitative data, population characteristics and environmental conditions. Specifically, the Project Manager formed an Evaluation Team to prepare the existing secondary data on tobacco-related disparities in North Carolina. The Evaluation Team presented that data to the Diversity Workgroup during two data forums. Diversity Workgroup members became involved in the qualitative data collection during the Population Assessment. They used a key informant interview approach to gather information from their community members on tobacco use. Another subcommittee within the Diversity Workgroup presented information on resources available to address tobacco use in North Carolina and presented that to the members. Then the entire Workgroup participated in a SWOT analysis exercise in a single meeting. The critical issues from these activities are included as Attachment 7.4.

The information from these three data collection and analyses pointed out the lack of quantitative data for small populations in the state. While some large-scale surveys are conducted, they usually key on race rather than the other self-selecting categories, such as “blue-collar” or “lesbian” for which there are few sources of valid data.

The Project Manager compiled all the data into a data book, and has subsequently contracted to develop a website of the data. This website can be found temporarily at home.bellsouth.net/p/PWP-DiversityWorkgroup. The website will later be integrated by TCPB into its web-site.

3.3 Developing the Strategic Plan

The workgroup discussed the critical issues and prioritized them in a group process. The group employed the CDC tool, Criteria for Analyzing and Prioritizing Critical Issues, which worked well.

The facilitator played a pivotal role in the successful completion of this aspect of developing the Strategic Plan. The facilitator ensured the group process

"Guidelines" were followed. This meant everyone's voice was heard and their input duly considered. The Workgroup did not experience any rancor or conflict because of the skillful way the Facilitator managed the group and the way the Program Manager designed the flow of the meetings.

The Data forums generated thirty Critical Issues that were grouped into 6 Themes. Those themes were converted into 6 goals.

The Diversity Workgroup developed and refined the strategies during 3 meetings. The members were actively involved in this aspect of developing the Strategic Plan. Despite the tedious review, the Facilitator and the Project Manager believed this was critical for the members to claim ownership of the outcome.

3.4 Adopting and Refining the Plan

Meetings ten and eleven were centered around honing the wording, making certain that the strategies were science-based and testing the feasibility of the strategies. These meetings usually began swiftly, but bogged down on details such as deadlines, milestones, assignments for each of the strategies. The problem was that no new funding was available to motivate the partners at the table to commit to the new strategies. The partners found it unrealistic to conduct such detailed action planning in the absence of resources and mandates. The workgroup tried to resolve this problem by suggesting that action planning be delegated to the TPCB, but found too strong a commitment to consensus and community involvement among Branch staff.

After spinning our wheels around these issues, meeting twelve was a watershed. The Diversity Workgroup showed their involvement and sense of ownership of the Strategic Planning process by revising the meeting agenda. Instead of creating a timeline and feasibility analysis of the goals and strategies as originally planned, they focused on internal marketing. The workgroup decided to formally endorse the plan, and identify which pieces their agency would commit to work on.

This could have been seen as a revolt from their delineated roles, but instead the Project Team viewed it as a positive step. By agreeing to take on these issues, it is more likely that the agencies will come to own this plan and see that eliminating disparities is a joint responsibility.

3.5 Preparing for Action

At meeting 12, the Workgroup discussed the need for a Preamble that would explain the context of the plan, serving as an executive summary. Two of the partners - representing the American Cancer Society and El Pueblo, a Hispanic organization – volunteered to craft this piece.

The external marketing plan also began this meeting, describing who the potential customers were and discussing how various products could be created to fit various customers.

The plan was written by Laurie Mettam-Rude, Project Manager, and reviewed by various members of the implementation and evaluation teams. The plan was transmitted electronically to the whole workgroup for review, suggested revisions and their approval that the Diversity Workgroup's decisions were correctly detailed in the written plan.

One of the final preludes to implementation was the decision by the workgroup on how they planned to function in the future. The Diversity Workgroup decided that they would take on a new name that better described the function the group decided they would take. The name selected was: *NC Steering Committee for Parity and Diversity in Tobacco Use Prevention and Control*. The Steering Committee agreed they would act as an advisory board - advising the lead agency and partner agencies as they take on the agreed-upon functions from the plan. The Steering Committee will advocate to community groups and other representative agencies to increase awareness and involvement in tobacco-related activities. The committee felt that many of the groups who could be engaged in these activities are not, because they either see themselves as speaking for a specific population or specific issue, rather than connecting the issue of tobacco-related health problems with their advocacy group. Finally, the Steering

Committee will serve as a forum for the partners to apprise the partner agencies on tobacco-prevention activities, especially those concerning disparate communities.

The group felt strongly that the plan they had developed would be more likely to be implemented if they continued to function in a role of Steering Committee, to encourage each other, to share successes and information, and to push their respective programs forward. The partners in this grant could have seen their role as completed when the Strategic Plan was developed, but instead, they decided to maintain their commitment to eliminating tobacco-related health disparities in North Carolina.

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

The Diversity Workgroup adhered to the standards of participatory planning, engaging members of the community, partner agencies, the Office of Minority Health and Health Disparities, and the Tobacco Prevention and Control Branch. An excellent, outside facilitator assisted in the smooth functioning of the workgroup.

4 Major Assets for Strategic Planning

The Workgroup was fortunate to have a good foundation upon which to build. The TPCB had already employed Ms. Mettam-Rude, Director of Diversity, an experienced facilitator and strategic planner. In addition, a statewide comprehensive planning process (*Vision 2010: A Comprehensive Plan*) to prevent and reduce the health problems associated with tobacco use had just been completed. Diverse community leaders, public health professionals in tobacco prevention expressed an interest in tobacco-related disparities were contacted to form the initial Diversity Workgroup. Because they had already self-identified as being interested, it made getting them to the table easier and gave them a reason to participate in the strategic planning process.

The project manager formed an Evaluation Team comprised of tobacco control experts in surveillance, evaluation, qualitative research, and GIS mapping technology. The Evaluation Team spent four months analyzing all available state and local data on prevalence, demographics, morbidity, mortality, economic impacts of tobacco use related to disparities. The resulting Data Book on Tobacco-Related Disparities represented the most comprehensive quantitative data review on the subject to date.

A critical asset for this initial phase of reviewing data was the responsive and collaborative staff at the North Carolina Center for Health Statistics (NCCHS). The staff were extremely helpful in analyzing data from several key data sets, particularly the BRFSS and mortality data.

The Evaluation Team's goal was for the information to be easily understood and to generate meaningful dialogue. The data forums were well attended. Most people reported enjoying the visual and interactive approach. The highlights of the five-hour Data Forum was the group exercises on sampling and seeing the data patterns in the GIS maps and the open, informal dialogue on the issues. The result was the inclusion of the rural, eastern region of North Carolina as a priority area. This "stroke belt" area showed these striking patterns:

- highest smoking prevalence rates geographically;
- high percent of rural poor and people with low educational attainment;
- highest percentage of NC American Indians;
- highest percentage of African Americans;
- area where tobacco is grown; and
- area where most Mexican migrant farm-workers are employed in NC.

Both qualitative and quantitative data forums garnered a great deal of discussion. Afterwards the group reported feeling more cohesive; they had created a sense of a shared agenda.

The CDC Process was well-planned and the tools useful. Many of the tools were adopted with little change, but sometimes the group decided the tool was not working well, and decided to go about the task differently. The workgroup

chose to utilize the goals and strategies as a tool to market the strategic plan internally to their own organizations.

5 Challenges to Strategic Planning

5.1 Challenges to Successful Planning

One of the most difficult problems to manage in this planning process was getting the right representation of people involved. There was considerable distrust initially that all voices were being heard. While representation from the African American and Hispanic populations were at each meeting, Asians and Native American representatives attended less often. In addition, disparities of socio-economics and lifestyle were also not well represented by an organization that advocates for them. Geographic distance also played a big part in the involvement of people on the Workgroup. Many from the far, Western regions of the state were challenged to make the 5-hour trip to a central location. Therefore, the Workgroup was over-represented from the center of the state.

Another large issue in getting the right people to the table was that the Workgroup, despite good intentions, was over-populated by university, state agencies, and TPCB staff. Even though they had no vote, they took part in the process that often weighted the balance of the discussion of state agency perspective and less community voice. A major lesson learned is to only allow a certain number of participants from each agency and to balance the state and community voice with more representation from the community.

The original plan of the process called for the Strategic Plan to be completed within nine months. This did not happen. It took a full year to be able to put the plan together, and many more than the nine planned meetings. The Project Team learned that creating a plan that is acceptable to a large group, requires a great deal of negotiation to get all the issues included that need to be, as well as to assure the wording is adopted by all. Because of the complexity of this assignment, it required long hours of discussion in the workgroup, often scrapping what had been previously agreed upon to take up a fresh attempt. In the end, it might have been easier if the group had been smaller or had been less

engaged, but the partners might not have implemented the product. Another idea put forth by the group was that the process may need to be shorter, or conducted differently to truly involve disenfranchised groups without staff or resources to attend meetings.

The lack of routinely collected data on disparate populations was also a barrier in this planning process. There was a great deal of data on the white population and a group of the remainder, identified as "nonwhite," but getting reliable data on Asians or subgroups within the Hispanic community was more problematic. Even though the BRFSS data can be conducted in Spanish, the number of Spanish language interviews had not yield enough information for use in this project. Other populations may require special surveys, for example, finding the tobacco-use prevalence among the gay, lesbian and transgender communities. Templates for special studies among disparate populations would be welcome in the surveillance arsenal.

Lastly, a large obstacle in developing the Strategic Plan was the overall feeling that it could not be implemented without an infusion of funds. With the economy in a slump, the members of the workgroup had to temper their desires to think "big picture" with the reality of the state's dire fiscal condition. The Diversity Workgroup believed this is a key component and included dedicated future funding as one of the six goal areas. Many discussions were held during meetings suggesting future CDC funds dedicating money specifically for implementing the strategic plan within the states and territories.

5.2 Assets Management

While there was sufficient funding in the grant to support the planning process, it depended largely on the support of various state, advocacy agencies and universities to pay for the person's time to attend. The few actual volunteers that were associated with this project were unable to attend regularly, perhaps because of the length of time the planning process took. A more representative group might have produced an entirely different document, but would have required more funding to pay for travel and subsistence. The committee

members who attended regularly were exclusively from within a 4-county area: Wake, Orange, Durham and Johnston.

This grant builds on existing resources, but additional assets in this area will needed to actually implement the entire Strategic Plan. The partners in the plan will carry on certain of the agreed-upon priorities, but expanding surveillance systems and programs will not be easy with the current budget crisis in State Government and level funding from CDC. At best, until the economy improves, existing programs and data systems will have to adjust resources to reallocate money into the identified diversity priorities. So, while the plan exists as a good roadmap for where the Workgroup agreed Tobacco Prevention and Control should go, more funding will be needed to actually implement all of the parts of the plan.

6 Conclusions

6.1 Major Planning Accomplishments

The workgroup developed a number of products that may be used in the adoption of the plan and development of future programs.

- North Carolina Tobacco-related Health Disparities Data Manual
- North Carolina Tobacco-related Health Disparities Website (temporarily at home.bellsouth.net/p/PWP-DiversityWorkgroup)
- North Carolina's Strategic Plan to Identify and Eliminate Tobacco-related Disparities
- Diversity Workgroup Strategic Planning Manual for all members

In addition to the written products, a power point presentation on the planning process, and the data gleaned from the process, was created for use in marketing the plan.

6.2 Lessons Learned Throughout the Planning Process

The final focus group revealed some interesting lessons for using a workgroup process to develop a strategic plan. Some of the lessons revealed strengths and some weaknesses of the process. While others revealed things the

workgroup should have done differently, and some were things that no one anticipated.

- The first issue was one of direction. The CDC-guided process called for the grantees to develop a strategic plan to address tobacco-related disparities. Disparate populations could have been involved to provide input and help develop the plan, as NC eventually did, or grantees could have used the process to develop relationships with agencies and organizations that serve and represent disparate populations. This process would have yielded a different plan, and would have required a time period long enough to develop relationships and increase readiness of community organizations. It is difficult to say if one-year would have been sufficient. During the focus group discussion, the workgroup agreed that it may have been a stronger process to spend a shorter time on developing a plan, then go out and spend more time with underserved and at-risk populations to strengthen relationships with the various partner organizations.
- An issue that runs hand-in-hand with the direction is the way the process itself was managed. The focus group felt the project manager, did a good job of keeping them on task, organized, and well-informed. The workgroup had an excellent facilitator. The focus group said that this was crucial. The facilitator needs to have a free and unimpeded process to build trust among workgroup members. With a good set of ground-rules and a facilitator with a strong understanding of the overall process (plus a good sense of humor), the group never encountered any issue that it could not discuss, clarify and resolve.
- This process was long and arduous for many of the workgroup members, but also valuable to them. They felt that the group was able to build consensus well. However, when the process runs as long as a year, the core members at the beginning are often not the same as the ones that are retained to the end.
- The project manager allowed the group to make decisions while sharing pertinent information on "Best Practices" and guided the process rather than managed it. Over the months the workgroup built trust and grew more

empowered to choose the group's future role. They chose a new name to reflect their new role, The NC Steering Committee for Parity and Diversity in Tobacco Use Prevention and Control.

- The tools the CDC and evaluation staff provided for the workgroup were very useful, but the group had no compunction about discarding some tools they felt were not giving them what they needed. Flexibility in the process was key. This decision to start over as needed drew the process out longer, but also gave the group permission to work and rework parts they felt needed more attention.
- The workgroup make-up was a continual problem. The right people need to be at the table to create a really successful strategic plan, but getting long-term commitments from busy people is difficult. In addition, getting community representation for disparate populations was difficult. North Carolina is a large state and the representatives were exclusively from the central region – more geographic diversity is needed. Lastly, there was an over-representation from government employees. These issues do not invalidate the process, but it would be a stronger plan if it reflected more input from the diversity community.
- Political realities affect the way the plan is developed and implemented. With no funding tied to the plan, each organization that adopts the plan and agrees to carry out the plan may need to shift priorities in order to use their own funds to ameliorate the problems. The complex realities of funding and sustainability affect how community agencies and leaders receive the plan. An independent non-profit group might be the most effective lead agency for this type of strategic plan to be implemented, rather than a state agency, since government agencies usually cannot lobby. This can also empower the communities experiencing tobacco-related disparities, putting money into the coffers of a community agency rather than a state agency. The Strategic Plan need not be implemented by the same agency that develops it. The states' tobacco programs have the necessary experience in planning and program development to pull together a workgroup to develop a plan, but without

continuous funding, the plan might be better implemented by an agency that has the freedom to lobby for political action and funding to completely implement the plan.

Recommendations to Enhance Future Strategic Planning

The use of a collaborative working group is key to creating a Strategic Plan. A top-down plan developed by a state agency is less likely to be positively received than one that is developed by the potential partners in reducing tobacco-related disparities. In order to obtain continued support from the diverse community organizations, this plan must be a genuine collaborative plan for community and state organizations to own and implement.

In order to shorten meeting time for the community members of the Diversity Workgroup a restructuring of the planning process would be recommended. In the initial phase of identifying disparities would be handled best by an Evaluation Team. These public health experts in statistics, surveillance and epidemiology can work with the state health department to gather and analyze all available state and local data on tobacco-related disparities. As mentioned earlier it is strongly recommended to also include someone with expertise in presenting such dense information in a visually interesting and interactive way.

After the quantitative data has been gathered and is being prepared for presentation, the Diversity Workgroup can be formed and have them develop group process guidelines. Then, the workgroup members can be asked gather the qualitative data during the population assessment. More time should be given for this critical piece. The NC Diversity Workgroup benefited from this in 3 ways:

- qualitative data is rich in depth and detail;
- offers insights into the community that can't be found in quantitative data;
- allows the workgroup members an opportunity to be more involved.

Money needs to be tied to this grant for stipends to keep community members engaged. The biggest failing of NC's workgroup was their inability to retain members of the actual communities the plan was developed to work with.

A longer time frame would help the process by allowing the plan to be developed and then marketed to the communities at risk. The workgroup felt strongly that taking the plan out to the disparate populations to discuss and contribute to would be the best way to proceed, if there were time and money for those activities.

