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

Submitted by

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EXECUTIVE SUMMARY

BACKGROUND

This case study report describes and documents the strategic and action planning processes of the Disparities in Tobacco Goal #4 Workgroup. The Centers for Disease Control and Prevention Office on Smoking and Health (CDC/OSH) provided funding and training to facilitate the creation of a workgroup that would develop a strategic plan, goals, objectives, strategies, as well as action and marketing plans to address eliminating disparities in tobacco across the state of Ohio. Goal #4 Workgroup was formed in March 2004 as one of the five workgroups for the Ohio Comprehensive Tobacco Use Prevention Strategic Plan 2004 – 2008 to focus on at-risk, culturally diverse, underserved populations in Ohio.

The purpose of the Goal #4 Workgroup (which has now emerged into the *Cross-Cultural Tobacco Control Alliance*, [CCTCA]) was to develop their own strategic and action plans for the identification, reduction, and elimination of tobacco-related disparities. The strategic plan was used to develop an action and marketing plan in order to lay the foundation for undertaking sustainable initiatives that will help to accomplish the goals and objectives of the Ohio Comprehensive Tobacco Use Prevention Strategic Plan (2004-2008) overall.

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

Funding from CDC/OSH allowed the CCTCA to build infrastructure for the community strategic planning and implementation processes by hiring a meeting facilitator for four meetings, a case study evaluator, and a focus group contractor to help us look more closely into at-risk populations to learn about their specific needs for tobacco control and prevention. The thirteen populations identified included: 1) African Americans, 2) Amish, 3) Appalachians, 4) Asian Americans, 5) Chemically Dependent, 6) the Deaf Community, 7) Hispanics/Latinos, 8) Immigrants/Refugees, 9) Lesbian-Gay-Bisexual-Transgender, 10) Medicaid Eligible, 11) Mentally/Physically Challenged, 12) American Indians/Alaskan Natives, and 13) Veterans/Active Duty Military Personnel. Two populations have since been added: Persons Affected by HIV/AIDS and Blue Collar/Union. The Ohio Tobacco Prevention Foundation provided a data analyst as in-kind support to assess data availability and to identify gaps in data information on the identified special populations/groups.

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

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

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

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

Involving Communities in the Process

During the CDC/OSH nine-month funding cycle, the CCTCA (formerly the Disparities in Tobacco Goal #4 Workgroup) convened five formal meetings on October 3, 2005, December 16, 2005, February 15, 2006, April 25, 2006, June 14, 2006 and a conference call on June 28, 2006. The five formal meetings were held in Columbus, Ohio at various locations. Approximately 15 - 20 workgroup members participated in each meeting. Much of the preliminary groundwork had been completed before the funding arrived such as, preliminary objectives were established, various communities provided input regarding the formation of a workgroup, a Power Analysis was conducted, and twelve populations were identified. A summary of each meeting is provided below:

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

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

Meeting 3: February 15, 2006: Workgroup members received leadership training on a topic called “Human Resources: People are Your Most Valuable Asset” given by Heard Management. The information focused on agency staff recruitment, training, and retention, along with overall agency development. Members provided ideas for the next grant cycle to continue the process.

Updates on focus group progress were given, and the group went through the Critical Issues process for the Youth Programs goal.

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

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

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

Goals and Strategies

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 collecting data related to at-risk, culturally diverse, underserved populations to reverse adverse health outcomes.
2. Establish an adequately funded and fully operational tobacco education and advocacy alliance among statewide at-risk, culturally diverse, underserved populations to build public health influence, capacity, and infrastructure.
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 population 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 among at-risk, culturally diverse, and underserved populations to reduce smoking prevalence and social acceptance of smoking.

The five objectives stated above were converted into goals for the action plan and their accompanying strategies and action steps are in the case study report.

The Workgroup members' evaluated four out of the five workgroup meetings in order to assess openness, participation, and productivity. In addition, phone interviews were conducted with four of the workgroup members in order to examine their perceptions of the overall process and the action plan that was created. During the next two CDC/OSH grant cycles, the CCTCA will receive $120,000 per year to hold community-specific forums, collect additional data, distribute mini-grants to engage communities currently not addressing tobacco for various specifically identified populations, advocate for state-wide community-appropriate policies, continue leadership and regional meetings, provide leadership development trainings, advocate for funding from national, state and local grant-making agencies, hire a project assistant to coordinate responsibilities, and expand the overall movement to improve adverse health outcomes related to tobacco use and secondhand smoke exposure until it is institutionalized in Ohio.

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Ohio's Cross-Cultural Tobacco Control Alliance

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

Building Infrastructure 2006-2008

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Action Plan

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

Gabrielle Brett-Sullivan
Alliance Development, Co-Chairperson

Funding for this project was provided by a supplement to Ohio's Co-operative Agreement number U58/CCU522797-03 from the Centers for Disease Control and Prevention, Office on Smoking and Health.
August 2006

A Message from the Director of Health

Dear Ohioans:

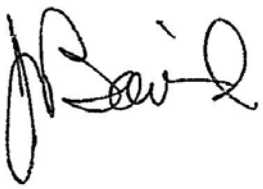
With great pleasure I would like to present an action plan to address tobacco-related health disparities among at-risk, culturally diverse, and underserved populations called *Empowering cross-cultural communities to take action to overcome tobacco-related health disparities.* The Cross-Cultural Tobacco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

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

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

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

Sincerely,



J. Nick Baird, MD
Director of Health

Background

National Adult and Youth Smoking Prevalence Rates

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

Adult Smoking Prevalence Rates in Ohio

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

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

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

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

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

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

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

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

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

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

Adult Regional Smoking Prevalence Rates in Ohio

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

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

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

Sources: Bennett, 2006; ODH, 2005.

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

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

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

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

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

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

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

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

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

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

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

Workgroup Leadership and Roles

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

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

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

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

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

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

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

Involving Communities in the Process

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

Goals and Strategies

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

Populations:

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

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

Bonnie Kirsch
Cessation & Associated Support, Co-Chairperson

Sustaining the Alliance

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

The following agencies support the work of this Action Plan:

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

Goal 1

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

Agencies interested in this goal:

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

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

Action Steps:

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

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

Actions Steps:

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

Goal 2

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

Agencies interested in this goal:

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

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

Action Steps:

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

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

Action Steps:

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

Goal 2 (cont.)

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

Action Steps:

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

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

Action Steps:

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

Goal 3

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

Smoke Free Ohio Passed November 7, 2006!

Agencies interested in this goal:

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

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

Action Steps:

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

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

Action Steps:

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

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

Action Steps:

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

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

Action Steps:

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

Goal 4

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

Agencies interested in this goal:

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

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

Action Steps:

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

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

Sue Doerfer
CCTCA Mini-Grant Recipient

Goal 5

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

Agencies interested in this goal:

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

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

Action Steps:

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

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

Action Steps:

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

Goal 5 (cont.)

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

Action Steps:

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

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

Action Steps:

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

The following agencies support this Action Plan:

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

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

Evaluating the Alliance's Progress

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

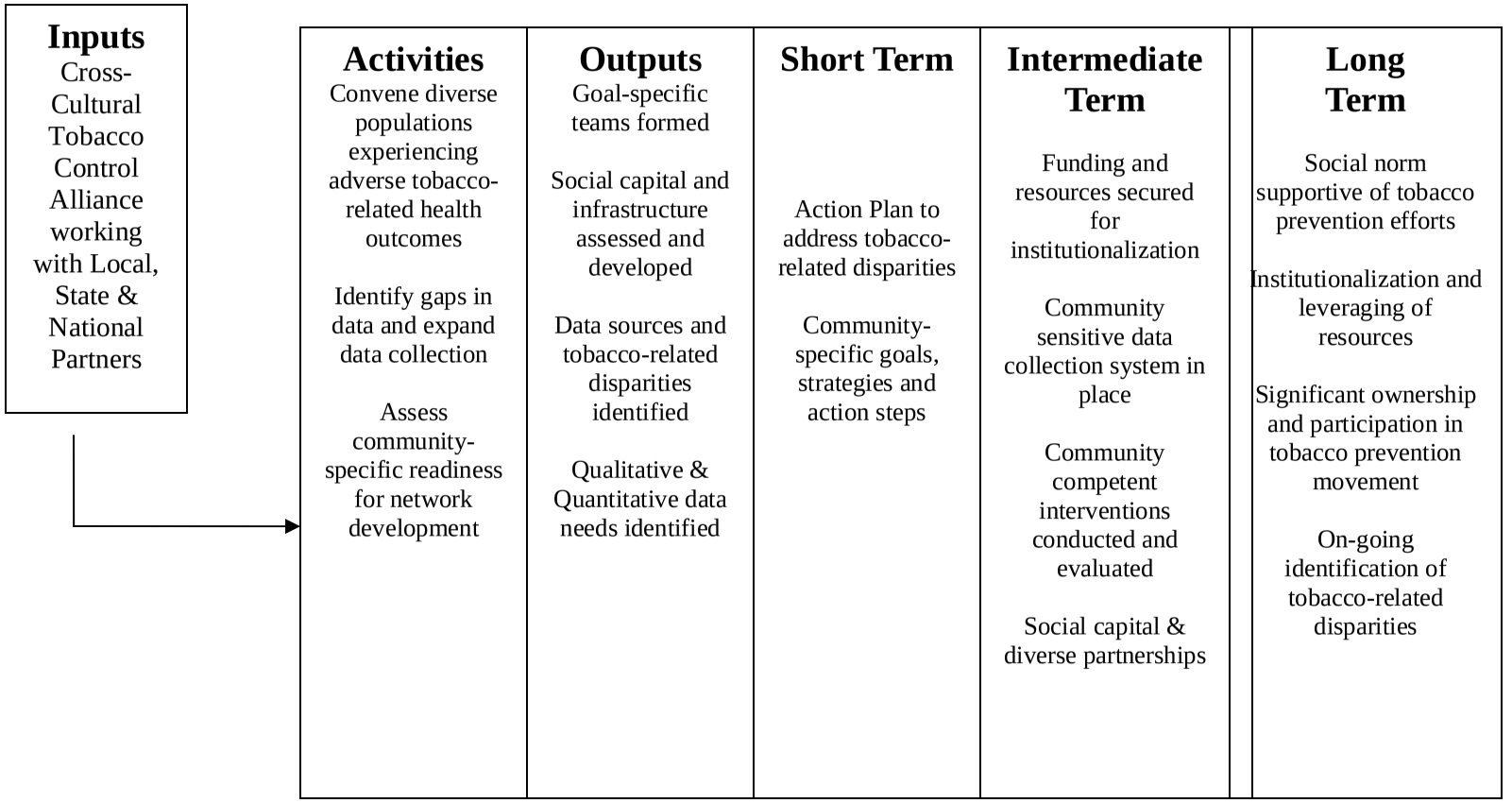
During the first year, a project assistant will be hired and the Alliance will continue to conduct internal meeting participant evaluations which look at various aspects of the group such as openness, participation and productivity after each meeting. The leadership for each of the five objectives, along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

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

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

Jason Fallon
CCTCA Member and Mentor

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



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. Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs. Atlanta, GA: Centers for Disease Control and Prevention; 2005 (Concepts were borrowed).

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Twenty-two focus groups were conducted with eleven populations receiving two focus groups each (except Amish and the Deaf Community who received one each), and there are plans to conduct focus groups among the Veterans/Active Duty Military and communities of color in Southeastern Ohio during the next grant cycle. Dr. Barry Oches (Qualitative Data Contractor) of Ohio University's Voinovich Center for Leadership and Public Affairs received a tremendous amount of support from the following people to conduct focus groups with 167 participants. Report copies are available through CD upon request from Tracy Clopton through the Ohio Tobacco Risk Reduction Program.

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Rod Lew, Association of Asian Pacific Community Health Organizations (APPEAL)

Galen Louis, Performance Planning Partners

Dave Nakashima, Nakashima & Associates

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APPENDIX

APPENDIX 1: OHIO TOBACCO CONTROL RESOURCE GROUP
MEMBERSHIP ROSTER 2006

Ohio Tobacco Control Resource Group Membership Roster 2006

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APPENDIX 2: HEALTH DISPARITIES COUNCIL'S SHORT- AND LONG-TERM GOALS

I. Committee: Monitoring and Surveillance

A. Long-term Goal

By 2008, The department will have implemented a data collection system which enables us to identify the disease and conditions in relation to morbidity, mortality, and health behaviors prevalence by race, ethnicity and cultural groups based on ODH data standards.

B. Short-term Goals

1. By December 2004, the department will have increased awareness of ODH data standards on race and ethnicity throughout ODH.
2. By December 2004, the department will have a plan to continue to support current resources used to provide over sampling by race, ethnicity and culture in BRFSS and AFHS surveys.
3. By December 2004, the department will have a completed an assessment to determine data gaps in the collection of data for racial, ethnic, and cultural groups.
4. By December 2004, the department will have encouraged programs across ODH to expand the analysis of health care disparities.
5. By December 2004, the department will have expanded the existing Health Disparities section on the ODH's Health Statistics website.

II. Workforce Development

A. Long-term Goals

1. By 2008, the department will have a culturally competent and diverse workforce.
2. By 2008, there will be a culturally competent and diverse public health workforce throughout Ohio.

B. Short-term Goals

1. By December 2004, the department will have developed a core set of cultural competencies and will have assessed the current status of the workforce against the core set.
2. By December 2004, the department will have assessed the diversity of the current workforce.
3. By December 2004, the department will have assessed feasibility of a mentoring program for retention and upward mobility of staff based on the outcome of the core competencies.

III. Infrastructure

A. Long-term Goal

By 2008, the department's policies, practices and resources will reflect their understanding and elimination of health disparities in Ohio as it relates to the six targeted areas (infant mortality, cancer screening and management, heart disease and stroke, diabetes, HIV/AIDS, child and adult immunization).

B. Short-term Goal

By December 2004, the department will have completed an assessment of the policies, practices, and resources that are committed to the elimination of health disparities in Ohio as it relates to the six targeted areas (infant mortality, cancer screening and management, heart disease and stroke, diabetes, HIV/AIDS, child and adult immunization).

IV. Best Practices

A. Long-term Goal

By 2008, the department will have identified, adopted, and shared best practices that eliminate health disparities in Ohio as it relates to the six targeted areas (infant mortality, cancer screening and management, heart disease and stroke, diabetes, HIV/AIDS, child and adult immunization).

B. Short-term Goal

By December 2004, the department will have identified best practices that could be used to eliminate health disparities in the six targeted areas (infant mortality, cancer screening and management, heart disease and stroke, diabetes, HIV/AIDS, child and adult immunization).

V. Awareness

A. Long-term Goal

By 2008, the department will have disseminated data that will have increased the public and the workforce's knowledge of health disparities in Ohio as it relates to the six targeted areas (infant mortality, cancer screening and management, heart disease and stroke, diabetes, HIV/AIDS, child and adult immunization).

B. Short-term Goal

By December 2004, the department will have developed a marketing plan to increase the public's and workforce's knowledge and understanding of health care disparities in Ohio.

VI. Partnerships

A. Long-term Goal

By 2008, the department will have increased their internal/external partners by providing leadership and resources to eliminate health disparities within the six targeted areas.

B. Short-term Goals

1. By December 2004, the department will have defined partnership and the role of internal and external partners.
2. By December 2004, the department will have assessed the utilization of internal partnerships in reducing health disparities within the six targeted areas (infant mortality, cancer screening and management, heart disease and stroke, diabetes, HIV/AIDS, child and adult immunization).

APPENDIX 3: GOAL #4 OBJECTIVE TEAM CHAIRPERSON LEADERS

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

- Dr. Surendra B. Adhikari was the Chairperson for the Data for Objective Team #1,
- Emily Lee and Gabrielle Brett, Gayden Fite, Kathryn Grayson, and Michael Byun were the Chairpersons for Objective Team #2 Statewide Alliances and Networks,[1]
- Najeebah Shine was the Chairperson for Objective Team #3, Smokefree Culturally-specific Restaurants and Bars,
- The seat for the Chairperson of Objective Team #4, Practice-based Evidence Culturally Competent Tobacco-use Prevention Programs for at-risk Youth was vacant, and
- The seat for the Chairperson of Objective Team #5, Adult Practice-based Evidence Cessation Programs was also vacant.

[1] Objective Teams #2 and 3, Statewide Alliance and Networks were merged based upon the two objective teams' leaders decisions to unite the two areas.

