IDENTIFYING AND ELIMINATING TOBACCO-RELATED DISPARITIES:

A CASE STUDY OF THE PROCESS TO DEVELOP AND ADOPT A STRATEGIC PLAN IN PENNSYLVANIA

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The dedication and effort that went into the development of Pennsylvania's Strategic Plan to Eliminate Tobacco-Related Disparities came from many. The commitment and richness brought to the Plan by the Workgroup cannot be overstated. Though I did not meet the Workgroup members until after the bulk of the planning process, their level of engagement and their motivation to see Pennsylvania's Plan succeed has continually impressed me. The leadership provided by Serina Gaston, Ray Howard and Laurie Mettam during the process was also invaluable. Their many hours of work and united vision sent Pennsylvania in the right direction. Judy Ochs from the Department of Health also provided necessary commitment to the process by being engaged and supportive while trusting the process and allowing ownership to belong to the Workgroup. In addition, many others gave their talents and advice to the process. I am also thankful to those who participated as key informants for the case study. Their insights enrich not only this project, but others to follow. Finally, guidance provided by CDC, the Office on Smoking and Health and other states was extremely helpful and informed Pennsylvania's strategic planning process from the beginning.

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1. Overview of the Disparities Project

1.1 Background

Pennsylvania's Department of Health (DOH) Tobacco Prevention and Control Program has been working towards a healthier Pennsylvania since 2001. Pennsylvania has facilitated and utilized tobacco prevention and control programs throughout the Commonwealth, in every county, and on a statewide basis. All tobacco control programs in the state aim to follow the Centers for Disease Control and Prevention (CDC), Office on Smoking and Health goals:

> The goal of a comprehensive tobacco control program is to reduce disease, disability, and death related to tobacco use by:
>
> 1) Preventing the initiation of tobacco use among young people.
> 2) Promoting cessation among young people and adults.
> 3) Eliminating nonsmokers' exposure to ETS (environmental tobacco smoke).
> 4) Identifying and eliminating the disparities related to tobacco use and its effects among different population groups. (CDC, 1999, p. 7)

However, nationally, as well as in Pennsylvania, addressing goal four, "Identifying and eliminating the disparities related to tobacco use and its effects among different population groups," remains a challenge as no clear evidence based framework exists for programs to follow in addressing tobacco-related disparities among specific populations (Starr et al, 2005).

In order to progress in the challenge of eliminating tobacco-related disparities in the state, PA DOH, with the encouragement of CDC officers, initiated the strategic planning process to design a plan around goal four. With funding from the Master Settlement Agreement and CDC, the planning process began in 2004. Consultants from the Center for Minority Health (CMH) at the University of Pittsburgh and Tobacco Technical Assistance Consortium (TTAC) facilitated the strategic planning process in 2004.

In 2005, Pennsylvania was selected to participate in the second wave of trainings by CDC that focused on identifying and eliminating tobacco-related disparities and the development of a statewide strategic plan to provide a framework to do so. CDC provided a series of three trainings in Atlanta between November 2005 and June 2006. Pennsylvania used the opportunity provided by these trainings to jump-start their strategic planning process, learn from other states that have completed their plans, and enhance and finalize their drafted plan from 2004.

1.2 Purpose and Goals of the Project

The purpose of writing a Strategic Plan to Eliminate Tobacco-Related Disparities in Pennsylvania was three-fold. First, pulling together a diverse workgroup of experienced professionals and non-professionals would allow for rich discussions that could guide Pennsylvania's Division of Tobacco Prevention and Control with long-term vision. Second, writing a plan would help to focus and give direction to county and statewide initiatives addressing tobacco-related disparities over a four-year period[1]. Third, the process of developing a strategic plan for CDC's fourth goal would pave the way for the development of an overall tobacco control strategic plan that encompassed all four CDC tobacco goals.