Finally, the workgroup felt that this process was very useful in producing *North Carolina's Strategic Plan to Identify and Eliminate Tobacco-related Disparities*. The workgroup's constituent agencies agreed to work on the goals and strategies identified in the plan and report back. In addition, the process resulted in the formation of a new group to act in overseeing the implementation of the Plan. This group, the NC Steering Committee for Parity and Diversity in Tobacco Use Prevention and Control, begins 2003 with a new purpose and a new plan.

Attachment 7.1
North Carolina Diversity Workgroup Membership

APPENDIX A WORKGROUP MEMBERS

NC Tobacco Prevention and Control Branch

The Diversity Workgroup

WORKGROUP MEMBERS

MAINOR ARAYA
El Pueblo
ANDREA BAZAN-MANSON
El Pueblo
NADEEN BIR
El Pueblo
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NC Commission of Indian Affairs
CHUCK BRIDGER
American Cancer Society
LESLIE BROWN
NC Office of Minority Health
STANLEY DAVIS
NC Office of Rural Health Dev.
DEBORAH GIVENS
NC Tobacco Prevention Control Branch
KATHY HARRELSON
NC Council for Women
LORNA HARRIS
HBCU Health Alliance
BETSY LEVITAS
Cancer Information Service
LYNN LOWRY-CHAVIS
NC Amer. Indian NOT Program
TIM MCGLOIN
UNC Health Promotion Disease Prevention
LAURIE METTAM-RUDE
NC Tobacco Prevention Control Branch
THEA MONET
Old North State Medical Society
KAREN H. MORANT
African-American Action Team
MILAN PHAM
NC Asian American & Pacific Islander Association
HARRIETT PURVES
El Pueblo
ANDY SACHS
Dispute Settlement Center
SHERI SCOTT
Evaluation Consulting
LAWRENCE SHORTY
Native American Consultant
FELICIA SNIPES DIXON
NC Tobacco Prevention Control Branch

RESOURCE PERSONS

KATHY BLUE
NC Tobacco Prevention Control Branch
PAUL BUESCHER
NC State Center for Health Statistics
ANNIE BUTZEN
UNC EnTER Program
FRED CHARLES
MediaSmartz
TRACI CLARK
Project ASSIST, Western Coalition
MICHAEL CUMMINGS
NC Native American Interfaith Ministries
AMY DIXON
Blue Ridge Healthcare System
LISA FASTNAUGHT
UNC-School of Public Health
LARRY GOURDINE
NC Tobacco Prevention Control Branch
SANDRA HEADEN
African American Action Team
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LISA HUGGINS-OXENDINE
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NC Tobacco Prevention Control Branch
KAREN KNIGHT
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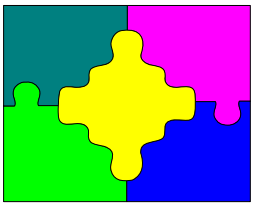
JENNY LEE
Fayetteville State University
SALLY HERNDON MALEK
NC Tobacco Prevention Control Branch
JIM MARTIN
NC Tobacco Prevention Control Branch
KURT RIBISL
UNC-School of Public Health
JERONO ROTICH
UNCG-HEALTH ACCESS
MARK SILLS
Faith Action International House
KALILA SPAIN
NC Prevention Partners
LYNICE WILLIAMS
NC Fair Share

Attachment 7.2

MILESTONES AND TASKS	TASK OWNER	MEETING TARGETED FOR TASK
Overview		
Overview of Strategic Planning Process	Project manager	1
Review CDC Mission and Values for project	Project manager	1
Clarify disparities vs. diversity	Project manager	1
Outline roles and responsibilities	Facilitator	2
Brainstorm "who's not here"	Workgroup	1
Assessment of Group Process - Key Informant Interviews	Evaluation Team	Between meetings 2-3
Quantitative Data Analysis		
Compile and analyze all available quantitative data	Evaluation Team	3
Data presentation	Evaluation Team	3
Brainstorm critical issues evident from available data	Workgroup	4
Prioritize 10 most critical issues from available Data	Workgroup	4
Wordsmith critical issues into consistent format	Implementation Team	Between meetings 3-4
Adopt critical issues	Workgroup	5
Progress Report	Project Manager	Between meetings 5-6
Quantitative Data presented on TPCB website to Diversity Workgroup	Implementation Team	Between meetings 6-7
Population Assessment		
Identify process for conducting population assessment	Implementation Team	Between meetings 4-5
Identify population groups for assessment	Implementation Team	Between meetings 4-5
Present population assessments	Workgroup	5
Brainstorm critical issues evident from population assessment	Workgroup	5
Prioritize 10 most critical issues	Workgroup	6
Wordsmith critical issues into consistent format	Implementation Team	Between Meetings 5-6
Adopt critical issues	Workgroup	7
Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis		
Identify process for conducing SWOT analysis	Implementation Team	Between Meetings 5-6
Brainstorm critical SWOT factors	Workgroup	6
Prioritize 10 most critical issues	Workgroup	6
Wordsmith critical issues into consistent format	Facilitators	Between Meetings 6-7
Adopt critical issues	Workgroup	7
Evaluate Group Process	Evaluation Team	7

ESTABLISH SIX GOALS TO INCLUDE IN STRATGIC PLAN		
Identify process for prioritizing from possible 30 critical issues identified	Implementation Team	Between Meetings 6-7
▪ Discuss criteria of what makes a critical issue	Workgroup	7
▪ Discuss process of eliminating other important issues	Workgroup	7
Identify six most critical issues	Workgroup	7
Establish six goals to match critical issues identified	Facilitator	7
Adopt six goals	Workgroup	7
ESTABLISH THREE to Five STRATEGIES FOR EACH IDENTIFIED GOAL		
Overview of the definition of strategies for this plan	Facilitator	8
Brainstorm strategies for each strategic goal	Workgroup	8
Identify process for prioritizing strategies	Facilitator	8
Prioritize three strategies for each goal	Workgroup	8
Wordsmith strategies for clarity and consistency	Implementation Team	Between meetings 8-9
Adopt strategies for each goal	Workgroup	8
OPERATIONALIZING THE PLAN		
Identify attainable deadlines to accomplish each goal	Workgroup & TPCB	9
Identify key parties to promote the plan	Workgroup	9
Brainstorm “marketing” approach to key parties for each goal	Workgroup & TPCB	9
Identify marketing strategy for each goal	Workgroup & TPCB	9
Identify responsibilities and timelines for each marketing strategy	Workgroup & TPCB	9
Identify attainable follow-up strategies	Workgroup & TPCB	9
Diversity Workgroup's Future Role delineated and accepted	Workgroup & TPCB	10
Develop Logic Model	Project Manager and Evaluation Team	11
Develop Action Plan	Project Manager and Evaluation Team	11
Strategic Plan written and accepted by Diversity Workgroup & NC TPCB	Project Manager	11
Case Study - written & presented	Evaluation Team & Implementation Team	11
Final Report sent to CDC	Evaluation Team & Implementation Team	11
Grant Complete! - Celebration	ALL	11

Attachment 7.3 Meeting Agendas and Minutes



Strategic Planning
Tobacco-Related Health Disparities

Meeting 1

Wednesday, December 12, 2001

American Cancer Society
11 S. Boylan Ave.
Raleigh, NC

Purpose:

- To initiate the strategic planning process
- To review the CDC grant on "Identification and Elimination of Disparities"
- To plan ways to expand the existing Diversity Workgroup
- To clarify roles for current and future Diversity Workgroup members

Agenda:

10 a.m.	Introduction (Laurie)
10:15	Opening Remarks (Sally)
10:30	Review of Diversity Workgroup's Progress: Priority Action Areas, Vision & Goals (Laurie)
10:45	Overview of CDC grant & goal of strategic planning process (Laurie)
11:15	Review Grant timeline and decide on Future meetings: dates, frequency, purpose & Possible outside meeting activities (Leslie)
11:45	Roles of current members and levels of involvement (Leslie)
12:15	Wrap Up: review agreements, clarify questions (Leslie)
12:30	Lunch
1:00	Adjourn

Diversity Workgroup
Meeting Minutes For 12/12/01

ATTENDING: Laurie, Felicia, Leslie Brown, Sally, Kurt Ribisl, Chuck Bridger, Lisa Fastnaught, Missy Brayboy, Betsy Levitas, Sheri Scott, Barbara Pullen-Smith, Tony Holmes, Sylvia Mentis, Lawrence Shorty, Sandra Headen, Jennifer Castillo, Kathy Harrelson

INTRODUCTION:
- Meeting Purpose
- Share: Name, Organization's Goal, Personal Goal

GOALS:
- Kurt: (UNC-CH) research & evaluate work with TPCB
- Lisa: (UNC-CH) visualization of this through maps showing the disparities.
- Jennifer: (El Pueblo) strengthen Latino community, help empower youth & teach them about smoking.
- Office of Minority Health (OMHHD): upgrade health status of minorities by any means necessary
- Leslie: (OMHHD) to enhance strategic planning goals
- Barbara Pullen-Smith: (OMHHD) Personal Goal work with DHHS to build capacity to address health disparities & unity gaps
- Missy: NC Commission of Indian Affairs provides link to all Tribes & organizations. Role to help build health prevention programs in communities and youth.
- Sheri: Evaluation consultant. Indian & Gay/Lesbian communities have high level of smoking rates.
- Tony Holmes: Council of Adolescents – educate youth – catch them before they start. Personal Goal to mentor the youth. Catawba county area.
- Sylvia Mentis: Council of Adolescents – Special Program – educate and prevent, mentor and educate on hazards.
- Betsy Levitas: Partnership Programs for CIS – medically under-served & minority populations to lower disparities. Empower with cancer prevention and treatment options. TA to groups to increase cancer info to special populations.
- Sandee: Consultation w/ TPCB. African American prevention network
- Laurie: (TPCB) Workgroup expanded to reflect NC Diversity. Strategic plan that is a product of the Diversity Workgroup and that they feel is their own. This plan is implemented and creates positive change.
- Kurt: Info clearinghouse – Research what is already out there. ROF how – will also be pulling info on this. TEC (Tobacco Education Clearinghouse) all materials from there for a reduced rate or for free. Peer review process.
- Sally-TPCB: Prevent initiation among youth; eliminate exposure to ETS; promote quitting in youth & adults; identify & eliminate disparities among population.

Leslie Brown- "Balancing" key word to remember during this process

DISCUSSIONS:

- Does CDC say anything about making money available for implementation process?
- Use the strategic plan to position ourselves for additional funding (MSA, Legacy, CDC)
- This grant limited to analyzing existing data.
- Next round of small grants for qualitative data collection?
- Priority of eliminating health disparities.
- We can have an impact on how CDC addresses disparities. Create excitement for CDC to find funds to support the plan.
- Would like to know how much of current budget goes towards health disparities and how much we can steer their way. (Next meeting talk about all funding sources.)
- Legacy – TPCB losing funding after 2003. Not funding groups past then.
- Substantial Native American & Alaskan Natives tribes now have opportunity to take advantage of census data to focus the funding.
- NC Council for Women – revamp mission, assess needs of women in NC, research based info. Advise for Leadership Connections Program, AAAT, educating young women and getting them involved.
- AAAT – longtime group and leaders for much of what we are doing in Tobacco prevention.
- Look at existing resources and how it's spent. Look at new resources.
- Send out a copy of the budget for the Vision Document/Health Trust
- Need to expose the disparity of where health trust money is going.
- Concern that CDC narrowed the focus to tobacco. Wish they had done this process for all health disparities.
- How to plan well?
- Collect data
- Be inclusive
- Share to broader populations & get their input

ACTION ITEMS:

- Determine what resources are out there
- Determine what national organization is developing an information clearinghouse
- Book to order – Health Issues In the Black Community, by Ronald Braithwaite & Sandra E. Taylor (Sandra Headen suggestion)
- Look at prevalence, policies and then look at resources.
- Timeline – we need to fit into timeline the community based info more qualitative items
- OMH- Eliminating Health Disparities Steering committee. Collecting baseline data about NC NOW. Survey underway right now. January – bring external folks into process & to identify disparities. There will be a State Plan.
- Start small with this Diversity Workgroup and get a good handle on data. Look also at celebrating the successes we see in the data.

FORUMS:

- Understand & digest existing data
- Identify gaps in data
- Draw meaning from data
- Choose data points & develop stories that have a face.
- February 5th – conference or training – back & forth dialogue. Talk about background experiences. How broad (or open) will the forum be?
- Allow public to know what we found. Don't just throw info at them that they already know.
- Forum – present data and understand what the data means.
- Forum – rich data, thoughtful about who to be at the forum.
- Forum – ask to collect stories about what the data means, to help explain the data in a deeper way.
- Community data needed.
- Look at county and city data
- 1st Forum, TPCB will be sharing the data
- What the data means. What does it have to do with your community?
- We should understand the data 1st as a workgroup and then have a more public forum a few months later.
- Collect data at the communities level
- Data with a person's picture of stories. Must have both. 2 internal forum's. 3rd forum, bring in more folks and show the larger picture prior to end of conference for broader audience.
- ***Meeting after Jan 1st to look at data.***
- Invite to 1st Forum:
  - A few reps of Local Assist Coalitions
  - Representative of *Question Y* youth centers; Lambda Youth Network; and Lesbian Health. Research Center
  - Dr. Don Ensley
  - Dr. Anita Jackson
  - Carole Bruce-Health Trust
  - Rosemary Summers – LHD
  - Rep from Shaw Divinity School
  - Greg Richardson
  - Rev. Michael Cummings
- Invite to 2nd Forum:
  - County Commissioners Ellen Reckhowt and M.A. Black - Durham

STRATEGIC PLANNING:

Leslie: Strategic planning should include old & new resources. Redirecting old resources if necessary.

- develop sub-committees
- develop new opportunities
- look at quantitative data
- Timeline needs to include qualitative data. Where do we get it from?

- A lot of people don't like giving out information about themselves. This means checking sources of data.
- Balance qualitative & quantitative data.

TEAMS:

Evaluation Team: Purpose – gather current data, analyze, plan & present data at data forum
Sheri Scott
Emmanuel Ngui
Karen Knight
Paul Buescher
Tim McGloin
Lawrence Shorty
Betsy Levitas
Lisa Fastnaught
Missy Brayboy

Policy, Media & Program Resources Team: Purpose – gather information on types of Resources available (human, fiscal, community).

Sylvia Mentis
Tony Holmes
Missy Brayboy
Lawrence Shorty
April Reese (NC Council for Women per Kathy)
Jim Martin
Ann Houston
Sally Malek
Kathy Harrelson

Implementation Team: Purpose – Plan & coordinate overall strategic planning project
Laurie, Leslie, Felicia

DIVERSITY WORKGROUP:
Policy, Media & Program Resources Team

Meeting Minutes for 2/27/02

Attending: Missy Brayboy, Sylvia Mentis, Kathy Harrelson, Tony Holmes, Melanie Chernoff, Ann Houston, Jim Martin, Sally Malek

Introduction:
Meeting Purpose
Sharing the positive

Discussions:
- Media – advocacy tool for enforcing policy. Challenge: educate before you legislate.
- Social Marketing – media to change behavior – effective with money
- Media Literacy – training people to evaluate media and be more "savvy" consumers
- Advertising Policy – different groups are handled differently – Disparities

ex: target marketing to African American Community

- Policy – change the larger social environmental norms (needs to be enforced. *ex:ETS*)
- Public Policy and Private Policy *Ex: Seatbelts.*
- School policy – may force existing smoke-free schools to find money to enforce. 100% tobacco free schools good for all. Sets good examples for youth.

NOTE: When looking at schools look at elementary, middle, high schools. Alternative schools. Young adult college age.

- Different types of "policy". Informal and Formal groups

IDEA: Amend current policy or enforce current policy.

- Program – use policy and media advocacy to drive up the demand for program services
  -First, educate and legislate
  -program services, culturally appropriate and accessible.
  ex: smoking cessation services as a basic benefit to workers
  -happens when employer groups ask for them
  ex: early education programs for youth can apply across the board.
  ex: Leadership Connections (Kathy Harrelson) – young women talk peer-to-peer on health impacts of tobacco use, and tobacco use prevention. Volunteer in community, community education programs.
  ex: Catawba County (Sylvia Mentis) – TATU (teen against tobacco use) training.
  TNT (towards no tobacco) life skills program. Peer athlete talk show – community wide.