APPENDIX 4: FOUNDATIONAL LEADERS

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, or established relationships with new members who may have benefited from or contributed to the process.

The Foundational Leadership includes:

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

APPENDIX 5: CDC/OSH's DISPARITIES SUPPLEMENT LEADERS

The CDC/OSH's Disparities Supplement Leadership consisted of the following: Dr. Surendra B. Adhikari the Data Analyst, Tracy Clopton, the Project Coordinator, Dr. Lucinda M. Deason, the Case Study Evaluator, Dr. Barry Oches, the Focus Group Contractor, and Wendy Berry-West, the Facilitator. The specific responsibilities for each CDC Disparities Supplement Leader are noted below:

- Data Analyst: Analyze and summarize verbally and in writing all data associated with communities of color and at-risk, underserved populations as it relates to tobacco use prevention and control. Review, use, and report on other relevant data sources as it relates to tobacco prevention among communities of color and at-risk, underserved populations (such as Medicaid, low income, etc.). Complete reports and give presentations as it relates to enhancing the accomplishments of the Goal #4 Workgroup Objectives. Work with the Ohio Team members and the ODH Tobacco Program's Epidemiologist, Brandi Bennett, to assess, publicly report and using qualitative and quantitative data associated with the CDC implementation reporting process and the overall strategic planning process to eliminate disparities among our identified populations.

- Project Coordinator: Coordinate the overall process to ensure the community implementation process is completed and the strategic plan for Ohio is a plan for action that many communities agree with and pursue.

- Case Study Evaluator: Conduct a case study evaluation on five full days of meetings for the community implementation process with the Goal #4 Workgroup for the Ohio Comprehensive Tobacco Use Prevention Strategic Plan 2004 – 2008; provide a summary of each of the five full meeting days with written input from the Goal #4 Facilitator and other project staff and leadership of the community planning process; attend periodic project meetings with the contract manager; provide a final written report of the case study evaluation for public review. Also, complete the CDC progress report, contribute to the overall data analysis with Dr. Surendra B. Adhikari, and provide evaluation support to help the workgroup accomplish their objectives as needed.

- Qualitative Data Contractor: Facilitate up to two focus groups each on the population groups identified in the Qualitative Data Contractor's Request for Quote for the Goal #4 Workgroup within the Ohio Comprehensive Tobacco Use Prevention Use Prevention Strategic Plan 2004 – 2008. The 12 population groups include: four communities of color, namely 1) African American, 2) American Indian, 3) Asian, 4) Latino); and other unique populations/groups, 5) Amish, 6) Appalachian, 7) Chemically Dependent, 8) Current Military/Veterans, 9) Lesbian, Gay, Bisexual & Transgender (LGBT), 10) Persons in Poverty, 11) Mentally/Physically Challenged, and 12) Refugee/Immigrant. Provide individual reports of each focus group, that is; provide a summary of the 24 focus groups conducted with the 12 populations assessed by June 29, 2006. Provide individual reports describing the results for each of the populations assessed, manage and distribute funds for national contractors (to be identified by Goal #4 participants), travel and financial incentives for communities of color and the at-risk, underserved communities not currently involved in this process.

- Facilitator: Facilitate up to five full days of meetings with the Goal #4 Workgroup for the Ohio Comprehensive Tobacco Use Prevention Strategic Plan 2004 – 2008; provide summary of each of the five full meeting days to the Case Study Evaluator and other project staff and leadership of the community planning process; attend periodic project meetings with the contract manager/project coordinator. Also provide support to help the workgroup accomplish their objectives as needed.

APPENDIX 6: MEETING SUMMARY NOTES October 3, 2005

Goal #4 Workgroup
Eliminating Disparities in Tobacco
Meeting Summary
October 3, 2005

Present: Najeebah Shine, Barry Oches, Laura Milazzo, Tracy Clopton, Victoria Wilder Crews, Justin Henderson, Marian Ghedi, Andrea Deasy, Surendra B. Adhikari, Cheryl Owens, Francisco Lopez, Kathryn Grayson, Alonzo C. Vance, Gabrielle Brett, Gayden Fite, Wendy Berry-West, and Lucinda M. Deason.

I. Introductions & Ice Breaker:

Tracy Clopton introduced herself and gave an overview to the group as to what the group is charged with accomplishing. An introduction was made to the group by the facilitator Wendy Berry-West. W. West opened the meeting with an icebreaker to help the group with getting to know one another personally.

II. Overview of Process/Role of Leadership Team for Goal #4:

T. Clopton gave an overview to the group about how the entire strategic planning process began and the purpose of the Goal #4 workgroup. The purpose of the Goal #4 workgroup is to address the disparities in Tobacco among all racial/ethnic and high-risk populations. The group has been meeting since August 2004. T. Clopton told the participants what is needed by the workgroup in order to accomplish the 5 objectives of Goal #4. T. Clopton noted that 5 teams have been established for each of the objectives and she also reviewed the responsibilities for each of the teams (see Objective Team meetings summary). The chairperson for each of the Objective Teams and Leadership Consultants were introduced.

III. Small Group Objectives Team Meetings

The group broke into their respective team meetings to discuss and expand upon the objectives or to narrow down the objectives for group discussion.

IV. Developing Our Timeline

The group discussed timelines needed to accomplish the objectives of Goal #4, the face to face meeting dates and plan for each meeting are as follows:

- **Friday, December 16, 2005** (*Snow Date- Monday, December 19, 2005)*
  - Draft completed on focus of needs and objectives
  - Recommendation of 2 speakers for 2006 meetings

- **Friday, February 17, 2006** (*Snow Date will be a Conference Call TBD)*
  - Final Documents
  - Chosen Speakers to present

- **Tuesday, April 18, 2005**
  - Finalization of plan

V. Objectives Team Reports:

The goal was to narrow down the brainstorming sessions for each objective.

Team #1 - Data (Dr. Surendra B. Adhikari)
The group felt that they needed to explore all possible funded grants and programs for those populations where data is lacking (Develop a matrix).

1) Need to create of Baseline data which will include:
a) Prevalence data,
b) Sources and dates of the data when it was collected,
c) Focus group data,
d) Determine if data is local, state or national,
e) Type of data collected (youth, adult, cessation, use and prevalence, or second-hand smoke)

2) Standardize data collection across various groups and populations

Teams # 2 & 3 Networks for Communities of Color (Kathryn Grayson)/Networks for High Risk Communities, (Gayden Fite)/Tobacco Education & Advocacy Alliance, (Gabrielle Brett) (Teams 2 and 3 merged and incorporated Team 4 to address objectives 2 and 3)

The teams looked at their objectives and discovered that there were some similarities in the objectives which needed to be merged so that the information and work could be narrowed down.

1) Establish an Alliance
    a. Mission –
    - Leadership
    - Coordination
    - Marketing
    - Information /Resources/Referrals
    - Training
    - Improve quality of health
    - Funding
    - Common Focus
    - Recognition of cultural differences
    b. Increase networks and support existing networks
    c. Vision Statement – *"Eliminate tobacco related deaths and disease(s) among at-risk and underserved populations by promoting a tobacco-free lifestyle*".

2) Objective #4 became #2 and #2 was incorporated as #3 as follows:

- Obj#2 – Establish an adequately funded and fully operational tobacco education and advocacy alliance among underserved racial/ethnic population's networks and
- Obj#3 – Increase the number of adequately funded and fully operational statewide at-risk, underserved and racial/ethnic tobacco use and prevention networks in Ohio.

3) Strategies

    1) Identify already existing networks to determine service gaps.

2) Establish networks where no networks exist
    - Identify leaders, movers, shakers and gatekeepers
    - Needs and support

Team#5 Smoke Free at Culturally Specific Restaurants and Bars (Najeebah Shine)

There was some discussion by this team regarding where the data collection process ends since there could be some existing resources to piggyback on. The decision on moving this goal forward is as follows:

- Stop data collection process and look at other ways for data collection
    - Incorporate labor issue or should it be under another area
- Look at other methods(i.e., resources, message) used to communicate to populations regarding smoke-free environments
- Narrow focus to family style restaurants or restaurants where you can sit down or in one community
- Combine existing data sources to calculate number of restaurants who are not smoke free.
- Consider participating in Smokefree Ohio campaign (11-18-05) or local CIA activities
- Contact LGBT organizations to identify list of restaurants/bars

VI. Qualitative Data Questions – Brainstorming Session:

Barry Oches facilitated this session to brainstorm with the group regarding important questions that need to be posed to the targeted population. The group input was as follows:

1) Awareness
2) Involvement
3) Attitudes
4) Behavior
5) Needs
6) Labor issues
7) Products used
    - Brands
    - Labels

8) Second Hand Smoke
9) Policies of Change
    - support ordinance or law
    - What would you be willing to do for change?

10) Programs (advocacy) in community
    - Utilizations
    - Barriers to use

11) Gender questions
12) Services
13) Cost factors
14) Health Literacy
15) Accessibility/Availability of Tobacco Products
16) Marketing/Advertising
17) Terminology (culturally specific)
18) Myths
19) Medicinal Benefits
20) Religious Beliefs

21) Cigarette Perception (light vs. regular)/(menthol vs. regular)

B. Oches indicated that the focus group set-up will be a balance of age ranges.

VII. Case Study Evaluator

Dr. Lucinda Deason identified her role on the project as the Case Study Evaluator and asked participants to note whether or not they would be willing to participate to be interviewed about the process and achievements of the objectives of Goal #4. T. Clopton suggested that Dr. Deason use the sign roster as a source for contacting participants for interviews.

VIII. Other-ACTION STEPS:

Final observations and charges for the group prior to the next meeting are:

1) Provide an assessment for all objectives,
2) Identify representatives to serve on the alliance,
3) Develop a Memorandum of Understanding so that all members of the groups will know what being on this alliance will entail (i.e., support, give and take, benefits, funding), and
4) Utilize other groups, organizations, information/culturally specific material to assist in advocating for smoke free environments.
5) Start working on finding out the needs of the groups currently at the table, as it relates to statewide network development.

APPENDIX 7: MEETING SUMMARY NOTES December 16, 2005

Goal #4
Eliminating Disparities in Tobacco
4th Strategic Planning Meeting
Friday, December 16, 2005
Meeting Summary Notes

Present: Leslie Anders (Hallenross), Ben Hall (Hallenross), Barry Oches (Qualitative Data Contractor), Wendy Berry-West (Strategic Planning Facilitator), Amy Hopping (NCI CIS), Marian Ghedhi (United Somali Refugee Women), Deborah Chambers (ODADAS), Anna Cruz (DeafLink), Joe Mazzula (OTUPCF), Dawn Emmons (DeafLink), Reina Sims (OTUPCF), Poongothai Jayaraj (Asian American Community Services), Graycee Shaw (Adelante Inc.), Surendra B. Adhikari (Data Analyst Chairperson, OTUPCF), Trill Cole (Charisma Community Connection), Lucinda M. Deason (Evaluator), Gayden Fite (Women's Health Recovery Coalition), Tracy Clopton (Project Coordinator, Ohio Department of Health), Amanda Wright (OTUPCF), Kathryn Grayson (UMADAOP), Icilda Dickerson (OTUPCF), Emily Lee (ALAO), Gabrielle Brett (NCI- Cancer Information Service)

I. Introduction and Ice Breaker

The meeting began at 10:00 am. Wendy Berry-West opened the meeting with an Ice Breaker allowing everyone to introduce themselves.

II. Role Clarification of Leadership Team for Goal #4

The overall purpose of this group is to create a diverse and inclusive group of people to create an infrastructure and to obtain funding in order to help us achieve our vision and mission. Tracy Clopton provided the role clarification of the Leadership Team and CDC Supplement Leaders for the group. The definition of the leaders' roles was described in a summary sheet that was provided to everyone present. The leaders present were introduced to the group.

III. Finalize Speakers for 2006 Meetings (2)

Suggestions were made as to possible speakers for the 2006 meetings that could provide training that would assist the group with creating a strategic plan and obtaining funding. The group identified the following areas of expertise as important for speakers:

- ✓ Infrastructure,
- ✓ Sustainability,
- ✓ Capacity building,
- ✓ Agency management,
- ✓ Strategic planning, and
- ✓ SWOT analysis.

Suggestions for speakers included:

1) Central State University- Ohio Minority Health Institute has expertise in infrastructure, agency management and alliance building.
2) Dr. Grace Ma (Rosita Edwards) – Philadelphia-Temple University has expertise in capacity building and infrastructure.
3) Joyce Lee – Greater Cleveland Health Education and Service Council has expertise in infrastructure, agency management and sustainability.
4) T-TAC Prevention Institute might have expertise.
5) Harlem group might have expertise.

Several members were assigned to contact the suggested speakers and ask them to submit resumes for consideration by the Project Coordinator. Deadline for submission – **Dec. 30th**.

IV. Review and Shape Goal #4 Mission & Vision

Dr. Lucinda Deason presented to the group a draft of the **vision** and **mission** for the Strategic Plan. The **vision** and **mission** were developed by Dr. Deason and Wendy Berry-West. Gabriel Brett suggested that the vision was too long. Suggestions for additions and deletions to the mission were made by the group. A consensus on the wording for the vision and mission was achieved as noted below:

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

Mission: To identify and systematically eradicate tobacco-related health disparities by using innovative approaches to: 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 at-risk, culturally diverse, underserved populations that are disproportionately affected by tobacco use.

V. Strategic Plan Update & Data Presentation

Dr. Surendra B. Adhikari presented data analysis on disparities in tobacco use in Ohio. This included smoking and smokeless tobacco. Gayden Fite indicated that the mentally ill population statistics were not included in the data. She will assist in providing this data to the group. Poongothai Jayaraj referred to the availability of prison population and Asian population data. She indicated that in a Texas study the Chinese population smoking is increasing with Southern Asians.

Gabriel Brett suggested that local data be obtained on the rate of smoking among pregnant women enrolled in the WIC program. The deaf community interpreter posed the question, "How is data obtained from the deaf communities in Ohio? Dr. Adhikari suggested using a focus group.

Dr. Adhikari will make available copies of the data for everyone.

VI. Review of CDC Requirements

The CDC required the group to complete their Critical Issue Analysis tool. Tracy Clopton provided instructions to each objective team for completing the CDC's Critical Issue Analysis tool as follows:

1) Discuss your Issues.
2) Rate or rank them based on the critical analysis tool.
3) Come up with other issues as necessary.
4) Determine their impact.

VII. Objective Team Reports

A) Objective Team #1- Data

Issues with highest scores: #1, 5/6

Critical Issue 1: What populations are in need of assessment?

Critical Issue 5/6: What disease-related and tobacco-related data do we need to address disparities? Dr. Deason will give a report due to Tracy Clopton 1-30-06.

B) Objective Teams #2 & 3 – Statewide Alliance and Networks

Issues with highest scores: To be determined based on Gabrielle Brett's report (Gabrielle took the group's responses with her when she left the meeting early). She will give a report due to Tracy Clopton 1-30-06.

VIII. Critical Issues Analysis

Due to the inability of all group members to stay until the meeting ended a couple of homework assignments were given prior to the next meeting scheduled for February 15, 2006.

XI. Next Steps

A) Homework: Completing a Critical Issues Analysis Report and contacting the suggested speakers.

B) Next meeting dates were decided to be on Wednesday, February 15th and Wednesday, April 19th.

Update since 12-16-06:

- Since the meeting Poongothai Jayaraj found the next meeting site (Northwest Library) for the February 15th meeting and she provided locating for Rosita Edwards at Temple University and Roger Dier at the University of Wisconsin Medical School.
- Vickie Stauffer from Wisconsin has contacted Tracy Clopton with an appropriate website for review.
- Adrienne Heard from Heard Management was contacted from the Ohio Minority Health Institute to provide a presentation on Human Resources for February 15th's meeting.
- Chairpersons were asked to contact their "Buddies" to encourage more Goal #4 Workgroup members to contribute through meeting involvement.
- The Ohio Tobacco Control Resource Group Position Statements relating to at-risk populations were accepted during the January 10th meeting.

