OHIO'S GOAL #4 WORKGROUP
ELIMINATING DISPARITIES IN TOBACCO
COMMUNITY STRATEGIC AND ACTION PLANNING PROCESSES: CASE STUDY EVALUATION REPORT

I. CHAPTER 1: BACKGROUND AND OVERVIEW OF THE PROJECT

A. Background

As of 2000, Ohio was the nation's 7th largest state with 11,353,140 people (U.S. Census Bureau, 2000). Eighty-five percent of the people residing in Ohio were Caucasian, 11.5% were African American, 1.9% were Latino/Hispanic, 1.2% were Asian American, and 0.2% were American Indian/Alaskan Native. The state of Ohio is largely rural and divided into five regions, including, the northeast, northwest, southeast, southwest, and central regions. The four industries in Ohio that employ the most employees include manufacturing, health care, social assistance, and retail trade, respectively (U.S. Census Bureau, 2000). Food manufacturing firms employ the largest number of people within the manufacturing industry (U.S. Census Bureau, 2000). In the health care industry, hospitals employ the largest number of people (U.S. Census Bureau, 2000). Lastly, within the retail trade industry, food and beverage stores employ the largest number of employees in the state of Ohio (U.S. Census Bureau, 2000).

1. National adult and youth smoking prevalence rates

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

2. Adult smoking prevalence rates in Ohio

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

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

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

Sources: U.S. Census Bureau, 2000, ODH 2006, and CDC 2005.

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

TABLE 2 ESTIMATED ADULT SMOKING PREVALENCE BY POPULATION IN OHIO

Population	Estimated Smoking Prevalence
Uninsured[2]	55%
Medicaid[3]	50.1%
Unemployed Caucasians	45.2%
American Indians/Alaskan Natives[4]	43.2%
Caucasians with less than a high school diploma	42.4%
Individual earning less than $15,000	35.9%
African American males ages 35-54 years	30.7%
African American females ages 35-54 years	30.4%
Vietnamese[5]	23%
Caucasians	22.5%
African Americans	22.2%
Koreans[6]	22%
Asian Americans[7]	10.9%

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

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

3. Adult regional smoking prevalence rates in Ohio

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

[1] CDC Tobacco Control Highlights 2005 data were used to estimate tobacco prevalence rates for American Indians/Alaskan Natives, Hispanic/Latino Americans and Asian Americans in 2003 for the state of Ohio since these data were not available from BRFSS 2004 or 2005.
[2] Ohio Comprehensive Tobacco Use Prevention Strategic Plan 2004 – 2008: 2006 Update. The year for this statistic is not reported.
[3] Ibid.
[4] State level data were not available for American Indians/Alaskan Natives. This is a national estimate obtained from 2003 data (CDC, 2005).
[5] This data was collected during the years 2000 and 2001 and is not based on a random sample; therefore it cannot be generalized to the population (Adhikari, 2002).
[6] This data was collected in 2004 and is not based on a random sample, therefore it cannot be generalized to the population (Katsuyama, 2005).
[7] State level data were not available for Asian Americans. This is a national estimate obtained from 2003 data (CDC, 2005).

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

Sources: Bennett, 2006; ODH, 2005.

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

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

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

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

B. Purpose and Goals

The Ohio Tobacco Control Resource Group (OTCRG) was started in response to the National Cancer Institute's (NCI) Project American Stop Smoking Intervention Study (ASSIST). The NCI required states to establish a tobacco control coalition in order to apply for funding. Beginning in 1990, the NCI funded tobacco control projects in 17 states. Ohio applied, but did not receive any funding. Believing that CDC would fund other states with similar requirements to those of the NCI, the ODH began the OTCRG around 1990-1991. Ohio began receiving funding from CDC in September 1993. The OTCRG is not a tax-exempt organization,

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

therefore, it receives no funding and does not provide direct services or grants. The ODH uses the CDC funding to support local grants, contracts, and surveillance projects to provide staffing for the OTCRG.

The 2006 OTCRG membership roster included representatives from various organizations (see Appendix 1). A few members from the OTCRG created a Strategic Planning Committee. The Strategic Planning Committee helped develop the Ohio Comprehensive Tobacco Use Prevention Strategic Plan 2004-2008. The Strategic Planning Committee currently consists of representatives from the American Lung Association of Ohio, the American Heart Association-Ohio Valley Affiliate, the American Cancer Society (ACS) —Ohio Division, Tobacco Free Ohio (currently, Smoke Free Ohio), the Ohio Tobacco Use Prevention and Control Foundation (currently known as the Ohio Tobacco Prevention Foundation [OTPF]), the ODH Tobacco Risk Reduction Program, the Foundation for Healthy Communities, the Ohio Department of Job and Family Services, and the Ohio Department of Alcohol and Drug Addiction Services. In 2003, members from the OTCRG developed a strategic plan to address tobacco use in Ohio, titled, "The Ohio Comprehensive Tobacco Use Strategic Plan."

The five goals of the Ohio Comprehensive Tobacco Use Strategic Plan, include: 1) prevent initiation among youth and young adults, 2) eliminate secondhand smoke exposure, 3) reduce tobacco use among those currently using tobacco, 4) identify and eliminate disparities among those disproportionately affected, and 5) assure public policy supports comprehensive tobacco control. Four of these goals reflect the program goals of the Centers for Disease Control and Prevention Office on Smoking and Health's (CDC/OSH) National Tobacco Control program. The fifth policy goal was added to address program sustainability.

This case study evaluation report will focus on the Disparities in Tobacco Goal #4 workgroup's strategic and action planning processes. To address eliminating disparities in tobacco the workgroup was formed in March 2004 to focus on disparities in communities of color and other at-risk underserved populations in the state of Ohio. Nationally, this has been one of the most challenging areas to address for state-level tobacco prevention and control programs. Despite the challenges, high tobacco-related morbidity and mortality rates among communities of color and other at-risk underserved populations call for culturally-competent, "practice-based evidence," innovative approaches that can facilitate reducing and eliminating tobacco-related disparities among these populations. The term "practice-based evidence" is used because oftentimes in underserved populations, there is a lack of evaluated interventions to confirm what works (best practices). The goal, now, is to conduct interventions and evaluate them in order to "provide evidence" of what did and did not work.

The purpose of the Disparities in Tobacco Goal #4 workgroup was to develop their own strategic action, and marketing plans for addressing the identification, reduction, and elimination of tobacco-related disparities. The strategic plan was used to develop an action and marketing plan in order to lay the foundation for undertaking sustainable initiatives that will help to accomplish the goals and objectives of the comprehensive strategic plan that was developed for Ohio overall.

The vision and mission statements of the Disparities in Tobacco Goal #4 workgroup are noted below:

Vision Statement: To eliminate tobacco-related health disparities across the state of Ohio.

Mission Statement: To identify and systematically eradicate tobacco-related health disparities by using innovative approaches: building networks, alliances, infrastructure, and capacity; identifying gaps in data collection; providing culturally-competent education; advocating for tobacco-control legislation; and developing and supporting culturally-competent best practices for culturally diverse and other at-risk underserved populations that are disproportionately affected by tobacco use.

The goal and objectives of the Disparities in Tobacco Goal #4 workgroup include:

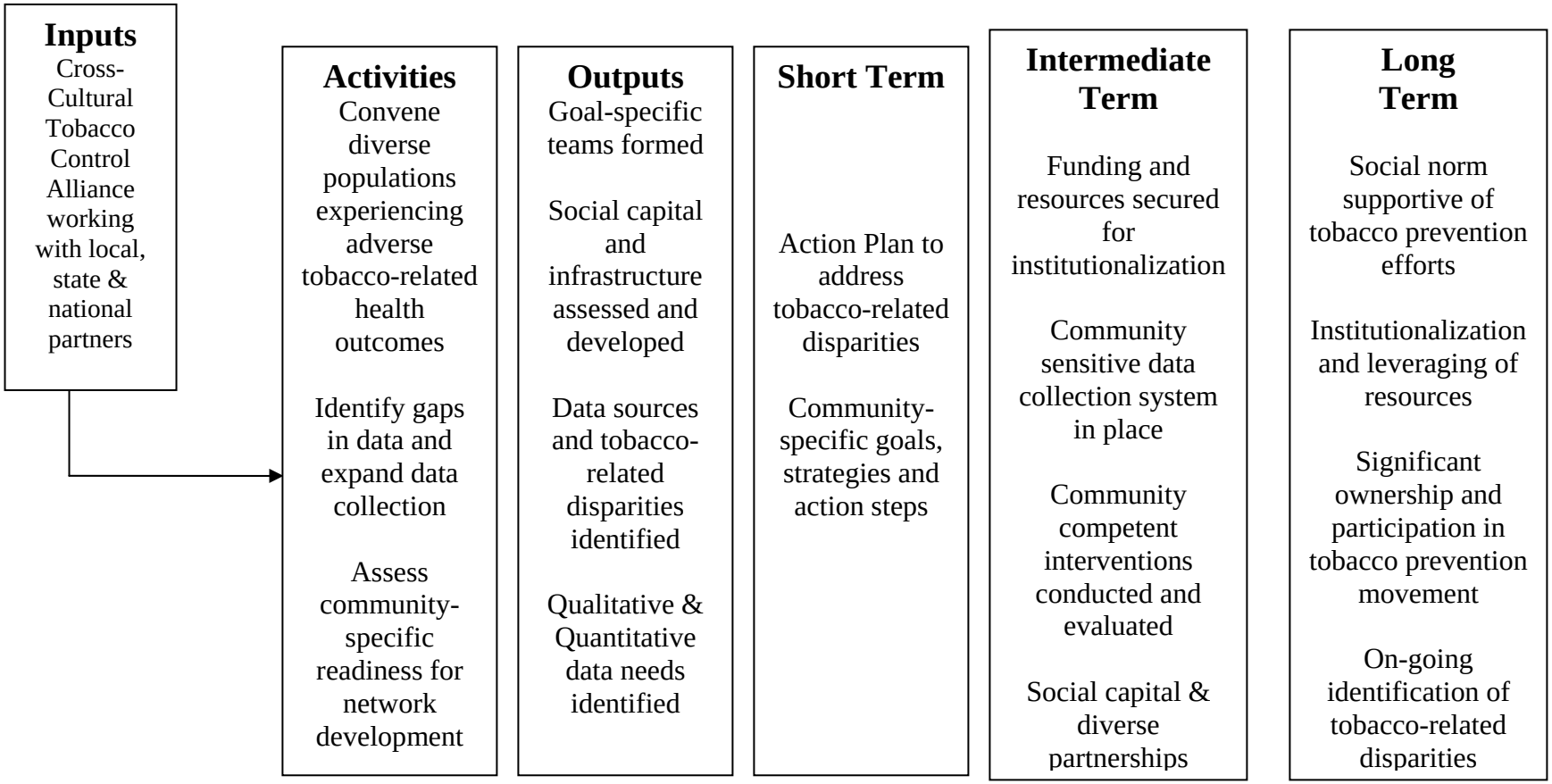
Goal: Identify and eliminate the disparities related to tobacco use and its effects among population groups disproportionately affected by tobacco use.