NOTE: Visual aids big impact on kids

- Community Resources –
  -churches – family resource centers, Boys & Girls Scouts, YMCA, YWCA
  -volunteer organizations
  -afterschool programs
  -women's groups

Definition: people as resources, existing community programs, organizations that serve the community

IDEA: do a graph that shows where the money is going on a community level
IDEA: show tobacco as gateway drug
NOTE: some community focus on other substance abuse issue impacts funding

- Financial –

CDC – Dose response need $42 million

IDEA: tobacco as a social norm data. Show graph: Nicotine as the drug being introduced.

- Meeting Forum Ideas

Existing Data
Quality Resources – site analysis

Agenda
Strategic Planning
Tobacco-Related Health Disparities

Meeting 2 Tuesday, March 5, 2002

American Cancer Society
11 S. Boylan Ave. Raleigh, NC

Purpose - Consensus Building Training

- Understand how the grant requirements have changed
- Establish the value of an effective group process
- Establish workgroup procedures for communication, conflict resolution and decision making.
- Define workgroup member roles & responsibilities

Agenda:

10 a.m. Welcome and introduction of the facilitator (Laurie)

10:15 Workgroup member introductions (Andy/all)

Meeting Overview (Andy/all)
Review/revise/adopt: meeting purposes, agenda, ground rules

10:30 CDC 's new focus on group process (Laurie/all)

10:45 Consensus Building Training (Andy/all)
Discussion:

- Why an effective group process is useful.
- What group process challenges can we anticipate?
- What needs do group members have with respect to communication, conflict resolution and decision making?

Presentation and Evaluation of Options

- Compare to needs: template of procedures/guidelines for communication, conflict resolution and decision making.

Decisions:

- Which template items to keep?
- Which to eliminate/revise?

Presentation/Discussion

Debrief/review of today's group process: How diverse groups generate consensus.

12:45 Wrap -up/ Evaluation

1:00 Lunch

1:30 Adjourn

Agenda
Strategic Planning
Tobacco-Related Health Disparities

Meeting 3

Thursday, March 28, 2002

American Cancer Society
11 S. Boylan Ave. Raleigh, NC

Desired Outcomes for 3/28:

- Understand the data we have on North Carolina demographics, what tobacco means to our state economy, who is adversely affected by tobacco use, who is using tobacco, and who is exposed to tobacco smoke
- Identify critical issues for specific population groups in our state
- Closure on revised group protocols

Agenda:

10:00	Welcome Sally Meeting Overview Andy Participant Introductions Andy
10:45	"Who Lives in North Carolina and What does Tobacco mean to our State?" Lisa
11:00	"Playing with Numbers" -Karen "Who is Adversely Affected by Tobacco in North Carolina?" - Karen "Who is Using Tobacco and Exposed to its Smoke?" - Karen
12:30	Break for Lunch (provided)
1:15	"What are the critical issues based on what you have heard today? For what North Carolina sub-populations do we need more information?" Worksheet and small group discussions (20 minutes)…Full group discussion (40 minutes)
2:15	Group Protocols Andy
2:30	Clarify next steps in strategic planning Andy
2:45	Meeting Evaluation
3:00	Adjourn

3/28/02 Data Forum
Small Group Discussion Notes

Worksheet Question Responses

1) What do we know?

- More smokeless tobacco use in rural North Carolina, and in the western counties.
- Rural areas have a higher exposure to ETS at home.
- More quit attempts among African Americans than Whites (statistically significant).
- Pregnant women who are WIC/Medicaid recipients have a higher prevalence of smoking than other pregnant women.
- 18-24 smoking rates increasing but they really want to quit. They also report higher exposure to ETS.
- American Indians are highest in almost all aspects.
- Low education group shows high rates in all areas (smoking, smokeless tobacco use, pregnant women who smoke, and infants exposed to smoke), and trends are increasing dramatically among some subgroups.

2) What don't we know?

- No information on quit attempts for smokeless tobacco use.
- Do all smokeless tobacco users also smoke? Some of the data on American Indian women show this.
- Unknown smoking prevalence among American Indian women in general (to compare to prevalence among American Indian pregnant women).
- Little/poor data on Hispanic population.
- How is race classified among those who are American Indian and Hispanic?
- Middle school data anomaly -- black/white less difference on YTS but not asthma. Is this just that cohort or a trend? Need to review 2001 YTS.
- Nothing about NC lesbian/gay/bisexual/transgender (LGBT) community smoking/spit use/exposure rates.
- Regional smokeless use and oral cancer incidence or mortality.
- Some concern about validity of data regarding sample size -- need larger samples (Hispanic, Asian, American Indian) to have more data to do more 3 dimensional (subgroup) analyses within these communities.

3) Which of the above are most critical to identifying disparities?

- Low education (< H.S.) is a consistent indicator for tobacco use and ETS exposure.
- WIC/Medicaid—is it an indicator/proxy for race in prevalence of pregnant women smoking?
- More quit attempts among African Americans. Why? And can we borrow any strategies from that group?
- American Indian tobacco use rates.
- 18-24 is important group to investigate further. We know that trends are going way up in all groups, especially whites. Could possibly look for other data sources or do additional analysis by subgroup within this age category.
- An "Eastern corridor" shows higher tobacco use & effects
- IN GENERAL, THE GROUP FELT THAT WE HAVE ENOUGH DATA TO IDENTIFY KEY GROUPS TO DO DEEPER ANALYSIS AND IDENTIFY CRITICAL ISSUES.

Agenda
Strategic Planning: Tobacco-Related Health Disparities

Meeting 4

Sheraton Chapel Hill Hotel
1 Europa Drive Chapel Hill, NC 27517

Thursday, May 2, 2002

Desired Outcomes:

- Understanding of the social norms approach to tobacco control and prevention.
- Awareness of the policy-related data we have -- and the data gaps we need to fill -- for tobacco-related health disparities on the TPCB's 3 goal areas: Prevent Youth Initiation, Promote Cessation, Eliminate Environmental Tobacco Smoke

Agenda

10:00 Welcome, Meeting Overview, Participant Introductions *Facilitator*

10:30 Social Norms Data

Why social norms analysis? *Sally*
Brief (10 minute) presentation explaining the social norms approach to tobacco control and prevention.

10:40Data that we have and gaps we need to fill

NC Tobacco Economy - GIS maps (15 minutes) *Lisa Fastnaught*

Instructions for Exercise (5 minutes) *Facilitator*
Four different stations will be set up around the room, each with a resource person and poster presentation communicating the data we have (and gaps we need to fill) on tobacco-related health disparities in NC from social norms studies in the four areas identified below.

Workgroup members will be divided into four equally sized small groups. Each group will begin at a different station, hear the resource person's presentation of the data and gaps, brainstorm responses to the question, *"Given the data and gaps we've presented here, what questions would you want answered in order to identify and eliminate tobacco-related health disparities in North Carolina,"* and then move on to the next station for presentation and brainstorming. Flip charts/markers/tape will be at each station for resource persons to record Workgroup member's reactions to the question.

<u>Four station sessions @ twenty minutes each, as follows:</u> 11:00 – 11:20, 11:20 – 11:40, 11:40 – 12:00, 12:00 – 12:20

- Program Services and Resources (Sally Malek - TPCB)
- Public policy #1: Prevent Youth Initiation (Jim Martin - TPCB)
- Public policy #2: Environmental Tobacco Smoke (Anne Butzen- UNC School of Medicine)
- Public policy #3: Promote Cessation (Kalila Spain - NC Prevention Partners)

12:30 Lunch Break

1:15 Presentations/Synthesis in full group by each Resource Person (5 resource persons @ 7 minutes each)

"What I'm hearing from workgroup members' brainstorming regarding the data we should use and gaps we need to fill to identify and eliminate tobacco-related health disparities in NC."

1:50 Discussion *Workgroup Members and Resource Persons*

2:30 Next Steps in Strategic Planning *Facilitator*

2:45 Meeting Evaluation Forms *Laurie*

3:00 Adjourn

DIVERSITY WORKGROUP MEETING
MINUTES FOR 5/2/02

ATTENDING: Andrea Bazon-Manson, Chuck Bridger, Traci Clark, Betsy Levitas, Margaret Brake, Kurt Ribisl, Sheri Scott, Lawrence Shorty, Mainor Araya, Kathy Harrelson, Larry Gourdine, Delmonte, Sally Malek, Jim Martin, Felicia Snipes-Dixon, Kathy Blue, Laurie Mettam-Rude, Deborah Givens
Andy Sachs-Facilitator, Annie Butzen-Presentor, Kalila Spain-Presentor

Programs & Resources: Data & Gaps
Sally **–**
- ✓ on definition of teen data (pregnant)
- ✓ disparities funding for other sources other than TPCB specific….
- ✓ Human Resources: FTE's on tobacco prevention & control, FTE's that address specific disparate pops @ state & community level
- ✓ Need resources for Media/Advertising (VERY IMPORTANT)
  -Marketing /promotions budget for pops
  -Counter marketing budget for pops
  -Community promotions data

Advocacy Resources for specific pops (policy / media)

Teen leaders and College aged leaders in TP&C – Contact lists by pop groups (who has not been groomed and could be tapped?) TATU groups & teams documented and list served * Need data on TI donations.

Disparities Workgroup Leadership

Process for distributing $775,000. Short term planning, need $ for 3 groups based on what criteria? Pop. need capacity. Responsible agency open or close process. Require collaboration.

Low SES Rates & Process four HWTFCS

Other programs not listed
- Council for Women – Leadership Connection (Kathy Harrelson)
- Cherokee Hospital cessation
- Youth Group Mt.Zion Baptist – Greensboro
- NAACP Youth
- Burnt Swamp – Robeson

Other groups to tap potential
- churches
- Lay Health Advisor groups
- Key Clubs
- Girls, Inc.
- HBCU's (Lorna Harris)
- Greensboro Lifeskills Center
- Old North State Medical Society

Look at program models in other states

Promote Cessation

Common Themes:

- ✓ Health plan data on utilization
  - profiles on disparities
  - test pilot data
  - demo – breakdown of plan purchase
  - offer quit line coverage in standard plans (no cost/free pub/show how save)
- ✓ Data on other effective research for youth on quitting?
  - no prescription drugs; Quit Line
  - successful web quitting program.?
- ✓ Media / Print campaign effective based on African. Am. / Lat./ Nat. Am.
- ✓ Consistent / periodic data for success. cessation especially for a low SES groups
  - decrease / increase.; why / where; demo?

Group 1: What we need

- who receives benefit? but within target population; Quit Now
- media list for consumer part (from El Pueblo)

Cessation Survey

- Copy of survey
- category of sites…… hospitals; health depts.
- constant survey / data on decrease / increase on cessation exp. on advocacy groups
- data on kids who call why / where
- where are successful cessation programs or web-site and measurements
- make prem. available of cessation. programs to consumers
- dependent coverage of quitting on quit line
- scare teens by group of prevalence African American, Latinos, media camp, and print media

✓health plan data on utilization and profiles on disparities
✓demographic breakdown on who buys the plan
✓data on cold turkey quit site?
✓CA data span. lang. quitting
✓offer quit line coverage in standard benefit package at no additional cost

- free pub for them
- show how $ save

✓Ann Houston & Laurie have media outlets for target populations
✓group meeting using web-site

ETS

<u>Group One</u>

- multiple venues
- gender specific data – why?
- different messages for - don't start no exposure
- American Indian most exposed
- data on policy broken down by occupation. NC specific. where? labor statistics by SES
- Alex Spears, VP Lorillard, died of lung cancer

Gaps in Data:

- occupational breakdowns
- race /ethnicity breakdowns

- homes – smoker in homes – children in homes
- surveys & focus groups should be culturally specific

Media & Education:
- culturally specific
- be smart – avoid backlash
- incorporate people's stories and give viewers something to do with emotion

Policy:
- involve people of power; survivors, leaders, political figures
- community based plans
- Our role
- stress home and workplace bans – create support for no preemption
- home-rule and preemption – leaders

Public Policy:
- Prevent Youth Initiation – Where kids spend the most time? Malls, airports, skating rinks, bowling alley's, indoor spectator, home, daycare, restaurants, churches, YMCA, YWCA, recreational facilities.
- Schools
- Youth access: county specified, data mapped, compliance checks targeted
- Taxes – proposed 5 cents

Group Two

- be smart about closing media campaigns; based on facts; avoid backlash
- dealing with trauma and grief – families of victims w/American Indian as well as other pops
- wellness & spirituality
- everyone has a story
- what to do with emotions evoked
- we want to know if person's death is due to smoking
- who are linked to powerful stories – how do we involve them?
- education – awareness about exposure – helps smokers quit
- African American community – hard to say "Don't smoke" – ADULTS
- American Indian community – respect
- Latino Community – show effects on family – surveys

Group Three

- Work & home policies among Latinos – b/c can't smoke at work.
  American Indian as well – race/ethnicity
- Must have Mexican/Latino/Am. Indian survey or focus groups.
- Understand cultures within cultures
- Must be in community – local solutions to local problems.
  -community research
  -not just tobacco
  -partnerships in community
  -generated by community
- Get the message out – Education & Advertising
  -Latinos on Spanish speaking TV, Soccer, Catholic Churches
  -go where they're at – Focus groups

Group Four

- Occupational Breakdown
- How many people are protected by s-f workplace policies
- Love My Lungs – Home Smoking Ban – AJHP
- How can we get county commissioners upset
- create groundswell
- who has home smoking bans – smoker in home – children in home
- African American youth exposure but not use rates. Focus on exposure.
- Develop short-term & long-term plans. Be sure $ spent where it needs to go. Watchdogs.

Map Data

✓ Tobacco use rates by county tobacco harvesters – farm workers.
-Migrant workers – health implications
-Location of community health clinics
-health care cost as consequence
✓ Community grants to Eastern NC

Programs & Resources

Urgent Request – ASAP
Convene mtg./design process for $775,000.
Establish this Disparities Workgroup as leadership for Decision Making
Define criteria, e.g. pop.? Need? capacity?
Define process e.g. open? competitive? closed?

Process Notes:
Shared expectation that AA/AI/H/L be a collaborative process & interactive
Request HWTFC addresses disparities across all budget items / program areas

Need more DATA:

✓ disparities $ for all sources of TPTC (not just Branch)
✓ human resources: state & community
-adults by geographic area & by skill / interest
-teen lists by geographic area & skill / interest (e.g. TATU)
-college aged leaders
✓ data on advertising & promotions by TI communities
✓ data on TI donations (& communities that refuse it)
✓ lists of advocacy groups that can be tapped
✓ programs not listed
✓ programs that can be tapped

HWTF

- brainstorm ideas-
-issues
-who needs to be here; blue collar, locals
-craft agenda
-no exclusion of ideas or people

- pick mtg. times
- determine how $ is allocated;
  -population
  -smoking rates
  -infrastructure of groups
  -competitive RFP's
- Process: ours to determine $ spent – HWTF process
  -5/15 next mtg.- conference call
  -guidelines on allocating $ process
  RFA's – school community, disparities
- We represent bigger picture
- We may have had goals about how to allocate $, only HWTF can allocate $, we can advise and suggest
- determine advisory committee – incl. members of diversity wkgrp., wkgrp can advise this group.
- help craft criteria for $ & collaboration for RFP
- We need help to est. ourselves as influential to advisory group.
- too early and too specific about how to spend $. – HWTF wary about pass-through organizations.
- Stay focused on immediate as well as Long Term Plan
- Missing key 2010 members – invite them back – new data based on disparities workgroup.
- who should be invited
  - locals – across state
  - blue collar
  - GLBT mentioned in HWTF
  - Latino – El Pueblo
  - Amer. Ind. – Council of Indian Affairs
  - African. Am. – Historically Black. Colleges, NAACP, Urban League
- Time-sensitive? Yes, be part of criteria process with HWTF. Next Tuesday mtg. b/t JD & Bruce general recommendations by then?
- will they take our input? by 5/15 or Tuesday. We must meet & rec. even if ignored
- need to build networks & programs
- not too much time on process so that we can get our needs met –open process, inclusive & respectful – don't need huge bureaucracy, will dilute funds – not as much $ as we hope.
- $ for infrastructure; program $ from other budget lines

Agenda
Strategic Planning:
Tobacco-Related Health Disparities

Implementation Team and Presenters Meeting
To Develop 10 Critical Issues Draft from 2 Data Forums

Orange County Dispute Settlement Center
Carrboro, NC

Friday, May 10, 2002

Desired Outcomes: (Complete Process Item II- Environmental Scan & SWOT Analysis)

- Review 10 Critical Issues drafts from 2 Data Forums
- Achieve consensus on 10 Critical Issues

Attending:

- NC TPCB: Laurie Mettam-Rude, Sally Malek, Felicia Snipes-Dixon, Jim Martin (conference call)
- Orange County Dispute Settlement Center: Andy Sachs (facilitator)
- Scott Consulting: Sheri Scott (grant evaluation)
- UNC Family Medicine: Anne Butzen (presenter on ETS policy data)
- UNC Prevention Partners: Kalila Spain (presenter on Cessation policy data)
- UNC School of Public Health: Lisa Fastnaught (GIS maps)

Agenda

8:30	Welcome, Meeting Overview	*Andy - Facilitator*
8:45	Review and clarify the two sets of input from the Data Forums	*Andy & presenters*
9:30	Brainstorm critical issues	*Andy & presenters*
9:50	Decide on ten draft critical issues	*Andy & presenters*
11:00	Adjourn	

Agenda
Strategic Planning: Tobacco-Related Health Disparities

Meeting 5

American Cancer Society
Boylan Ave. Raleigh, NC

Wednesday, June 19, 2002

Desired Outcomes:

- Understanding of the tobacco industry's marketing impact on diverse populations.
- List the media outlets for diverse populations.
- Consensus of 10 critical issues from 2 Data Forums.
- Share population assessment data and draft 10 critical issues for that qualitative data.