APPENDIX 8: MEETING SUMMARY NOTES February 15, 2006

Goal #4
Eliminating Disparities in Tobacco
4th Strategic Planning Meeting
Wednesday, February 15, 2006
Meeting Summary Notes

Present: Andrea Peters (Hallenross), Anthony Nelson (Hallenross), Wendy Berry-West (Strategic Planning Facilitator), Amy Hopping (NCI Cancer Information Service-Columbus), Deborah Chambers (ODADAS), Anna Cruz (DeafLink), Dawn Emmons (DeafLink), Reina Sims (OTUPCF), Graycee Shaw (Adelante Inc.), Surendra B. Adhikari (Data Analyst Chairperson, OTUPCF), Lucinda M. Deason (Evaluator), Tracy Clopton (Project Coordinator, ODH), Kathryn Grayson (UMADAOP- Lucas County), Michael Hayes (UMADAOP-Lucas County), Adrienne Heard (Heard Management), Gabrielle Brett (NCI- Cancer Information Service-Cleveland),Thomas W. O'Hara (Voinovich Center), Laura Milazzo (Qualitative Data Contractor, Voinovich Center), Grayce Shaw (Adelante), Justin Henderson (ODH), LeAnn Matvey (Appalachia Community Cancer Network), Alberto Vribe (Ohio Hispanic Coalition), Victoria Wilder Crews (CEASE, NBCCRC), Emily Lee (ALAO), Najeebah Shine (Cuyahoga County Board of Health).

I. Introduction

The meeting began at 10:00 am. Wendy Berry-West opened the meeting with a welcome and allowed everyone to introduce themselves.

II. June Meeting Date

A vote was taken on the meeting date for June. A consensus was made that June 14th is the meeting date with the location TBD.

III. Needs Assessment & Greatest Challenge Form

Tracy Clopton presented a needs assessment form entitled, "Key Questions in Assessing Interest and Program Direction for State Level Community Specific Tobacco Control Networks and Alliances" that she obtained from the Praxis Project. This form is to assist in determining the interest and program direction for the Tobacco Control Network and Alliances to assist with building statewide networks and alliances. Local coalitions can also use this form for their own communities. Tracy requested that the form be returned by February 17th.

IV. $120,000 Next Grant Cycle Input

Tracy provided the group with a form entitled, "Future Plan Input." The plan is to continue with the strategic planning process. The group was asked to think of three (3) areas of focus that would assist in moving the planning group closer to accomplishing its vision and mission. Tracy asked that their input be returned to her by February 17th.

V. Adrienne Heard (Heard Management)

Adrienne Heard of Heard Management gave a presentation on Human Resources: People Are Your Most Valuable Asset. The purpose of the 2-hour presentation was to assist participants in understanding how to best utilize people as resources for their organizations, groups and coalitions by effectively recruiting, training and retaining staff. A handout was made available for everyone to follow.

VI. Update on the Focus Group Assessments for Goal #4 – Laura Milazzo (Voinovich Center-Ohio University)

Laura Milazzo in the absence of Barry Oches (Qualitative Data Contractor) presented an update on the focus groups meetings that took place in the state. The focus groups were to be conducted with 12 identified at-risk populations. Six focus groups have been completed as of February 15, 2006. Laura also shared some of the barriers that they have encountered with scheduling focus groups, gaining access to some populations, and using interpreters to conduct focus groups in foreign languages. The group gave Laura some suggestions for addressing some of the barriers that she has encountered. Laura asked the group to provide her with contacts in the Amish, Immigrant/Refugee, and Native American communities because she was having problems with gaining access to these communities.

VII. Najeebah Shine and Justin Henderson (Objective Team #4- Restaurant Report)

Najeebah Shine provided the group with an update on Objective Team #4's Report (Objective Team #4 has been changed from Objective #5). She indicated that after having read the Wisconsin report, she felt that team #4 should broaden its objective. Specifically, Najeebah felt that the objective should be changed to either workplace safety or decreasing secondhand smoke exposure. Tracy indicated that we couldn't change the objective as it was stated in the upcoming Strategic Plan document during this grant cycle, but we can work on this objective in a way the group sees beneficial. Objective Team #4 did not complete the critical issues process prior to this meeting. Tracy noted that the entire group would complete the critical issues process at the current meeting.

VIII. Power Analysis Report for Goal #4

The leadership decided to go over the Power Analysis Report at the April 25, 2006 meeting, in the interest of time.

IX. Finish Critical Issues and Determine Goals

The group spent the final portion of the meeting on the Critical Issues Analysis for objectives #4 (Smoke Free Restaurants & Bars and developed critical issues for Objective #5 (Evidence Based Youth Programs).

Wendy West assisted the group in completing the critical issues process for objectives #4 and #5. The group completed the critical issues process and the results of the critical issues for all five objectives are attached.

X. Next Steps

A change was made to the meeting date from April 19th to Tuesday, to April 25th. At the April 25, 2006 meeting the group will go over the Power Analysis and conduct a SWOT analysis. The meeting will be at the American Cancer Society, Ohio Division, Dublin, Ohio from 9:30am to 3:30pm.

Critical Issues Reports for all Objective Teams

Objective Team #1 (Data)

Critical Issue	Score
1. What populations are in need of assessment?	**(31)**
2. Do the current sources of data address communities of color, at-risk populations and the underserved?	**(30)**
3. What tobacco-specific data do we need to address disparities?	**(29)**
4. What tobacco-related disease data do we need to address disparities for communities of color, at-risk populations and the underserved?	**(31)**
5. What socio-medical information do we need to know?	**(30)**
6. Are assessment tools currently available for us to collect missing data for communities of color populations, at-risk populations and the underserved?	**(28)**
7. Are qualitative tobacco-related data available for communities of color, at-risk populations and the underserved?	**(29)**
8. Who collects quantitative and qualitative data on communities of color, at-risk populations and the underserved?	**(30)**

The two issues that received the highest scores were issue number one and issue number four.

Objectives #2 & #3 Critical Issues (Networks & Alliances)

Vision	Alliance/ Network	Overall Score	Rating
1. Resource Center to include but not limited to: medical interventions, best practices, central resource center, and list serve	Alliance	38	1
2. State polices	Alliance	34	3
3. Collaborations with state and national	Alliance	30	5
4. Collaborations within Ohio	Network	30	5
5. Fundraising	Alliance	35	2
6. Fundraising	Network	33	4
7. Media/Marketing	Alliance	26	6
8. Media/Marketing	Network	30	5

Objective Team #4
(Smoke Free Culturally Specific Restaurants and Bars)

Critical Issue		Score
1.	100% Smoke free Restaurants and Bars	**(28)**
2.	What gaps in secondhand smoke policy advocacy are all high risk populations experiencing?	**(35)**

The issue that received the highest score was issue number two.

Objective Team #5
(Evidence-based Tobacco Use Prevention Programs that are Culturally Competent for racial/ethnic and other at-risk population youth)

Critical Issue		Score
1.	Funding to address evidenced-based culturally competent youth tobacco prevention programs	**(35)**
2.	Development of evidenced-based culturally competent youth tobacco prevention programs	**(33)**
3.	Accessibility and portability of evidenced-based culturally competent youth tobacco prevention programs.	**(34)**

The issues that received the highest scores were issue numbers one and three.

APPENDIX 9: MEETING SUMMARY NOTES April 25, 2006

Goal #4
Eliminating Disparities in Tobacco
Strategic Planning Meeting
Tuesday, April 25, 2006
Summary Notes

In Attendance: Jennifer Brindle, ASIA; Justin Henderson, ODH; Dr. Leroy Cothran, United Missionary Baptist Church; Amy Hopping, NCI; Gabrielle Brett, NCI; Emily Lee, ALAO; Najeebah Shine, Cuyahoga County Board of Health; Fatima Perkins, United Way-Cleveland; Dr. Lucinda Deason, Evaluation Services; Gregg Carol & Leslie Anders (Hallenross & Associates); Anna Cruz & Dawn Emmons, DeafLink; Dr. Barry Oches, Ohio University; Kathryn Grayson, UMADAOP of Lucas County; Alberto Uribe, Ohio Hispanic Coalition; Victoria Wilder-Crews, CEASE Project; Deborah Chambers, ODADAS; Tracy Clopton, ODH.

I. Welcome

The welcome was provided by the facilitator, Wendy Berry-West.

II. Guest Speaker

Fatima Perkins, Director of Senior Programs at the United Way of Greater Cleveland, gave a presentation about obtaining funding and tobacco cessation and prevention projects that have been funded by the United Ways across the state of Ohio. She presented information about the funding priorities of the United Way of Greater Cleveland. She also emphasized that the United Way (UW) places emphasis on outcome measurement. In addition, Ms. Perkins shared strategies for obtaining funding from the UW. She also noted that the UW has 3 pools of funding available, including:

- Contingency Dollars- provide funding to support diversity initiatives, strategic plans and collaborative initiatives.
- Capacity Building Dollars – provide funding for projects that focus on issues such as support for board development and human resource issues.
- Tobacco Initiatives – provide funds to support tobacco initiatives at the local level.

Lastly, Ms. Perkins presented the steps necessary for securing funding from the UWs across the state of Ohio.

III. Regional Meetings

Tracy Clopton gave an overview of the reasons for conducting regional meetings in the state. The goal is to conduct 5 regional meetings across the state of Ohio. The purpose of the meetings is to present information about the strategic plan developed by the Goal #4 workgroup to reduce and/or eliminate tobacco-related disparities in communities of color and at-risk underserved populations to community stakeholders and to obtain their feedback about the plan. The following meeting dates and locations have been scheduled:

- Northwest (Lucas County) – Friday, May 5, 2006 – UMADOP of Lucas County; 2447 Nebraska Avenue, Toledo, OH; (10:00 am – 1:00 pm).
- Central Ohio (Franklin County) – Tuesday, May 16, 2006 – Neighborhood House Resource Center, 1060 Mount Vernon Avenue, Columbus, OH; (10:00 am – 12:00 pm).
- Southeast (Athens County) – Monday, May 22, 2006 – Voinovich Center, Ohio University Building 20, The Ridges, Athens, OH; (10:00am – 12:00 pm).
- Northeast (Cuyahoga County) – Wednesday, June 7, 2006 – Cuyahoga County Board of Health, 5550 Ventura Drive, Parma, OH; (10:00 am – 12:00 pm).

- Southwest pending (at the time of the meeting).

Najeebah Shine provided the following comments regarding the regional meetings:

1) The organizations hosting the regional meetings should take the opportunity to discuss the plan and share what has been done in their region. Efforts should be made to recruit additional people to become members of the workgroup.
2) We should be clear about what we want the communities to do. Also, it is important that the community feels like they are a part of the process.

IV. Statewide Conference Discussion

Tracy shared with the group that the plan for the next cycle of funding is to emerge into an alliance to implement the strategic plan as a team in order to move things forward. The following things should occur:

1) stabilizing the workgroup,
2) moving the workgroup outside of the Department of Health,
3) using the $120,000 of core funding obtained from the ODH tobacco money for sustaining the workgroup and implementing the strategic plan,
4) hiring a Project Assistant, and
5) planning a statewide conference.

The group spent some additional time discussing the need for a statewide conference. Some of the suggestions included:

- Develop partnerships with other conference planners in order to educate them about tobacco-related disparities among communities of color and at-risk underserved populations.
- Piggyback on annual conferences held by the Ohio Commission on Minority Health (OCMH), TUPCF, American Cancer Society (ACS), and Bowling Green State University's State of the State Conference.
- Presentations should be made at the conferences about the twelve populations.
- Set a tentative date for a conference sponsored by the workgroup is April 2007.
- TUPCF 2007 conference could be combined with the workgroup's conference whereby the Goal # 4 Workgroup could have a pre-conference.
- Collaborate with the Ohio Commission on Minority Health's annual conference held in Columbus.
- Conduct sessions at the Bowling Green State University's annual State-of-the State Conference held in Ohio.
- Piggyback onto untraditional conferences.

Some immediate and feasible suggestions provided by the group included participating in 3 conferences that will be held within the next year:

- UMADAOP's annual conference held in August 2006 in Cleveland, Ohio (the UMADOP conference can add a Tobacco prevention and cessation track. Contact Jessica Horne for more information on the UMADAOP conference).
- TUPCF and OCMH 2007 conferences held in March or April of 2007, and
- Bowling Green State University's State of the State conference that will be held in March 2007 in Cleveland, Ohio.

V. Review Implementation Plan (Using the Model of Wisconsin)

The group reviewed the Wisconsin Strategic Plan and agreed that it will serve as a model for Ohio. The goal is to use this model to develop an action plan for Goal 4. The group reviewed Wisconsin's plan and developed the following action plan for Ohio based upon our original goals in the strategic plan:

Goal I: To increase the availability of tobacco-specific baseline data related to all racial/ethnic and other at-risk populations.

Strategy 1.1: Review and Identify tobacco-related disease data that are available and needed for the disproportionately affected or underserved populations.
Action Steps:

- Compile comprehensive listing of data sources,
- Review data sources to identify gaps,
- Establish plans to reach new groups that haven't been assessed,
- Develop a dissemination plan,
- Sponsor and conduct primary research,
- Participate on key state committees that are involved in tobacco-related instrument design and data collection so that we can provide input, and
- Create data access through a website.

Strategy 1.2: Influencing policy through data.
Actions Steps:

- Develop a concept paper, and
- Share and create dialogue about the concept paper with policymakers, funders, and other interested parties.

Goal II: Establish an adequately funded and fully operational tobacco education and advocacy alliance among statewide communities of color and at-risk underserved populations in Ohio.

Strategy 2.1: Identify key organizations that serve communities of color and at-risk underserved populations in Ohio.
Action Steps:

- Develop a list of organizations,
- Establish and publish a resource directory,
- Maintain the resource directory, and
- Place the resource directory onto the website.

Strategy 2.2: Develop partnerships and collaborative opportunities among programs serving communities of color and at-risk underserved populations in Ohio.
Action Steps:

- Create or improve communication channels between different organizations,
- Offer networking opportunities by providing information at conferences and meetings,
- Develop memoranda of understanding, and
- Outreach to new partners with one-on-one visits to programs serving communities of color and at-risk underserved populations in Ohio.

Strategy 2.3: Develop resources to support and implement mutually beneficial strategies.
Action Steps:

- Create a virtual resource center,
- Identify existing materials about tobacco control strategies,
- Create new informational material about tobacco control strategies,
- Create training and technical assistance modules about tobacco control strategies,
- Disseminate information, and
- Provide training and technical assistance.

Strategy 2.4: Create networks and strengthen support for communities of color and at-risk underserved populations in Ohio.
Action Steps:

- Create relationships with local and regional governmental social service agencies that serve the poor; food pantry organizations; shelters; trade unions and churches serving low socioeconomic communities, and
- Establish network link with communities of color and at-risk underserved populations in Ohio.

Strategy 2.5: Actively engage communities of color and at-risk underserved populations in Ohio in developing and enacting implementation plans.
Action Steps:

- Identify communities of color and at-risk underserved populations in Ohio.
  to assist with developing and implementing the plans
- Provide training and technical assistance for developing and implementing the plans,
- Develop a list serve, best practices and interventions, and
- Develop a fundraising, media and marketing plan.

Goal III: By 2007, the number of Smoke Free culturally-specific restaurants and bars will increase by 5 percent from the number found in 2005 at baseline.

Strategy 3.1: To expand the comprehensive assessment of bars and restaurants in order to obtain baseline data.
Action Steps:

- Compile local data sources, and
- Complete a report.

Strategy 3.2: Review resources to support and implement environmental changes.
Action Steps:

- Compile existing resources, and
- Design implementation plan.

Strategy 3.3: Provide training and technical assistance to assist restaurants and bars in establishing smoke-free policies.
Action Steps:

- Schedule training, and
- Create regional strategies.

Strategy 3.4: Implement recognition activities and update existing smoke-free establishment guidelines.

Action Steps
(Developed after the meeting)

VI. Review of Power Analysis

Tracy reviewed the power analysis that was completed in October 2004 with the workgroup. Tracy explained that the goal of the power analysis was to define allies and opponents among agencies as it relates to what the workgroup is trying to accomplish. The power analysis helped the group to assess its "Political Power." Tracy also stated that the power analysis has probably changed since the one conducted in 2004 based upon the change in Ohio's political climate since then, but some players may still be in place.