Objectives:

1. Increase the availability of tobacco-specific baseline and continuity of data collected related to communities of color and other at-risk, underserved populations to reverse adverse health outcomes.
2. Establish an adequately funded and fully operational tobacco education and advocacy alliance statewide among communities of color and other at-risk, underserved populations in order to build public health influence, capacity, and infrastructure.
3. Establish baseline data and increase by five percent the number of tobacco free workplaces (bars and restaurants included) that employ or serve at-risk, culturally diverse, underserved populations.
4. Increase the number of practice-based evidence tobacco-use prevention programs that are culturally competent for at-risk youth that also addresses age group and socioeconomic influences.
5. Increase the availability of adult practice-based evidence cessation programs, pharmaceutical support, interventions, awareness campaigns and information in communities of color and other at-risk, underserved populations.

The goal and objectives noted above will help the workgroup with accomplishing its short-, intermediate-, and long-term outcomes (see Figure 1). Figure 1 provides an illustration of the workgroup's overall plan to achieve its vision and mission.

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



Public Health Impact: Policy and Environmental Change, Improved Health Outcomes, and Social Justice

Source: Starr G., Rogers T., Schooley M., Porter S., Wiesen E., Jamison, N. (2005). Key outcome indicators for evaluating comprehensive tobacco control programs. Atlanta, GA: Centers for Disease Control and Prevention.

The Disparities in Tobacco Goal #4 workgroup held a series of brainstorming meetings in November 2004, February, 2005, and June 2005 which eventually led to the identification of the following priority populations that should be targeted for eliminating and reducing tobacco-related health disparities: 1) African Americans, 2) American Indians/Alaskan Natives, 3) Amish, 4) Appalachians, 5) Asian Americans, 6) Chemically Dependent, 7) the Deaf Community, 8) Hispanics/Latinos 9) Immigrants/Refugees, 10) Medicaid Eligible, 11) Mentally/Physically Challenged, 12) Lesbian-Gay-Bisexual-Transgender (LGBT), and 13) Veterans/Active Duty Military Personnel.

C. Overview of Tobacco Control Support and Opposition Efforts in Ohio

1. Tobacco Control Support Efforts

Local Smoke Free Ordinances. As of June 2006, 21 cities and townships had clean indoor air ordinances around the state (Tobacco Public Policy Center, 2006).[10] The OTPF, the Ohio Commission on Minority Health, the ODH, the ACS's Smoke Free Ohio have been engaging in efforts to eliminate and/or reduce health disparities, some of which are associated with tobacco-related health disparities among Ohioans. For instance, the ODH has undertaken various projects within the past couple of years to support tobacco control efforts. Case in point, last year, the ODH provided funding to Lucas County to work with blue-collar firms to develop smoke free policies in the workplace and Jackson County Health Department received funding to increase awareness about second-hand-smoke to build support for smokefree policies in cities and villages. In addition, the ODH funded a project for the Bacchus & Gamma network, which is a network of colleges that conduct wellness programs. The Bacchus & Gamma project will work with 2-year nursing programs in Northeast Ohio. They have found that among health care professionals, nurses have the highest rates of smoking. The ODH has also provided funding for schools to provide tobacco training in the Life Skills program. The ODH received funding from the OTPF and the Ohio Department of Alcohol and Drug Addiction Services to buy the Life Skills curriculum and the student handbooks that are needed to complete the tobacco program.

ODH Smoke Free Initiatives. The ODH received $285,000 from the CDC, which they gave to the OTPF to enhance the Quit Line. During the first year, the ODH used part of the funding they gave to the OTPF to make sure that the Quit Line was culturally appropriate for African Americans, pregnant women, and other high risk populations. The OTPF also used some of the funding to provide Quit kits to health care providers that provide the 5 A's to high-risk populations.[11] The ODH's Surveillance and Training unit supports the Adult Tobacco Survey and the Youth Tobacco Survey. In 2004, the Ohio Tobacco Risk Reduction Program did not have funding to give to the schools in order to facilitate their collection of adequate and meaningful data. In a partnership to encourage school participation, OTPF's Board approved a $400 incentive for every school that participated in the Youth Tobacco Survey in 2006. Currently, 92 schools have participated in the Youth Tobacco Survey at the middle and high school levels. Lastly, the ODH formed a Health Disparities Council in order to broadly address health disparities in 2004. Some of the goals of the Health Disparities Council will synergistically help to identify, reduce, and eliminate tobacco-related disparities among communities of color and other at-risk, underserved populations in Ohio, even though their focus is on health disparities in general. The mission of the Health Disparities' Council is: To understand and eliminate racial, ethnic, and cultural health inequities in Ohio. The Health Disparities workgroup consists of six committees, including 1) Monitoring and Surveillance, 2) Workforce Development, 3) Infrastructure, 4) Best Practices, 5) Awareness, and 6) Partnerships. The long- and short-term goals of the six committees are provided in Appendix 2.

[10] Summit County had passed an ordinance, however it was repealed. Source: Confidential interview.

[11] The 5 A's program is the Agency for Health Care Research and Quality recommended brief intervention designed to promote the motivation to quit smoking cigarettes. This 3-minute intervention involves having clinicians do the following with patients: 1) Ask about tobacco use, 2) Advise to quit, 3) Assess the willingness to make a quit attempt, 4) Assist in the quit attempt, and 5) Arrange for follow up.

OTPF Smoke Free Programs. The Director of Health at the ODH, the Executive Director of the Ohio Commission on Minority Health, representatives from the American Cancer Society, American Heart Association and the American Lung Association, along with 14 other members sit on the Board of the OTPF. One of the OTPF's seven goals is to decrease tobacco-related health disparities. OTPF works toward this goal by integrating culturally appropriate mechanisms in all aspects of its programming. Specifically,

- Since 2002, OTPF has funded more than 20 grants ranging from $50,000 to $200,000 to reach high risk populations, including African American, Hispanic, Amish, Appalachian, Deaf and Hard of Hearing, American Indian, and other important communities with culturally appropriate programming. These grants total $3 million per year. In addition, many of the 47 OTPF community grants also focus on serving minority and other disproportionately affected populations.
- Since 2002, OTPF has outreached to several communities, especially African American youth, as part of its **STAND** youth counter-marketing campaign.[12] The outreach included advertising in African American media on issues specific to the community, support of **STAND** teams, etc.
- The Ohio Tobacco Quit Line was launched as a pilot in 2003 by reaching out to the African American communities in Toledo and Cleveland, as well as five counties in Appalachia. The pilot received tremendous support from the community as well as high numbers of callers and successful quit rates. Since the Quit Line launched statewide, OTPF has made a significant investment in promoting the service to the African American and Hispanic communities as well as the Lesbian, Gay, Bisexual, Transgender (LGBT) and other populations. In 2006, OTPF piloted a program for African American churches that will be rolled out statewide in 2007. In addition, the Quit Line has employed culturally sensitive approaches that include providing interpreters to help address language barriers.
- Since 2005, OTPF has funded grants with the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services to serve Ohioans with mental illnesses and or multiple addictions.
- In 2006, OTPF launched a program for uninsured Ohioans, which provides them with reduced cost Nicotine Replacement Therapy patches (NRT) when they enroll in the Quit Line counseling program.
- OTPF provided grants to both ODH and the Ohio Commission of Minority Health to conduct a chronic disease pilot program.

The OTPF has funded grants across all regions and many counties in Ohio that focus on different populations. OTPF plans to stay in touch with the Cross-Cultural Tobacco Control Alliance (formerly the Disparities in Tobacco Goal #4 workgroup) in order to use terminology that is consistent with the Alliance's phraseology. OTPF will be moving away from the term high risk in the future and, in 2007, will continue to provide grant funding for communities of color, Appalachian populations and other populations disproportionately affected by tobacco use via its community grants structure. They also plan to incorporate more programming to reach communities that are aggressively targeted by the tobacco industry, such as young adults ages 18-24 and the LGBT community.