Through the strategic planning process, the Workgroup and the state, in cooperation with CDC, identified six priority planning areas and six disparately affected populations in Pennsylvania. Each priority planning area has an associated goal with objectives and strategies tied to its accomplishment. Addressing issues within these six planning areas is considered critical to success in eliminating tobacco-related health disparities. The six priority planning areas defined by Pennsylvania's Workgroup are:

1) Improve the quality of existing data to enhance identification, monitoring and evaluation of tobacco-related disparities.
2) Ensure that program providers, funding agencies and communities share in the decision-making process to design, implement, and evaluate prevention and cessation programs and to establish contractual responsibilities.
3) Incorporate and address tobacco-related health disparity needs at all levels of legislative and public health programming.
4) Increase the capacity of community-based organizations serving the identified population groups to reduce tobacco-related health disparities to change cultural/social norms of tobacco use acceptance.
5) Enhance the capacity of state and local governments to promote and sustain tobacco prevention control initiatives to reduce tobacco-related health disparities.
6) Identify and secure funding to sustain programs for the elimination of tobacco-related health disparities.

[1] Originally, and during Workgroup meetings, the Strategic Plan was intended to cover a three-year period. However, now that the Plan is closer to release, PA DOH and CMH have decided to make the Plan cover a four-year period so that it coincides with other 2010 plans.

1.3 Target Populations in Pennsylvania

Following the CDC strategic planning model, the Workgroup examined county and state-specific race and ethnicity demographics, as well as statistics for tobacco-related chronic disease, by different factors, including geography. The Workgroup used the State Health Improvement Plan (SHIP) document from 2002 as a starting point and branched to examine data from various sources. As part of the statistical review and data assessment, the Workgroup was presented with national and Pennsylvania specific socio-demographic (e.g., age, income, education level, geographic location), chronic disease (e.g., cancer, asthma), and tobacco (e.g., quit rates, smoking prevalence) data to help establish disparity in tobacco use and health status.

National data sources included:
US Census Bureau, CDC, Cancer Control Planet, NCI, NCHS, HRSA, Federal Office of Management and Budget, and USDA.

Statewide data sources included:
Data from the Pennsylvania Department of Health Bureau of Health Statistics and Research, Pennsylvania Vital Statistics through Health Statistics EpiQMS, Pennsylvania Cancer Registry, BRFSS, YTS, PHC4 Data, PA Quitline, and Center for Rural Pennsylvania.

After review and discussion of the data, the group reached consensus and agreed that the focus of the strategic plan over the initial three-year period[2] should be on the following six populations because of the tobacco-related health disparities[3] these groups face:

1) African American
2) American Indian/Alaskan Native
3) Asian American/Pacific Islander
4) Hispanic/Latino
5) Rural, including Amish
6) Lesbian, Gay, Bisexual, Transgender[4], Queer or Questioning (LGBTQ)

"This (planning) process has helped me be attuned to who people are and more accepting."

-Workgroup member

[2] The Plan was later adjusted to cover an initial period of four years.
[3] CDC Office on Smoking and Health defines tobacco-related disparities as, "differences in the patters of tobacco use and exposure to second-hand smoke, and the availability of prevention and treatment resources. These disparities are further visible in differential levels of risk, morbidity, mortality, and the related differences in capacity and infrastructure, social capital that exist among population groups in the U.S." (CDC, 2003).
[4] Initially the term "transsexual" was used, but the broader term "transgender" was ultimately used in discussions.

1.4 Project Team: Leaders and Workgroup Members

The project team for the Strategic Plan was made up of two parts: 1) The Implementation Team; and 2) The Workgroup.

The Implementation Team had three primary members, composed of representatives from PA DOH, TTAC and CMH. These three members went on to lead, organize and facilitate Workgroup meetings. Together, these project leaders conceptualized the structure for the Workgroup and researched background material specific to tobacco use in Pennsylvania. A guiding document for the Implementation Team was the *State Health Improvement Plan, Special Report on the Health Status of Minorities in Pennsylvania, 2002* (SHIP Special Report).