VII. SWOT Analysis for the Strategic Plan

Dr. Lucinda M. Deason, the case study evaluator, conducted a SWOT Analysis with the workgroup. The results of the SWOT Analysis are in the table below:

Critical Issues	Strengths	Weaknesses	Opportunities	Threats
Data	➢ Collaboration ➢ Access to ODH/OCMH/TUPF data ➢ Diversity in data ➢ Different levels of data ➢ Dissemination of information	➢ Difficulty of evaluators understanding and buy-in to ask specific questions, ➢ Not having clear idea of what to collect, ➢ Inconsistent data, ➢ What needs to be done with data	➢ Broader dissemination through partnerships ➢ Influencing data collection at the state level (TUPCF/ODH) on smokeless tobacco ➢ Influence of impact and policy ➢ Changing where "Black n' Milds" are located in retail outlets ➢ Increase funding sources ➢ Influencing and/or increasing stakeholders ➢ Create or piggyback on conferences and educational opportunities in Ohio ➢ Changes in messaging	➢ Awareness of conditions of disease ➢ Resources ➢ Schools and organizations make it difficult to collect data ➢ Lack of collective representation at the decision-making table ➢ Survey design (no voice) ➢ Difficulty in collecting data ➢ Diversity in software in data analysis ➢ Difficulty in connecting with grassroots organizations
Critical Issues	**Strengths**	**Weaknesses**	**Opportunities**	**Threats**
Alliances and Networks	➢ National and regional representation ➢ Diversity in membership ➢ Website ➢ Access to local data ➢ Access to	➢ Adequate time for workgroup member participation ➢ Media and marketing expertise	➢ Large number of media outlets that have health reporters ➢ Stabilize tobacco control ➢ Reach diverse markets	➢ Tobacco Industry ➢ Lack of interest among funders ➢ Lack of interest among funders due to visibility of issues (questions as to local

	resources (Ohio Resource Network) ➢ A common vision ➢ Advertising TTY for the Deaf		➢ Demanding, commanding and getting accountability ➢ Representation on TUPCF Board ➢ Advertising and awareness in the media	funders role) ➢ Self-promotion as opposed to health promotion ➢ Media promoting negative messages as opposed to positive to move in the right direction ➢ Funding cuts (loss of committed human resources) and sustainability ➢ Inconsistent messaging system priorities
Critical Issues	**Strengths**	**Weaknesses**	**Opportunities**	**Threats**
Culturally Specific Restaurants and Bars	➢ Access through systems (infrastructure). ➢ Examples and existing ordinances ➢ Increasing awareness	➢ Government employee limitations ➢ Workgroup not addressed environments of non-smoking ➢ Not tapped into the Ohio movement	➢ More information and educational opportunities on second-hand smoke ➢ Become part of smoke-free Ohio ➢ Educate small businesses on their role as employers/accurate decisions ➢ Partnering with Medicaid and agencies that serve the underinsured. ➢ Partnering with hospitality agencies and groups and	➢ Hospitality group threats regarding clean in-door air ➢ Threat-on individual rights by hospitality industries, corporations because of more resources ➢ Government system bureaucracy to encourage regulatory policy ➢ Messaging to restaurants and hotel

			insurance companies	
Critical Issues	**Strengths**	**Weaknesses**	**Opportunities**	**Threats**
Evidenced-Based Youth Programs	➢ Cultural competence ➢ Funding from CDC ➢ Level of Expertise ➢ Level of curriculum	➢ Lack of youth representation on workgroup ➢ Lack of Evidenced-based programs	➢ Prevention ➢ Policy changes in schools (promote wellness) to add into policy ➢ Flagship state for youth ➢ Identify and connect with entertainment industry to serve as role-models to connect with youth ➢ Partnering with recreational facilities (park, etc.)	➢ Youth ➢ Evidence-based programs communities of color ➢ Funding ➢ Advertising and mailing lists ➢ Role models ➢ Parents and families that smoke or influence smoking (Infiltration of promotion groups) ➢ Not enough time to get information to schools ➢ Convenience store owners /tobacco online products
Critical Issues	**Strengths**	**Weaknesses**	**Opportunities**	**Threats**
Cessation 6-7-06 developed by NE Ohio during Action Plan review meeting	➢ Persistence: Longevity in programming ➢ Access to the quit line & NRT Program ➢ Trained Cessation Providers ➢ Employers support from programs in the workplace	➢ Approach to youth cessation ➢ Unequal school funding ➢ (Need more) Representation from minority populations ➢ Choice of General Assembly to take	➢ Influence other insurance providers ➢ Cessation Centers – classes at different times and in different languages ➢ Educate Legislators	➢ Funding $ ➢ Continued advertising by tobacco companies ➢ Economy (not good) ➢ Lack of knowledge regarding what is available and the harm of tobacco use.

	➢ All counties have access to programming ➢ Data Available ➢ Community Partnerships ➢ History of collaboration ➢ Existing ordinances ➢ Funding $	tobacco funds (lack of) education and lack of interest - 7 priority trust funds. ➢ Influence of economy on tobacco programs and other issues ➢ Link tobacco with other programs ➢ Concern about the vision of OTUPCF ➢ (Lack) knowledge regarding other programs		

VIII. Team Building Meeting for June 14, 2006

Leadership change considerations will occur at this time. New officers are needed. Next meeting location: Ohio Hispanic Coalition – 6161 Busch Blvd., Columbus, Ohio. 614-840-9934. Time: 9:45am to 3:30pm. Contact Person: Judith Briceno.

APPENDIX 10: MEETING SUMMARY NOTES June 14, 2006

Goal #4 Workgroup
Eliminating Disparities in Tobacco
Meeting Summary
June 14, 2006

Present: Kathryn Grayson, Mary Avina, Wendy Berry-West, Victoria Wilder - Crews, Deborah Chambers, Reina Sims, Gabrielle Brett, Emily Lee, Dr. Surendra B. Adhikari, Tracy Clopton, Poongothai Jayaraj, Barry Oches, Roberto Santos, Barbara Johnson, Dr. Lucinda Deason, Dr. Judith Alizo-Briceno, Dave Nakashima, Rod Lew.

I. Introductions and Welcome

Wendy Berry-West, Facilitator, asked the group to individually introduce themselves and introduced the guest speakers and the facilitators for the day.

II. Ohio Hispanic Coalition

Judith Briceno, MD, Health Director of the Ohio Hispanic Coalition. The goal of Dr. Briceno's presentation was to address changing and adapting perceptions of the Latino population, access issues, and building trust. She also presented information about the Latino population, services available for the Latino population, and population statistics.

III. Ohio Tobacco Disparities Group Initial Team Building Exercises

APPEAL - Asian Pacific Partners for Empowerment, Advocacy and Leadership facilitator, Rod Lew and David Nakashima of Nakashima & Associates introduced themselves and served as the facilitators for this part of the meeting. The objectives of their facilitation were fourfold, including: 1) to reassess community priorities (assets and readiness) for tobacco control, 2) revisit 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 following expectations and workgroup guidelines were established by the meeting participants:

Expectations

- feeling of sustainability → movement
- concrete next steps → how to move PARITY
- more effective use of resources
- how to be more inclusive
- develop a name → Goal "4"
- establish tour guides → contacts/ partnerships
- sense of accomplish – leave with sense we have done something

Working Guidelines / Group Agreements

- Respect each other ideas
- Everybody participate
- Be on time (honor time)
- Take home messages
- Communicate

- Be a good listener
- Be creative
- Include communities not here today
- Come to consensus
- Dream big – eliminate : can't, won't → don't get stuck
- Technology is set to silent
- Follow-up

The range of methods 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 was discussed. Some of the resources that the meeting participants identified as needed to begin achieving the cross-cultural vision and mission include leadership development, technical assistance, and infrastructure building.

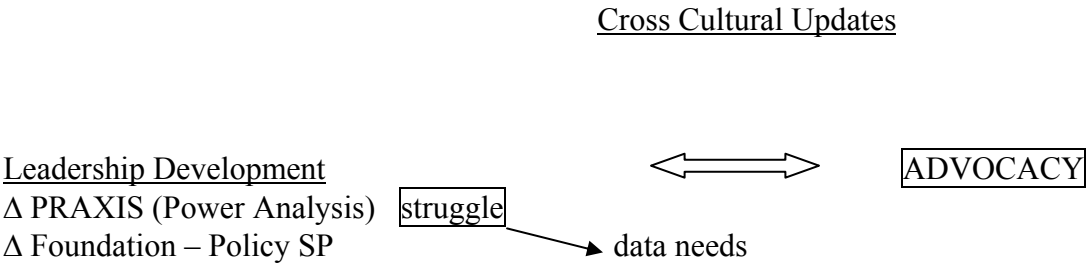
IV. Cover Story Vision Activity

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. The facilitator had the group participate in a "Cover Story" activity to access various visions of the group and where each person hopes the plan will accomplish. The group came up with the following messages:

(Counter-Message)

- Strategic relationships with community leaders
- Need for counter-marketing industry(Frame as social justice)
- Culturally/linguistically appropriate services
- Communication between specialized agencies
- Engage key partners in developing multi-sector relationships

The goal was to develop a vehicle to do all of the aforementioned things. Then the meeting participants shared their thoughts on what was needed to move forward. The figure below provides a depiction of the resources that were identified as being needed to move forward.



Δ AACOH Biennial Workshop
Δ Regional Meetings

Infrastructure Building
Δ Coalition / networks – not centralized
Δ Goal 4 Committee/ WG/ Team
Δ Development of AACOH
Δ CDC – next grant cycle

COUNTER-MESSAGE

Leadership Development
□ need strategic relationships with community leaders

Technical Assistance
Media literacy
↕
Δ need for counter-marketing/ counter-industry
↕
FRAME AS SOCIAL JUSTICE

Row Lew, facilitator, provided the group with a "Framework for Advancing Parity" shown below. The following 4 major areas that determine the framework for moving forward with the process and working collectively as a group:

Infrastructure Building
□ culturally / linguistically appropriate services
□ engage key partners in developing multi-sector relationships

- Strategic Plan
- Capacity Building
- Implementation of Programs and Policies
- Vision – reduced tobacco use and related diseases (Long-Term Impact)

The following framework for advancing parity was shared and discussed with the meeting participants:

A Framework for Advancing Parity

Strategic Plan
•Vision & Mission
•Community Readiness Assessment
•SWOT
•Prioritized Issues
• Action Plans

↓↓

Capacity Building
• Leadership Development
• Technical Assistance
• Infrastructure Building

↓↓

Implementation of Effective
• Programs
&
• Policies

↓↓

Reduced Tobacco Use
&
Tobacco-Related Diseases

↓↓

Empowerment
Of
Communities

V. **Update of Cross Cultural tobacco control work in OH (APPEAL)**

The group identified what currently exists in Tobacco Control in Ohio and what to build upon:

Leadership Development
- Power Analysis (Praxis)
- Policy
- Strategic Building

Technical Assistance
- Staff Development
- Power Analysis
- CDC Trainings

- TTAC – Fund Development
- Marketing Development
- State Conference

Infrastructure/Building
- Coalition/Network
- Goal 4 Committee/WG/Team
- AACOH Development
- CDC Funding (Build Capacity)
- AACOH Biennial Workshop
- Regional Action Plan Workshop

VI. Tinker Toy Activity

A Tinker Toy exercise was conducted to help the workgroup gain an understanding of the factors that can 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.

The discussion was followed up with activity (TINKER TOYS) to determine the level of communication needed and how effective communication is to implementation of the project. Group discussed from this exercise what did and did not work.

Tinker Toys Activity

Visionary	Communicator	Implementer
Innovator	Positive Influence	Good decision maker
Visionary	Navigator	Risk taker
Thinks outside the box	Compassionate Attitude	

(*leader produces leaders, empowers others, listener & for community [people person], leads by example*)

+ What worked	Δ Challenges
• Dividing into parts / pieces / sections • Change of terms to understand • Could ask questions • Patience of all people / communities • Implementer understood because she was focused on one thing. Each of us had one task, not multiple.	• Too much info at a time • Visual Sample • Paper & pencil to take notes • Recorder • Language Barriers

Community #2

+ What worked	Δ Challenges
• 1 step at a time	• too much info

• effort to succeed • patience • enthusiasm • focus on problem	• instructions too detailed • terms not consistent • distance leading to communication barriers • not enough time

+ What worked	Δ Challenges
• Breaking it down • Perseverance • Specialization • Team effect • Pre-Questions • Using definitions & labeling • Process – plan & organizing • Humor / Fun	• Complex shapes • Complex connections • Language barriers • Initial communication & rules • Time Pressure
+ What worked	**Δ Challenges**
• Piece by piece • Color & shape • Regrouped to discuss product • Trust in the Communicator • Best possible outcome given the situation	• No specifics • Didn't know what it was supposed to look like • Language of communication • Frequent changes in instructions • Time constraint

APPEAL ended the facilitation of the meeting with the following thoughts for the group.
What happens if the vision is not shared by everyone?

To make sure that the vision is shared by everyone, the need is to:
1) Follow directions
2) Be creative
3) Work in diverse communities and organizations because communication can get sticky

VII. Next Steps/Closing

Tracy Clopton went over the next steps in the process. They are as follows:

6-14-06 Team Building Meeting: Tasks To Do and Approximate Time Frame
Next Steps

A. Leadership Needs for June 30, 2006 to June 29, 2007:

1. Objective Team #1 / Data Analyst: Dr. Surendra Adhikari- Increase and identify the availability of tobacco – specific baseline data related to at-risk, culturally diverse, underserved populations. Work with all persons, and include all data sources to develop a clear picture of tobacco related disparities among at-risk populations in Ohio. Guide: Action Plan Strategies and Action Steps.

2. Objective Team #2 / Tobacco Education & Advocacy Alliance: Emily Lee and Gabrielle Brett- Contribute ideas to develop the infrastructural plan for the alliance, garner support (phone calls, e-mails and other correspondence) of agencies from multiple at-risk populations by inviting them to

Goal #4 meetings to contribute input, locate new partners from populations not currently involved in the process; attend Goal #4 meetings and conference calls; participate in the evaluation process; contribute to the process as needed to develop the alliance. Guide: Action Plan Strategies 2.1, 2.2 and 2.3 and related Action Steps.

3. Objective Team #2 / Community Networks: Kathryn Grayson, Gayden Fite, Jennifer Brindle - Contribute ideas to develop the infrastructural plan for **each community's statewide network**, garner support (phone calls, e-mails and other correspondence) of communities from each identified community by inviting them to Goal #4 meetings to contribute input, locate new partners from the specific communities that are not currently involved in the process; attend Goal #4 meetings and conference calls; participate in the evaluation process; contribute to the process as needed to develop the networks. It is important to identify a lead agency member for each specific community for which the network will exist. Guide: Action Plan Strategy 2.4 and related Action Steps.

4. Objective Team #3 Tobacco Free Workplaces: Najeebah Shine – Work towards tobacco free culturally-specific workplaces by connecting with management and workers of these businesses to promote tobacco free environments; and whenever possible, connect with the Smoke Free Ohio campaign to raise awareness and promote the acceptance of a smoke free Ohio by 2006. **Currently:** ODH can possibly contribute funds towards developing a toolkit that is community-competent (based upon the current model being developed by the OTUPCF) for educating business owners/managers about the new statewide ban. Guide: Action Plan Strategy 3.1, 3.2, 3.3 and 3.4 and related Action Steps.

5. Objective Team #4 Youth Prevention Programs: Open - Increase the number of evidence-based tobacco use prevention programs that are culturally competent for racial/ethnic and other at-risk population youth that also address age group and socioeconomic influences. **Currently:** We need follow up and close monitoring of American Lung Association of Washington State because they are revising TATU for the Native American Indian Community. This may be available soon; work is also being done to revise it for the Latino Community (please see Tracy C for contact persons to follow up with to learn more.) Guide: Action Plan Strategy 4.1 and related Action Steps.

6. Objective Team #5 Cessation: Open - Increase the availability of adult practice-based evidence cessation programs, pharmaceutical support, interventions, and awareness campaigns/information among at-risk, culturally diverse, underserved populations to reduce smoking prevalence and social acceptance of smoking. Guide: Action Plan Strategy 5.1, 5.2, 5.3 & 5.4 and related Action Steps.

Note: Each Chairperson will speak with Tracy C. to discuss the tasks they will work on for their Objective Team. <u>We should have these conversations between now and the mid-August.</u> We'll use an agency Matrix for task partnerships for each team.