[12] On February 28, 2002, the Ohio Tobacco Prevention Foundation (OTPF) launched Ohio's first-ever, statewide, tobacco counter-marketing campaign, branded "**stand**." That was the day that **stand** as we know it was born. To introduce the campaign and its purpose to the public, the Foundation held four launch events in Toledo, Cincinnati, Columbus and Cleveland. Toledo, for example, had the highest smoking rate in the United States when the **stand** brand first launched. With banners, signs, a huge video screen used to reveal the new TV ads and, most importantly, a huge following of Ohio teens and anti-tobacco organizations, the successful launch event drew lots of media attention (Retrieved April 4, 2007 from www.standonline.org/stand101/stand_history_2002_2003/index.asp

ACS's Smoke Free Ohio Campaign and the Stay Free Athlete Mentor Program (STAMP). The ACS serves populations statewide including all of the major metropolitan and rural communities in Southeast Ohio where there is an increase in tobacco use among the populations that grow tobacco. The ACS developed and sponsored the Stay Tobacco-Free Athlete Mentor Program (STAMP). STAMP is a student-mentoring program. This peer program is implemented through extracurricular school programs, whereby high school athletes present the program to 4^{th} – 6^{th} graders throughout the state of Ohio.

The ACS's primary direction for their tobacco program was to lead the Smoke Free Ohio campaign to put Issue Five onto the ballot for the November 2006 election. Issue Five would ban smoking in all public places. The Smoke Free Ohio campaign received enough signatures from citizens to put Issue Five onto the ballot. Smoke Free Ohio had tremendous support from faith-based and community-based organizations statewide.

The ODH, OTPF, and the ACS have also worked together to support tobacco control initiatives. One of the biggest successes thus far has been the influence of the Ohio Partnership for Prevention, a coalition consisting of the ACS, Ohio African American Communities for Optimum Health (AACOH), public health, and other minority coalitions that had never worked together before. The Ohio Partnership for Prevention was successful in getting a $0.70 sales tax assessed on tobacco to earmark funding to replenish the OTPF. Unfortunately, the tax revenues have been used for the general budget. However, some of the tax revenues were used to restore funding to pay for prescription drugs for low-income individuals.

2. <u>Tobacco Control Opposition Efforts</u>

R.J. Reynolds partnered with the Ohio Licensed Beverage Liquor Association to oppose smoke free ordinances and state statutes. These partners pursued a constitutional amendment that would allow smoking in restaurants, bars, bowling alleys, bingo halls, and anyplace that prohibited children. The proposed constitutional amendment would repeal any state statute and/or ordinance enacted. That is, the proposed constitutional amendment would overturn voters' ballot decision in November 2006 with regard to mandating that smoking be prohibited in all public places in Ohio.

3. <u>Ohio Enacts Legislation that Bans Smoking in all Public Organizations</u>

On November 7^{th}, Ohio voters strongly supported Issue Five (referendum to ban smoking in all public places, including restaurants, bars, and night clubs). This was a resounding victory for Smoke Free Ohio and a historic step towards improving the health of Ohio workers and customers. Effective, December 7, 2007 businesses were expected to comply with the law. However, citations will not be written and fines will not be levied until the rules of enforcement are finalized by the Ohio Department of Health. In the meantime, the Ohio Department of Health's has a toll-free reporting number that citizens can call to report those public organizations that violate the law.

D. Project Team Leadership

The Disparities in Tobacco Goal #4 workgroup consisted of three groups of project leaders. One group consisted of the objective team chairperson leadership, the foundational leaders, and the CDC/OSH's disparities supplement leaders (see Appendices 2 through 5). The Goal #4 objective team chairperson leaders were volunteers from the workgroup who agreed to serve for a term of one year (see Appendix 3). Four of the five goal areas had leadership during this cycle. The foundational leaders volunteered their time to contribute input based upon the community they were working on behalf of, participated in the strategic planning and evaluation process, and/or established relationships with new members who may have benefited from or contributed to the process (see Appendix 4). The CDC/OSH's disparities supplement leaders were either funded by CDC/OSH or gave their in-kind support to analyze relevant data to determine current prevalence rates and identify gaps, led the workgroup meetings to accomplish tasks, evaluated the community strategic and action planning processes,

coordinated the movement of the workgroup, and/or collected focus group data from the 13 populations of interest (see Appendix 5).

Three of the four CDC/OSH's disparities supplement leaders were selected based on the state of Ohio's competitive bidding process.[13] The positions included: case study evaluator, workgroup facilitator, data analyst, and focus group data contractor. The roles and responsibilities of the chairperson leadership and the CDC/OSH's disparities supplement leaders can be found in Appendix 3.

The workgroup leadership structure will change during the next grant cycle. That is, there will be two co-chairs that will include Tracy Clopton representing the ODH and a community-based member. Additionally, the current chairpersons' terms of one year have expired. The former chairpersons were allowed to volunteer to keep their positions or one of the current workgroup members could volunteer to chair one of the committees. Decisions regarding the chairperson leadership will be formally announced at the next workgroup meeting scheduled for September 6, 2006.

E. Roles and Responsibilities of the Workgroup Members

The workgroup consisted of 55 members. The members consisted of representatives from the following groups: African Americans urban and rural, Latinos/Hispanics, Veterans, American Indians/Alaskan Native Indians, the United Way, OTPF, NCI, the ACS, Immigrants/Refugees, Asian Americans, Neighborhood Health Centers, LGBT, Deaf Community, Poverty Missions, Appalachians, Women, Pregnant Women, and the Faith-based community. The workgroup members' roles and responsibilities are noted below:

1. attend meetings for the CDC/OSH's disparities supplement process and other future meetings as time allows,
2. secure funding and infrastructure for the plan,
3. contribute input based upon the community you are working on behalf of,
4. participate in the evaluation process as requested, and
5. invite or establish relationships with new members who may benefit from or contribute to the development of the plans for each objective.

[13] The Data Analyst, Dr. Surendra B. Adhikari, representing the OTPF volunteered his services.

II. CHAPTER 2: EVALUATING THE PROCESS

A. Purpose and Goals of the Evaluation

The purpose of this evaluation was to describe how the workgroup was formed and how the strategic plan was developed. Some of the goals of the evaluation included:

- Documenting the main activities throughout the process,
- Identifying challenges that were encountered both in forming the workgroup and facilitating the workgroup,
- Documenting milestones achieved throughout the process,
- Documenting lessons learned during the workgroup formation process and the strategic planning process,
- Monitoring the workgroup's progress toward achieving their strategic planning goals, and
- Making recommendations based on the lessons learned.

B. Process Evaluation Design

The process evaluation involved the collection and analysis of descriptive information that addressed the following questions:

- What methods were used to form the workgroup? Were the workgroup chairpersons' and members' roles and responsibilities fulfilled?
- What milestones in forming the workgroup were reached through their efforts?
- What methods were used to create the strategic plan? What players were at the table?
- What milestones have been reached in completing the strategic plan?
- What major lessons have been learned during these processes and how will these insights help to enhance future efforts to eliminate tobacco-related disparities in the state of Ohio?

C. Evaluation Methods

The information that was examined regarding the process of forming the workgroup and developing the strategic plan involved using a number of methods. The workgroup reviewed the meeting summary notes and materials provided and discussed the outcomes of each meeting. This proved to be an effective method for keeping the workgroup members involved and focused on the timelines and objectives for each meeting.

In addition, the project evaluator consciously observed workgroup meetings to determine how workgroup members interacted, how conflicts were resolved, and how consensus was reached on various issues and topics. The project evaluator also administered an evaluation form to assess workgroup members' perception of the openness, participation, and productivity at the end of each of the workgroup meetings.[14] The workgroup used this information to encourage individual strengths and to diffuse those less helpful to the group's dynamics. Individuals on the workgroup also participated in phone meetings and had discussions with other workgroup members after the formal workgroup meetings. This allowed the workgroup to obtain feedback regarding the process and progress of the meetings and to elicit suggestions for problems or concerns that were identified. The project evaluator conducted phone interviews with some of the workgroup members in order to assess the outcomes of the strategic and action planning processes. The project evaluator also conducted phone interviews with representatives from the OTPF, the ACS, and the ODH-Tobacco Risk Reduction Program in order to identify and describe the current tobacco control efforts occurring in Ohio. Lastly, the project evaluator met with the data analyst and focus group contractor in order to identify the populations that had the highest tobacco-related disparities using the most current quantitative and qualitative

[14] The meeting evaluation form was administered at four of the five workgroup meetings. The workgroup's first formal meeting took place on October 3, 2005 before the CDC/OSH's training session where the meeting evaluation form was provided to the Evaluator. The CDC/OSH held its first training session with the workgroup's coordinator, facilitator, data analyst, and evaluator in November 2005.

data available (see Tables 1 through 4 pages 1-3 and Chapter 3, section B. Identifying Disparities and Assessment Focus Group Results pages 13-19).

III. CHAPTER 3: DISCUSSION ON PROCESSES AND MILESTONES

A. Formation of the Group

1. What are the general characteristics of the group?
2. What were the roles of the members?
3. What was the decision-making process?