Agenda

10:00 Welcome, Meeting Overview, Participant Introductions *Andy – Facilitator*

❖ *Strategic Planning Process review (30 critical issues narrowed to 6 goals)*

10:15 Tobacco Industry Marketing and Media Outlets for Diverse Populations *Ann-Presenter*

11:00Ten Critical Issues *Laurie*
Present and ask for consensus on 10 critical issues from data forums.

11:20Population Assessment Data
Presentations (10 minutes each) from Diversity Workgroup members on the Population Assessment (survey) as follows:

OverviewLMR/AMS

List of <u>possible</u> presenters:

African American:
Karen Morant
Lorna Harris
Kenny Ray
Sandra Headen

Asian American /Pacific Islander:
Milan Pham
LMR

12:30Lunch

1:15Presentations (continued)

Latino
Minor Araya, Julie Tatko, Harriett Purves

GLBT
Sheri Scott

Low SES
Lynice Williams
Kathy Harrelson
Rural
LMR
Margaret Watkins

Immigrant
LMR

American Indian (population assessment and tobacco industry marketing to A.I.)
Lawrence Shorty

2:45-3:00 Break

3:00 Q&A and Discussion of Consideration of Critical Issues

3:50 Meeting Evaluation

4:00 Adjourn

Diversity Workgroup Meeting
Minutes for 6/19/02

Attending: Sheri Scott, Mainor Araya, Julie Tatko, Harriet Purvis, Lorna Harris, Karen Morant, Kathy Harrelson, Sandra Headen, Margaret, Watkins, Lawrence Shorty, Ann Houston, Kathy Blue, Larry Gourdine, Delmonte Jefferson, Tim McGloin, Laurie, Deborah

CRITICAL ISSUES FROM POPULATION ASSESSMENT

- General concern about youth: smoking sooner, habituated earlier.
  What's critical for each group?

- How comfortable are we w/ respect to proportion sampled?
  *Primary data subgroups: those **in** the population vs. those working **with** the populations.*

- Same methods for primary & secondary groups?
  Shouldn't categorization schema for first set of issues apply here too?

- Are there values that can be tied into prevention/cessation which cut across populations?
  *Communication channels – media, use **targeted** media.*

- Messages coming from the community are most effective.
  The church is an effective vehicle for communicating. Faith based.

- Lay advisors.
  Social settings suggest that smoking is acceptable.

- Native Americans & Appalachians – messenger has to be from within.
  A lot of different populations depend on tobacco for livelihood.

- Lack of awareness among Latino leadership for tobacco prevention/cessation.
  *It's more **economics** than health in the American Indian community.*

- Address the historical ties to tobacco/industry.
  *If communities are receiving funds from Tobacco, then what **alternatives** can we find?*

- How can we handle the diversity? How to set priorities across our differences?
  Communicating prevention messages across SES, e.g. have to segment all the time, makes it harder.

- See commonalties: SES across groups.
  Think like advertisers!

- Common message: You are being exploited.

  Counter-market by lifestyle, not ethnic/race groups.

- Music, dance.
  We are not as slick as tobacco companies!!

- So hire real marketers
  "Not in Mama's Kitchen" campaign…. We can do this!
  How to transfer the message to all other communities.
  Several different messages will be <u>expensive.</u>

- The messages we put out will shape their thinking.

Age: music & dance ok for 14 year olds

- Lisa Oxendine converted a national model for cessation into a community intervention.
  The racial/group categories put us in a box. If we stay in it, ask ourselves what capacity/infrastructure exist within those groups.
  GLBT has less developed infrastructure, compared to African American.
  And low SES even worse off.
  Need pride to have infrastructure. So how do we reach SES???
  Ten coalitions working in health departments provides an infrastructure. Maybe not self – empowered.

- Also: Fair Share.
  Health Promotion Funds.
  KB Reynolds Funding.

- Programs serving the county, not communities serving themselves.
  Each community has to consider how SES within is to be addressed.
  May be same, may be different across groups.
  All groups must reach their own SES.
  Common Cause:
  Earmark funds for low income people to access services.

- Get them here, on this group.
  Identify social norms in home country for new immigrants.

- Also, follow the routes people traveled to get here.
  Tax rates is a burden on low income people; yet opportunities exist in low income counties to change tobacco-friendly behaviors.
  Smoking as a good alternative to other drugs!

- Can't take a monolithic approach. Have to lead **<u>individuals</u>** to change their behaviors.

10 Critical Issues Revision From Data

- High prevalence rates exist in Eastern NC corridor. Multiple factors including high rates of poverty, tobacco-dependent community, limited access to health care.
- Bring out the numbers relative to other regions in NC. Justify the statement.
- A tendency.
- How is #5 different from #1? #1 emphasizes SES, not geography. Especially education.
- Redundancy on the list helps keep different issues "on the table".
- Stratify the info by category:

  Geography
  Race/ethnicity
  Gender
  SES
  Geographically unique items

does this schema work?

- The brainstormed points on western NC/pregnant woman/high prevalence also fits with geographic category.
- SES: be sure you have current status; lots of industries closing.
- Local politics affects workplace smoking bans
- American Indians high across all aspects:
  - age at which youth begin
  - adult chewing prevalence
  - pregnancy
  - etc.
- Occupational exposure to tobacco (green tobacco sickness): How does that relate to "stroke belt". And chemicals in agriculture (herbicides).
- Loyalty in tobacco-dependent communities.
- What populations do we need marketing info about?
  - We have a little info from organizations.
  - but not a community level.

Agenda
Strategic Planning: Tobacco-Related Health Disparities
Meeting 6
Sheraton Chapel Hill Hotel, 1 Europa Drive, Chapel Hill, NC 27517

Wednesday, July 24, 2002

Desired Outcomes: (Complete Process Item II- Environmental Scan & SWOT Analysis)

- Clarification of Workgroup's progress in strategic planning
- Review Critical Issues from Data Forums & Population Assessment & Achieve Consensus
- Implement a SWOT analysis of NC tobacco-related disparities
- Develop 10 Critical Issues for SWOT analysis

Agenda

10:00 Welcome, Meeting Overview, Participant Introductions *Andy - Facilitator*
10:15 Strategic Planning Progress Report Kathy Blue - Evaluator
10:30 Review Critical Issues - Data Forum & Population Assessment *Laurie - Project Manager*
Workgroup Discussion/Decision: Clarify/Revise/Adopt
11:00 S.W.O.T Analysis - Affinity Exercise *Andy - Facilitator*

Internal - Strengths and Weaknesses (arenas over which the NC Diversity Workgroup and NC TPCB have some control or influence)

- Diversity Workgroup, NC TPCB, Collaborative Organizations lists their strengths and weaknesses regarding: skill sets, populations represented, human resources, financial resources, leadership, availability in terms of time, commitment, capacity for strategic planning, communication processes, political savvy, access to decision makers, role in communities, relationship to media

External - Opportunities and Threats (arenas over which the NC Diversity Workgroup and NC TPCB have little or not influence)

- Diversity Workgroup and NC TPCB Political lists their opportunities and threats in the following areas: environment, economic conditions, culture, educational system, and environmental stress or current events

12:00 **Lunch Break**

12:30 SWOT Analysis (continued) - Small Group Preparation and Reports

1:30 Brainstorm Critical Issues

2:00 Develop Consensus on Critical Issues

2:30 Meeting Evaluation & Distribute Travel Reimbursement Forms*

NEXT MEETING: Thursday, August 22, 02 Place : TBA

3:00 Adjourn * Please remember to request reimbursement for travel expenses which includes mileage and accommodations (for those who travel long distances)

DIVERSITY WORKGROUP MINUTES 7/24/02

S.W.O.T. DISCUSSION

Attendees: *Mainor Araya, Sheri Scott, Andy Sachs, Paul Savery, Lisa Fastnaught, Kathy Blue, Milan Pham, Tim McGloin, Lynn Lowery-Chavis, Chuck Bridger, Leslie Brown, Delmonte Jefferson, Jim Martin, Felicia Snipes-Dixon, Laurie Mettam-Rude, Deborah Givens*

Strengths

Branch

- ✓ Training offered
- ✓ Summits planned and financed.
- ✓ Technical assistance provided.
- ✓ Partnerships between Branch and other agencies focused on tobacco control.
- ✓ Incredible knowledge of tobacco strategy and issues, with many years of experience in tobacco and dedicated staff members.
- ✓ Strong African American advocates within branch and great experience and successes (UJIMA, ?Y).
- ✓ Dedicated workgroup members/organization which participated in the planning process.
- ✓ Paid staff to coordinate, facilitate & evaluate the strategic planning process.
- ✓ Branch's priority of re----? tobacco – related health disparities among all state and local resources.
- ✓ Good summary and follow-up to members of results of meetings
- ✓ Strong commitment from Branch for eliminating tobacco-related health disparities.

Workgroup

- ✓ Commitment of workgroup.
- ✓ The process of development of the strategic plan.
- ✓ Emergence of "New Voices" from specific populations – New leadership.
- ✓ Strategies to engage communities not involved in tobacco prevention (Empowerment).
- ✓ We have built capacity through the experience of the branch and the organizations involved in this process.
- ✓ Workgroup focused on one mission (everybody working for the same goal).
- ✓ Consistent participation, esp. by El Pueblo & UNC.
- ✓ Strong experience with tobacco control. (What has, and has not worked in the past)
- ✓ Department/Government strong. (TCB, ALA,….)
- ✓ Diversity of workgroup (race / ethnicity / culture).
- ✓ Diversity of workgroup (skill mix – policy, researchers, managers, administrators).
- ✓ Great facilitation and leadership.
- ✓ Excellent data resources (UNC maps, NCHS).
- ✓ Great group of thinkers.
- ✓ Timing.
- ✓ Offers of Minority Health and Health Disparities leadership.
- ✓ Experience.

Knowledge

- ✓ Strong knowledge of tobacco: industry, prevalence, health effects, and marketing.
- ✓ Dedication of those involved.
- ✓ Prevention and control at its strongest forward momentum.
- ✓ Academically strong.
- ✓ Expertise in public health.

Resources

- ✓ "Permission" (and CDC$) to undertake this systematic, time-consuming analysis and planning process.
- ✓ Current CDC Disparities Grant within the Branch.
- ✓ Vision 2010
- ✓ Expel tobacco campaign
- ✓ ?? tobacco media.
- ✓ ?? smoking date

Strengths Summary

A group of 4 worked to categorize the areas identified as "strengths" (internally).
Four core strength areas emerged:

1) within the Branch
2) within the workgroups
3) knowledge within
4) resources within

Branch: trainings, technical assistance, years of expertise, priorities identified.
Workgroup: strategies, empowerment efforts, diversity.
Knowledge: of tobacco, dedication, experience in PH.
Resources: things to build up.

Weaknesses

Branch

- ✓ State Tobacco as part of bureaucracy (some may view as distrust).
- ✓ Partnerships and relationships hampered by involvement with the TPCB.
- ✓ Broaden focus need in Health Trust on Disparities.
- ✓ State infrastructure – ability for the TPCB to have more autonomy.
- ✓ Resistance to change and allow new leadership new leadership to emerge.
- ✓ Lack of credibility with some groups. (e.g. LGBT, some immigrant, low-income)
- ✓ Health Department image
- ✓ Lack of ability to make structural and process changes to enhance disparities work (e.g. local coalitions)
- ✓ Lack of effective communication system between TPCB. Local organizations and coalitions.
- ✓ Link between planning process and resource. Allocation Process in Branch, Public Health.
- ✓ Lack of political clout.
- ✓ Lack of influence with decision makers.

Funding

- ✓ Not having funding for the implementation of the strategic plan already secured.
- ✓ No money identified for GLBT, Asian, and other disparities groups.
- ✓ Limited resources to adequately address tobacco related health disparities on a statewide level.

Community Capacity

- ✓ Capacities of some communities to do tobacco control.
- ✓ Community weak.
- ✓ Currently seems to be a limited capacity among organization/agencies to effectively reach specific populations groups. Lack of infrastructure and staffing, specific to tobacco use prevention and control.
- ✓ Lack of leader's commitment (in the Latino community) and knowledge of the problem.

Social Marketing

- ✓ Social marketing skills.

Workgroup

- ✓ Some reps. in Diversity Workgroup do not focus inclusively on tobacco use prevention in their organizations.
- ✓ Lack of time – Most Diversity members have other work priorities – can't invite.
- ✓ Raise expectations we cannot (or do not) meet.
- ✓ Extent to which existing workgroup has capacity to move from strategic planning to program planning & implementation of multitude of activities that will be called for to address issues identified.
- ✓ Not reaching grass roots leaders.
- ✓ Not receiving grass roots participation in planning & delivery. Not experiencing target ?????

Lack of Representation & Know.

- ✓ Lack of information: on origin and culture of immigrant-smokers. (we don't now if they started smoking in US or they came with the habit.
- ✓ Lack of knowledge of living styles of different groups.
- ✓ Unsuccessful attempts to include LGTST community in process.
- ✓ Need more local community organization representation.
- ✓ No specific low SES representation.
- ✓ Not enough workgroup participation/representation from all the groups at the meetings.
- ✓ Lack of broad representation (not all populations represented)
- ✓ Groups overwhelmed with many issues.
- ✓ Could there be more state or local representation in the workgroups. Equal representation e.g. Public schools.
- ✓ Lack of lower SES representation.

<u>Opportunities</u>

Comprehensive / Holistic

- ✓ Recognition of a more "holistic" approach e.g. family components to prevention and cessation programs.

Schools / Youth

- ✓ The opportunity to continue the discussion about "smoke-free" and "tobacco-free" schools.
- ✓ Strengthening the current NC Public Schools resolution for tobacco-free school.
- ✓ Chance to create statewide diverse youth movement.

New voices / partners

- ✓ Engage community groups and statewide advocacy groups in Tobacco Prevention.
- ✓ Work effectively with Office of Minority Health and Health Disparities.
- ✓ New partners, new synergy, grass roots movement.
- ✓ HWTC $?
- ✓ Focus on defining community approaches to reach minority & other youth.
- ✓ Latinos
- ✓ Emerging community and homogenous population.

Low SES

- ✓ Strive for inclusiveness
- ✓ What's really at stake for people of lower SES in tobacco prevention and control?

"Big Tobacco" awareness

- ✓ Increasing public contempt with Big Tobacco

Funding

- ✓ Possibility of additional funding.
- ✓ Direct funds to resource poor communities.
- ✓ Securing HWTF money to address eliminating disparities for African American, Native American, and Latino groups.
- ✓ Articulate proposed linkage between planning and resource allocation.