B. June 14 to June (?) Conference Call date/time.

1. Complete the Implementation Plan and Case Study:
    - Name/Theme
    - Interview with Dr. Lucinda for case study
    - Review Marketing Plan (preliminary); RFP will include a consultant.
    - Drs. Lucinda, Barry and Surendra will get together on the data and evaluation parts of the case study to: a) report on the prioritization of communities we will focus on from 6/2006 to 6/2008; b) at least have a draft of case study by the week of the conference call 6-26-06 for leadership to review.

- Prioritizing communities and assess readiness levels
- Proposal: Goal #4 Statewide Forum for Community Network Building- Let's Pick a date today.
- Case Study, Implementation Plan and Marketing Plan is due by July 31, 2006

2. Leadership Decisions for next cycle
    - Facilitator position from various communities. Will be 4 contracting opportunities.
    - Evaluation: Will not be Case Study, but will be routine based upon meetings and we'll have a "coalition type" evaluation by 6/2007. Will be a contracted position for the next grant cycle to end 6/2008.
    - Current Objective Team Chairperson Leadership: Who will stay, move, change?
    - Fill New Objective Team Chairperson Leadership positions for #5 and #4
    - Co-Chair Goal #4 with Tracy C- local person needed.

C. Sept. 6, 2006 Next Meeting at American Lung Assn. of Ohio in Columbus.

1. CDC Project Officer will attend (Deborah Borbely)
2. Recognition for service during current grant cycle.
3. Training Needs for the coming year.
4. Planning for the Statewide Forum.
5. Marketing Campaign for our Action Plan.
6. Mini-grant communities (priority communities)
7. Needs assessment communities (priority communities)
8. Team Leadership Reports on Action Plan responsibilities.

Wendy West closed the meeting with final information on the evaluation. Lucinda Deason (evaluator) presented the group with the letter for conducting a study of the strategic planning process.

VIII. Adjournment

Meeting adjourned at 3:30pm.

APPENDIX 11: MEETING SUMMARY NOTES June 28, 2006 (Conference Call)

Cross-cultural Tobacco Control Alliance

Conference Call Attendees: Dr. Barry Oches (Ohio University); Amy DeSantos (Cleveland City Health Dept.); Nichelle Brown (Cuyahoga County Board of Health); Emily Lee (American Lung Association of Ohio); Bonnie Kirsch (Zanesville-Muskingum Health Dept.); Gabrielle Brett (National Cancer Institute-Cleveland); Grayce Villa-Shaw (Adelante); Deborah Chambers (Ohio Dept. of Alcohol and Drug Addiction Services); Dr. Surendra Adhikari (OTUPCF); Jennifer Brindle (Asian Services in Action);
Dr. Lucinda Deason (Evaluation Services, Inc.); Amy Hopping (National Cancer Institute-Columbus); Kathryn Grayson (UMADAOP of Lucas County); Gothai Jayaraj (Asian American Community Services); Tracy Clopton (Ohio Tobacco Risk Reduction Program-ODH).

1. Goal #4 is now called: *Cross-cultural Tobacco Control Alliance*

2. Theme for our Implementation/Action Plan: *Empowering cross-cultural communities to take action to overcome tobacco-related health disparities*

3. Prioritizing Communities: Our evaluation team will meet again and have final determinations by July 14th. We will be using tobacco use prevalence data (Ohio and national where state data is lacking) and lung and bronchus cancer health outcome data because this is the strongest determinant of tobacco-related chronic disease. Dr. Barry provided a summary of population needs in tobacco control based upon discussions with Dr. Lucinda and review of his own focus group data. We will also be considering community readiness and level of engagement in the alliance to prioritize our communities from June 30, 2006 to June 29, 2008.

4. Future Training Needs for Leadership Development: Budget & Financial Management; Grants (seeking funding sources); Prevention strategies and smoking habits among persons in poverty; Volunteer Recruitment for the CTC Alliance; Community Organizing; Creating Community Partnerships; Agency Office Organizing; Building Institutional Infrastructure; Supervision and Management of Personnel. Leadership development will be our focus this cycle because based upon the June 14th Team Building meeting, we learned this area needed to be strengthened.

5. The draft case study was not reviewed as planned. We will wait until mid-July to have the leadership review a more inclusive and current version.

6. The CTC Alliance leadership received a preliminary marketing plan matrix June 23rd and we will work on this during the September 6, 2006 meeting at the American Lung Association of Ohio from 9:30am to 3:30pm.

7. We will continue to have our Statewide Forum for Community Network Building on May 9, 2007 (begin planning during the Sept. 6th meeting).

8. Barry is still looking for veterans/current military persons to complete the intercept interview forms. This information will go towards the knowledge base we are building on all underserved communities. During the next grant cycle we will work with our lead contact for Veterans/Current Military to obtain focus groups in the central and southern areas of Ohio.

9. New leadership for the Cross-cultural Tobacco Control Alliance:
The proposed time commitment is June 30, 2006 to June 29, 2007 with the option to continue to June 29, 2008.

- Dr. Surendra Adhikari – Data Analyst and will share chairpersonship with Dr. Lucinda Deason and Dr. Barry Oches for Goal I. (Data).

- Gabrielle Brett, Emily Lee, and Kathryn Grayson- will share chairpersonship for Goal II (Alliance and Community-specific Network Building). Amy Hopping will be a member.

- Najeebah Shine (we will await her decision) can continue chairpersonship if she wishes; Grayce Villa-Shaw is interested in a co-chairpersonship for Goal III (Tobacco Free Workplaces). Jennifer Brindle will contribute.

- Jennifer Brindle and Dr. Lucinda Deason will share chairpersonship for Goal IV (Culturally-competent Youth Programs). Emily Lee will contribute. Deborah Chambers will be a member.

- Bonnie Kirsch and Gothai Jayaraj will share chairpersonship for Goal V (Culturally-competent Adult Cessation Programs & Support). Grayce Villa-Shaw will be a member, and Kathryn Grayson will contribute.

- All the work we do will be for the underserved communities listed in our action plan, and those we may discover in the future.

- **Vacant Position**: Tracy C. would like a local person to work with as a co-chairperson for the Cross-cultural Tobacco Control Alliance.

- **Action-To Do-Immediate Task**: All CTC Alliance leadership will be encouraging their regional and community partners to complete the Agency Commitment Form & Action Plan Matrix for their agency and the vote for the Goal III Tie Breaker sent via e-mail on June 23rd. This information is due by Friday, July 14th to Tracy Clopton. The Agency Commitment form should have a hand-written signature so it must either be mailed (Ohio Dept. of Health, 246 North High Street, 8th Floor, Columbus, OH 43215) or faxed 614-564-2409. Tracy C. will also make "friendly reminder" calls to follow up.

- **Action-To Do- In August**: All CTC Alliance leadership, between the weeks of August 21st and 28th please be ready to discuss your plan to address the goal you are responsible for with Tracy C.

- **RFP Review Volunteer Opening(s):** One or two persons will be needed to review the Request for Proposal responses for our Ohio Comprehensive Tobacco Use Prevention Strategic Plan: Identify and Eliminate Disparities Among Population Groups Disproportionately Affected by Tobacco Use in early August, 2006. The person(s) will work with Tracy C. and the Ohio Dept. of Administrative Services to rate the proposals for agencies applying to manage the infrastructure development of our alliance/action plan.

  Again, thank you all for your help, hard work and participation!!!
  "A goal without a plan is just a wish."
  Antoine De Saint-Exupery, Author (1900-1944)

APPENDIX 12: MEETING EVALUATIN REPORT AND RESULTS FOR December 16, 2005

Eliminating Disparities in Tobacco
Goal #4 Workgroups'
Evaluation Checklist Form to Assess Workgroup Meetings
Report for the December 16, 2005 Meeting

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

Mission: To identify and systematically eradicate tobacco-related health disparities by using innovative approaches to: 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 at-risk, culturally diverse, underserved populations that are disproportionately affected by tobacco use.

Twelve of the 25 meeting participants completed the "Evaluation Checklist Form to Assess Workgroup Meetings" at the December 16, 2005 meeting. The majority of the respondents indicated that the meeting was open, there was active participation and the meeting was productive (see attached results). Moreover, one respondent wrote onto the evaluation form that the workgroup is a "great group." Specifically, 83% or more of the respondents felt to a great extent and some extent that:

- there was adequate representation of population groups with disparities,
- participants were encouraged to attend all workgroup meetings,
- participants felt comfortable expressing their views,
- informal procedures were used to facilitate discussion/decision making, and
- adequate time was given for questions, answers and discussion.

However, 58% of the respondents felt to a great extent and 33% felt to some extent that formal procedures were used to facilitate discussion/decision making.

In the area of participation, at least 83% of the respondents felt to a great extent that:

- all participants can bring issues to the table,
- lay language was used so that everyone can understand, and
- decisions are made through consensus and/or working consensus.

Fifty-eight percent of the respondents felt to a great extent and 33% felt to some extent that workgroup members from population groups with disparities participated actively in the meeting. Additionally, 75% felt to a great extent and 25% felt to some extent that the participants demonstrated high levels of interest in the proceedings.

Lastly, in the area of productivity, at least 83% or more of the respondents felt to a great extent that:

- participants received agendas/other materials to review before the meeting,
- all agenda items were addressed,
- conflicts were resolved to the satisfaction of each party, and
- meetings end with action steps/task assignments with deadlines.

Sixty-six percent felt to a great extent and 33% felt to some extent that the meeting ran smoothly with minimum interruptions/disruptions. Overall, the respondents' were content with the openness, participation levels, and productivity at the meeting.

Eliminating Disparities in Tobacco
Goal #4 Workgroups'
Evaluation Checklist Form to Assess Workgroup Meeting
December 16, 2005

Vision: To eliminate tobacco-related health disparities across the state of Ohio.
Mission: To identify and systematically eradicate tobacco-related health disparities by using innovative approaches to: 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 at-risk, culturally diverse, underserved populations that are disproportionately affected by tobacco use.

Results

Openness	*Great* **Extent 4**	*Some* **Extent 3**	*A* **Little 2**	*Not At* **All 1**	**No Response**
There is adequate representation of population groups with disparities.	8.3% (1)	83.3% (10)	8.3% (1)		
Participants are encouraged to attend all workgroup meetings.	91.7% (11)	8.3% (1)			
Participants feel comfortable expressing their views.	83.3% (10)	8.3% (1)	8.3% (1)		
Chairs/co-chairs/facilitators are responsive to participant concerns.	83.3% (10)	16.7% (2)			
Formal procedures are used to facilitate discussion/decision making.	58.3% (7)	33.3% (4)	8.3% (1)		
Informal procedures are used to facilitate discussion/decision making.	83.3% (10)	8.3% (1)			8.3% (1)
Adequate time is given for questions, answers and discussion.	100% (12)				
Participation					
All participants can bring issues to the table.	91.7% (11)	8.3% (1)			
Workgroup members from population groups with disparities participate actively in the meetings.	58.3% (7)	33.3% (4)	8.3% (1)		
Lay language is used so everyone can understand.	83.3% (10)	16.7% (2)			
Participants demonstrate a high level of interest in the proceedings.	75% (9)	25% (3)			
Decisions are made through consensus and/or working consensus.	91.7% (11)	8.3% (1)			
Productivity					
Participants receive agendas/other materials to review before the meetings.	83.3% (10)	16.7% (2)			
All agenda items are addressed	83.3% (10)	16.7% (2)			
Meetings run smoothly with minimum interruptions/disruptions	66.7 (8)	33.3% (4)			
Conflicts are resolved to the satisfaction of each party	83.3% (10)	8.3 (1)			8.3% (1)
Meetings end with action steps / task assignments with deadlines	83.3% (10)	8.3% (1)			8.3% (1)

APPENDIX 13: MEETING EVALUATION REPORT AND RESULTS FOR February 15, 2006

Eliminating Disparities in Tobacco
Goal #4 Workgroups'
Evaluation Checklist Form to Assess Workgroup Meetings
Report for the February 15, 2006 Meeting

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

Mission: To identify and systematically eradicate tobacco-related health disparities by using innovative approaches to: 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 at-risk, culturally diverse, underserved populations that are disproportionately affected by tobacco use.

Twelve of the 24 meeting participants completed the "Evaluation Checklist Form to Assess Workgroup Meetings" at the February 15, 2006 meeting. The majority of the respondents indicated that the meeting was open, there was active participation and the meeting was productive (see attached results). More specifically, 75% or more of the respondents felt to a great extent and some extent that:

- there was adequate representation of population groups with disparities,
- participants were encouraged to attend all workgroup meetings,
- participants felt comfortable expressing their views,
- formal procedures were used to facilitate discussion/decision making,
- informal procedures were used to facilitate discussion/decision making, and
- adequate time was given for questions, answers and discussion.

However, 25% of the respondents felt to a little extent that formal procedures were used to facilitate discussion/decision making.

In the area of participation, at least 83% of the respondents felt to a great and some extent that:

- all participants can bring issues to the table,
- workgroup members from population groups with disparities participate actively in the meetings,
- lay language was used so that everyone can understand,
- participants demonstrate a high level of interest in the proceedings, and
- decisions are made through consensus and/or working consensus.

Lastly, in the area of productivity, at least 75% or more of the respondents felt to a great and some extent that:

- participants received agendas/other materials to review before the meeting,
- all agenda items were addressed,
- meetings run smoothly with minimum interruptions/disruptions,
- conflicts were resolved to the satisfaction of each party, and
- meetings end with action steps/task assignments with deadlines.

Several workgroup members provided comments about the meeting location, the meeting itself, timelines, and making a distinction between the network and alliance development. For instance, In the area meeting locations, one workgroup member indicated that the "location was a little difficult to find." Another workgroup member stated, "I would like to see the location of meetings rotated to other regions in the state." "Meeting attendance is a challenge…Perhaps we could have conference calls and emails as a resolution to overcome this challenge" noted another workgroup member.

With regard to the meeting itself, one workgroup member indicated that "too much time is spent on presentations not enough group work time at the meetings and the meeting should end by 2:30pm…Some items discussed do not apply to many members." Another workgroup member noted "we addressed racial/ethnic youth prevention…Please give a synopsis/agency history for the newbies." "Tracy has maintained great communication and there were no conflicts" stated a couple of workgroup members.

Lastly, in the area of network and alliance development, one workgroup member stated, "the major challenge I saw was distinguishing the network development from the alliance development…Combining workgroups and having open discussion allowed us to identify critical issues and assign tasks to each workgroup." Another workgroup member indicated that we "need timelines for the year and next steps noted at each meeting."

Eliminating Disparities in Tobacco
Goal #4 Workgroups'
Evaluation Checklist Form to Assess Workgroup Meeting
February 15, 2006

Vision: To eliminate tobacco-related health disparities across the state of Ohio.
Mission: To identify and systematically eradicate tobacco-related health disparities by using innovative approaches to: 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 at-risk, culturally diverse, underserved populations that are disproportionately affected by tobacco use.

Results

Openness	*Great* **Extent 4**	*Some* **Extent 3**	*A* **Little 2**	*Not At* **All 1**	**No Response**
There is adequate representation of population groups with disparities.	41.7% (5)	58.3% (7)			
Participants are encouraged to attend all workgroup meetings.	58.3% (7)	33.3% (4)			8.3% (1)
Participants feel comfortable expressing their views.	58.3% (7)	41.7% (5)			
Chairs/co-chairs/facilitators are responsive to participant concerns.	75% (9)	25% (3)			
Formal procedures are used to facilitate discussion/decision making.	58.3% (7)	16.7% (2)	25% (3)		
Informal procedures are used to facilitate discussion/decision making.	58.3% (7)	41.7% (5)			
Adequate time is given for questions, answers and discussion.	83.3% (10)	16.7% (2)			
Participation					
All participants can bring issues to the table.	58.3% (7)	41.7% (5)			
Workgroup members from population groups with disparities participate actively in the meetings.	58.3% (7)	25% (3)	8.3% (1)		8.3% (1)
Lay language is used so everyone can understand.	58.3% (7)	33.3% (4)	8.3% (1)		
Participants demonstrate a high level of interest in the proceedings.	50% (6)	33.3% (4)	16.7% (2)		
Decisions are made through consensus and/or working consensus.	58.3% (7)	33.3% (4)	8.3% (1)		
Productivity					
Participants receive agendas/other materials to review before the meetings.	75% (9)	25% (3)			
All agenda items are addressed	75% (9)	8.3% (1)	8.3% (1)		8.3% (1)
Meetings run smoothly with minimum interruptions/disruptions	75% (9)	16.7% (2)	8.3% (1)		
Conflicts are resolved to the satisfaction of each party	58.3% (7)	33.3% (4)			8.3% (1)
Meetings end with action steps / task assignments with deadlines	50% (6)	25% (3)	8.3% (1)		16.7% (2)

APPENDIX 14: MEETING EVALUATION REPORT AND RESULTS FOR April 25, 2006

Eliminating Disparities in Tobacco
Goal #4 Workgroups'
Evaluation Checklist Form to Assess Workgroup Meetings
Report for the April 25, 2006 Meeting

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

Mission: To identify and systematically eradicate tobacco-related health disparities by using innovative approaches to: 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 at-risk, culturally diverse, underserved populations that are disproportionately affected by tobacco use.