Icilda Dickerson from the OTPF and Tracy Clopton from the ODH initially developed the preliminary objectives for the Disparities in Tobacco Goal #4 workgroup and then presented them at a State of Ohio Tobacco conference in March 2004. Specifically, Icilda and Tracy gave the conference participants information about the preliminary objectives they had developed and asked if any of the conference participants were interested in working on the Goal #4 workgroup. In addition, phone calls were made to agency leaders asking them to participate and provide the project coordinator with their contact list so that other organizations could be invited to participate in the workgroup. After the initial workgroup members were recruited from the conference, they were asked to assist with recruiting additional members. The OTPF also encouraged its high priority grantees to participate in the workgroup meetings. During the strategic and action planning processes the workgroup consisted of 55 members. Out of the 55 members, approximately 15 – 20 were active during the project period. Many of the members were inactive and might have preferred to receive emails from the list serve, even though they expressed an interest in participating in the processes. Some of the members' inactive participation might have been a result of their organization's lacking the resources to cover travel expenses to the meetings held in Columbus, Ohio (the central region of Ohio). The members of the workgroup consisted of representatives from the following groups: African Americans urban and rural, Latino/Hispanic Americans, Veterans, American Indians/Alaskan Natives, the United Way, OTPF, NCI, the ACS, Immigrants/Refugees, Asian Americans, Neighborhood Health Centers, LGBT, the Deaf Community, Poverty Missions, Appalachians, Women, Pregnant Women, and the Faith-based community. The workgroup members' roles and responsibilities are noted below:

1. attend meetings for the CDC/OSH's disparities supplement process and other future meetings as time allowed,
2. secure funding and infrastructure for the plan,
3. contribute input based upon the community they were working on behalf of,
4. participate in the evaluation process as requested, and
5. invite or establish relationships with new members who might have benefited from or contributed to the development of plans for each objective.

The decision-making process consisted of obtaining group consensus and voting on issues that arose during the strategic planning processes.

B. *Identifying Disparities and Assessment*

1. What type of quantitative data was available?
2. What type of qualitative data was available?
3. How did the environmental scan work?
4. What process was used to identify Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis?

A power analysis, the CDC/OSH's critical issues analysis process, and a SWOT analysis were employed in order to facilitate the workgroup's scan of the environment (see Appendices 7, 8, 21 and 22). [15] Makani Themba-Nixon from the Praxis Project conducted the power analysis with the workgroup on October 29, 2004. The power analysis allowed the workgroup to determine whom the meeting attendees viewed as "allies" and

[15] The Praxis Project also developed a report to provide guidance to states and organizations that are implementing action plans to address Goal Four. This document is available at www.thepraxisproject.org/tools/CDC_goal4.pdf.

"opponents" that could facilitate or impede reducing and/or eliminating tobacco-related health disparities. Initially, the power analysis involved having the workgroup partake in a brainstorming session in order to identify which organizations and/or groups would play a role in helping them to accomplish their goals and objectives. The categories of organizations and groups that the workgroup identified during the brainstorming session included: media outlets, the OTPF's board, voluntary organizations, medical/health professional groups, community-based organizations, the governor, and elected officials. Then, the workgroup developed a strategy for approaching the OTPF's board and state political officials. This strategy was not carried out due to the other demands of the workgroup and the lack of a plan to secure funding.

Following the brainstorm and strategy sessions, the Goal #4 workgroup placed the organizations and groups into three categories: 1) alliance, 2) on the fence, and 3) opposition. The workgroup also rated the level of power they perceived the organizations and groups possessed in facilitating or impeding the reduction and elimination of tobacco-related health disparities. The power levels ranging from highest to lowest included: decision maker, active role, significant, important, and not on the radar. Some of the names and agencies listed as "opposition" were surprising to the state leaders at the time. The workgroup also learned that Ohio has a vast wealth of persons in influential positions that could be educated about the needs of at-risk populations. These persons could possibly become "allies" if an educational campaign were to be implemented. Since the power analysis, the climate in Ohio has changed and more at-risk populations have been publicly involved in the tobacco control movement in Ohio. Furthermore, the power analysis results are dated and the positions of the workgroup members might have changed (see Appendix 21).

The CDC/OSH's critical issues analysis process was conducted with the Disparities in Tobacco Goal #4 workgroup at the February 15, 2006 meeting (see Appendix 8). This process involved having the workgroup divide up into their respective teams in order to identify critical issues for each of the five objectives, including data, alliances and networks, smoke-free culturally-specific restaurants and bars, and evidenced-based culturally competent tobacco use and prevention programs for youth. The critical issues included: 1) Identify which populations are in need of assessment, 2) Create a resource center to include but not limited to: identifying medical interventions and best practices, creating a central resource center and a list serve, 3) Identify what tobacco-related disease data needed to address disparities for communities of color, 4) Identify what gaps in second-hand smoke policy were all high risk population groups experiencing and 5) Secure funding to address practice-based evidence culturally competent youth tobacco prevention programs.

Dr. Lucinda M. Deason, case study evaluator, conducted a SWOT analysis with the Disparities in Tobacco Goal #4 workgroup at the April 25, 2006 meeting. More specifically, the SWOT analysis was conducted on the five critical issues that the workgroup selected at the February 15, 2006 meeting (see Appendix 8). The results of the SWOT analysis can be found in Appendix 22.

In addition, quantitative and qualitative data were used to scan the environment. Initially, Dr. Adhikari, data analyst, reviewed national, state, and local data to determine which populations were disproportionately affected by tobacco use. National data was used to estimate smoking prevalence rates among the populations wherever the workgroup lacked state or local data. As the ODH developed the CDC/OSH supplemental grant application, the workgroup members decided to focus on the following populations: 1) African Americans, 2) Amish, 3) Appalachians, 4) Asian Americans, 5) Chemically Dependent, 6) the Deaf Community, 7) Hispanics/Latinos, 8) Immigrants/Refugees, 9) Lesbian-Gay-Bisexual-Transgender, 10) Medicaid Eligible, 11) Mentally/Physically Challenged, 12) American Indians/Alaskan Natives, and 13) Veterans/Active Duty Military Personnel.

Quantitative data were not available for some of the populations that the workgroup identified for Ohio. The focus group facilitator, Dr. Barry Oches from Ohio University's Voinovich Center for Leadership and Public Affairs, was contracted with to conduct two focus groups with the 13 special populations listed above in order to provide the workgroup with some data on the tobacco use rates among these populations. The results of

the focus groups were also used to help identify populations that have the highest tobacco use and tobacco-related health disparities.[16] In the sections that follow, a brief report of the focus group qualitative results are provided. These sections were presented in the qualitative data contractor's reports as findings from each population's focus groups. These results are in no way presented as representative of the entire population group as the headings may indicate. The findings are merely from the groups of people who met at a designated time and place, were members of the population group being studied, and discussed the topic of tobacco control and prevention. The three categories that guided the analysis were: 1) personal experience with tobacco use and cessation/prevention, 2) awareness of tobacco use and cessation/prevention programs in their population group, and 3) participants' perspective on tobacco use and cessation, including secondhand smoke.

African American – The participants in the African-American focus groups were aware of televised tobacco prevention messages and could remember specific story lines from the commercials as well as the messages they were exposed to. Others remembered billboards about tobacco prevention. They were also aware of the tobacco companies targeting African-Americans as customers. Ads for cigarette brands favored by African-Americans always had African-American models in them.

Most participants had tried to quit multiple times and with multiples strategies. The strategies expressed included acupuncture, hypnosis, nicotine replacement therapy and stopping "cold turkey." They were aware of the health hazards associated with tobacco use, yet, the habit of associating smoking with other activities and addiction to nicotine made it extremely hard to quit. One participant described the resistance to quitting smoking to be "stubbornness."

The use of menthol cigarettes is very prevalent among African-Americans. The community attitudes about secondhand smoke are changing from not even knowing it is bad, to knowing it is bad and changing one's views of smoking because of the knowledge. Most were in favor of clean air ordinances because they are respectful to nonsmokers, but there was a concern expressed that the government should not be taking away personal rights.

Asian – The Asian American participants did not have a strong awareness of television commercials about tobacco prevention. They were more aware of American television shows, such as *Sex in the City* that had characters who smoked. They thought that some people in their culture were influenced by such shows. However, this population is becoming more educated about the hazards associated with tobacco use and is becoming more active in promoting smoking cessation. There are several barriers to providing cessation services to this community. For example, Asian Americans will respond best to services provided in their native language, but this is problematic because there are many languages represented within the state of Ohio. Furthermore, some of the recent immigrants who are not familiar with the American health care system exhibit a fear about doctors who tell them they must quit using tobacco. They do not understand what will happen to them when they quit.

Hispanic/Latino – The Hispanic/Latino focus group participants agreed that the media messages about hazards associated with tobacco use were widespread. They knew that smoking and exposure to secondhand smoke was bad. Several had attempted to quit smoking (a few multiple times), by using patches and gum to do so. Cigarettes were the main products favored, however, other participants have used and/or were aware of other types of tobacco products. The cost of the product was of concern to the participants. They noted that cigarettes were very cheap in Mexico, but here they needed to look for coupons or special offers. They emphasized that there was a difference between a person who was an addicted smoker and one who just smoked occasionally in social situations. The former was really hurting his or her health while the latter was not. The fact that cigarettes and smoking were considered to be bad for children in the family proved to be an effective

[16] The focus group results will not be generalized to the population's examined given the limitations of this qualitative approach.

deterrent to smoking in the home. The participants supported clean indoor air ordinances even to the point of saying that it would help them control their own tobacco use.