Priority of Disparity Reduction: State

- ✓ New Secretary for DHHS has a priority of eliminating disparities and could be an ally for the Strategic plan.
- ✓ Trend towards a broader, increasing acceptance of the need for (and potential impact of) decreasing health disparities among population groups.
- ✓ Priority of the Health and Wellness Trust Fund Commissioner in reducing tobacco-related health disparities in the Teen Tobacco Use Prevention and Cessation Plan.
- ✓ Strategize an effective and efficient way to reduce tobacco related disparities.

Threats

Funding

- ✓ State Government taking Settlement Funds for other purposes.
- ✓ Potential of Health and Wellness Trust funds to be cut in order to fill the budget gap.
- ✓ Uncertainty of funding.
- ✓ Budget.
- ✓ NC's budget deficit could endanger funds within NC being secured for this strategic.
- ✓ Didn't pass cigarette tax.
- ✓ Major economic threat in NC - $8 billion deficit.

Lack of Political will

- ✓ Tobacco interest taking precedence over health interest.
- ✓ NC's being a tobacco growing state with strong ties to the tobacco industry.
- ✓ Tobacco industry influence on politics.
- ✓ Timidity – not taking on Big tobacco. One size fits all approach.
- ✓ Redistricting of political voting areas.
- ✓ Lack of attention to Public Health.

Approaches

- ✓ Rely too heavily on school focus / based approaches to reach minority and other youth.
- ✓ Tobacco use prevention isn't systematically included in educational system.
- ✓ Chewing tobacco use rate.
- ✓ Big Tobacco: $ to groups (local) $ in advertising (global)

Competing Issues

- ✓ How priority tobacco prevention has in comparison to other issues – income, education, health, housing employment.
- ✓ Competition from other health related priorities and/or other critical issues faced by minority populations – can tobacco use & related health consequences stay on the agendas of all involved?
- ✓ Tobacco not "flavor of the month".

Culture

- ✓ Sensitive approach to diverse communities.
- ✓ Population is ever changing.
- ✓ Difficult to reach new immigrant groups.

AGENDA
Strategic Planning: Tobacco-Related Health Disparities

Meeting 7

Holiday Inn – Crabtree 4100 Glenwood Avenue Raleigh, NC
Thursday, August 22, 2002

Desired Outcomes:

- Renewed inspiration to fighting the marketing, promotion and addiction of tobacco.
- Goals and strategies for identifying and eliminating tobacco-related health disparities in North Carolina.

Agenda

10:00 ***Welcome, Meeting Overview, Participant Introductions Andy***

10:30 ***Brief announcements - Health Trust RFP - Priority PopulationsLeslie Brown Suzanne Depalma***

10:45 ***"WHY"Video - to rally and inspire the troops Laurie***

11:00 ***Critical Issues Laurie***
Review three sets of critical issues (from the Data Forum, the Population Assessment, and the SWOT analysis) and group into common themes.

11:30 ***Goals and Strategies (see handouts) Andy***
Converting the common themes generating from the critical issues into 6 goals.
Use criteria to choosing the 6 goals. Test Goals
Choose 3-5 strategies for each goal. Test strategies

12:00 ***Lunch***

- Small group presentations
- Discussion
- Consensus on goals and strategies by full group, or delegation to sub-group for development of a proposal for next meeting.

2:45 ***Meeting Evaluation***

3:00 ***Adjourn***

AGENDA
Strategic Planning:Tobacco-Related Health Disparities

Meeting 8

Holiday Inn – Crabtree 4100 Glenwood Avenue Raleigh, NC

Wednesday, September 4, 2002

Desired Outcomes:

- Refine and adopt Goals
- Develop strategies for each of the goals
- Consider the impact of women and tobacco use
- Gain knowledge of Consumer Health Profiles Database as a tool for marketing strategies

Agenda

10:00 ***Welcome, Meeting Overview, Participant Introductions Andy***

10:30 ***Presentation on Women and Tobacco Use Renee Douglas***

10:45 ***Presentation on Consumer Health Profiles database Betsy Levitas***

11:15 ***Goals(see handouts)Andy***

- Review draft of goals from last meeting (8/22/02)
- Test goals and reach consensus on goals

12:00 ***Lunch - Preview of Website Consultant - Fred Charles***

12:30 ***Strategies Andy***

- Review population assessment data to focus on NC specific information
- Generate 3-5 strategies for each goal.
- Test strategies
- Consensus on goals and strategies by full group, or delegation to sub-group for development of a proposal for next meeting.

2:15 ***Meeting Evaluation***

2:30 ***Adjourn (HWTF grant RFA conference call at 3 p.m.)***

STRATEGIC PLANNING: TOBACCO-RELATED HEALTH DISPARITIES
MEETING MINUTES --------SEPTEMBER 4, 2002

Attending: Mainor Araya H Leslie Brown H Larry Gourdine H Kathy Harrelson H Sandra Headen Delmonte Jefferson H Betsy Levitas H Sally Malek H Jim Martin H Tim McGloin H Paul Savery Andy Sachs H Sheri Scott H Latasha Alston H Renee Douglas H Felicia Snipes-Dixon H Laurie Mettam-Rude

Mission: To identify and eliminate tobacco related health disparities in NC using culturally appropriate methods.

Approved Goals:

1. Lower tobacco use prevalence rates among all populations with a priority on reducing the highest rates in our state.
2. Improve the collection, analysis, and systematic use of valid data – relevant to tobacco related health disparities for strategic planning, program development implementation and evaluation.
3. Raise awareness about tobacco related health issues.
4. Change tobacco-related social norms and policies using culturally-appropriated methods.
5. Empower organizations and community leaders at the state and local level with knowledge, expertise, resources, and infrastructure.

Rough Draft of Strategies:

1. Lower tobacco use prevalence rates among all populations with a priority on reducing the highest rates in our state.

Draft Strategies:

a) Increase diversity of youth and adult leaders, community groups and organizations representing LOW SES, American Indians, 18-24 yr.olds, and individuals from rural areas actively involved at the local level in prevention of tobacco use.
b) Increase the # of colleges and universities that adopt a 100% smoke-free dormitory policy.
c) Increase the # of schools with large rural and minority populations that adopt a 100% tobacco-free policy.
d) Provide technical assistance, training, and resources to assist rural, service and blue collar manufacturing and farming worksites in adopting smoke-free policies and reducing tobacco related workplace hazards.

2. Improve the collection, analysis, and systematic use of valid data – relevant to tobacco – related health disparities for strategic planning, program development, implementation and evaluation.

Draft Strategies:

a) Consult with community leaders to develop and implement appropriate data collection methods.
b) Adopt the best method for aggregating community survey data.
c) Collect quality data to compliment existing quantitative data.
d) Raise awareness about tobacco related health issues. (Develop, Distribute, Disseminate)
e) Culturally-appropriate community assessment on: Knowledge level, behavioral norms (research lifestyles, data), resources currently available. Where do they obtain information? (people, places, etc.) Community forums – focus groups. Incentives – what will get people together?

f) Target Populations - different for different cultures, gender, age
g) Evaluation of information
Pre: starting point, effectiveness, rates, focus groups
Post: after, ongoing, every 6 months

3. Change tobacco related social norms and policies using culturally appropriate methods.
Draft Strategies:
a) Engage organizations (state & local)
b) Engage diverse communities and individuals
c) Workplace non-smoking policies in blue collar and service settings
d) Medicaid policy to cover tobacco cessation as a most basic benefit.
e) Make all NC schools 100% tobacco free
f) tobacco free homes (especially among disparate pops)

4. Empower organizations and community leaders at the state and local level with knowledge, expertise, resources and infrastructure.
Draft Strategies:
a) Culturally appropriate training workshops with clear objectives, reaching all needed people:
•Grant Writing • Tobacco 101 education • Best Practices • Data and surveillance
•collection and evaluation • Social Marketing • Internet use • Advocacy – media policy
•Hands on experience learning • Peer education • Train-the-trainer
b) Partner mentoring groups with new groups (train-the-trainer)
c) Culturally specific and appropriate media campaigns
- id & understanding use of media channels
- social norms marketing campaigns

d) Develop Advisory Group to guide the process
e) Linking groups with non-traditional partners for inclusive collaboration (ex: faith-based groups, academic institutions and research centers)
f) Conduct community needs assessments and key informant interviews

AGENDA
Strategic Planning: Tobacco-Related Health Disparities
Meeting 9
Thursday, September 19, 2002
Marriott Courtyard on Wake Forest Road, Raleigh

Desired Outcomes:

- Decision on 3-5 strategies for achieving each of the goals agreed upon on at the September 4 workgroup meeting.
- Ideas for objectives for achieving each of the strategies and for tasks needed to implement those objectives.

Agenda

10:00 Convene; Introductions/Meeting Overview

10:15 Strategic Planning

Divide attendees into 5 small groups organized by criteria

- Clarity
- Likely to move us toward goal
- Specific (can tell if it has been achieved)
- A decision on a priority (not a bundle of ideas)
- Feasible and manageable by some entity or partnership

Each small group:

- reviews all of the 22 draft strategies for compliance with their single criterion
- agrees on any suggested improvements to any draft strategy
- writes suggested improvements on post-its and affixes suggestions to Goal-specific posters.

12:00 Lunch Break

Divide attendees into 5 new small groups organized by Goal.
Each small group:

- reviews the suggested improvements pertaining to their goal's set of strategies.
- agrees on revisions to their strategies based on post-it suggestions and 5 criteria
- generates ideas for objectives and tasks for each agreed-upon strategy

1:30 Reports from 5 Goal groups on revised strategies and draft objectives
2:00 Workgroup Discussion
2:50 Meeting Evaluation
3:00 Adjourn

DIVERSITY MEETING MINUTES
SEPTEMBER 19, 2002

Attending: Mainor Araya H Leslie Brown H Larry Gourdine H Delmonte Jefferson H Betsy Levitas H Sally Malek H Jim Martin H Paul Savery H Chuck Bridger H Harriet Purves H Lawrence Shorty Andy Sachs H Sheri Scott H Felicia Snipes-Dixon H Laurie Mettam-Rude

Mission: To identify and eliminate tobacco related health disparities in NC using culturally appropriate methods.

Goals:

1. **Lower tobacco use prevalence rates among all populations with a priority on reducing the highest rates in our state.**
2. **Improve the collection, analysis, and systematic use of valid data – relevant to tobacco related health disparities for strategic planning and program development, implementation, and evaluation.**
3. **Raise awareness among diverse communities about tobacco related health issues**
4. **Change tobacco related social norms and policies using culturally-appropriated methods.**
5. **Develop organizations' capacity and empower community leaders at the state and local level with knowledge, expertise, resources, and infrastructure.**

Goals & (revised) Strategies:

Goal 1: Lower tobacco use prevalence rates among all populations with a priority on reducing the highest rates in our state.

Strategies:

a) Increase active involvement of youth and adult leaders, community groups and organizations representing Low SES, American Indians, young adults (aged 18-24 years), and rural areas at the local level in prevention and cessation of tobacco use.

b) Increase the # of colleges and universities that adopt a 100% smoke-free campus policy.

b) Increase the # of schools with large rural and minority populations that adopt a 100% tobacco-free policy.

d) Provide technical assistance, training, and resources to assist rural, service and blue collar manufacturing and farming work-sites in adopting smoke-free policies and reducing tobacco related workplace hazards.

e) Increase the # of faith communities that serve American Indians, African Americans, Asians, Latinos, and rural areas challenged with high unemployment and low educational attainment who are actively involved in tobacco use prevention and cessation.

Goal 1 - Objectives:

a.Increase the number of diverse groups actively involved in tobacco use prevention activities from _____ to _____ by _____.

b) Increase the # of colleges and universities that adopt a 100% smoke-free campus policy in NC from _____ to _____ by _____.

c) Increase the # of schools with large rural and minority populations that adopt a 100% tobacco-free policy. from _____ to _____ by _____. Specific: Work with schools that serve disparate populations.

d) Provide technical assistance, training, and resources to assist rural, service and blue collar manufacturing and farming work-sites in adopting smoke-free policies and reducing tobacco related workplace hazards. From _____ to _____ (for service and blue-collar workers, and from ____ to____ (rural) by ____.

Tasks (for those objectives)

- Identify individuals and groups that represent and advocate for Low SES populations.
- Work with Commission of Indian Affairs to identify Am. Indian individuals and Organizations.
- Provide, promote and develop (as needed) culturally appropriate tobacco use prevention and cessation models.
- Offer training and TA workshops for disparate populations.
- Outreach to youth advocates currently enrolled in higher ed.
- Assess status of existing university campus policies, with priority on community colleges and campuses with high disparate populations.
- Assess student population by district to identify high disparate populations.
- Provide TFS policy training to recruited groups (districts).

Goal 2: Improve the collection, analysis, and systematic use of valid data – relevant to tobacco related health disparities for strategic planning and program development, implementation, and evaluation.

Goal 2 - Strategies

2a) Collaborate with community leaders to conduct culturally – appropriate community assessment to document the beliefs, customs and attitudes on tobacco use in priority populations with little or no valid state/local data (e.g. American Indian tribes, LGBT communities, Asian subgroups, Latino subgroups)

2b) Share all collected data with communities in formats they agree to be most useful and meaningful.

2c) Develop innovative methods and venues to collect qualitative and quantitative data to guide program development and evaluation (e.g Low SES - survey public housing)

GOAL 3: Raise awareness among diverse communities about tobacco-related health issues

Goal 3 Strategies

3a) Reach disparate populations through a variety of state & local organizations serving disparate populations such as: faith communities, civic groups, colleges, cultural / arts groups, mentoring groups, medical groups.

3b) Create mass media campaigns that focus on lifestyle behaviors and target diverse community media markets.

Objective: Produce a mass media campaign that focuses on lifestyles and behaviors using culturally appropriate media markets by_____

Tasks for 3b)

✓Develop and disseminate inventory of traditional and non-traditional media and info dissemination outlets in diverse communities.

✓Use Consumer Health Profiles database to develop the target markets

✓Engage diverse youth and community leaders to develop messages and provide graphics that reflect community norms

3c) Encourage community leaders to promote dialogue on tobacco use and cessation.

Goal 4: Change tobacco related social norms and policies using culturally-appropriated methods.

Goal 4 Strategies:

4a) Educate and engage both statewide and local community organizations to advocate for pro-health policies such as access to cessation for low SES populations.

4b) Promote policy advocacy leadership within diverse communities.

4c) Identify and advocate for specific public & private policies that improve tobacco-related social norms of disparate groups in school settings, blue collar and service work-sites, and farming

4c) Collaborate with disparate communities to develop campaigns promoting tobacco- free homes.

Goal 5: Develop organizations' capacity and empower community leaders at the state and local level with knowledge, expertise, resources, and infrastructure.

Goal 5 - Strategies:

5a) Conduct culturally appropriate training and workshops.

Objective: ?

Tasks for Objective:

✓Develop training needs assessment and develop curriculum based on those needs.

✓Train trainers to implement curriculum

✓Offer workshops across the state that will be given by the trainers

5b) Promote partnerships between organizations experienced in providing effective tobacco use prevention and cessation programs to diverse communities and less-experienced organizations

Objective: ?

Tasks:

✓Convene all participating groups twice a year for the purposes of info exchange

✓Create a directory of participating groups.

✓Assess current capacity and infrastructure of participating groups.

✓Link groups with non-traditional partners for inclusive collaboration

5c) Increase cultural competence of all tobacco use prevention and cessation organizations and programs

AGENDA

Strategic Planning: Tobacco-Related Health Disparities
Meeting 10
Tuesday, October 1, 2002
Marriott Courtyard on Wake Forest Road, Raleigh

Desired Outcomes:

- Consensus on a set of well-tested Goals and Strategies
- Preparations for the next step in strategic planning: assignments, milestones, and timeframes for the Goals and Strategies.

Agenda

10:00 Convene
Introductions
Meeting Overview
Review revised Goals and Strategies for understanding.

10:30 Test the revised Goals and Strategies (G&S) against five criteria:

- Attention: are they being pursued by anyone else?
- Impact: will pursuing them produce a reasonable impact?
- Feasibility: Can we ever really achieve them?
- Integration: Do they relate to other initiatives within the strategic plan or the Branch?
- Time Frame: Can they be accomplished within the anticipated timeframe, or do they support ongoing efforts?