Twelve of the 19 meeting participants completed the "Evaluation Checklist Form to Assess Workgroup Meetings" at the April 25, 2006 meeting. The majority of the respondents indicated that the meeting was open, there was active participation and the meeting was productive (see attached results). More specifically, 65% or more of the respondents felt to a great extent and some extent that:

- there was adequate representation of population groups with disparities,
- participants were encouraged to attend all workgroup meetings,
- participants felt comfortable expressing their views,
- Chairs/co-chairs/facilitators were responsive to participants' concerns,
- formal procedures were used to facilitate discussion/decision making,
- informal procedures were used to facilitate discussion/decision making, and
- adequate time was given for questions, answers and discussion.

However, 25% of the respondents felt to a little extent that participants felt comfortable expressing their views.

In the area of participation, 75% or more of the respondents felt to a great and some extent that:

- all participants can bring issues to the table,
- workgroup members from population groups with disparities participate actively in the meetings,
- lay language was used so that everyone can understand,
- participants demonstrate a high level of interest in the proceedings, and
- decisions are made through consensus and/or working consensus.

Lastly, in the area of productivity, at least 66% or more of the respondents felt to a great and some extent that:

- participants received agendas/other materials to review before the meeting,
- all agenda items were addressed,

- meetings run smoothly with minimum interruptions/disruptions,
- conflicts were resolved to the satisfaction of each party, and
- meetings end with action steps/task assignments with deadlines.

Only one workgroup member provided comments about the meeting. More specifically, the workgroup member stated,

> The facilitator is extremely frustrating. She is confusing and doesn't clarify items. When she does try she is biased and confusing. Sometimes we move too fast. Small group discussion is helpful; not sure exact roles of chairs and participants; formal procedures could be improved; sometimes we move too quickly. Great open discussion. Some people have dropped off. I would like a timeline of where we're going and how we are going to get there. I still need additional direction.

Eliminating Disparities in Tobacco
Goal #4 Workgroups'
Evaluation Checklist Form to Assess Workgroup Meeting
April 25, 2006

Vision: To eliminate tobacco-related health disparities across the state of Ohio.
Mission: To identify and systematically eradicate tobacco-related health disparities by using innovative approaches to: 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 at-risk, culturally diverse, underserved populations that are disproportionately affected by tobacco use.

Results

Openness	*Great* **Extent 4**	*Some* **Extent 3**	*A* **Little 2**	*Not At* **All 1**	**No Response**
There is adequate representation of population groups with disparities.	33.3% (4)	41.7% (5)	16.7% (2)	0	8.3% (1)
Participants are encouraged to attend all workgroup meetings.	66.7% (8)	16.7% (2)	8.3% (1)	0	8.3% (1)
Participants feel comfortable expressing their views.	50% (6)	16.7% (2)	25% (3)	0	8.3% (1)
Chairs/co-chairs/facilitators are responsive to participant concerns.	41.7% (5)	25% (3)	16.7% (2)	8.3% (1)	8.3% (1)
Formal procedures are used to facilitate discussion/decision making.	25% (3)	41.7% (5)	16.7% (2)	8.3% (1)	8.3% (1)
Informal procedures are used to facilitate discussion/decision making.	33.3% (4)	50% (6)	8.3% (1)	0	8.3% (1)
Adequate time is given for questions, answers and discussion.	58.3% (7)	8.3% (1)	8.3% (1)	8.3% (1)	16.7% (2)
Participation					
All participants can bring issues to the table.	50% (6)	25% (3)	8.3% (1)	8.3% (1)	8.3% (1)
Workgroup members from population groups with disparities participate actively in the meetings.	50% (6)	25% (3)	16.7% (2)	0	8.3% (1)
Lay language is used so everyone can understand.	58.3% (7)	16.75 (2)	16.7% (2)	0	8.3% (1)
Participants demonstrate a high level of interest in the proceedings.	50% (6)	33.3% (4)	8.3% (1)	0	8.3% (1)
Decisions are made through consensus and/or working consensus.	50% (6)	41.7% (5)	0	0	8.3% (1)
Productivity					
Participants receive agendas/other materials to review before the meetings.	83.3% (10)	8.35 (1)	0	0	8.3% (1)
All agenda items are addressed	83.3% (10)	8.3% (1)	0	0	8.3% (1)
Meetings run smoothly with minimum interruptions/disruptions	50% (6)	33.3% (4)	8.3% (1)	0	8.3% (1)
Conflicts are resolved to the satisfaction of each party	58.3% (7)	16.7% (2)	8.3% (1)	8.3% (1)	8.3% (1)
Meetings end with action steps / task assignments with deadlines	66.7% (8)	0	25% (3)	0	8.3% (1)

APPENDIX 15: MEETING EVALUATION REPORT AND RESULTS FOR June 14, 2006

Eliminating Disparities in Tobacco
Goal #4 Workgroups'
Evaluation Checklist Form to Assess Workgroup Meetings
Report for the June 14, 2006 Meeting

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

Mission: To identify and systematically eradicate tobacco-related health disparities by using innovative approaches to: 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 at-risk, culturally diverse, underserved populations that are disproportionately affected by tobacco use.

Six of the 18 meeting participants completed the "Evaluation Checklist Form to Assess Workgroup Meetings" at the June 14, 2006 meeting. The majority of the respondents indicated that the meeting was open, there was active participation and the meeting was productive (see attached results). More specifically, 83% or more of the respondents felt to a great extent and some extent that:

- there was adequate representation of population groups with disparities,
- participants were encouraged to attend all workgroup meetings,
- participants felt comfortable expressing their views,
- Chairs/co-chairs/facilitators were responsive to participants' concerns,
- formal procedures were used to facilitate discussion/decision making,
- informal procedures were used to facilitate discussion/decision making,
- adequate time was given for questions, answers and discussion,
- all participants could bring issues to the table,
- workgroup members from population groups with disparities participate actively in the meetings,
- lay language is used so everyone can understand,
- participants demonstrated a high level of interest in the proceedings,
- decisions were made through consensus and/or working consensus,
- participants received agendas/other materials to review before the meetings,
- all agenda items were addressed,
- meetings ran smoothly with minimum interruptions/disruptions,
- conflicts were resolved to the satisfaction of each party, and
- meetings end with action steps/task assignments with deadlines.

However, 67% of the respondents felt to some extent there was adequate representation of population groups with disparities present at the meeting. Overall, the participants felt to a great extent that the meeting was open, participation for the most part was more than adequate, and that the meetings were productive.

Eliminating Disparities in Tobacco
Goal #4 Workgroups'
Evaluation Checklist Form to Assess Workgroup Meeting
June 14, 2006

Vision: To eliminate tobacco-related health disparities across the state of Ohio.
Mission: To identify and systematically eradicate tobacco-related health disparities by using innovative approaches to: 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 at-risk, culturally diverse, underserved populations that are disproportionately affected by tobacco use.

Results

Openness	*Great* **Extent 4**	*Some* **Extent 3**	*A* **Little 2**	*Not At* **All 1**	**No Response**
There is adequate representation of population groups with disparities.	66.7 (4)	33.3% (2)	0	0	0
Participants are encouraged to attend all workgroup meetings.	100% (6)	0	0	0	0
Participants feel comfortable expressing their views.	100% (6)	0	0	0	0
Chairs/co-chairs/facilitators are responsive to participant concerns.	83.3% (5)	16.7% (1)	0	0	0
Formal procedures are used to facilitate discussion/decision making.	83.3% (5)	0	0	0	16.7% (1)
Informal procedures are used to facilitate discussion/decision making.	100% (6)	0	0	0	0
Adequate time is given for questions, answers and discussion.	100% (6)	0	0	0	0
Participation					
All participants can bring issues to the table.	100% (6)	0	0	0	0
Workgroup members from population groups with disparities participate actively in the meetings.	100% (6)	0	0	0	0
Lay language is used so everyone can understand.	100% (6)	0	0	0	0
Participants demonstrate a high level of interest in the proceedings.	100% (6)	0	0	0	0
Decisions are made through consensus and/or working consensus.	100% (6)	0	0	0	0
Productivity					
Participants receive agendas/other materials to review before the meetings.	100% (6)	0	0	0	0
All agenda items are addressed	100% (6)	0	0	0	0
Meetings run smoothly with minimum interruptions/disruptions	100% (6)	0	0	0	0
Conflicts are resolved to the satisfaction of each party	100% (6)	0	0	0	0
Meetings end with action steps / task assignments with deadlines	100% (6)	0	0	0	0

APPENDIX 16: ELIMINATING DISPARITIES IN TOBACCO CONTROL GOAL #4 WORKGROUP's EVALUATION CHECKLIST FORM TO ASSESS WORKGROUP MEETINGS

Openness	*Great* **Extent 4**	*Some* **Extent 3**	*A* **Little 2**	*Not At* **All 1**	**No Response**
There is adequate representation of population groups with disparities.					
Participants are encouraged to attend all workgroup meetings.					
Participants feel comfortable expressing their views.					
Chairs/co-chairs/facilitators are responsive to participant concerns.					
Formal procedures are used to facilitate discussion/decision making.					
Informal procedures are used to facilitate discussion/decision making.					
Adequate time is given for questions, answers and discussion.					
Participation					
All participants can bring issues to the table.					
Workgroup members from population groups with disparities participate actively in the meetings.					
Lay language is used so everyone can understand.					
Participants demonstrate a high level of interest in the proceedings.					
Decisions are made through consensus and/or working consensus.					
Productivity					
Participants receive agendas/other materials to review before the meetings.					
All agenda items are addressed					
Meetings run smoothly with minimum interruptions/disruptions					
Conflicts are resolved to the satisfaction of each party					
Meetings end with action steps / task assignments with deadlines					

APPENDIX 17: ELIMINATING TOBACCO-RELATED DISPARITIES DEMOGRAPHIC SURVEY

Eliminating Tobacco-Related Disparities
Demographic Survey

1. What type of organization(s) do you represent on the Tobacco Related Health Disparities (TRHD) Workgroup? (**Please circle your response below**).
   a. City or county government
   b. University/research
   c. Healthcare organization
   d. Nonprofit organization
   e. Public/Private Foundation
   f. Other _____
   g. None. I am an individual volunteer

2. What is your position in the organization? (**Please write your response in the space provided below**).
   _____

3. How long have you held this position? (**Please write your response in the space provided below**).
   _____

4. How long have you worked for this organization? (**Please write your response in the space provided below**).
   _____

5. How many clients do you serve annually? (**Please write your response in the space provided below**).
   _____

6. What types of services does your organization provide? (**Please write your response in the space provided below**).
   _____

7. How long have you participated in the Tobacco Related Health Disparities (Goal #4) Workgroup? (**Please write your response in the space provided below**).
   _____

8. What area of the state are you from (City or Public Health Region)?
   (**Please write your response in the space provided below**).
   _____

9. Were you already working on tobacco prevention and control before the workgroup began working on the strategic plan? (**Please circle your response below**).

   YES NO

10. Were you already working on Tobacco Related Health Disparities? (**Please circle your response below**).

    YES NO

APPENDIX 18: KEY PARTICIPANT PHONE INTERVIEW QUESTIONS

Name_____Date_____

1. Is the TRHD workgroup an effective method for addressing the tobacco prevention and control efforts in your area? Why or Why not? Please explain.

2. Was the workgroup open to recruiting representatives from the populations facing the greatest burden of tobacco use and related diseases?
    i. Did the workgroup consist of representatives from other areas of expertise that met the workgroup's inclusiveness and effectiveness goals?

3. Do you feel you were part of the process? Was your voice heard? In what ways? What was done to create that sense? Examples.
    i. How would you describe your experiences with this process? Was it meaningful? How? Please explain.
    ii. Was the role you ended up experiencing in line with your expectations?
    iii. Will you continue to work on the TRHD into the next phase?

4. How did the State representative(s) do in organizing and moving the process along? Did they lead too much? Not enough? Just right?
    i. Are the local leaders prepared to move the agenda to the next phase? Why or Why not? Please explain.
    ii. What does your group still need to better understand and address TRHD in your area?

5. Do you think that the strategic planning process was productive? What were the major assets that facilitated the process? What challenges impeded it? How did you address the challenges?

6. After viewing the strategic plan – Do you have faith that this plan will move forward? Why or Why not?

7. To what extent does the strategic plan reflect what happened at the workgroup meetings?
    i. To what extent did the meeting minutes reflect what was discussed at the meetings?

APPENDIX 19: ELIMINATING TOBACCO-RELATED DISPARITIES
DEMOGRAPHIC SURVEY AND PHONE INTERVIEW RESULTS

Eliminating Tobacco-Related Disparities
Demographic Survey Results

1. What type of organization(s) do you represent on the Tobacco Related Health Disparities (TRHD) Workgroup?
   County government, 2 not-for-profits, an a research institute.

2. What is your position in the organization?
   Assistant Director of Community Health Services, Director of Senior Programs, Senior Research Associate, and Tobacco Prevention Coordinator.

3. How long have you held this position?
   3 years, 6 years, 10 months, and 4 years.

4. How long have you worked for this organization?
   4 years, 6 years, 7.5 years, 3 years.

5. How many clients do you serve annually?
   2,500 – 3,000, 6-12 projects per year, 10,000, 830,000

6. What types of services does your organization provide?
   Prevention, direct health care services, disease reporting, and environmental health services.
   Funder of programs and community wide initiatives.
   Program evaluation, geographic information systems, facilitation, data and census reports, survey research.
   Substance abuse prevention (youth and adult), youth mentoring, women's programs, and re-entry.

7. How long have you participated in the Tobacco Related Health Disparities (Goal #4) Workgroup?
   3 years, 3 months, 16 months, and 9 months.

8. What area of the state are you from (City or Public Health Region)?
   Appalachia, Cleveland, Cuyahoga County, Lucas County.

9. Were you already working on tobacco prevention and control before the workgroup began working on the strategic plan?

   2 YES 2 NO

10. Were you already working on Tobacco Related Health Disparities?

    1 YES 3 NO

PHONE INTERVIEW KEY QUESTIONS
Results

1. Is the TRHD workgroup an effective method for addressing the tobacco prevention and control efforts in your area? Why or Why not? Please explain.

Responses:
Yes, because the group has a tendency to look at what other people are doing and not reinvent the wheel. They don't isolate themselves. That is helpful.

It was effective in increasing awareness that disparities exist. Increasing awareness is the most that can be done with a plan.

Yes, it was a system that 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. Now we have a plan to begin working to address the needs.

Yes, I think it was a critical place to begin. It helped all individuals involved get on the same page.

2. Was the workgroup open to recruiting representatives from the populations facing the greatest burden of tobacco use and related diseases?
    i. Did the workgroup consist of representatives from other areas of expertise that met the workgroup's inclusiveness and effectiveness goals?

Responses:
Yes.
Yes, the workgroup was more than open recruiting. They went out of their way to make phone calls to get people to come to the meetings.
Most definitely. The populations were not as open to participating. Lack of awareness and education didn't understand the importance of participating.

Yes.

3. Do you feel you were part of the process? Was your voice heard? In what ways? What was done to create that sense? Examples.

Responses:
Yes, because everybody had an opportunity to speak, no one was ignored, and comments were respected and documented.

For example, Tracy really puts forth an effort to get people to participate and be engaged. The Facilitator were good at going around the room to determine if everyone was heard and that their questions were addressed.

Someone would email everybody about tobacco between meeting dates continuously

Yes, the people there knew what needed to be done and how to go about doing it.

I think so. Could have done a better job. They brought a lot of people with different expertise together. Given our resources, we were somewhat limited. We set a precedent.

Yes, in everyway. Meetings, suggestions, the way we worked with each other, giving people opportunities to state their ideas, seeing things I actually suggested actually being implemented. Seeing that my role was important to the whole process.