Native American – The Native American Indian participants had a unique perspective about tobacco in comparison to the other groups. That is, they used tobacco as a part of their spiritual ceremonies. They smoke a pipe as a part of their Pow-wow ceremonies and they also perform a ritual called "smudging," which involves burning sacred plants in order to purify a place or object. Communication was facilitated after an acknowledgement of language was made. Use of tobacco is a practice that they feel strongly must be continued. They believed that the abuse of tobacco is what is hazardous to a person's health. They were aware of media messages about preventing tobacco abuse. They had seen many billboards as well as television commercials about tobacco abuse. The barriers to accessing resources that will help people in their community quit tobacco abuse included lack of time and lack of awareness about the resources that were available. Many participants had family members who had died from illnesses associated with tobacco abuse, but they were hesitant to claim that was the only issue their family member faced. On the topic of secondhand smoke, they felt there needed to be a two-way form of respect: smokers needed to respect that nonsmokers don't want to breathe the smoke, and nonsmokers needed to respect that smoking is still a legal activity practiced by many people because they enjoy it.

Appalachian – The participants in the Appalachian focus groups were knowledgeable tobacco prevention media messages to the point where they remembered specific details and story lines about the commercials. They were aware that secondhand smoke was just as hazardous to one's health and that smoking around children was very bad for their health. They also felt that resources to help people quit smoking were not being advertised as much as they could. Many of the participants in the focus group had already sought out cessation services and they were familiar with multiple types of cessation aids, including: group classes, individual counseling, patches, gum, lozenges, and Welbutrin. Of the participants that expressed an interest to quitting smoking, one of the things they appreciated during their attempt to quit was the support they received from family and friends in the form of encouragement and caring.

Some of the reasons for using tobacco included enjoying the flavor and the experience. Furthermore, there is a tradition of tobacco use in this part of the state, especially smokeless tobacco. Male youth tend to prefer smokeless tobacco to cigarettes because they can easily hide it from authority figures. The participants acknowledged that even though some had parents who died early from tobacco-related illness, they still used tobacco. They admitted that they were addicted. They knew that secondhand smoke was hazardous. Even though participants thought that people had a choice to not be around others who were smoking and would not want a clean air ordinance in their community, they would still vote for one because they knew it was the right thing to do.

Refugee/Immigrant – The immigrants that participated in the focus groups generally agreed that smoking was a social activity they enjoyed. They shared that it felt good to be around friends, talk, and smoke. Their product of choice was cigarettes. Some of the participants talked about their homeland where in Somalia many people chewed tobacco and in the Ukraine where there was a particular product that was a paper pipe filled with strong tobacco. They thought that the trend of tobacco use was declining, citing effective health education for children and media messages for adults. They personally did not use quitting aids such as patches or gum, but they knew they existed. Unique from many of the other populations, they were reluctant to relate tobacco use with the death of family members and friends. They knew tobacco use had adverse health effects that could result in death, yet the participants maintained that there were other problems as well.

Mentally/Physically Challenged – The participants of the mentally/physically challenged focus groups were aware about the media messages that encouraged people to quit using tobacco. They could not recall many specifics of the messages, but what they remembered was that Phillip Morris, a producer of cigarettes,

was running ads that told people that smoking was bad for their health. Addiction was the one of the main reasons mentioned most often that kept the participants using tobacco. Nicotine had control of their bodies and it prevented them from quitting use of cigarettes. Many participants continued using cigarettes because it became a habit and it helped them relieve stress. Cigarette smoking was strongly associated with other behaviors such as drinking coffee or beer. Many of the participants grew up with parents who smoked daily. They thought that an effective message designed to attract people to cessation programs would consist of providing people with the help they needed to quit, whether it was patches, counseling, or some other means. The person would get whatever he or she needed to assist them with quitting smoking. Many participants believed that secondhand smoke was dangerous. They could also understand why people did not want to be around people who were smoking. However, they argued that nonsmokers should just go somewhere else. They, as smokers, would do their part to not bother others with their smoking.

LGBT – The Lesbian, Gay, Bisexual, Transgender persons in the two focus groups conducted were very familiar with the media messages about the hazards associated with tobacco use. They knew terms such as the Great American Smoke Out. They had heard or read the messages from television commercials and magazines, even recalling school assemblies on the topic. The messages they remembered were that tobacco was "not cool" and it was bad for one's health. The participants were familiar with a wide range of tobacco products such as clove cigarettes, flavored cigarettes, mentholated brands, as well as paraphernalia like the hookah. Tobacco use was described as a ritual associated with other behaviors such as meeting in bars, socializing between acts in a play, or being on break at work. Some of the participants did not personally feel the health hazards of tobacco were a priority in their lives because they were exposed to lifestyle hazards that were much more serious. They did not consider smoke-filled environments to be unfair to non-smoking workers within that environment. They said that the worker knew the situation when he or she applied for the job and could have chosen to work someplace else.

Persons in Poverty – The participants of the persons in poverty focus groups were generally aware of the health hazards associated with tobacco use. They were familiar with media messages against tobacco use, both on television and in magazines. Most of the participants that smoked had tried to quit multiple times. Some tried nicotine patches, while others quit "cold turkey." They recounted the effects of trying to quit smoking on their bodies, including migraine headaches, withdrawal symptoms, and not knowing what to do with their hands. Of the participants that were incarcerated at some point in their lifetime, some were forced to quit when they placed in jail. The participants thought that some effective messages that would encourage persons in poverty to quit using tobacco should focus on personal health, the health of children, and cost. They were in favor of smoking bans, but a ban should exclude bars, bowling alleys and pool halls, places where people could go to relieve stress.

Chemically Dependent – The participants in the chemically dependent focus groups were very aware of media messages about tobacco prevention. They could recall specific details and story lines on television commercials. One of the topics that resonated with this group was that tobacco use was hazardous to children. They wanted their children to be in a safe environment and they did not want their children to grow up to become smokers.

Many participants used tobacco because it was a legal addiction. They associated tobacco use with alcohol and other drug use. The participants indicated that tobacco use helped them cope with quitting the use of the other drugs. They were aware of the hazards associated with tobacco use, but they acknowledged that trying to quit two or more substances at once was more than they could handle. They were not in favor of clean air ordinances, feeling that the government was taking away too many private rights. They were worried about exposing their children to secondhand smoke, yet they still felt that people should have a choice, that is, they should be able to exercise their rights as long as others know that they should stay away from the smoke. Also, many of the participants shared stories about family members who had died as a result of smoking tobacco.

Deaf – People in the deaf community were generally not aware of media messages that explained the hazards associated with tobacco use. According to the research, the deaf community does not access communication media in the same way that the hearing community does. Consequently, they were not aware of tobacco company advertising. Typically, deaf people, who have been deaf since birth, have a lower reading level than the hearing population; therefore, printed materials explaining tobacco prevention services need to be written at a lower reading level than for the general population. The participants were aware that tobacco use was hazardous to their health, but they did not believe that it would cause cancer in every person that smoked. Modeling was an important way that people in this community learned. They model deaf people older than themselves much more than they model people in the hearing community, even celebrities. They did not have strong feelings about secondhand smoke. They considered the issue to be more of a matter of respect. That is, smokers should not smoke around nonsmokers, and nonsmokers should not criticize smokers.

Amish –The Amish community was separated from the surrounding culture by choice. Some of the participants believed that the tobacco use prevalence rate was much lower than the state average. The Amish were not aware of many anti-tobacco media messages because they did not access typical media outlets. They did not have televisions and they typically subscribed to a common Amish newspaper. Similarly they were not exposed to tobacco advertising. When their youth are in their late teens they go through a phase of exploring the world around them. During the teen years, many Amish youth are exposed to tobacco use and tobacco advertising. The Amish were also aware of the physical ailments that are caused by tobacco use and recently they have been becoming more aware of the hazards of secondhand smoke. They tend to be healthy because they have a lifestyle that includes natural foods and much physical activity. Another part of their culture that reduces tobacco use is their religion. They are devout Christians and consider tobacco use to be against the teachings of scripture.

Military/Veterans – The active duty military personnel and the veterans who responded to the questions posed were aware of media messages that communicated the health concerns associated with tobacco use, but they could not recall specifics about the ads or the messages. When asked about the demographics of smokers, they estimated that younger people tended to smoke more than older people and men and women tended to smoke at about the same rate. Tobacco use was typically associated with other behaviors and activities, generally social in nature. The use of smokeless tobacco was also reported. Some respondents said it was rarely seen; others said that it was commonly seen. Some of the participants noted that tobacco use makes a person less physically fit, which is important in the military culture. However, military personnel lead very busy lives, and it would be difficult to arrange time for cessation classes or counseling for those who desired those services. Secondhand smoke was not considered as hazardous as it has been reported to be. A few of the participants believed that people should just respect the rights and wishes of others, both smokers and nonsmokers.

Ohio exhibits great cultural diversity. This is displayed in the breadth of ethnic minorities, including persons from around the world who have come to Ohio to live, work and become communities. Diversity is also evident in groupings having to do with persons' outlook, behaviors, occupation, religion and even where in the state they live or have come from. These communities are willing to work together collaboratively to solve common issues. One of the issues they all face is the health hazard that tobacco use brings to persons in their community. Through talking with each of the communities targeted by this project, it has been learned that there is as much diversity within each community as there is between the communities. Strategies to solve problems need to include diversity and be flexible, rather than place individuals into categories that are externally defined.