12:00 Lunch

1:00 Discussion/Decision: improving and reaching closure on the Goals and Strategies

Preparing for the next step in strategic planning: assignments, milestones, and timeframes for the Goals and Strategies.

2:50 Meeting Evaluation

3:00 Adjourn

AGENDA

Strategic Planning: Tobacco-Related Health Disparities
Meeting 11
Sheraton - Chapel Hill, NC
October 17, 2002

Desired Outcomes:

- Consensus on a set of well-tested Goals and Strategies
- Initiate "Feasibility Considerations:" Who? When? Oversight, Reporting, and Feedback for each Strategy

Agenda

10:00 Convene, Introductions, Meeting Overview

10:15 Review Goal 5 (Organizational Capacity) and Goal 6 (Funding) for clarity.

- ♦ *Individual reflection*
- ♦ *Full group discussion*

11:00 Test all of the revised Goals and Strategies against the following five criteria:

Small groups organized by Goal consider the following:

- Attention: are they being pursued by anyone else?
- Impact: will pursuing them produce a reasonable impact?
- Feasibility: Can we ever really achieve them?
- Integration: Do they relate to other initiatives within the strategic plan or the Branch?
- Time Frame: Can they be accomplished within the anticipated timeframe, or do they support ongoing efforts?

Full group discussion, goal-by-goal.

12:00 Lunch

12:45 Begin "Feasibility Considerations:" Who? When? Oversight, Reporting, and Feedback

Small groups organized by Goal discuss/fill-in worksheets
Full group discussion

2:50 Meeting Evaluation

3:00 Adjourn

AGENDA
Strategic Planning: Tobacco-Related Health Disparities
Meeting 12
Wednesday, November 13, 2002
Marriott Courtyard on Wake Forest Road, Raleigh

Desired Outcomes:

- "Feasibility Considerations" for each strategy *(Who? When? Oversight, Reporting, and Feedback)*
- A timeline and milestones for implementing the Strategic Plan
- Outline of a Preamble for the Strategic Plan

Agenda

10:00	Convene, Introductions, Meeting Overview
10:15	Review Draft Feasibility Considerations *Divide into small groups* *Read quietly* *Evaluate in small groups* *Discuss in full group* *Agree on revisions*
12:00	Lunch
12:45	Timeline and Milestones *Group exercise to map key events relevant to implementation of the strategic plan against a 5 year timeline.*
2:00	Preamble for the Strategic Plan *Review ideas generated so far, brainstorm additional ideas, evaluate, outline and delegate writing task.*
2:45	Meeting Evaluation
3:00	Adjourn

AGENDA
Strategic Planning: Tobacco-Related Health Disparities
Meeting 13
Tuesday, November 26, 2002
Marriott Courtyard on Wake Forest Road, Raleigh

Desired Outcomes:

- Commitments by workgroup members to seek endorsements of the Plan from organizational/community decision makers
- Review Preamble
- Ideas for marketing the Plan to other audiences
- Overview of Action Plan template

Agenda

10:00	Convene, Introductions, Meeting Overview
10:15	Comments on draft Preamble *Discussion* *Delegate revisions to writer(s)*
10:45	Endorsements *Discussion/commitments by workgroup members to seek endorsements of the Plan from organizational/community decision- makers. Progress report due back to workgroup by December 19 (final) meeting. (Note: received 3 endorsements to date)*
11:15	Marketing the Plan *Brainstorm ideas for marketing the Plan to other audiences. Refinement of ideas to take place at December 19 (final) meeting.*
12:00	Lunch
12:45	Discuss Policy Considerations
1:30	Review Templates for Annual Action Plan
1:45	Meeting Evaluation
2:00	Adjourn

Nov. 26th - Diversity Workgroup Strategic Planning Meeting Notes

WHO'S OUR EXTERNAL AUDIENCE?

- John Q. Public
- Up line: Division, Dept.,
  Secretary, DHHS Work Group
- Medical Centers
- School-based health
- Migrant Health Programs
- Housing Communities
- Faith-based Communities
- Smaller Community advocacy groups
- Wake County Baptist Assoc.
- General State Baptist Convention
- Population Assessment Leaders
- NC Fair Share
- Asian American organizations
- GLBT Organizations
- Health & Wellness funded groups
- American Indians (Interfaith Council)
- Legislators
- Barbara Pullen-Smith – present to Minority Caucus
- Alma Adams
- Student Groups
- Military
- AARP
- NC Health Alliance
- Health Action Council – Am. Lung Assoc. and Am. Cancer Society
- Daycare Alliance
- NC Social Services
- DHHS – Mental Health
- DPH Management Team
- DHHS Steering Committee
- OMH Adv. Council
- Immigrant / Refugee Organizations

Marketing

- Turn the plan into a less bureaucratic document for better marketing.
- Different languages
- Use the Web effectively
- Invite people in: Frame the plan around the questions that diverse populations already have.
- Power Point
- Laurie has sample brochures
- Statewide kickoff
- People needed to carry brochure to departments / agencies
- NC Steering Committee for Parity & Diversity in Tobacco Prevention & Control - front and center at April kickoff of Health & Wellness grant meeting.
- Smaller version of the Strategic Plan to wider audience: includes preamble, goals, strategies, & partners.

Diversity Workgroups' New Role & Name

NC Steering Committee for Parity and Diversity in Tobacco Use Prevention and Control. (SC)

What about original name of Diversity Workgroup?

- Focus: eliminating disparities & ensuring diversity - Diversity Promoting – Disparities Eliminating
- Tobacco related disparities
- To help partner agencies implement the strategic plan.
- Diversity strategic plan implementation board
- NO authority
- Advising ….. selecting lead agency… receiving reports

DIVERSITY IMPLEMENTATION GROUP (?)

- Technical support
- Information clearinghouse on who else is doing similar
- How to develop an evaluation for this.
- Lead agency (OMH) - Advisory Board - Statewide communication
- Advisory board – voluntary – ad hoc – periodic meetings
- How to move fast? - TPCB will provide help right away?
- So who needs an Advisory Board?

ADVISORY BOARD (?)

- Communication Central
- Link all the partner agencies with the others
- Review regularly what's being done.
- Considering how activities relate to strategic plan.
- Connecting - Branch
- Technical Assistance
- Analysis – Advisory Board
- OMH – 3 health trust entities. What about other community groups & organization?
- need to build capacity
- Power to do something. Group that shares.
- Somebody has to pay attention to ensure plan is being implemented.

<u>Identify</u> those things important to identify & eliminate tobacco – related health disparities, calendars, makes them happen. Getting the funding.

Role of Advisory Board:

- Branch plays lead role on tobacco-related disparities.
- Office of Minority Health and Health Disparities (OMH) advises on health disparities
- Advisory Board - Advises the lead agency and the partner agencies
- Advocates to universities & others who should be involved.
- Maintains both Diversity & Disparities on the agenda.
- Works with all the partner agencies.

- Appraises the agencies on what's happening.
- Connect OMH's training & technical assistance work with the 3 populations to each other to other initiatives. NO SILOS.
- Branch doesn't control the funding.
- Bigger question: How to keep diversity & disparities on the Tobacco Prevention & Control agenda?
- More inclusive
- Funding is a stick, but we also need carrots.
- Raise consciousness / awareness.
- Beyond the three Priority Populations
- Who you answer to. The community that can determine if we've achieved diversity in tobacco prevention & control
- A subcommittee of NC Alliance for Health?
- DHHS Steering Committee
  - Advises & guides OMH
  - Steering each other & themselves
- Focus on Parity & inclusion
- Steering Comm. won't develop the timelines & milestones
- Partner agencies will develop their own timelines & milestones & funding.
- An infrastructure that supports movement toward parity & inclusion in TPC.
- New grants??? You look for the opportunities. What you do with the dollars & who directs the funds, not more funding.
- Develop new leadership: lays foundation for resources needed to achieve parity & inclusion.
- Looking for new funding to support this plan
- A plan to guide those who have funding. Not a dictate.
- technical support & incentives
- Lead agency does not assign tasks.
- Strategic Plan - TPCB lead agency with Diversity Workgroup and other partners implementing specific strategies.
- How does it get done?
  - ✓Moral persuasion
  - ✓Formal link to Health & Wellness Trust Commission
  - ✓Commitment by partners.
  - ✓Steering Committee coordination & support
  - ✓Formal link to DHHS Steering Committee
  - ✓Steering Committee communicating way cool achievements.
- How we get our work done…..
  - ✓Partner with researchers to test/evaluate innovative methods for identifying & eliminating tobacco-related health disparities.
- SC – percolates up ideas for this extra work.
- SC - hosts a diverse practitioner – researcher dialogue
- Promote opportunities for young, minority researchers.
- Partner with more established researchers.
- Branch can <u>educate</u> but not lobby … also can <u>convene</u>.
- Steering committee as an outside entity can advocate for policy.

- NC Alliance for Health
- Bring diverse voices to the Alliance table
- Champions for social justice – broaden the movement; tobacco as a social justice issue!
- NC Fair Share
- Whatever we do, trace it back to the strategic plan (4.2)
- Housing Authorities

- What's the crossover between the plan & the excise tax?
  - low income advocates can blunt opposition to the tax
  - "Regressive" = more burdensome to lower income people

- Consider:
  - 80% of smokers want to quit
  - Quitting frees-up $$ from tobacco
  - Raising prices encourages quitting. (We got evidence)
- Use rural health centers to advocate.
- Steering Committee can support Alliance, ask the Alliance, "what can we do to help this initiative?"
- Share email lists.
- Volunteer Liaison: Wait until Steering Committee is constituted!

Policy Consideration Discussion (relating to TPCB Policy)

- Home-based "policies"
  - relevant to populations of concern
  - (intuitively) cost effective
  - might rely upon mass media
  - relates to 3.3 strategy
- Other target groups and institutions for disparately affected populations:
  - Housing Authorities
  - Prisons
  - Group Homes
  - Focus on low-income disparate populations

AGENDA
Strategic Planning: Tobacco-Related Health Disparities
Last Meeting
Thursday, December 19, 2002
Chapel Hill - Sheraton

Desired Outcomes:

Awareness of new developments related to:
- δthe Health Trust Priority Populations
- δSmoking Cessation Resource Guide
- δIdeas for Marketing the Strategic Plan

δProcess for giving feedback on the Strategic Plan document
δCelebration of Accomplishments!

Agenda

10:00 Convene

Introductions and Meeting Overview, *Andy Sachs, Facilitator*

10:15 Announcements

- NC Health Trust Priority Populations Grant Recipients, *Leslie Brown, NC Office Minority Health and Health Disparities*
- Availability of Smoking Cessation Resource Guide in Korean, *Delmonte Jefferson, NC TPCB - Youth Empowerment Director*

10:30 Marketing the Strategic Plan

- Media Presentation "Start Spreading the News," *Ann Houston, NC TPCB - Director of Public Ed. & Communications*
- Brainstorm ideas for marketing the Strategic Plan, *All*

11:00 Strategic Plan Document

- Presentation, *Laurie Mettam-Rude, NC TPCB - Director of Diversity*
- Decision on process (deadline) for providing feedback to Laurie, *All*

11:45 Process Evaluation

- Handout and explanation, *Felicia Snipes, NC TPCB*
- Complete and hand-in the evaluation form, *All*

12:00 Awards Ceremony, *Laurie Mettam-Rude*

12:30 Lunch

1:30 Adjourn

Attachment 7.4 Critical Issues

NC TPCB Diversity Workgroup Data Forum's
Critical Issues

We can begin to address tobacco-related disparities in North Carolina by…

Lowering tobacco use prevalence rates in the following population groups

- ✓ Individuals with Low Socio-Economic Status (SES)
  - Individuals with high school or less education levels have highest rates in smoking, exposure to second-hand smoke, smokeless tobacco use
  - Medicaid and WIC recipients show high smoking prevalence among pregnant women

- ✓ NC American Indians
  - focus on: youth initiation, adult smoking & chewing tobacco prevalence, tobacco use during pregnancy

- ✓ 18 – 24 year olds : high smoking incidence, ETS exposure, willing to quit, trends increasing dramatically in all population groups, African Am. have different patterns of use based on age

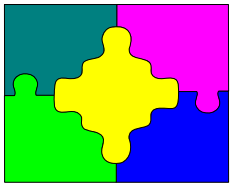
- ✓ Rural areas of
  - Western region -
    - Male smokeless tobacco rate extremely high
    - Counties with extremely high rates of smoking among pregnant women in Western region and 4 counties in southeast region
  - Eastern region - High smoking prevalence. Multiple factors include: high rates of poverty, tobacco dependent communities, migrant farm workers, limited access to health care.
  - Geographic disparities of youth initiation

Developing strategies to lower the Smoking Attributable Mortality Rates in Coronary Heart Disease and Lung Cancer

- ✓ Current data shows the rates are highest among African Americans, American Indians, White Americans (respectively). The Lung Cancer rates are highest in the Eastern NC region where corresponding high levels of tobacco use occur.

Collecting quantitative or qualitative data as follows:

- ✓ Policy level data on Cessation for all population groups
- ✓ ETS Policy data by Occupation (labor, service, farm, etc) and in homes.
- ✓ Occupational health issues related to Spanish - speaking migrant workers in Eastern NC.
- ✓ Effects of industry marketing and donations upon populations & communities
- ✓ State-level data on tobacco use prevalence for :
  - Asian-Americans
  - Gays/Lesbians/Bisexuals/Transgender
  - Latinos and other Immigrants/Refugees



NC TPCB Diversity Workgroup
Population Assessment
Critical Issues - Draft

We can begin to address tobacco-related disparities in North Carolina by:

✓ ***Developing a system to collect additional data for those groups with little or no current state-level data.***

Discussion notes:

- Use primary data from community members - not secondary data from those working with the populations. Identify the social norms for each population group when collecting qualitative data.

Examples include:
Immigrants -tobacco use in country of origin
Substance abuse clinics -Smoking cigarettes used as an alternative to other drugs.

- High Cigar use among African Americans - related to use of blunts?
- LGBT- collect data at community venues
- American Indians- faith based and tribal communities

✓ Developing and supporting community-based programs that reflect the cultural norms, values, and lifestyles.

Discussion notes:

- Increased community involvement increases success.

Examples include:

- Lay Health Advisors messages and messenger coming from the community are most effective (e.g. NC Am. Indian's faith-based cessation model).
- Faith based communities are effective channels
- Incorporate protective factors (e.g. African Am. parental sanctions for youth)

✓ Gaining the support of leaders in the communities with tobacco-related disparities to make tobacco issues a priority.

Discussion Note:
Barriers: language and lack of awareness of the health impact of tobacco use.

- Hispanic/Latino - largest immigrant population in NC. Most are from Mexico, but all 26 South American countries are represented in NC. Many of the young Latino men smoke.
- East European immigrants see smoking as a common practice - "most adults smoke"
- Increased smoking among Asian youth due to tobacco industry marketing in their country of origin. Vietnamese - third largest Asian population in NC. Many men and younger women smoke, as do Korean American youth. Adults males from the Philippines smoke heavily.

✓ Focusing on the health impacts of tobacco use while recognizing economic and historic ties to tobacco/industry.

Discussion Notes:

- Various groups had depended on tobacco economically (farming, manufacturing, industry sponsorship)

- Work with communities to develop alternative strategies to receiving funds from Tobacco. (See "*A Tool Kit for Corporate Donations - Helping Local Groups Say NO to Tobacco money*")
- Analyze tobacco industry marketing and sponsorships - how does it differ in various communities?

✓ Creating culturally appropriate public awareness campaigns of tobacco-related disparities within specific populations throughout the state.

Discussion Notes:

- *Develop social norms marketing approach. Counter-market by lifestyle, not ethnic/race groups. Literature shows the most successful approach is to focus on consumer attitudes and lifestyle. (needs and values of smokers and nonsmokers) Example: family health, youth, cultural identity.*
- Communicating prevention messages across SES. Focus on commonalties: SES across groups. Common message: You are being exploited. Your cultural identity is being threatened.

✓ Identifying and enhancing the capacity/ infrastructure of each population group.