The 34-member Workgroup came together through a call for nominations process designed by the Implementation Team. Workgroup members were nominated, screened for minimum qualifications and were interviewed by an Implementation Team member. The group was considered reflective of the minority groups and subpopulations of interest in Pennsylvania (as guided by the SHIP Special Report).

1.5 Roles and Responsibilities of Project Team Members

A tobacco program manager from PA DOH initiated the vision for the strategic planning project after learning about the benefits of this type of plan at a CDC conference. After intense preparation, the program manager became the coordinator of the strategic planning process in Pennsylvania, taking on the project with great energy. The program manager asked the CDC to present the initiative to PA DOH to gain approval and buy-in for the process. Through an existing contract with CMH and recommendations from the CDC, the program manager was able to organize the strategic planning Implementation Team. An experienced facilitator from CMH was brought onboard, bringing to the committee familiarity with Pennsylvania and health disparities. An experienced facilitator from TTAC was also brought on as a consultant, bringing expertise and prior experience with CDC's recommended strategic planning process. This three person Implementation Team worked together intensely to make the strategic planning process a reality.

The program manager and two facilitators became a true team as they developed a plan for the first nine in-person Workgroup meetings[5], which took place between March and July of 2004. The team's combination of experience and passion fueled their planning process. This Implementation Team was charged with organizing the Workgroup meetings, informing and engaging Workgroup members, guiding the strategic planning process, and drafting a strategic plan.

"I have been working on tobacco for 25 years… but with this group, the burden has been a little lighter because we are all pushing the rock in the same direction."

-Workgroup member

[5] A tenth Workgroup meeting lead by the two original facilitators took place in June 2006.

The committee worked exceedingly well together and was able to enrich the process with a blend of perspectives.

Workgroup members were charged with making final decisions about which disparately affected groups to first address in Pennsylvania, as well as with identifying the critical issues that a strategic plan would need to incorporate in order to be functional and practical. Workgroup members were continually working together, both at meetings and between meetings, to make these important decisions. Workgroup members generously gave their time, providing insight and real value to the process. Workgroup members empowered the process because of their willingness to share and listen to one another in order to make decisions based on consensus.

The two Workgroup facilitators followed the strategic planning model recommended by CDC. This planning model includes three critical steps:

1) Data Assessment
2) Population Assessment
3) Strengths, Weaknesses, Opportunities, Threats (SWOT) Analysis

Workgroup members worked with each other and the facilitators through the three recommended central planning steps. Workgroup members were responsible for participating in discussions, bringing back follow-up information to the group, being part of a population specific subgroup, and giving presentations to the group.

"(The Workgroup) embraced me… my voice was never shut down, even being new to the field. My voice was just as important in the process."

-Workgroup member

2. Evaluating the Strategic Planning Process

2.1 Purpose and Goals of Evaluation

An evaluation component was incorporated in the initial planning of the strategic process. However, due to staff turnover at the University of Pittsburgh, the specifics of the original plans for the process evaluation are not known. The Implementation Team recognized the existing need for evaluation and brought on a second independent evaluator, also from the University of Pittsburgh, partway through the process to take on a limited process evaluation. The evaluator attended six of the nine in-person meetings and collected information on the Workgroup's reactions and suggestions to increase effectiveness. Though the second evaluator was not part of the planning process, the evaluation conducted was useful in providing the Implementation Team with timely feedback.

After the nine initial Workgroup meetings were complete, Pennsylvania began participation in CDC's strategic planning training. As part of this training, Pennsylvania brought on a third external evaluator from Philadelphia Health Management Corporation to write a case study of their strategic planning process. The CDC suggested writing a case study of this experience to facilitate

communication between and within states around strategic planning, and to document lessons learned through the process.

2.2 Evaluation Design And Methods

The evaluation of the strategic planning process incorporated a number of data collection methods, including, a self-assessment tool, document review, key informant interviews and limited direct observation.