The passion and commitment of the people involved as a whole. I fully understood the partnership and I did not feel judged. I felt we could trust each other. We were "egoless." We all had a joint vision and a mission and we were clear on it. We had resources to do what we needed to do and skills. There were personal and collective incentives. Having an action plan we can implement to bring about change.

Yes. Yes, my voice was heard. I felt that at each meeting and on the conference calls 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. How would you describe your experiences with this process? Was it meaningful? How? Please explain.

i. How would you describe your experiences with this process? Was it meaningful? How? Please explain.

Responses:
Someone would email everybody about tobacco between meeting dates continuously.
Yes, it was meaningful because I learned a lot about tobacco. I learned how communities are trying to become smoke free, businesses are trying to become smoke free; yet other people are trying to open smoking bars. I also learned about tobacco use and teens as I have a teen age son who smokes once a week. I got some nuts and bolts. I learned that different organizations in the state have different efforts toward tobacco and disparities in health.

Yes, when we talked about the questions that were developed for conducting the focus groups, I was able to get good input, everyone was able to voice concerns, and everybody listened and respected one another.

Yes, it was personally and professionally meaningful. I felt culturally incompetent. I have been faced with people from different backgrounds and it was a good experience for me. I see the beauty of diversity. Professionally, doing 22 focus groups in a 6-month period stretched me. There was an overwhelming number of people who agreed to help. However, there were unforeseen roadblocks, including scheduling appointments for conducting focus groups, learning about doing focus groups in different languages. Trying to get everyone engaged in the focus group. I was successful with 20 out of the 22 conducted.

My experience was very meaningful to me and my community.

This provided a way to use the process at the local level to connect. This process can be replicated at the local levels.

It was a very good process. It was very meaningful. I have not gone through a process like this before. It was a very valuable experience. It brought people together with a similar interest to come up with an end product; an action plan with strategies. The brainstorming sessions, next steps, conference calls helped to prepare. There were a lot of direct and indirect opportunities to provide input.

ii. Was the role you ended up experiencing in line with your expectations?

Responses:
Yes, because my role involved my wanting to learn and contribute by letting people know what the United Way was doing and how to get funding from the United Way. I also learned some things from the perspective of a parent with a child who smokes.

Yes, pretty much. I think I underestimated the amount of effort and time it took was more than I had expected. It has taught me how to use more technology.

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.

No, only because I did not know what to expect in this process with a large group. I didn't have any large or small expectations.

iii. Will you continue to work on the TRHD into the next phase?

Responses:
Yes, I will.
Yes.
Yes, I intend to at this point.
Definitely.

4. How did the State representative(s) do in organizing and moving the process along? Did they lead too much? Not enough? Just right?

Responses:
Just right. However, she went above and beyond what she as supposed to do; she didn't over do it. She could have been the person who delegated to everybody.

She was more like a person who preferred to be the guide on the side rather than the sage on the stage.

She did a tremendous amount of support work that normally committee members would be expected to do.

She did a tremendous job. She was on top of things all of the time, she was quiet but effective.

She did very well. This area was new for everybody. The persons with the right skills stepped up when needed.

I am very pleased with the way the Coordinator handled the process. We were included not excluded.

She kept us focused.

She led just right. She gave us agendas ahead of the meeting times which helped, she sent out a lot of information. She did a great job keeping us on track and she was very thorough. Sometimes I felt

overwhelmed because if I missed a meeting I felt behind and then I could read everyone of her emails to get caught up.

i. Are the local leaders prepared to move the agenda to the next phase? Why or Why not? Please explain.

Responses:
I think that they are ready and prepared. It will take strong leadership in this community to get things moving.

Yes, they are ready to accept direction. There is a tight group of people in Appalachia where they got to know one another. They cover 29 counties and are stretched out quite a bit. They have to reach out to one-third of the Appalachian population across the state. Appalachians don't have a common identity.

They need more awareness. They know they are under-resourced; that is, industry, jobs, and politicians don't visit them or provide them with much in the way of resources.

No, because they have not come through the process. We have been training these last couple of years. It will take the communities time to go through the same process.

I would say yes at the very beginning phase. I am not sure that everybody was able to get a good sense of what were going to do next. It is not very clear yet. There was a good turn out of people at the regional meeting. It would have been helpful to have provided the meeting attendees with information beforehand. Some people were wondering what the action plan and strategies meant for their agency.

ii. What does your group still need to better understand and address TRHD in your area?

Responses:
It will need to be an organization that has experience with tobacco issues and is able to say which strategies would work.

They do look at best-practices form other states.

Bottom line is that in order to decrease tobacco use and health disparities.

The outcome provided a strategic plan. I was a little frustrated with the pace, the meetings could have been compressed or more could have been added to the agenda.

Everybody had the opportunity to provide input.

The skills of the people at the table.

The cooperativeness of the people at the table.

Every there were a core of regular attendees, while the rest were different meeting participants.

Tracy did everything she could to try to get people to attend the meetings.

Training is needed. A stronger awareness campaign is needed to bring their awareness levels up. We are seeing some changes in awareness.

Lacking major resources to move things forward.

We don't have a collaborative vision and we are very fragmented.

We have not looked at tobacco and health disparities as a Social Justice issue.

Some of the groups doing work in our area include groups working on clean indoor air ordinances, second-hand-smoke, direct programming, as well as cessation and prevention. These groups need a joint vision and they need to prioritize how to go after resources and partners.

Continuing to engage the local players in our next steps will be crucial because the regional meeting was their first opportunity to hear about the action plan. The people must stay engaged.

5. Do you think that the strategic planning process was productive? What were the major assets that facilitated the process? What challenges impeded it? How did you address the challenges?

Responses:
One or two people trying to jockey for a position and get their agenda across.
The facilitators were able to control this behavior.

Yes, the people were the major assets. Resources available to us helped.

The support of other players such as OTPF and the OCMH.

Early on we established a vision and mission that provided direction and we were focused.

This process gave us an opportunity to plan and we didn't have to do crisis management. We had time needed to plan.

Travel impeded the process from around the state.

Resources of individual communities to get people to participate.

Not rotating the meetings to different regions of the state.

It took time to build trust and rapport, it was not a waste of time.

The lack of resources.

My agency has a commitment to tobacco control and she had resources to participate, that is, it was mandated by the vision of her organization.

Definitely yes.

Assets: Having an outside Facilitator is necessary for neutralizing things, brainstorming, different expertise, and community-based agencies helped. Many of the activities were very helpful. This process got people to focus on certain components of the issues.

Challenges: Getting enough people to come to the meetings. The location in Columbus could pose problems for some people. We were given a lot of information in one email which could be problematic when we had busy days. This is a double-edged sword because the detailed email messages also helped me to get caught up when I missed a meeting.

Address the Challenges: Perhaps we could pick one day out of each month to have a phone conference with the leadership to help keep us abreast of things.

6. After viewing the strategic plan – Do you have faith that this plan will move forward? Why or Why not?

Responses:
Yes, I have faith. My only concern is funding. We have to have funding to move this forward.

There are a lot of territorial issues and ownership issues that need to be cleared up.

More players, stakeholders, and more people need to do more of the work at the community level, other organizations in the community need to step up and do the work.

Yes, the Facilitator, Tracy, Lucinda, and the people on the workgroup were experts and deeply involved with this process. Tracy is doing everything she can't continue to do this alone. She needs assistance.

If people continue to set this as a priority, then it will move forward. It will take resources to do it as well. OTPF will have to help.

I have faith it will move forward as long as the human's stay committed. On paper we have a plan. How people take pieces of the plan and put it into action could be a challenge. I have faith in the people on the workgroup for now because they demonstrated their sincerity by going through the process.

I have faith that the plan will move forward because there are some very achieveable strategies and others will take more time. I also envision the plan as being flexible as opposed to being rigid. If things are not working then we can come back to the table.

7. To what extent does the strategic plan reflect what happened at the workgroup meetings?

Responses:
Totally reflects it.
I think it represents what was discussed accurately.
I think it reflects a great deal of what we did. It summarized the key tasks that were accomplished that amount of work, and commitment to work and have a tool that is practical. A workable plan. It is very representative given constraints.
I think the plan reflects what happened very accurately because we had an opportunity to put it together with the Critical Issues Process.

ii. To what extent did the meeting minutes reflect what was discussed at the meetings?

Responses:
Totally, very accurate, and very clear.
They looked like they did. The meeting minutes recapped what was discussed.
The meeting minutes were very accurate. Everything I read, she recalled and used to prepare for the next meeting.

The meeting minutes helped me to recall what we did.
The meeting minutes were a good summary of the meetings and helped me to get caught up.

APPENDIX 20: GOAL #4 PLAN FOR ADDRESSING TOBACCO-RELATED HEALTH DISPARITIES AGENCY COMMITMENT FORM

Agency Commitment Form & Goal III Vote
Goal #4
Eliminating Tobacco-Related Disparities
6-23-06

Dear Colleague:

We are requesting your response in three areas:

First, we are down to the last two most popular options for Goal III (Tobacco Free Workplaces). Please choose one and we will use the most favored goal for our action plan.

_____ Option #1: Increase the number of tobacco free workplaces (restaurants and bars included) who employ or serve at-risk, culturally diverse, underserved populations.

_____ Option #3: Establish baseline data and increase by five percent the number of tobacco free workplaces (restaurants and bars included) who employ or serve at-risk, culturally diverse, underserved populations.

Second, now that you have either attended a regional meeting, or participated in the workgroup community implementation process, you have become familiar with the Action Plan for Addressing Tobacco-Related Disparities. Based upon being familiar with the plan (the latest version is attached to this correspondence (*July 11th Almost Final*), your agency's specialty/experience, and your history of working with the certain identified populations/communities listed, please complete the preliminary matrix for the most appropriate Goal(s) and Strategy(s) if your agency were to be funded to do the work. All agencies agreeing to the Goals/Strategies they've chosen will be listed in the final Action Plan for public distribution as supporting this plan and willing to work on the plan if funding were available to do so. Please review the goal/strategy/action steps carefully to be sure it is within your agency's scope of expertise (or you have some experience) in relation to your identified populations/communities. We want to create a matrix where we have goals/strategies and then connect them to the agencies responsible. Please see sample matrix below:

SAMPLE MATRIX

Strategy 1.1 Review and Identify Data	Strategy 3.1 Expand Assessment of workplaces for baseline data.
Blue Agency (Blue Collar)	Red Agency (Appalachian, Persons in Poverty)
Geographic Area: Youngstown	Geographic Area: Adams, & Brown Counties

We need to know your interest and commitment level in working on the plan and where you believe your agency fits to help underserved communities. Please do not be concerned with whether or not you can do all the strategies within the goal, just chose the one(s) of which you are certain or somewhat certain. Also, you do not need to work on every Goal.

Once you have completed the Preliminary Action Plan Matrix, and voted on Tobacco Free Workplaces (Goal III) above, please review the Agency Commitment Form below, have the appropriate person in your agency

initial the statement of your choice and sign and return this form with your matrix, if required. Your completed matrix and Goal III vote can be sent to Tracy Clopton at tracy.clopton@odh.ohio.gov . But to ensure we have a handwritten signature from your appropriate agency person, please either fax or mail this page to 614-564-2409 or Attn: Tracy Clopton, Ohio Department of Health, Tobacco Program, 246 North High Street, 8th Floor, Columbus, Ohio 43215.

Due Date: All votes, matrix and signature pages are due by Friday, July 14, 2006. Based upon our time constraints, please reply by Friday, July 14, 2006

Third, just a friendly reminder: Our conference call to wrap up the process for this grant cycle will be Wednesday, June 28th 9:00am until 10:15am. An agenda is stated below and a preliminary Case Study will be sent two days before the call.

June 28th Conference Call Agenda

Toll Free Number: 800-510-7500; Pass Code 1158486 then hit # sign.

- A name for Goal #4 (choices in an attachment on 6-23-06)
- Theme of our plan (choices in an attachment on 6-23-06)
- Dr. Surendra: Discuss preliminary community prioritization
- Dr. Lucinda: Accept comments on draft case study
- Agency Commitment Form-review purpose
- Determine Objective Team Leadership for 5 Goals
- Determine Alliance Co-Chairperson interests among locals
- Training needs for community leadership development

-

Goal #4 Action Plan for
Addressing Tobacco-Related Health Disparities
Agency Commitment Form
Due Date: Friday, July 14, 2006

This form confirms that we have read the Goal #4 Action Plan for Addressing Tobacco – Related Disparities and our agency agrees to the following:
Please initial next to the statement of your choice, sign and please either fax or mail this page to 614-564-2409 or Attn: Tracy Clopton, Ohio Department of Health, Tobacco Program, 246 North High Street, 8th Floor, Columbus, Ohio 43215.

_____ We support the action plan, but we are unable to make a commitment to work on this plan, even if funding were available.

_____ We support the action plan and would commit to working on the Goal(s), Strategy(s), and Action Steps if funding were available. We have completed the Preliminary Action Plan Matrix and returned it with this signature page.

Please Print Clearly on the first two lines.

_____
Agency Name

_____
Print Name

_____
Signature

Thank You for your help and participation!!!

Power Analysis - Praxis Training 10-29-04

Key Questions to be resolved:

- How representative is our group?
- Identify good candidates
- Change representation scheme
- Do more research on decision-makers- what do they care about; why are they there; do TUPCF grantees need separate "political space" to strategize around the work of the TUPCF.
- Need stronger state infrastructure to support local advocacy to move agenda forward. Local work uneven, some good and some not so good.

Media Outlets

1. Minority Health Organizations
    - Word – of – Mouth
    - Faith-based organizations
    - Community Leaders
    - Minority Newsletter; minority-focused newspapers; billboards
    - Conferences
    - Minority television and radio
    - Church
    - Migrant Camps
    - Free Clinics
    - Internet
    - Schools
    - Boards/Governing Authority
    - Community Members
    - CDC
    - Office of Minority Health
    - Doctors & Hospitals
    - Famous Minorities
    - Minority Issue Coalitions (HPTN Coalition & HAO)
    - Homeless
    - Health Fairs

2. Board - OTUPCF

- Staff
- Spouse
- Own Organization
- Grantees
- Other political people
- Media- newspaper, TV, Radio
- Lobbyists
- Research Journals
- Networking
- Themselves
- Nat'l Institute of Drug Abuse
- Other Foundations Boards
- Corporations/Businesses
- Special Interest Groups
- Public Outcry
- World Wide Web
- Governor
- Medical Associations
- Professional newsletters / publications
- Neighbors
- Legislators
- CDC
- Nat'l Heart, Lung & Blood Institute

3. Voluntaries

- National Organizations
- Media
- Medical Field
- Community Organizations
- Church
- Health Fairs
- Local Health Departments
- Local Networks
- Health Car Providers
- Contributors
- Board
- Public
- Newsletter updates from Campaign for Tobacco Free Kids, SFO, OTUPCF
- Websites
- Conferences, Seminars, Workshops (local & national)
- Funders
- Research
- CDC/NIH
- Staff Newsletters
- Community Volunteers
- State Health Dept.
- National Offices
- Professional Organizations
- Coalitions
- Other voluntary agencies

4. Medical / Health Professional Group

- Professional Associations
- Research
- Trainings/ CEU's/ Licensure
- Journals
- Patients
- ALA, ACS, AHA
- Continuing Education
- Word – Of – Mouth
- Colleges and Universities
- CDC's Newsletters
- Conferences
- ODH
- Their friends
- Roundtables & Grand Rounds
- Drug Companies
- State Medical Board
- Websites
- JAMA
- Insurance Companies
- Networking
- Lawyers
- Dinners and Fundraisers
- Lobbyists

5. Community Based Organizations

- Media, Radio, TV
- Members
- Community Coalitions
- Local Health Departments
- Local Agencies of ALA, ACS and AHA
- Hospitals
- Community Members
- Council People
- Advocates
- Council Meetings
- Education Materials
- Trainings / Workshops
- Health Fairs
- Networking; Word – of – Mouth
- State Organizations
- Mayor
- Churches
- Southern Christian Leadership Conference (SCLC)
- NAACP
- Urban League
- Public Safety Organizations
- Family / Friends
- Conferences
- Golf Outings
- Bars
- Consumers / Clients
- Board
- Funders

6. Governor

- Cabinet
- Legislators
- Hope Taft
- Friends
- Voters
- Lobbyists
- State Agencies
- Coalitions
- Media – print, radio, TV
- CDC
- Citizens
- Federal Government
- Golfing Buddies
- Mayors
- Task Forces
- President
- Governor's Dentist and Physician
- Fundraisers
- Extended Family
- OTUPCF
- U. S. President
- Governor's Staff
- All State Caucuses

7. Elected Officials

- Wives
- Newspapers, radio and TV
- Billboards
- Constituents
- Polls
- Friends
- Clergy
- Voters/Citizens
- Coalitions
- Businesses
- Lobbyists
- State Agencies
- Health Departments
- Smoke Free Ohio
- Staff
- Other Officials
- Professional Associations /Affiliations
- Local Events
- Youth
- Industries
- Community-based Organizations
- National Party Organizations
- Local Events
- Networking
- Special Interest Groups

Praxis Session Notes 10-29-04

Target: OTUPCF Board & Governor

Policy Initiative is to Fund Goal #4 and the Strategic Plan. It needs to be representative and sensitive to the board (either through advocating for good individuals or advocating for individuals and a new representation plan, scheme, or statute).