Each of the communities has its champions; organizations and agencies that provide resources and services to the community they represent. Often these organizations advocate for a common sense of identity among the

community members that will help people understand that the community has a unique culture. The communities served by this type of organization included: African-American, Hispanic/Latino, Native American, Asian, LGBT, Deaf and Amish. Other communities were defined by current composition or occupation. Organizations providing social services were often arms of the state/national government, or received governmental funds. These organizations served the communities out of a commitment to meet the health/wellness needs of people in the community who fit the established criteria for being part of the community. The communities served by this type of organization included: persons in poverty, chemically dependent, mentally/physically challenged, refugee/immigrant and active duty military personnel/military veterans. The one community in Ohio that does not fit into the previous categories is the one that is defined by geography – Appalachian Ohio. Appalachian Ohio covers 29 counties in the southeastern part of the state, including the counties in Ohio where tobacco is grown. It is a federally designated area that is part of Appalachia. Appalachia also covers all of West Virginia and parts of 12 other states. Any social service organization within those 29 counties would, by definition, be serving Appalachians.

The community organizations that serve specific groups of communities of color and other at risk underserved populations are critical to the successful accomplishment of Ohio's Comprehensive Tobacco Use Prevention Strategic Plan. Institutional capacity to provide services is the key element for eliminating the disparities. Networking among organizations and knowledge about specific populations will certainly increase the institutional capacity of the organizations that are committed to improving the health and well being of all.

C. *Workgroup Meetings*

The Goal #4 workgroup convened five formal meetings on October 3, 2005, December 16, 2005, February 15, 2006, April 25, 2006, and June 14, 2006 over a 9-month period (see Appendices 6 through 11). These meetings were scheduled in the central region of the state (Columbus, Ohio) at various locations. The meetings were usually scheduled from 9:30 am – 3:30 pm and included a working lunch. Approximately 15 - 20 workgroup members participated in each of the meetings. A summary of the each the meetings will be described in the sections that follow.

Meeting 1: October 3, 2005. The first workgroup meeting began with participant introductions. Then, the Project Coordinator, Tracy Clopton, provided an overview of the strategic planning process, the purpose of the workgroup, and what had been accomplished since August 2004. The workgroup was formed in March 2004, but the formal Kick-Off for the Ohio Comprehensive Tobacco Use Prevention Strategic Plan 2004-2008 began in August 2004. Since August 2004, the workgroup has established five teams that were each assigned to address the respective objective of their team. The workgroup also identified 13 populations that they felt were disparately affected by tobacco in Ohio. Next, the project coordinator reviewed the roles and responsibilities for each of the teams**.** Then, the project coordinator introduced the chairpersons for each of the teams and the CDC/OSH's disparities grant leadership consultants. The workgroup members were then given time to identify which team they wanted to join and break up into their respective teams to discuss, expand, or narrow down their team's objectives. After the teams met in their respective groups, they shared their revised objectives with the larger workgroup members. Next, the workgroup developed a timeline for developing the strategic plan. Then, Dr. Barry Oches, the focus group contractor, shared his tentative focus group questions with the workgroup in order to obtain their input for revising the questions that would be posed. Dr. Deason, the case study evaluator, asked participants to note whether or not they would be willing to be interviewed about the process and achievements of the workgroup. The project coordinator suggested that Dr. Deason use the sign in roster as a source for contacting the workgroup members for interviews. The group was then asked to determine the subsequent four meeting dates, assess the new objectives developed, identify representatives to serve on the alliance, and develop a memorandum of understanding that described the roles and responsibilities of the workgroup members prior to the next scheduled meeting (see Appendix 6).

Meeting 2: December 16, 2005. At the beginning of this meeting the project coordinator clarified the roles of the chairperson leadership team and the CDC/OSH's disparities supplement leaders, then the workgroup leaders that were present introduced themselves to the workgroup. The workgroup was then asked about their needs for training that would assist the group with creating the strategic and action plans, as well as secure funding. The workgroup was also asked to provide the project coordinator with names and contact information about possible speakers that could provide the training sessions that the workgroup felt it needed. The project facilitator and evaluator created a draft of the vision and mission statements for the workgroup prior to the second meeting and shared them with the workgroup at the second meeting. The workgroup provided their input and finalized the vision and mission statements.

The data analyst, Dr. Adhikari presented disparities in tobacco use in Ohio data to the workgroup. This presentation included smoking and smokeless tobacco. Some of the workgroup members wanted data on the mentally ill, incarcerated, Asian American, pregnant women, and the deaf populations. One of the workgroup members noted that local data about pregnant women could be obtained from the Women, Infant, and Children's (WIC) nutrition program. Dr. Adhikari indicated that data on the deaf community was available from a grant program funded by the OTPF and he suggested that a focus group be conducted with members from this population in order to get more insight due to the complexity of data collection associated with this unique group. The project coordinator reviewed the critical issues analysis process tool that the CDC/OSH required the workgroup to complete. Then, the workgroup members broke up into their respective teams to complete the critical issues analysis process that related to their team's objectives. Due to the inability of all of the workgroup members to stay throughout the duration of the meeting, the workgroup was asked to transcribe the results for their team by tallying the votes prior to the next scheduled meeting and to provide the project coordinator with names and contact information about potential speakers for the training sessions the workgroup felt it needed. The workgroup's chairpersons were also asked to contact their team's workgroup members to encourage them to attend more of the meetings (see Appendix 7).

Meeting 3: February 15, 2006. The project coordinator presented a needs assessment form titled, "Key Questions in Assessing Interest and Program Direction for State Level Community Specific Tobacco Control Networks and Alliances," (see Appendix 23), which was obtained from the Praxis Project. This form was used to assist the workgroup with determining the interest in developing and planning the program direction for the proposed Tobacco Control Networks and the Alliance. The form could also be used for their own local communities. The project coordinator also provided the workgroup with a form titled, "Future Plan Input" (see Appendix 24). This form was used to help the workgroup with identifying three areas to focus on that would assist them in moving them closer to accomplishing their vision and mission during the next grant cycle. During the meeting Adrienne Heard of Heard Management provided a training, titled, "Human Resources: People are Your Most Valuable Asset" to the workgroup on recruiting, training, and retaining staff. Laura Milazzo provided the workgroup with an update on the focus groups being conducted with the 13 populations the workgroup selected. During Laura's presentation she shared some of the barriers that she had encountered. She asked the workgroup for assistance with providing her with contacts in the Amish, Immigrant/Refugee, and American Indian/Alaskan Native communities because she was having problems with gaining access to these populations.

Najeebah Shine, chairperson for objective team #4 (Restaurants & Bars), provided the group with an update on the smoke free culturally-specific restaurants and bars and she also noted that her team had not completed the CDC/OSH's critical issues analysis process. The CDC/OSH's critical issues analysis process had not been completed for objective #5 (Youth Programs) as well. The project facilitator had the entire workgroup complete the critical issue analysis process for objective teams #4 and #5.

Meeting 4: April 25, 2006. Fatima Perkins, Director of Senior Programs at the United Way of Greater Cleveland, gave a presentation about strategies for securing funding from the United Way and tobacco cessation

and prevention projects that have been funded by the United Ways across the state of Ohio. She also noted that the United Way places emphasis on outcome measurement. Tracy Clopton, the project coordinator gave an overview of the need for conducting meetings in each of the five regions across the state of Ohio. The purpose of the meetings was to present information about the strategic and action plans developed by the workgroup and get "buy-in" from other potential partners. The project coordinator then shared with the group that during the next cycle of funding, the plan was to emerge into an alliance to implement the action plan the workgroup developed as a team in order to move things forward. There was also some discussion about conducting a statewide conference. Next, the workgroup reviewed the Wisconsin Strategic Plan and agreed that it would serve as a "template" for the action plan being developed for Ohio. Also, some of the concepts for the smoke-free worksite were borrowed from Wisconsin's plan because they served as a template for the workgroup's strategic and action plans and they clearly articulated the direction in which the group wanted to go with their objectives. After reviewing the Wisconsin Plan, the workgroup created a draft of the action plan. The project coordinator then reviewed the Power Analysis that was completed in October 2004. The Power Analysis helped the workgroup to assess its "political power." The project coordinator also cautioned the workgroup that the results of the Power Analysis conducted in 2004 had probably changed, given changes in Ohio's political climate. Lastly, Dr. Deason conducted a SWOT Analysis with the workgroup. The results of the SWOT Analysis and a summary of the meeting can be found in Appendices 22 and 9 respectively.

Meeting 5: June 14, 2006. This meeting was facilitated by Rod Lew, of Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL) and David Nakashima of Nakashima & Associates. The objectives of this meeting were fourfold: 1) to reassess community priorities (assets and readiness) for tobacco control, 2) revisit the community and cross-cultural vision and mission, 3) facilitate further building of community and cross-cultural teams, and 4) identify next steps for building tobacco parity in Ohio. The plans for advancing the objectives moved along a continuum that ranged from strategic planning, capacity building, implementation of effective programs and policies, reduced tobacco use and related diseases to empowerment of communities. Some of the resources that the meeting participants identified for achieving the cross-cultural vision and mission included leadership development, technical assistance, and infrastructure building. A "Cover Story Vision Activity" was conducted with the workgroup in order to get them to begin thinking about goals and objectives that could be achieved in 5 years. A Tinker Toy exercise was conducted to help the workgroup gain an understanding of the factors that could facilitate and impede effective communication between individuals and/or groups. Lastly, the group discussed things that could be done to sustain momentum and foster leadership development in various communities (see Appendix 10).