The self-assessment tool consisted of a 32 question survey, including 28 five-point Likert scale items and 4 open-ended questions, centered on the process and structure of the Workgroup meetings (Appendix A - Self-Assessment Form for the Workgroup)[6]. Scores of the scale questions were analyzed to determine which areas of the process and structure of Workgroup meetings were strongest and weakest. The qualitative questions were grouped by theme by the independent evaluator and used by facilitators to inform the process. The self-assessment tool was used as a feedback mechanism for Workgroup members. Facilitators worked to be responsive to issues that arose and to address challenges in a timely manner.

The document review included collection and review of a variety of meeting notes, agendas, Workgroup presentations, Plan drafts, available email communications and summary notes. The document review was used to outline the documented processes used in the strategic planning effort and to organize questions for key informants around undocumented planning processes.

Six key informant interviews were conducted in May 2006 as part of the case study process. A suggested key informant list was generated by CMH, as CMH was actively involved with the drafting of the Plan at that time. Informants were asked questions about many topics, including, but not limited to, their responsibilities in the process, their impressions of specific pieces of the process including decision making, strengths of the plan, barriers faced, expected/unintended outcomes, plans for presentation and marketing of the plan, and recommendations to enhance future strategic planning meetings. Information gathered through interviews was used to supplement the document review.

Direct observation of the first nine Workgroup meetings was not part of the case study process. However, there was an opportunity for direct observation at the tenth meeting in June 2006. At this meeting attending Workgroup members were given an opportunity to reflect on the planning experience with the group. As well, members were asked to provide written feedback about the best and most challenging parts of the process, their recommendations for future efforts and

[6] The "Self-Assessment Form for the Workgroup" was adapted with permission from the Minnesota Department of Health (1990). This tool was made available by the Centers For Disease Control and Prevention at the *Pilot Training Program on Tobacco Use Among Population Groups* in 2002.

their overall reflections on the experience (Appendix B - Workgroup Feedback, 10th Workgroup Meeting).

3. Strategic Planning Processes and Milestones

3.1 Step 1: Forming the Strategic Planning Workgroup

The Implementation Team began the planning of the Workgroup with a discussion of the outcomes they expected from the meetings. Together they decided that the Workgroup should be comprised of a representative community group, rather than solely academics or well-known professionals. The facilitators wanted input directly from the community so that the consensus building process would be meaningful and useful in a strategic plan.

Ultimately, the Workgroup recruiting process utilized a call for nominations. CMH assumed a lead role in the formation of the Workgroup and set up a web-link for electronic submission of nominations. The call for nominations was announced via the internet, through multiple email databases available to PA DOH and CMH, including county level community-based tobacco control program lead agencies, tobacco service providers, the Governor's Advisory Commission on African American Affairs, and the Governor's Advisory Commission on Latino Affairs. People could nominate themselves or others; all nominations were considered as long as they met the following selection criteria that the Implementation Team agreed upon in advance:

- Pennsylvania residency;
- Availability and commitment to attend workgroup meetings;
- Background experience with racial and ethnic minority groups and/or rural and LGBTQ subpopulations; and
- Knowledge relevant to tobacco prevention and intervention services.

The call for nominations was very successful and 115 individuals were nominated (Appendix C – Example Nomination Form). Nominations were screened for eligibility criteria and qualifying nominees received follow-up phone calls to further discuss their interest and availability to participate. Thirty-four individuals were invited to become the Workgroup and challenged with the task to develop Pennsylvania's Tobacco-Related Health Disparities Strategic Plan.

The group was composed of 25 women and nine men, and was considered reflective of the minority groups and subpopulations of interest in Pennsylvania (as guided by the SHIP Special Report). The Workgroup brought together perspectives across populations, including racial and ethnic groups, rural and urban dwellers, sexual orientations, as well as low socioeconomic and homeless representatives. Geographically the group was varied, representing five of the six health districts and 14 of the 67 counties in Pennsylvania. The Workgroup included individuals who identified with or worked intensely with one or more of the six population groups selected as the focus for the strategic plan. Workgroup

members represented primary contractors of Pennsylvania's Tobacco Control Program (tobacco prevention and control coordinators), service providers, chronic disease researchers, counter-marketing specialists, county health officers, community organizers/advocates, school-based educators, evaluators and program planners.