Discussion Notes:

- LGBT - communication is through social groups, human rights organizations, political organizations and local events
- *Look at current infrastructure of those agencies that provide tobacco use prevention and cessation such as: TPCB 10 local coalitions, ? Why Youth Centers, Healthy Carolinians, etc. But what capacity does it group have? Look at this at SWOT analysis.*

✓ Ensuring the strategic and action plan is effectively marketed, widely disseminated, and executed among diverse groups.

✓ Engaging communities in proactive strategies to gain funding to implement the plan.

✓ Increasing the capacity to reach and serve Low SES individuals

Discussion notes:

- Focus on the under-served (individuals with low educational attainment and low income.
  Recognize the shared economic barriers.
  Ear mark funds for people with low-income to access services.
- Collaborate with agencies that serve the Low SES population and new allies (e.g. public housing)

NC TPCB Diversity Workgroup
SWOT analysis - Critical Issues Draft

We can begin to address tobacco-related health disparities by:

- ✓ **Building Community Capacity**
  - Developing ways to identify, nurture, and develop youth & adult leadership in tobacco use prevention and control (internships, community leadership, fellowships, etc.)
  - Building capacity of community-based organizations on counter marketing and political advocacy
  - Addressing the communities where they are by integrating tobacco use prevention and cessation into current programs

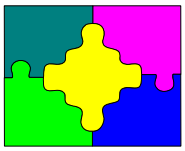
- ✓ **Fostering Partnerships**
  - Increasing partnering organizations representative of disparate groups in the planning and implementation of the plan.
  - Using a community based approach such as:
    - Engaging minority college/universities in tobacco use prevention/control.
    - Incorporating tobacco prevention in educational systems (i.e. Title IX, HBCU's)
    - Bringing in and working with faith-based organizations to reach disparate groups
  - Creating stronger partnerships between politicians, programs, and organizations representing diverse populations, not only in tobacco-related issues, but in general.

- ✓ **Increasing organizational capacity to address disparities**
  - Building a strong working relationship of the Diversity Workgroup, TPCB, Office of Minority Health & Health Disparities and other organizations addressing health disparities
  - Encouraging more input from outside state government

- ✓ **Disseminating Information**
  - Sharing core messages (goals and strategies) to all population groups and TPCB services available to community (technical assistance, training, information dissemination, program evaluation, etc.)
  - Publicizing/disseminating information on community success via culturally appropriate channels
  - Demonstrating tobacco related health consequences (disparities) proper significance as priority issue – to community leaders and members and other decision makers
  - Educating political candidates and other decision -makers about health consequences related economic impact, and the importance of this issue to minority populations.

- ✓ **Counter Marketing**
  - Use social marketing techniques using pro-health messages

- ✓ **Distributing Funds**
  - Developing infrastructure for distribution that ensures recipients success



Attachment 7.5 Goals and Strategies

NC TPCB - Diversity Workgroup Goals and Strategies

Goals	Strategies
Population-Specific Interventions	
1. Lower tobacco use prevalence rates among all populations with a priority on reducing the highest rates in North Carolina.	1.1 Increase active involvement at the local level of youth and adult leaders, community groups and organizations representing all disparate populations. This includes but is not limited to populations with the highest prevalence rates as determined by current data (Low SES, American Indians, Hispanic/Latinos, 18-24 year olds, and rural residents).
	1.2 Increase the # of faith communities that serve American Indians, African Americans, Asians, Latinos, LGBT, and rural areas challenged with high unemployment and low educational attainment who are actively involved in tobacco use prevention and cessation.
	1.3 Increase the # of colleges, universities with large rural and minority populations that adopt a tobacco-free buildings and dorms policy. Increase the # of school districts with large rural and minority populations that adopt a 100% tobacco-free school policy.
	1.4 Provide technical assistance, training, and resources to assist rural, service and blue collar manufacturing and farming work-sites in adopting smoke-free policies and reducing tobacco-related workplace hazards.
Surveillance & Evaluation	
2. Eliminate gaps in data by improving the collection, analysis, and systematic use of valid data relevant to tobacco-related disparities.	2.1 Collaborate with community leaders to conduct culturally – appropriate community assessment on tobacco use in priority populations with no valid state/local data (e.g. LGBT communities, Asian subgroups, Spanish-speaking Latinos, farm-workers in Eastern NC, and immigrants/refugees) and little valid state/local data (e.g. American Indians, 18-24 year olds, low SES, rural residents)
	2.2 Share all collected data with communities in formats they agree to be most useful and meaningful.
	2.3 Develop innovative methods and venues to collect qualitative and quantitative data to guide program development and evaluation (e.g. Low SES - survey public housing)
	2.4 Use the data in the ongoing strategic planning, implementation, and evaluation processes
Information	
3. Raise awareness of tobacco-related health issues through the organizations serving disparately effected population groups.	3.1 Create mass media campaigns that focus on lifestyle behaviors (social marketing and Consumer Health Profiles data)and target diverse community media markets.
	3.2 Provide incentives to community leaders to promote dialogue on the health implications of the addictive use of manufactured tobacco.
	3.3 Collaborate with disparately affected communities to develop education campaigns promoting tobacco- free homes and home-based day care centers. (Note: homes may include institutional homes such as group homes and prisons.)

Goals	Strategies
	3.4 Increase awareness of tobacco-related health issues including Green Tobacco Sickness
Advocacy	
4. Change tobacco related social norms and policies using culturally-appropriate methods.	4.1. Engage both statewide and local community organizations to advocate for pro-health policies (e.g. access to cessation services for low SES populations).
	4.2 Identify and advocate for specific public & private policies that improve tobacco-related social norms of disparately-effected groups in school settings, blue collar and service work-sites.
	4.3 Provide incentives to community advocates to disseminate information on health impacts of increased exposure to secondhand smoke to local restaurants and other public places.
	4.4 Recruit health care providers who serve diverse communities to provide patient education on tobacco use prevention and cessation.
Organizational Capacity	
5. Provide community leaders at the state and local level with the opportunities to increase knowledge, expertise, resources, and infrastructure.	5.1 Provide culturally appropriate training, workshops, and creative learning opportunities that move organizations toward reducing tobacco-related disparities.
	5.2. Promote partnerships between new allies and organizations experienced in providing effective tobacco use prevention and cessation programs to diverse communities.
	5.3 Increase cultural competence in all organizations providing tobacco use prevention and cessation programs.
	5.4 Provide incentives to increase active involvement of youth and adult leaders, community groups, and organizations representing all disparately effected populations.
Funding	
6. Secure sustainable funding for population groups with identified disparities to build capacity and/or implement interventions.	6.1 Provide grant-writing training and technical assistance to communities/population groups with identified disparities.
	6.2 Obtain external funding sources that focus on the identification and elimination of disparities.
	6.3 Commit 10% of funding for evaluation, including evaluation of innovative, pro-health policies and programs.

7.6.1 Workgroup General Meeting Observer Checklist

	Great Extent	Some Extent	A Little	Not at All	Comments
Openness					
There is adequate representation of population groups with disparities.	4	3	2	1	
Participants are encouraged to attend all workgroup meetings.	4	3	2	1	
Participants feel comfortable expressing their views.	4	3	2	1	
Chairs/co-chairs and/or facilitators are responsive to participants concerns.	4	3	2	1	
Formal procedures are used to facilitate discussions/decision-making.	4	3	2	1	
Adequate time for Q&A and discussion.	4	3	2	1	
Participation					
All participants bring issues to the table.	4	3	2	1	
Workgroup members from population groups with disparities actively participate.	4	3	2	1	
Lay language is used so everyone can understand.	4	3	2	1	
Participants demonstrate a high level of interest in the proceedings.	4	3	2	1	
Decisions are made through consensus and/or working consensus.	4	3	2	1	
Productivity					
Participants receive agendas or materials to review before the meeting.	4	3	2	1	
All agenda items are addressed.	4	3	2	1	

Meetings run smoothly with minimum interruptions or disruptions.	4	3	2	1	
Conflicts are resolved to the satisfaction of each party.	4	3	2	1	
Meetings end with tasks assigned/action steps.	4	3	2	1	
Meeting sticks to time schedule	4	3	2	1	

General Meeting Details

	Description and Comments
Date/Time of Meeting	
Purpose of Meeting	
Agenda Topics	
Meeting Location	
Who Lead the Meeting (affiliation)	
Number of Attendees	
Breakdown of Attendees (include group represented)	
Atmosphere of Meeting (cooperative, tense, confused, etc)	
Additional Comments/Notes	

Subgroup Meeting Details

Evaluation
# of meetings

Members:

Average attendance:

Resources
# of meetings

Members:

Average attendance:

Attachment 7.6.2 Meeting Observation Data

Observation Items

Openness	Mtg.1	Mtg.2	Mtg.3	Mtg.4	Mtg.5	Mtg.6	Mtg.7	Mtg.8	Mtg.9	Mtg.10	Mtg.11	Mtg.12
Diverse representation	3	3	2	2	2.5	2	3	1.5	2	2	2	2
Encourage attendance	4	3	3	2	4	2	4	4	3	2	4	2
Participants comfortable	2	4	4	4	4	4	4	4	3	4	4	3
Facilitators responsive	2	4	4	4	4	4	4	4	4	4	4	4
Formal discussion*												
Adequate time	4	3	4	3	4	3	4	4	3	4	4	3
Openness	15	17	17	15	18.5	15	19	17.5	15	16	18	14
Openness	3	3.4	3.4	3	3.7	3	3.8	3.5	3	3.2	3.6	2.8

Participation	Mtg.1	Mtg.2	Mtg.3	Mtg.4	Mtg.5	Mtg.6	Mtg.7	Mtg.8	Mtg.9	Mtg.10	Mtg.11	Mtg.12
All bring issues	2	4	2	3	4	3	4	3	3	4	4	3
?Disparate groups active	2	4	3	3	4	3	4	3	3	4	4	3
Lay language	2	4	4	3	4	4	4	4	4	4	4	4
Participant interest	3	3	4	4	4	4	4	4	3	4	4	3
Consensus	1	4	4	2	4	4	4	4	3	3	4	3
Participation	10	19	17	15	20	18	20	18	16	19	20	16
Participation	2	3.8	3.4	3	4	3.6	4	3.6	3.2	3.8	4	3.2

Productivity	Mtg.1	Mtg.2	Mtg.3	Mtg.4	Mtg.5	Mtg.6	Mtg.7	Mtg.8	Mtg.9	Mtg.10	Mtg.11	Mtg.12
Pre-meeting materials	3	3	1	2	3	4	1	4	4	1	2	2
All items addressed	4	3	3	1	4	4	3	3	3	3	2	3
Minimum disruptions	3	4	4	3	3	2	3	2	3	2	3	3
Resolve conflicts*		4								4		
Tasks assigned	2	4	3	1	4	3	4	4	4	2	4	2
Stayed within time	3	1	4	3	3	2	3	2	4	2	3.5	4
Productivity	15	15	15	10	17	15	14	15	18	10	14.5	14
Productivity	3	3.0	3	2	3.4	3	2.8	3	3.6	2.3	2.9	2.8

Scale = 1 "Not at all" 2 "A little" 3 "Some extent" 4 "Great extent"

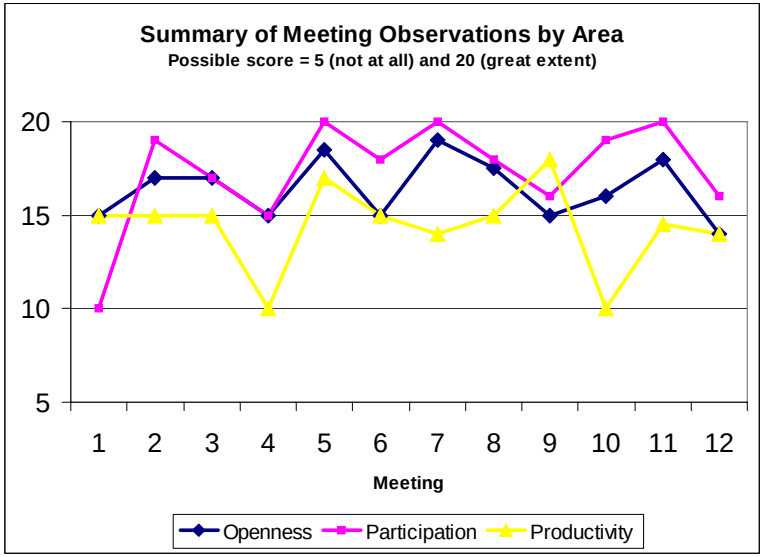
*Only used if consensus is not achieved or conflicts exist, otherwise left blank (not included in stats)

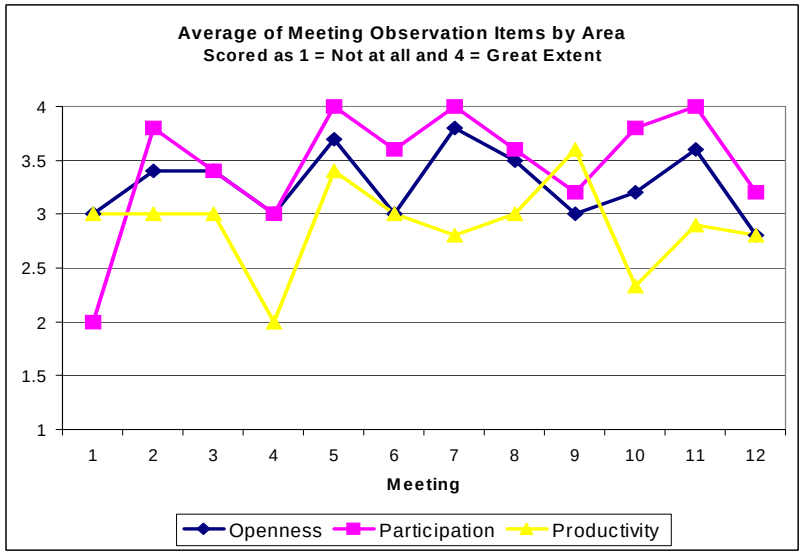
Other Items													
Length (hours)		3	3.75	5	5	6	5	5	4.5	5	5	5	5
Location	R	R	R	CH	R	CH	R	R	R	R	R	R	
Facilitator		2	1	1	1	1	1	1	1	1	1	1	1
# of attendees		18	14	15	20	16	14	22	12	13	18	9	8
# of agencies or groups**		11	7	8	11	9	8	13	7	6	9	5	6
Breakdown by group***													
State - TPCB		1	1	1	1	1	1	1	1	1	1	1	1
State - Other divisions		3	1	2	1	1	1	3	2	1	2	1	2
Nonprofit National		1	1	0	1			1	1	1	1	1	1
Nonprofit State		0	0	0	1			1					
Voluntary		1	0	0	1		1				1		
Statewide ethnic		1	1	2	2	2	2	2	1	1	2	1	1
Local/Community		1	2	0	1	1	1	1	1	1	1	1	1
Academic		1	0	2	1	2	1	2	1		1		
Individual Minority		2	1	0	1	1		2		1			
Atmosphere of meeting		3	1	1	4	1	1	1	1	4	4	2	1

**Will not match # of attendees because multiple individuals attend for some groups

***Full list in qualitative items

Codes: Facilitator 1=Nonstate, 2=State; Atmosphere 1=cooperative, 2=tense/frustrated, 3=confused, 4=mixed