***Conference Call Meeting: June 28, 2006*.** The foundational leaders, goal/objective team chairperson, and CDC/OSH's disparities supplemental grant leadership voted on a new name for the Goal #4 workgroup and the theme for the action plan. The new name became the Cross-Cultural Tobacco Control Alliance (CCTCA) and the theme for the action plan is empowering cross-cultural communities to take action to overcome tobacco-related health disparities. Some of the workgroup members volunteered to serve as chairpersons for the period June 30, 2006 through June 29, 2007 with the option of continuing until June 29, 2008. The group also received a preliminary marketing plan matrix in preparation for the September 6, 2006 meeting scheduled from 9:30am to 3:30pm. All of the CCTCA leadership agreed to encourage their regional and community partners to complete the Agency Commitment Form and Action Plan Matrix for their agency as well as vote for the Goal III language Tie Breaker (see Appendix 11).

D. Evaluation Results of the Workgroup Meetings

1. How were critical areas or themes derived?
2. How was feasibility of the critical areas determined?
3. What was done to assure role assignment?
4. How were partners identified to implement the plan?

A meeting evaluation form titled, "Evaluation Checklist Form to Assess Workgroup Meetings," was administered to the meeting participants at the end of four of the five formal workgroup meetings commencing at the December 16, 2005 meeting (see Appendix 16). The meeting evaluation form was used to assess meeting openness, participation, and productivity. The meeting evaluation results and reports were completed and shared with the project coordinator (see Appendices 12 through 15). Overall, the majority of the participants felt that the meetings were open, there was adequate participation from various communities at the meetings, and the meetings were productive.

E. Developing the Plan

1. How were critical areas or themes derived?
2. How was feasibility of the critical areas determined?
3. What was done to assure role assignment?
4. How were partners identified to implement the plan?

As stated earlier, the initial objectives for the action plan were developed in fall 2003. The objectives have evolved based upon workgroup input over time. The CDC/OSH's critical issues analysis process was used to help the Goal #4 workgroup with developing the strategic and action plans. The critical areas were based on all of the objective brainstorming sessions that began in November 2004 as well as the February 2005 and June 2005 meetings. The critical areas were based on the CDC/OSH's critical issues analysis process that was completed for objectives #4 and #5 at the April 25, 2006 meeting with the Goal #4 workgroup (see Appendix 8). The final critical issues were derived based on the workgroup members' voting on each issue considered and selecting one or two issues that had the highest score for each of the objectives. Feasibility of the critical areas was assessed by having the workgroup complete a SWOT Analysis (see Appendix 22).

The assignment of roles for implementing the action plan developed consisted of considering some of the workgroup members involved in the process, getting input from participants at the five state regional meetings, and prioritizing communities in terms of the tobacco-related disparities data using the Ohio Minority Health Profile, ODH 2000 – 2004 Regional Smoking Prevalence Data, Behavioral Risk Factor Surveillance Survey (BRFSS) 2004 and 2005 data, CDC data, data generated from selected grants funded by the OTPF, as well as focus group data collected by Dr. Oches. Plans were being put into place to identify partners that could implement the plan that were not at the table, especially if there was a high need in specific communities. Some of the communities that will be engaged in the next cycle include: African Americans, Amish, Appalachians, Asian Americans, Blue Collar/ Union, Chemically Dependent, the Deaf Community, Hispanics/Latinos, Immigrants/Refugees, Lesbian-Gay-Bisexual-Transgender, Medicaid Eligible, Mentally/Physically Challenged, American Indians/Alaskan Natives, Persons Affected by HIV/AIDS and Veterans/Active Duty Military Personnel. Representatives will also be recruited to implement a part of the action plan for populations who do not have representation on the workgroup.

F. Workgroup Members' Assessment of the Action Plan

The demographic survey and interview questions posed can be found in Appendices 17 and 18. Four workgroup members completed the demographic survey and participated in a phone interview to assess the plan that was created (see Appendix 17). The results of the phone interviews were analyzed to identify themes and patterns that emerged (see Appendix 19). The participants worked for government, not-for-profit, and academic institutions and their positions included: Tobacco Prevention Coordinator, Director Senior Programs, Senior Research Associate, and Assistant Director of Community Health Services. The amount of time that they had worked for their respective organizations ranged from 10 months to 6 years and they had held their current positions for a period of 3 years to 7.5 years. The number of clients the participants served ranged from 2,500 to well over 850,000 individuals. The participants' organizations provided the following types of services: substance abuse prevention (youth and adult), youth mentoring, women's programs, re-entry, funding programs and community-wide initiatives, program evaluation, geographic information systems, facilitation, data and

census reports, survey research, prevention, direct health care services, disease reporting, and environmental health services. The interviewees had participated in the Goal #4 workgroup anywhere from 3 months to 3 years. All of the participants except one were already working in tobacco prevention and control before the Goal #4 workgroup began. Lastly, half of the interviewees were already working on tobacco-related health disparities before the Goal #4 workgroup commenced.

The phone interview questions addressed the strategic and action planning processes (see Appendix 18). All of the interviewees felt that the workgroup process was an effective method for addressing tobacco prevention and control efforts in their state. For instance, it was stated, "this system allowed us to address the needs of those populations identified and we didn't have this before. It kept us focused; we went from very general to being specific." Similarly, all of the respondents felt that the workgroup was open to recruiting representatives from populations facing the greatest burden from tobacco use related diseases. One person stated, "the workgroup was more than open to recruiting … the workgroup consisted of representatives from different areas of expertise that met the workgroup's inclusiveness and effectiveness goals."

> They went out of their way to make phone calls to get people to come to the meetings," noted another participant. The participants unanimously felt that they were a part of the process and that their voices were heard. Case in point, "we were given ample opportunity to provide input. As long as we stayed on top of things, our voices were heard. In the actual meetings we went through several different activities such as the SWOT analysis that required direct requests for the workgroup members' input.

Generally, all of the respondents indicated that the role they played on the workgroup was in line with their expectations. As one interviewee shared, "my role was beyond my expectations because the workgroup actually worked. This process has changed my mind. This has been a positive process. I feel like change is coming. People can talk and act on their ideas."

Given the participants experiences with the workgroup, they all plan to continue to be involved in the process during the next phase. The participants felt that the state representative did a tremendous job, was very thorough, organized, and handled the process well. One interviewee shared, 'the coordinator was the guide on the side rather than the sage on the stage." The participants had reservations with regard to their regions being ready to move the plan forward into the next phase. Specifically, there were concerns about raising awareness about the process, providing training and resources, developing a collaborative vision, finding ways to continually engage the regions and local communities in the next steps, and providing strong leadership. In addition, the participants felt that the meeting minutes, strategic and action plans reflected what was agreed upon at the workgroup meetings. Overall, the interviewees felt the strategic and action plans will move forward as long as the workgroup stays passionate and committed, additional funding is secured, the plan is a flexible document that is revisited, and the OTPF provides assistance.

G. Adopting the Plan

1. <u>How were audiences for the plan determined?</u>

Meetings were conducted in the five regions of the state in order to share the action plan with 71 attendees. Flyers and email notices were sent out to each regional representative. The regional representatives, who were workgroup members and chairpersons in some cases, then mobilized their community coalitions and organizations to attend the meetings in their respective regions.

2. <u>What political issues were addressed?</u>

Two salient political issues arose during the strategic and action planning processes. First, the OTPF had planned to issue an RFP for regional grants starting in January 2007. However, the underserved communities advocated against the regional grants because they wanted autonomy and decision making authority about

interventions that would allow for community input rather than having regional oversight. The OTPF is now preparing to release a more prescriptive RFP (closed to current Foundation grantees) in August 2007 for another year's extension to the grantees. This will give the grants committee within the OTPF's board time to determine their new direction for the next funding cycle. This also gives a window of opportunity for the Goal #4 workgroup, which is now the CCTCA, to educate the board about its action plan, and "sell" it to all possible grantors statewide and nationally.

A second political issue among local organizations is the conflict between the accessibility to the community and capacity to manage the grant. That is, most mainstream organizations have stronger capacity to implement the projects; however, many do not have access to the disparately affected populations or the ability to implement culturally-competent interventions. The community-based organizations understand and have access to the disparately affected populations, yet many struggle with the ability to manage grant reporting and they need stronger infrastructure to meet the requirements of grantors, in comparison to mainstream organizations.

3. Who wrote the plan?

The Goal #4 workgroup shaped and changed the strategic and action plans according to who was involved in the meetings and the views that were shared. The Goal #4 workgroup's facilitator, Wendy Berry-West, and the case study evaluator, Dr. Deason were responsible for the actual mechanics of recording what the workgroup decided and writing the summary meeting minutes (see Appendices 6 through 10 and 12 through 15).

4. How was it presented and adopted?

Five regional meetings were conducted around the state to determine which agencies/organizations would be a part of the implementation of the action plan. Written commitments were secured from organizations statewide that were willing to implement some of the strategies and action steps if funding was secured. The project coordinator distributed the form to the workgroup members, agencies, and individuals attending the regional meetings. The Agency Commitment form and a matrix were developed to note the agencies/organizations and their goal/strategy commitments (see Appendices 20 and 25).[17]

H. Preparing for Action

1. What is the plan to market the document?

The CCTCA developed and issued a request for proposals through the Ohio Department of Administrative Services in order to secure a fiscal agent that would be responsible for the financial management of the CCTCA in the next funding cycle. The contractor selected to be the fiscal agent will manage the alliance in partnership with the alliance leadership, and coordinator from September 1, 2006 to June 29, 2008. In September 2006 the marketing plan will begin to be developed in partnership with a contractor who specializes in marketing and media once the fiscal agent for the alliance has been selected. The plan will address whether or not the whole plan or certain goals should be marketed to specific grantors or partners; the actions being requested of grantors/partners; the benefits and barriers to taking certain actions; message delivery, the persons/leaders responsible; and the most appropriate approach for delivery of specific messages. The goal is to first reach the OTPF's staff and board to show that communities in greatest need have come together to create a plan to address disparities in tobacco. This will provide an excellent opportunity because OTPF will be extending their current grants for another year while they re-assess their direction for the next funding cycle, since the regional grant approach will not move forward as originally planned. Other priority agencies include the Ohio Commission on Minority Health (staff and board), ODH, Osteopathic Heritage Foundation, CDC Reach 2010,

[17] The matrix concept was borrowed from Indiana.