Using the nomination procedure instead of appointing members was beneficial to the establishment and success of the Workgroup in a couple of important ways: the nomination process helped the Workgroup to bond early as it became clear that each member had something unique to offer the group, and ensured personal investment in the process since members volunteered. As a result, Workgroup members stayed committed throughout the planning process. Ultimately, the Workgroup benefited from the group's diversity, and the sharing of information and perspectives enriched the strategic planning process.

Workgroup facilitators were careful to share their expectations with the Workgroup and give members as much information as possible early in the process. Facilitators also prioritized reimbursing Workgroup members for their travel, organizing a schedule and timeline before asking for commitment, and making meetings comfortable on multiple levels. Meeting facilities were carefully chosen and remained in the same location in Central Pennsylvania through the first nine Workgroup meetings. An additional virtual meeting was held via the Internet after the nine face-to-face meetings. Meetings were structured to accommodate various learning styles as well, allowing members to participate in large and small groups with diverse data sets and multiple avenues to share information.

At the first meeting, Workgroup members were given a tabbed binder with background and orientation information, including a scope of work and a timeline. At this meeting, facilitators also established the ground rules for their future meetings. Ground rules included items such as "all members will participate at each meeting," and "one speaker at a time," so as to ensure that meetings would be orderly, productive, and discussion would be representative of all participants. The decision-making process was also discussed at the onset of the meetings. Decisions would be made by consensus when possible. If consensus could not be reached, a super-majority (2/3) vote could decide. To facilitate transparency in the decision-making process the Implementation Team drafted "Guidelines for Communication, Conflict & Decision Making" (Appendix D). At subsequent meetings, proposed meeting outcomes were presented at the beginning of each meeting so everyone was working in the same direction.

As the TTAC consultant facilitator wrote in her final report on the process, "Active participation in the process and decision making by consensus requires an environment of trust among all members of the planning committee." Facilitators worked diligently to establish trust and promote respect at their meetings. Over time, participation and involvement built up among members, in part because the

"We were a group of talented, informed people, but putting us in one room with a topic with so much complexity… we grew as a group."

-Workgroup facilitator

meetings were structured to offer many opportunities to talk. One member of the group noted his appreciation of these efforts, commenting that not only was there the opportunity to talk, but that you really felt heard when you did. Workgroup members would listen to others, consider what they were saying, and then work on the issue at hand together.

Workgroup members accepted responsibility for key tasks throughout the strategic planning process. These responsibilities included:

1) Share their time, energy and perspectives with the group;
2) Form consensus about the Strategic Plan vision and mission;
3) Participate in population subgroups, including presenting the subgroup's work to the larger Workgroup;
4) Identify focused critical issues/planning priority areas in Pennsylvania;
5) Completion of population assessments;
6) Completion of local SWOT analyses; and
7) Group writing of Plan goals and strategies.

"(We made a) transformation from strangers and agenda guards to friends and teammates."

-Workgroup member

3.2 Step 2: Identifying and Prioritizing Tobacco-Related Disparities

In order to identify and prioritize tobacco-related health disparities in Pennsylvania, the Workgroup was guided through three exercises: a data assessment, a population assessment, and SWOT (Strengths, Weaknesses, Opportunities, Threats) analyses.

Data Assessment - The purpose of the data assessment was to understand existing data (e.g., morbidity, mortality, tobacco prevalence, tobacco exposure) and identify gaps in available data. The Workgroup was presented with national and statewide statistics, graphs, charts and maps. The Implementation Team felt strongly that the Workgroup should also be given resources to interpret these data. For example, a statistical analyst would explain data with the help of appropriate comparison data and, when possible, data trends. These data would then be displayed on a Pennsylvania county map. Maps were used in small group learning activities and then displayed in the meeting room to be used for reference. The Workgroup was able to ask key questions about those data presented, identify gaps in population specific data and note inconsistencies in statewide data collection and reporting. Data assessment activities lead the group to their first priority, to improve the quality of existing data and fill data gaps (planning area 1).