	Initiate Strategic Planning 12/12/01	Consensus Building Training 3/5/02	Data Sharing 3/28/02	Policy Data Sharing 5/2/02
Agenda Topics				
1	Review Action Areas/Goals	CDC requirements	Share context/prevalence data	Understand social norms approach
2	Overview of CDC and timeline	Effective Group Process	Identify critical issues	Awareness of policy-related data
3	Roles	Membership Rules	Closure on group protocol	
4				
Major accomplishments				
1	Sign up for workgroups	Ground rules agreed upon	Reviewed data	Reviewed data
2		Established membership requirements	Identified critical issues	Met resource people
3			Education on stats 101	
Facilitator notes		(-)Agenda too "thick". Too much to do	(-)Poor turnout, few workgroup members (-)talking over each other (+)follow-up on discussion (+)people engaged, interested (+)came together as planned	
Additional notes	*Academic/branch members dominated *Lack low-income, rural, LGBT *Facilitator very informal, no clear consensus procedure *Lack of clarity on follow-up tasks	*Small group #2 had a hard time getting started, facilitator stepped in and directed, this really helped. *Lack low-income or educ, LGBT reps *Had to work through lunch and still did not complete agenda *ACS rep left after 15 minutes *More vocal community members (b/c fewer professionals at meeting?)	*Facilitator stepped in to redirect small group with branch head and academic "expert" *Reviewing and setting up the process at the beginning helped *Difficulty is that people move into strategy almost immediately, aren't used to reflection on data	*Emerging issue (Trust $) took time, diversion from agenda *Professionals dominated full group discussions, small groups less so *Few locals - plus no one east of Raleigh only one west of Greensboro *Small group discussion format worked well for full participation but did not focus on disparities
Participants				
State - TPCB	Branch head + 3	5 (Include paid evaluator)	Branch head + 4 (2 eval)	Branch head + 7 (2 eval)
State - Other divisions	NC Commission on Indian Affairs NC Council of Women OMH	OMH (Leslie)	OMH (Leslie) NCSCHS (Karen & Paul)	NC Council of Women
Nonprofit National	CIS	CIS		CIS
Nonprofit state				Prevention Partners (presenter)
Voluntary	ACS			ACS
Statewide Ethnic	El Pueblo	El Pueblo (3)	El Pueblo (Mainor, Andrea) AAAT (Karen Morant)	El Pueblo (Mainor, Andrea) AAAT (Margaret)
Local/community	Council on Adolescents	Council on Adolescents (2) Hi-top ASSIST		Hi Top Assist
Academic	UNC - Kurt R		UNC- Kurt, Tim, Lisa (presenter) HBCU	UNC- Kurt, Lisa & Anne (presenters)
Individual Minority	Am Ind - Shorty AA-Sandra Headen	Am Ind - Shorty		Am Ind - Shorty

	Population Assessment 6/19/02	SWOT Analysis 7/24/02	Goal Setting 8/22/02	9/4/02
Agenda Topics				
1	Review industry marketing issues	Critical issues from previous meeting	Develop goals & strategies	Info Sharing
2	Share info on media markets	Conduct SWOT analysis	Renew inspiration to fight	Review and Finalize goals
3	Consensus on 10 critical issues		**DATA FOR THIS MEETING	Develop strategies
4	Share population reports & draft 10 critical isssues		FROM DIFFERENT OBSERVER	
Major accomplishments				
1	Learn about issues for AA, LGBT, Hispanic, AI, mountain, Hmong	Learned about immigrant issues from new member	Excellent discussion re: goals	
2		Critical reflection on strengths/weaknesses		
3				
Facilitator notes	(-) Jokes about mountain folks (+) People attentive, listened well	(-) Not being on time-only 4 at 10:00 (+) Those there great participation		(-) presenters not needed took time
Additional notes	* Began by going over entire process and reminded folks of where we are and how they need to participate and give feedback. *Facilitator did an excellent job and gently but very firmly stopped stereotype comments, asked group to continue in respectful manner. *Individuals listened attentively and stayed active throughout. *GLBT community info done well but individual NOT organizational, no low SES, Asian represented	*Facilitator did excellent job of encouraging people to be "ruthless" about weaknesses, yet "brag" about strengths. Set up meeting for honest discussion	Very open/very productive/rich discussions	Facilitator took goals to "wordsmith" after meeting rather than coordinator (to avoid the coordinator's desire to change meaning or add things)
Participants				
State - TPCB	7 (2 eval)	6 (2 eval)	6 (1 eval)	6 (2 eval)
State - Other divisions	NC Council of Women	1 Office of Minority Health	NC Council of Women	NC Council of Women
			OMH	OMH
			Office of Rural Health	
Nonprofit state			Old North State	
Local/community	Hi Top Assist (Margaret)	Durham Center (Paul - new)	Durham Center	Durham Center
Nonprofit National			CIS	CIS
Voluntary		American Cancer (Chuck)		
Statewide Ethnic	El Pueblo (Mainor + 2) AAAT(Karen)	El Pueblo (Mainor), NC Asian group (Milan)	El Pueblo (Mainor + Harriet) AAAT (Karen)	El Pueblo (Mainor)
Academic	UNC - Tim, HBCU Lorna	UNC - Tim, Lynn (AI liaison), Lisa	UNC -Tim	UNC - Tim
			HBCU (marg))	
Individual Minority	AA-Sandra Headen		AA - Sandra Headen	
			AI -Lawrence	

	9/19/02	10/1/02	11/13/02	
Agenda Topics 1 2 3 4	 Develop strategies for each goal Initial ideas for objectives	 Finalize strategies	 Feasibility/Timeline & Milestones	
Major accomplishments 1 2 3	 Clarified definition of strategies Developed list to be wordsmithed	 Finalized strategies	 Changed agenda of steering group	
Facilitator notes	Frustrated by initial "rush" to get closure rather than spend time understanding process; felt some tension between the rush and wanting to get clarity before moving forward. Felt that opening up was important, especially given that this was an extra meeting.	Group felt ownership, dug in. Concerned about getting through the process.	-Unfolded different than agenda - needed to listen and be flexible -Get buy in before too much detail b/c we are going back -Disempowerment of staff by both CDC (by changing midstream) and branch head	
Additional notes	The group really showed a willingness to work, stayed engaged.	Facilitator reminded us that "this is the day to own it". Got through some major discussion issues around the issue of "evidence based" strategies and how this is a catch-22 for disparities work because evidence isn't there	-Facilitation was excellent at identifying the frustration & allowing feedback to revise agenda FOR CDC - group experienced "feasibility, timelines, milestone" as ridiculous and irrelevant to reality of which there was not funding and no control.	
Participants State - TPCB State - Other divisions Nonprofit state Local/community Nonprofit National Voluntary Statewide Ethnic Academic Individual Minority	 7 (2 eval) OMH Durham Center CIS El Pueblo (Mainor & Harriet) AI -Lawrence	 7 (2 eval) OMH Office of Rural Health Durham Center CIS ACS (left early) El Pueblo (Mainor, Harriet/Kathy 1:30) AAAT (Karen) UNC (Tim and Lynn Chavis - AI)	 4 (2 eval) Office of Rural Health Durham Center CIS El Pueblo (Harriet & Nadeen)	

Attachment 7.6.3
Key Informant Interview Questions - Get Organized section

1. Do you feel the membership of this group represents the diversity of the populations that we know are adversely affected by tobacco problems? If not, who is missing?

2. What techniques used in the workgroup seem most effective in keeping members involved and committed?

3. Do you feel you received enough background information on the issues involving tobacco control to get you oriented?

4. Are the workgroups organized well? What changes in the way the group is organized might facilitate the process if it were duplicated in another place?

5. What overall changes would you suggest to the early stages of this planning process to make it work more effectively and efficiently?

Key Informant Survey Results:
Getting Organized

Ten workgroup members responded.

Did the membership represent the diversity of populations adversely affected?

- Some populations well-represented others left out or under represented
- The racial/ethnic groups were well represented with the exception of the Asian community.
- The Gay/Lesbian/Bisexual/Transgender persons were represented by an individual from the Lesbian community, not a representative from an organization.
- People with low socio-economic status were under-represented with only one organization whose mission focused on the needs of the under-served.
- The people at the table are all "the usual suspects" - needed to include some new faces.
- Over-represented in some areas, such as the University community, the TPC Branch, and African Americans

What techniques effective in keeping members involved?

- Email has helped keep people involved and informed in-between meetings
- Open atmosphere for frank dialog
- Strong agendas and shared expectations
- Small group discussions
- Slowing down the discussion so people can listen
- A facilitator is helpful

Did you receive enough information to get you oriented?

- Letting people know how tobacco money is being used was good
- Orientation materials very well done
- Would have liked more information on the background of the grant and the goals. This information was only shared at the first meeting in December, so anyone who joined the group later was not as well informed on this aspect of the grant
- All the data was very useful

Was the workgroup well-organized?

- Yes, the smaller teams had specific focus that allowed members to share their specific interest and expertise
- Breaking up into committees people felt comfortable and increased involvement
- A professional facilitator helps keep the process working well
- Ideally better representation from more community-based organizations
- Branch staff is the strength of the process
- Workgroup well-organized and information is shared effectively
- Might need to move meetings around geographically to help the dispersion of the group

Overall changes in organization phase:

- Would have been nice to have had more community organizations involved
- Balance – get good balance of voices
- More focus on under-served rather than race
- CDC's vision was evolving as we began. New focus on group process evaluation and the change toward gathering qualitative data was a good move.
- Not everyone needed is at the table
- Don't begin workgroup meetings until all the quantitative data is gathered. More time is needed in the beginning to get more involvement from other community groups and agencies
- Hold meeting in various regions of the state

Attachment 7.6.4
Key Informant Interview Questions:
Population Assessment and SWOT Analysis sections

Please answer the following questions for our Case Study of the process. Your responses will be kept confidential and aggregated to form our assessment of what worked well and what didn't, to help the Centers for Disease Control in future planning grants.

Population Assessment Phase

As you recall, in this phase we asked specific disparate groups to report back on their community's specific issues regarding tobacco use (meeting held at the American Cancer Society Building). Members of the Diversity Workgroup and other community leaders filled out a survey form as well as reported back to the group as a whole.

1. Thinking back to the Population Assessment Process, what do you think worked well about the data gathering to learn more about these communities? What barriers did you see?

2. Was there a value to the reporting back to the group, or did you feel it was not as useful as you'd hoped? What could have made this process better?

3. What could have been done to improve the population assessment aspect of the data gathering for this grant?

4. Do you have additional comments about the population assessment for the disparities grant?

SWOT Analysis

During the SWOT Analysis, the strengths, weaknesses, opportunities, and threats were examined (meeting held at the Sheraton Europa in Chapel Hill) and boiled down to a set that was acceptable to the Diversity Workgroup.

5. Did you think the process used to set the SWOT lists was appropriate and effective? Do you have suggestions about this part of the process that might make it run smoother?

Synthesis

6. Looking back over the Data Collection, Population Assessment, and the SWOT Analysis, what would you say are the strengths of this process so far?

7. What are the weaknesses?

Thanks so much for your opinions. Please email the responses to kathy.blue@ncmail.net or fax them to me at (919) 715-4410.

Key Informant Survey Results:
Population Assessment and SWOT Analysis

Seven workgroup members responded:

Population Assessment Phase

What worked well:

- Follow-up with communities not at the table – Project Manager did a good job of getting information from groups other than those represented at meetings
- Workgroup was able to get qualitative data on issues the quantitative data would not reveal – helped the group see linkages
- Helped put flesh on the framework – the data doesn't show everything
- Allowed the workgroup to share some of the burden of work and get more involved instead of just being passive recipients of information

What barriers:

- Some groups weren't represented at all or were inadequately represented– low SES, blue collar, Asian subgroups
- Communities based on broad racial characteristics are not all the same – there are many subcultures in the Hispanic population – each has its own differences

Was reporting to the group valuable?

- Found it very useful to hear the individual reports. Made me think about bigger issues
- Wish we could have had all the people at the table instead of written reports
- Learned a lot

What could have made it better?

- Longer time period for Population Assessment questionnaires to go out to the communities
- More regional dispersion
- Wish we could have worked out in the communities to gather the data rather than doing it by phone

SWOT Analysis

- The process was useful – brainstorming opportunities was especially good
- Surprising how much convergence and consensus there was
- Didn't find this part as useful as the data and qualitative pieces
- Too much representation from State and University staff
- Needed a bigger group

Synthesis

Strengths of the process:

- Laurie does a good job of information sharing, getting the data out for people to look at and sharing information
- Lots of data available for some groups on general population characteristics
- Great deal of interest in the data collection process
- It helped people look at the data and then think about the "why"
- This was a good way to present data. The maps were especially nice.

Weaknesses:

- Much data for subgroups missing – just not collected at the state level
- Not enough voices at the table
- The lack of statewide organizations representing some groups made it hard to get good Population Assessment information difficult
- Wish we could have taken the information from the data forums and taken it out in the community to get their response

Attachment 7.6.5
Focus Group Results (Completed Plan)

What are the barriers and advantages of the way the grant was implemented in the following areas:

Assembling the Workgroup?

- Initial Diversity Workgroup members from *Vision 2010*
- "Who's not here?" was a constant question
- A constant struggle for community representation
- Large time commitment
- Lack of awareness and commitment from community
- Resources
- Hardly anyone used the travel reimbursement, although there was money in the budget
- Few community leaders/volunteer members
- Travel restrictions for state government/county employees
- Location was a problem
- Statewide organizations represented, such as El Pueblo, but those without a statewide presence were absent
- Stipends would help or the promise of tangible benefits such as grants
- More outreach to people in the community
- Make sure disenfranchised groups see benefit of participation
- Road trips might have helped
- No low SES representation
- Ground-rules were a big help
- Too many voices from NC TPCB – it sometimes felt like a branch staff meeting
- Lack of consistency in attendance and participation
- High trust level – the group threw out a CDC tool because they felt they needed to do it differently
- CDC/State determined the priority populations ahead of time – group felt they should have had the power to choose who was in need
- Lots of knowledge sharing and learning
- Excellent facilitator is the key – need an impartial 3rd party
- Power dynamics of the branch was often visible and outsiders could see how it built consensus.

Identifying and Prioritizing Problem Areas?

- The forums were well received
- People reported having fun at the data forums
- Lots of various data represented – GIS and other sources were eye-opening
- Use of visual aids enhanced the data
- Looking at the data and discussing it helped coalesce the group – each one saw the data and began to lose their own agendas

- CDC provided a good process and tools
- If possible, the group would have liked to have taken the data out to fill in the gaps
- Would liked to have seen more data on policy support
- The scientific weighting process didn't work for the group – they liked it as a starter, but then moved into a more intuitive process of discussion and consensus building

Developing the Plan?

- Breaking it down into chewable chunks really helped
- Sometimes you just have to move on
- Huge projects like this are so overwhelming
- The meetings were exhausting
- Perhaps fewer meetings, more email discussions and more work by committee
- Committee structure didn't work well except for those with a specific product to create (evaluation team – and they were all being paid)
- Preamble was written by Harriett, Nadeen, and Betsy, saving the workgroup lots of work
- Laurie wrote the products and the group reacted – efficient, but a burden
- There was a core group that developed and hashed out issues, but several responded with comments via email
- Some feedback is needed from groups absent from the process
- If the purpose of the grant had been cleared in the beginning the product may have been different

Adopting the Plan?

- Workgroup adopted it but how it's implemented remains
- Concrete consensus helps with incremental adoption
- Good way to adopt the plan is by having agencies identify how they plan to implement the various portions
- Has the TPCB adopted the plan? The priorities aren't explicitly listed – But they will be in the CDC grant extension in some manner – Is the TPCB really committed to doing it?
- Will the Health and Wellness Trust Fund adopt the plan?
- How will priority populations adopt the plan?
- Need strong political advocates
- Might be better to have funded this through an outside group or at least implement it through a non-state group, so that they can use lobbying. State and local agencies also have their hands tied due to funding and legislative restrictions.
- Process may not have been politically savvy enough to navigate it through dangerous political waters.

MAJOR LESSONS

1. Think about what you want – input or relationship building or both.
2. Facilitator is a key. Must have the backing of the agency for an open, unimpeded process. The facilitator needs to be highly skilled and the right personality for the group.
3. Consensus! Let the group decide.
4. Flexibility – be ready to start over.
5. Long process results in a smaller core group at the end than the beginning. Keep it shorter than a year.
6. Shorten planning time frame, then go out and get input and build relationships.
7. When money gets tight, priority population projects get shunted aside.
8. The group felt so empowered, they decided to stay together.
9. Political realities affect the way the plan is developed and implemented.
10. Complex realities of funding and sustainability affect how the plan is received.
11. Money needs to be earmarked for implementation.
12. CDC needs to be clear in what they want grantees to actually achieve.
13. Process is important, so the product can be applied across issues. If the process is conducted correctly, the resulting planning product is useful with other problems.
14. If you can mobilize the populations involved, you can build a strong coalition that can actually share results.
15. An independent non-profit group might be the most effective lead agency rather than a state agency, since they cannot lobby. This empowers the disparity community, for whom this is a real concern, rather than folks who may be addressing it just because there is funding available.
16. Need to figure how to get the right folks to the table and keep them there.