Robert Wood Johnson Foundation, and local community foundations. Aside from funding opportunities, the matrix also identifies the need for raising awareness about the action plan to other statewide and local organizations that can partner with the CCTCA by incorporating tobacco activities into their own areas of service. Some of the agencies that were being considered included: the Ohio Commission on African American Males, the African American Male Empowerment Commission (Columbus), Ohio Asthma Coalition, Ohio Diabetes Alliance, county and city health departments, Multi-ethnic Advocates for Cultural Competence in Behavioral Healthcare, and the Governor's Office of Appalachia.

2. What are obstacles to marketing this plan? How identified?

An assessment of the obstacles will be conducted during the development of the marketing plan as each identified agency is reviewed. Overall, the obstacles may include funding priorities, a lack of sufficient staff and time to partner with CCTCA, or geographical constraints.

3. What are the next steps for this process?

A request for proposal has been issued by the Ohio Department of Administrative Services that will be responsible for overseeing the selection process for a fiscal agent, along with Tracy Clopton and two persons from the ODH. The ODH contracted fiscal agent will also help with hiring a project assistant, media/marketing consultant, trainers for leadership development, mini-grants that will be distributed to unengaged communities that are at risk, facilitators for focus groups on new communities, and the current meeting facilitator position for the quarterly meetings. As a result, during this next cycle, the CCTCA will focus its efforts on the following: 1) building capacity (leadership development, getting the networks built for each community, getting the alliance fully staffed, assessing the stages of readiness for the communities, 2) reaching out to new communities, and 3) conducting the Community Forums on May 9, 2007 to facilitate the development of statewide community specific networks. During the September 6, 2006 meeting the CCTCA will begin to look at strategies for marketing the plan, pursuing additional funding, and members of the CCTCA will be given an opportunity to submit their Agency Commitment Form and/or tobacco-related disparities preliminary action plan matrix to the project coordinator (see Appendices 20 and 25). A contracted marketing/media consultant will be available to help the alliance raise awareness about the action plan to address disparities in tobacco among local, statewide and national potential partners.

IV. CHAPTER 4: MAJOR ASSETS FOR THE STRATEGIC AND ACTION PLANNING PROCESSES

One of the most important major assets of the strategic and action planning processes was the community membership on the Goal #4 workgroup. The members have established relationships with one another based on trust and respect as a result of their participation in the strategic and action planning processes. There was a lot of cooperation among the workgroup members that occurred throughout the process.

The second greatest asset involved having a federal agency directly support the workgroup in addressing disparities among underserved communities. Federal agencies have the ultimate power and authority to encourage states to improve their service to underserved communities, especially among those highly dependent on federal funds for programs. The CDC/OSH's funding for the strategic planning process helped the Disparities in Tobacco Goal #4 workgroup get organized and move forward. There were numerous other assets that the Goal #4 workgroup possessed and/or obtained that facilitated the strategic and action planning processes. For example, this process allowed for an opportunity for the workgroup members to get to know each other better over the course of the process. As one workgroup member noted, "It took time to build trust and respect…this was not a waste of time." They were also able to examine their own assets and begin to think about sharing their skills or resources (i.e. evaluation tools) with those communities that were not yet engaged in tobacco control or did not have similar infrastructure.

The third major asset was the CDC/OSH's funding and training for the strategic and action planning processes. The CDC/OSH's funding and training helped to provide some of the infrastructure necessary for completing the strategic and action planning processes. More importantly, the strategic and action planning processes facilitated increasing influence among underserved communities within the state of Ohio and plans for the development of infrastructure and capacity building necessary for laying the foundation to identify, eliminate, and reduce tobacco-related health disparities among communities of color and other at-risk, underserved populations. Additionally, the strategic and action planning processes allowed for local and state people to work together; thereby leading to decreasing some of the hierarchical barriers between the state and local communities/organizations. Another major asset that resulted from this strategic and action planning processes is the sharing of leadership. That is, during the next cycle, a co-chair from a local community will hopefully work along with Tracy Clopton to lead the workgroup.

Although the project coordinator, Tracy Clopton, sends a substantial amount of information to the workgroup members and chairpersons via email, the workgroup members felt a little overwhelmed at times. However, for the most part the workgroup members appreciated the information because it helped them to stay abreast of the process and get caught up when they missed a meeting. "The meeting minutes were a good summary of the meetings and helped me to get caught up," noted a workgroup member.[18]

The strategic and action planning processes proved to be a major asset as well. The process has helped the Disparities in Tobacco Goal #4 workgroup get organized and move forward. As one workgroup member noted, "the process gave us an opportunity to plan and we didn't have to do crisis management. We had time needed to plan."

[18] Source: Confidential interview.

V. CHAPTER 5: MAJOR CHALLENGES FOR STRATEGIC AND ACTION PLANNING PROCESSES

The Goal #4 workgroup also encountered some challenges during the strategic and action planning processes. Some of the challenges included: getting people to make progress in feeling comfortable with doing things for themselves rather than waiting for others to do it for them. Specifically, during this process, the workgroup had to learn how to help their communities realize that they did not need approval to address problems on a statewide level from others if their communities were sick and dying from preventable diseases. They had a right to help themselves when they were in need. Another major challenge involved helping the workgroup members to recognize that the state agency staff did not have all of the answers. That is, the experts are in the community and the workgroup had to figure out ways to get the government bureaucracy to think in those terms. There were also some challenges with working together at the state and local levels.

One of the major challenges encountered involved getting the ODH, the OTPF, and the Ohio Commission on Minority Health to work together rather than in silos/isolation/competition. The communities are not served optimally because these three organizations do not work together as effectively as they could. For example, there were no clearly defined divisional tasks to which each agency had agreed, in spite of having a statewide strategic plan. As one interviewee summed it up:

> The ODH has tried to work together with the OTPF in order to keep each other abreast of what the other is doing. The OTPF has so much money that the ODH-Tobacco Risk Reduction Program has had trouble finding an appropriate niche they could carve out for themselves. That is, what gap in funding can they address.[19]

Regular meeting attendance and recruiting new members proved to be a major challenge. There were a core of approximately eight workgroup members that attended the meetings regularly, however, the majority of the members had sporadic attendance at the meetings. A few workgroup members felt that travel to the meetings that were held in Columbus, Ohio (central region) created a challenge for some communities that lacked the resources for traveling to the meetings.

Another major challenge that the workgroup will have to confront during the next cycle will involve engaging communities across the regions. The workgroup must develop plans for providing and obtaining local community support across the state. The workgroup must also begin pursuing additional funding to address the action steps and strategies outlined in the action plan (see Appendix 26).

[19] Source: Confidential interview.

VI. CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

A. Major Planning Accomplishments

The first major planning accomplishment consisted of the development of an action plan with input from agencies serving those most affected by tobacco-related disease. Second, seeing new leadership willing to chair objectives during the second grant cycle was a major planning accomplishment. Third, growth in the membership of the workgroup was an accomplishment. Fourth, the workgroup made progress in becoming an alliance by voting to change its name to the CTCCA. Fifth, the workgroup members established rapport, developed relationships, and built trust amongst one another. Lastly, the workgroup created a joint vision and mission statement.

B. Lessons Learned Throughout the Process

We should never underestimate the power of local communities to influence state agency decisions. For example, when the decision was made to move to a regional grant system by OTPF, many objected. However, this was a reaction to something being imposed upon them. The action plan will facilitate the communities becoming proactive and shaping their future by advocating for something they've created.

During the next cycle, the workgroup must consider ways to engage the communities around the state in order to increase awareness about the action plan and gain their support. A few workgroup members felt that they needed to determine how to keep the local communities involved in their activities, gain their input, and provide support to help them with accomplishing the CCTCA's goals and objectives.

One method for increasing meeting participation could involve establishing a routine phone meeting once a month to keep the CTCCA members abreast of progress, activities, issues needing attention, etc. As one workgroup member suggested,

> Perhaps we could pick one standard day and time out of each month to have a phone conference with the leadership to help keep us abreast of things, for example, a call every second Thursday of the month at 10am. In addition, perhaps a review of the overall CDC/OSH & workgroup timeline including deadlines from the CDC to remind team members of the short time frames could be provided to the workgroup members.[20]

C. Recommendations to Enhance Future Strategic Planning

Various things can be done to enhance future strategic and action planning. Some of the recommendations noted are provided below:

- The process should be at least one and one half to two years, preferably two years for full impact without the added stress resulting from the short time frames and deadlines to get goals accomplished,
- The final meeting with the CDC/OSH should be at least three months prior to when the case study and implementation plans are due, and

CDC Evaluation tools should be made available before the first CDC/OSH training meeting in Atlanta.

[20] Source: Confidential interview.