Population Assessment - The population assessment step had two parts. 1) An independently completed population assessment conducted on the local level with the aid of a "Population Assessment Form" (Appendix E); and 2) Population subgroup presentations.

The Workgroup established population-focused subgroups to pull together population specific information as part of the overall population assessment. Each Workgroup member chose to belong to one of the following subgroups[7] (primarily based on their experience): African Americans, Latinos/Hispanics, Asians/Pacific Islanders, Rural/Amish, or LGBTQ. Subgroups brainstormed and researched information to present to the whole group. Each subgroup was also asked to consider the following groups within their assessment: homeless, veterans, military, institutionalized, undocumented, persons with disabilities, substance abuse populations, and low-income.

Workgroup members used their professional and/or personal experiences to educate others, which promoted cultural competency in the planning process. This process was very participatory and informative; one Implementation Team member described the subgroup presentations as "eye opening." The combination of efforts aided in identifying critical issues for each prioritized population and for the Statewide Strategic Plan. Priority planning areas 2 and 4 came from this process calling for inclusion in intervention activities from design through evaluation (Priority Area 2) and increased local capacity of community-based organizations (Priority Area 4).

SWOT Analyses - SWOT analysis was an important tool used by the Workgroup to organize current strengths, weaknesses, opportunities and threats in Pennsylvania. To foster a cohesive picture of the state, both PA DOH and the Workgroup conducted SWOT analyses. PA DOH completed their analysis and presented findings to the Workgroup (Appendix F - SWOT Analysis Questions, PA DOH), recognizing both the challenges Pennsylvania is currently facing as well as its assets. The Workgroup completed a statewide analysis from a local perspective as well, braking into four small groups to complete a thorough analysis (Appendix G - Workgroup SWOT Analysis).

SWOT analyses were useful to the group as they discussed about next steps for eliminating tobacco-related health disparities in Pennsylvania. Findings included:

- Strengths: Pennsylvania has an adequate infrastructure in place to advance a strategic agenda; Pennsylvania has critical buy-in and leadership to address health disparities at this time;
- Weaknesses: there is a historical lack of trust in working with government agencies; there is limited knowledge of cessation resources and limited collaboration for statewide media campaigns;
- Opportunities: Pennsylvania has opportunities to collaborate with statewide and national agencies to drive change; and
- Threats: funding threats and shifts in legislative priorities may deter efforts in Pennsylvania; and there are risks of stereotyping and challenges in maintaining cultural competency in efforts to eliminate tobacco-related health disparities.

"Hearing what others have said has impacted who I am as a provider."

-Workgroup member

[7] There were five Workgroup subgroups, though six population subgroups were ultimately identified. There was not an American Indian subgroup for this exercise.

SWOT analyses informed priority planning areas 3 and 5, to incorporate and address tobacco-related health disparities in legislative and programming policy (Priority Area 3), and to build state and local government capacity to reduce tobacco-related health disparities (Priority Area 5). Complete SWOT findings are included in appendices E and F.

Finally, all three exercises used to identify and prioritize disparities pointed to the importance of securing and sustaining funding for programs to eliminate tobacco-related health disparities (Priority Area 6). The issue of funding influences each of the other five planning priority areas. Workgroup members were clear that funding concerns could not face delays in being addressed.

"I wish more people on the local level had been here, it was great."

-Workgroup member

3.3 Step 3: Developing the Strategic Plan

Once priority planning areas were identified, the Workgroup spent two meetings concentrating on the wording of goals around those areas and the development of strategies to guide agencies in their efforts to reach the Plan's goals. Reaching consensus on these goals and strategies was challenging. Facilitators and the Workgroup struggled with wording, goal order and time constraints. On occasion, the pace of the decision-making process was overwhelming. Facilitators had to balance meeting time constraints with the impact of the consensus building framework used by the group. As a result, not all of the objectives set for and by the Workgroup were accomplished in juncture with the original timeline.