Basic Message: We want the plan to be fair. Helping those who need help makes sense, and is a public health value. You would not waste your money on people who don't need help.

Fund According to Need

Communities have the answer: We need to be a part of the solution, not government alone.

Become More Consumer-Oriented: Make the system work for all consumers.

Who Decides (A, B, or C)

- A. State Legislative Mandate; B. Especially Ordered by the Governor;
  C. OTUPCF Rulemaking and Appropriations.
- How to reframe the issue for maximum power.
- Tools for demonstrating power: White Papers; Resolutions; Media (Letters to Editor, Editorial Boards, Stories, Personal Communication); Letters and Visits.

OTUPCF 2/3 Year Term (information as of 10/29/04) (Also see Dr. Lucinda's Notes from 10-29-04 attached)

- Meets every other month, first Friday
- Board – Governor appointed, see website for terms; push a "slate."
- Ohio Commission on Minority Health- Cheryl Boyce
- Voluntaries: ALA (Tracy Ross, as of 2005); ACS (Harvey Schwartz); AHA (Steve Francis)
- ODH: Dr. Nick Baird; Dr. Schorr (ODH Disparities Workgroup as of 2005)
- Franklin County School Superintendent – Dr. Bart Anderson
- Dr. Patricia Hicks – Owns an Evaluation and Research Firm
- Dr. Rob Crane – OSU/ Tobacco to 21
- Dr. Sopko (spelling?) – Cleveland Physician
- Dr. Allen Letson
- Senator Fingerhut & Rep. Dixie Allen by statute
- Dr. David Rommel – Dentist, past President of the Ohio Dental Association
- O'Neil Saunders (AG?) Governor's Dentist
- Tim Ingram – Health Commissioner of Hamilton County
- Lynn Ayers – Ohio Hospital Association
- 3 Vacant Seats – Media, Insurance

Power Analysis Grid
10-29-04

Note: This information should not be considered without viewing the grid. Some information falls between two power levels and this could not be captured in writing, thus giving an inaccurate picture of the full grid results.

Alliance

Power Level- Decision Maker: Governor Taft; Joy Padgenar (sp?) In the House of Rep.; City Council; Sen. Ray Miller; Mayor Jack Ford; Columbus City Councilwoman Charletta Tavares.

Power Level- Active Role: OTUPCF; Ohio United Way (Juliet Rowland); OTUPCF (Aaron Bryant); Hispanic Awareness Organization; Local Coalitions & Groups; Health Care Professionals.

Power Level- Significant: Faith-Based Organizations; Hospitals & Clinics; Urban League; Rural Opportunities; Barber Shops & Beauty Shops; Schools; Smoke Free Ohio (Formerly TFO).

Power Level- Important: STAND Youth; County – City Health Districts

Power Level- Not On Radar: Ex-Smokers; ACS, AHA and ALA Associations; Low Power - NAACP.

On The Fence

Restaurants and Businesses; Media Outlets; Insurance Companies; Ohio Commission on Minority Health (Cheryl Boyce); ODH.

Opposition

Power Level – Decision Maker: Ken Blackwell; Legislators; Sen. Doug White (Brown County); Sen. Trekkas (Parma, Whip); Commissioners & Politicians; City Council.

Power Level – Active Role: Tobacco Industry Lobbyists.

Power Level – Significant: Restaurant Association; Religious Leaders; Tobacco Companies; ODH-Tobacco Program; Media Outlets; Can the Ban; OTUPCF; Ohio Commission on Minority Health; Hispanic Awareness Organizations and Community Organizations.

Power Level – Important: Rural Opportunities; Urban League

Power Level – Not On Radar: Smokers

APPENDIX 22: SWOT ANALYSIS RESULTS

Critical Issues	Strengths	Weaknesses	Opportunities	Threats
Data	➢ Collaboration ➢ Access to ODH/OCMH/TUPF data ➢ Diversity in data ➢ Different levels of data ➢ Dissemination of information	➢ Difficulty of evaluators understanding and buy-in to ask specific questions, ➢ Not having clear idea of what to collect, ➢ Inconsistent data, ➢ What needs to be done with data	➢ Broader dissemination through partnerships ➢ Influencing data collection at the state level (TUPCF/ODH) on smokeless tobacco ➢ Influence of impact and policy ➢ Changing where "Black n' Milds" are located in retail outlets ➢ Increase funding sources ➢ Influencing and/or increasing stakeholders ➢ Create or piggyback on conferences and educational opportunities in Ohio ➢ Changes in messaging	➢ Awareness of conditions of disease ➢ Resources ➢ Schools and organizations make it difficult to collect data ➢ Lack of collective representation at the decision-making table ➢ Survey design (no voice) ➢ Difficulty in collecting data ➢ Diversity in software in data analysis ➢ Difficulty in connecting with grassroots organizations
Critical Issues	**Strengths**	**Weaknesses**	**Opportunities**	**Threats**
Alliances and Networks	➢ National and regional representation ➢ Diversity in membership ➢ Website ➢ Access to local data ➢ Access to resources (Ohio Resource Network) ➢ A common vision ➢ Advertising TTY for the Deaf	➢ Adequate time for workgroup member participation ➢ Media and marketing expertise	➢ Large number of media outlets that have health reporters ➢ Stabilize tobacco control ➢ Reach diverse markets ➢ Demanding, commanding and getting accountability ➢ Representation on TUPCF Board ➢ Advertising and awareness in the media	➢ Tobacco Industry ➢ Lack of interest among funders ➢ Lack of interest among funders due to visibility of issues (questions as to local funders role) ➢ Self-promotion as opposed to health promotion ➢ Media promoting negative messages as opposed to positive to move in the right direction ➢ Funding cuts (loss of committed human resources) and sustainability ➢ Inconsistent messaging system priorities
Critical				

Issues	Strengths	Weaknesses	Opportunities	Threats
Culturally Specific Restaurants and Bars	➢ Access through systems (infrastructure). ➢ Examples and existing ordinances ➢ Increasing awareness	➢ Government employee limitations ➢ Workgroup not addressed environments of non-smoking ➢ Not tapped into the Ohio movement	➢ More information and educational opportunities on second-hand smoke ➢ Become part of smoke-free Ohio ➢ Educate small businesses on their role as employers/accurate decisions ➢ Partnering with Medicaid and agencies that serve the underinsured. ➢ Partnering with hospitality agencies and groups and insurance companies	➢ Hospitality group threats regarding clean in-door air ➢ Threat-on individual rights by hospitality industries, corporations because of more resources ➢ Government system bureaucracy to encourage regulatory policy ➢ Messaging to restaurants and hotel
Critical Issues	**Strengths**	**Weaknesses**	**Opportunities**	**Threats**
Evidenced-Based Youth Programs	➢ Cultural competence ➢ Funding from CDC ➢ Level of Expertise ➢ Level of curriculum	➢ Lack of youth representation on workgroup ➢ Lack of Evidenced-based programs	➢ Prevention ➢ Policy changes in schools (promote wellness) to add into policy ➢ Flagship state for youth ➢ Identify and connect with entertainment industry to serve as role-models to connect with youth ➢ Partnering with recreational facilities (park, etc.)	➢ Youth ➢ Evidence-based programs communities of color ➢ Funding ➢ Advertising and mailing lists ➢ Role models ➢ Parents and families that smoke or influence smoking (Infiltration of promotion groups) ➢ Not enough time to get information to schools ➢ Convenience store owners /tobacco online products
Critical Issues	**Strengths**	**Weaknesses**	**Opportunities**	**Threats**
Cessation 6-7-06 developed by	➢ Persistence: Longevity in programming ➢ Access to the quit line &	➢ Approach to youth cessation ➢ Unequal school funding	➢ Influence other insurance providers ➢ Cessation Centers –	➢ Funding $ ➢ Continued advertising by tobacco companies

NE Ohio during Action Plan review meeting	NRT Program ➢ Trained Cessation Providers ➢ Employers support from programs in the workplace ➢ All counties have access to programming ➢ Data Available ➢ Community Partnerships ➢ History of collaboration ➢ Existing ordinances ➢ Funding $	➢ (Need more) Representation from minority populations ➢ Choice of General Assembly to take tobacco funds (lack of) education and lack of interest - 7 priority trust funds. ➢ Influence of economy on tobacco programs and other issues ➢ Link tobacco with other programs ➢ Concern about the vision of OTUPCF ➢ (Lack) knowledge regarding other programs	classes at different times and in different languages ➢ Educate Legislators	➢ Economy (not good) ➢ Lack of knowledge regarding what is available and the harm of tobacco use.

APPENDIX 23: KEY QUESTIONS IN ASSESSING INTEREST AND PROGRAM DIRECTION FOR STATE LEVEL COMMUNITY SPECIFIC TOBACCO CONTROL NETWORKS AND ALLIANCES

Key Questions in Assessing Interest and Program Direction for State Level Community Specific Tobacco Control Networks & Alliances

Identifying Target Audiences and Their Needs

Identify as many groups within the target community that will be involved in the network (e.g., faith networks, people living with disabilities, people with positive HIV status, high school students, young adults in the workforce, healthcare professionals, etc.) and sketch out how to approach them for feedback. Initial questions should include:

1. What are the most important issues facing your community? Most important health issues?

2. Is there anything about tobacco related problems (people becoming sick, dying; targeted advertising in your community; second hand smoke and children, etc.) that concern you?

3. We are organizing a network and an alliance to address the specific ways that tobacco affects our communities individually and cross-culturally. What do you think such a network and an alliance should do?

Looking at Specific Issues and Outcomes

1. Research is an important part of identifying the problem and many of the solutions to these problems. What kind of research should we be gathering? What kind of information would be helpful to make sure we are taking on the right issues? If it's easier, you can rank the following ideas or add some of your own.

   ___ Youth smoking and access to tobacco ___ Sale and use of blunts

   ___ Targeted advertising in our community ___ Raising excise taxes to fund programs

   ___ How tobacco affects our community in particular

   ___ How the tobacco industry influences our community

   ___ The impact of menthol cigarettes ___ Tobacco and elders

   ___ Effective ways to quit and support others to quit using tobacco

   ___ Other ideas?

2. What kind of change would you like to see in the environment as a result of this network/alliance?

   ___ Clean indoor air for everyone ___ More ways/places for people to quit tobacco

___ More resources in our community ___ More public awareness of tobacco

___ More youth that never start smoking ___ Other ideas?

3. Would you be interested in becoming involved? Who else might be interested in becoming involved?

4. We are very interested in making sure this network/alliance serves the needs of community members. What do you think are good ways of ensuring we get maximum community input?

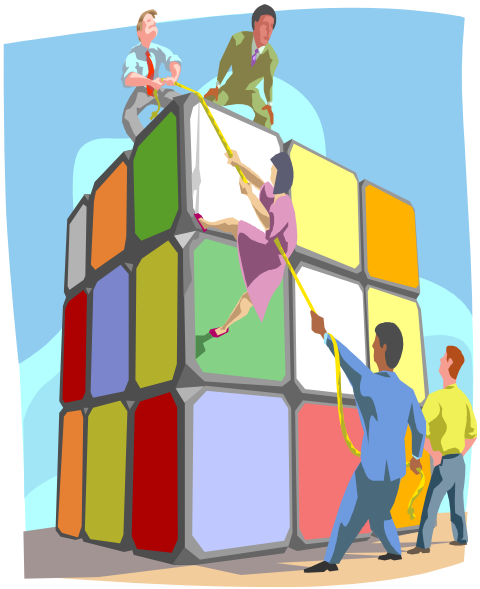
___ Local Advisory Boards ___ Online forums, e-mail and web site

___ Ethnic media ___ Community Forums and Town Hall Meetings

___ Newsletter ___ Other

5. Any other comments or suggestions?

APPENDIX 24: FUTURE PLAN INPUT FORM



Goal #4 Workgroup
Future Plan Input
June 29, 206 to June 30, 2007
Amount $120,000

Our plan is to continue the process of building statewide relationships and resources during the next Tobacco Program Grant Cycle even though the CDC Disparities Supplemental grant will be ending in June 2006. You all have done a great job contributing to the process and completing the tasks to get us started and going in a new direction. For the next grant cycle, we have three objectives to move us closer towards our Vision and to accomplish our Mission. Please give your thoughts about these three areas. There are no wrong/right answers, just "brainstorming thoughts. Thank you for your input.

1. **Develop a Goal #4 specific campaign to raise awareness among the 12 identified at-risks populations.**

_____

_____

_____

_____

2. **Collecting additional data among our 12 identified at-risk populations.**

_____

_____

_____

_____

3. **Convene new and current stakeholders for a statewide forum and/or regional meetings to address disparities among our 12 identified at-risk populations.**

_____

_____

_____

_____

APPENDIX 25: TOBACCO-RELATED DISPARITIES PRELIMINARY ACTION PLAN MATRIX
WORKGROUP MEMBERSHIP INPUT GOAL #4

Tobacco-Related Disparities
Preliminary Action Plan Matrix
Workgroup Membership Input
Goal #4

Agency Name: _____

Contact Person: _____

E-Mail: _____

Area Code/Phone & Fax: _____

Goal I	Check the Appropriate Box	List Population(s) / Community(s) from beginning of Action Plan	List the Geographical Area City(s) or County(s)	Can you Serve as a Mentor to less experienced agencies?
Strategy 1.1				
Strategy 1.2				

Goal II	Check the Appropriate Box	List Population(s) / Community(s) from beginning of Action Plan	List the Geographical Area City(s) or County(s)	Can you Serve as a Mentor to less experienced agencies?
Strategy 2.1				
Strategy 2.2				
Strategy 2.3				
Strategy 2.4				

Goal III	Check the Appropriate Box	List Population(s) / Community(s) from beginning of Action Plan	List the Geographical Area City(s) or County(s)	Can you Serve as a Mentor to less experienced agencies?
Strategy 3.1				
Strategy 3.2				
Strategy 3.3				
Strategy 3.4				

Goal IV	Check the Appropriate Box	List Population(s) / Community(s) from beginning of Action Plan	List the Geographical Area City(s) or County(s)	Can you Serve as a Mentor to less experienced agencies?
Strategy 4.1				

Goal V	Check the Appropriate Box	List Population(s) / Community(s) from beginning of Action Plan	List the Geographical Area City(s) or County(s)	Can you Serve as a Mentor to less experienced agencies?
Strategy 5.1				
Strategy 5.2				
Strategy 5.3				
Strategy 5.4				

APPENDIX 26: CCTCA's ACTION PLAN

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

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

Action Steps:

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

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

Actions Steps:

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

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

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

Action Steps:

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

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

Action Steps:

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

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

Action Steps:

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

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

Action Steps:

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

- Seek funding for the establishment of a staffed community-specific network entity for communities as they demonstrate readiness.
- Create community-specific plans to acquire replacement funding to decrease the tobacco industry influence in media, cultural arts and non-profit social service programs.

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

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

Action Steps:

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

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

Action Steps:

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

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

Action Steps:

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

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

Action Steps:

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

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

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

Action Steps:

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

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

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

Action Steps:

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

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

Action Steps:

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

- Seek funding through pharmaceutical companies that develop cessation products to support programs and interventions in the community.
- Create culturally-appropriate media campaigns with the community.
- Evaluate the effectiveness of culturally-specific programs and media campaigns.

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

Action Steps:

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

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

Action Steps:

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

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