However, the extra time that went towards discussion was "the glue" of the process. At the end of the Workgroup meetings, the Workgroup wanted to stay involved because they were so motivated by the work they had done so far. As a result, the Workgroup members volunteered to continue the process in a new capacity by participating on sub-committees. Between August and December of 2004 four sub-committee groups were formed:

1) Planning sub-committee;
2) Action Plan sub-committee;
3) Data/Evaluation sub-committee; and
4) Marketing sub-committee.

Initially the timeline the group was working towards was scheduled to produce a final Plan by the end of 2004 (12/29/2004). This targeted deadline, however, was not met, though much of the Plan content was complete, due to staff turnover and communication challenges between lead agencies. After completion of the Workgroup meetings, questions around editing the draft Plan and leadership in Plan approval remained unanswered, ultimately delaying the Plan's completion. The current goal is to have a final Plan by July 2006. PA DOH and CMH are working closely now to finalize the format of the Plan and organize for its production and release.

As part of this wrap-up process, the Workgroup was called back together for a tenth meeting to look at the Plan's new executive summary, and to critique and improve the proposed work plan.

3.4 Step 4: Adopting and Refining the Plan

Currently the Plan is in the final stages of formatting and editing. An executive summary has been created and printed. Two additional pieces will be part of the final Plan, a full Plan (which will include a work plan and logic models) and a Data Book (which will include statistics, maps, etc.). PA DOH intends to release the entire Plan in 2006 through continued work with their partners at CMH.

There are many intended audiences for the Plan and when the Plan is released a critical step will be in its introduction to key audiences. Key audiences include, in no particular order:

- Public Health Decision Makers, including the Department of Health and the Bureau of Chronic Disease;
- PA DOH's Primary Contractors at the county level;
- Service Providers at the local level;
- Statewide and National Organizations; and
- Legislators, State Lawmakers, Policy Staff.

Once finalized, PA DOH intends to make the Plan available on the internet and to issue press releases. However, while public release is important, Pennsylvania does not want to focus on mass distribution of the document. Other Plan releases being considered include face-to-face presentations, hosted events, personalized mailings, and regional meetings. Another possibility for release is to partner with another program(s) currently working on health disparities and conduct a joint release. The Workgroup will have additional opportunities to stay involved with the Plan through marketing and implementation phases.

3.5 Step 5: Preparing for Action

Pennsylvania wants to be sure to send a consistent message about the Plan, including how it can be used and how to translate it into action. The Plan presents an opportunity to focus on a shared vision in Pennsylvania:

- A Pennsylvania free of tobacco-related health disparities. -

The Strategic Plan can be used as a "blueprint" or a "guide" for multiple organizations and agencies. While putting the Plan into action will not be easy, Pennsylvania has a strong foundation from which to advance towards the elimination of tobacco-related health disparities.

Part of preparing for action is also tied to vertical and horizontal networking. Communication between local service providers and countywide contractors is

critical for grassroots efforts, but new lines of communication also need to be established to aid local efforts. The state recognizes that this Plan will encourage relationships with more organizations/agencies in Pennsylvania and elsewhere. This Plan also presents an opportunity for national organizations to have a more active role in Pennsylvania.

4. Major Assets for Strategic Planning

4.1 Factors Facilitating the Planning Process

Overall, the planning process in Pennsylvania was a success. Much of the credit for the success stems from the following five factors:

1) Good facilitation from the Implementation Team. Facilitators did a lot of preparation work before the meetings began. They worked well together and provided needed balance in the process. Facilitators were interested in producing a quality Plan and in improving their techniques, making them responsive to feedback and engaged at each meeting.
2) The Workgroup was diverse. The nomination process was a good choice for Pennsylvania because so much tobacco work was currently underway. Through choosing the right process for recruiting members and designing the process so members were encouraged to learn from one another, the diversity of Pennsylvania was constantly a focus at the table.
3) The CDC recommended planning steps engaged participants. Again, the sharing that was happening at the Workgroup meetings allowed for rich discussions and will ultimately lead to a complete and informed Plan.
4) Data was used as the foundation of the planning process. The initial focus on data during the first Workgroup meetings kept the group grounded in using data in their discussions and decisions.
5) PA DOH was invested in the process. It was important for the group to know and trust that they had a "door opener" at PA DOH advocating on their behalf. PA DOH was involved, but not controlling of the Workgroup's efforts.

4.2 Maximizing Planning Assets

All of the factors facilitating the planning process were enhanced by the initial creation and maintenance of a comfortable environment for the Workgroup. Communication among Workgroup members was successful because members were free to disagree with each other respectfully, and because members felt that they each had a valued and necessary voice in the process.

"I've been part of many strategic planning processes and this is the only one… I left with the sense that the input, the work that we've done will make a difference in the community."

-Workgroup member

5. Challenges to Strategic Planning

5.1 Challenges to Successful Planning

The strategic planning process was challenging for many reasons, including:

1) Time - Time constraints were a problem for everyone involved. There was no full-time person to dedicate efforts solely towards this time-intensive process, and all of the key players in the process had to divide their time between other jobs as well.
2) Missing Data - Missing data made it difficult to know if the target groups identified were really the best place to begin. When adequate data about disparately affected populations could not be found, the group had to move on in spite of data gaps.
3) Lack of Trust - Some of the Workgroup members did not trust working with the state. Workgroup members were clear upfront that they did not want to be involved unless they could be assured that something would happen as a result of their work and recommendations. The state's reputation had to be acknowledged before some felt comfortable with their involvement. Later in the process there were speculations about the strength of wording that would be allowed in the Plan by the state again raising concerns about "politics."
4) Special & Competing Interests - Special and/or competing interests emerged at many stages in the process. At times it was difficult for Workgroup members to focus on the whole state, especially since there was so much opportunity to discuss issues about which they were passionate. Facilitators were challenged with keeping Workgroup members from feeling abandoned by "larger" interests.
5) Staff turnover - Staff turnover was a challenge during the meeting process. A new evaluator had to be found during the meetings, and after the nine initial meetings PA DOH staff changes left the position of Disparities Project Coordinator open.
6) Limited Documentation - The limited evaluation and formal documentation from the process was damaging during Plan drafting. An organized evaluation piece for the process would have helped document key decisions, organized data citation and aided in forming a concise Plan outline.

5.2 Strategies to Overcome Challenges

CDC staff helped Pennsylvania move forward through some of their process challenges. Having a relationship with the CDC was critical when barriers were interfering with the process. As well, having outside facilitators from CMH and through TTAC brought additional credibility to the Workgroup's strategic planning process.

"I believe that because of the personalities and people here, change has to happen."

-Workgroup facilitator

Communication with the group was clearly an asset in overcoming challenges. The Implementation Team would remind Workgroup members to focus on the collective interest of the group when diverging special interests emerged. Facilitators had to be open about the need for a wide focus when it was time to make decisions.

5.3 Challenges that Were Not Overcome

At the time of this reporting, Pennsylvania is still without a final Strategic Plan to Eliminate Tobacco-Related Disparities. The challenge now is to follow through with the Plan finalization, publication and release effectively. PA DOH and CMH were concerned that the delay in plan release may affect relationships with the Workgroup members. In part, this concern motivated the organization of a tenth Workgroup meeting, which became an opportunity to reestablish connections. Though, as one of the Workgroup members said, "some of the family did not make it to the reunion," the attending Workgroup members jumped back into the process to discuss Pennsylvania's next steps.

Strategic planning is still an evolving initiative. This planning process and its challenges can be used to inform next steps in Pennsylvania.

6. Conclusions

6.1 Major Planning Accomplishments

Through this process Pennsylvania has pulled together a successful Workgroup, which allowed for consensus and community guidance. The Workgroup not only impressed the Implementation Team, but also the Secretary of Health of Pennsylvania who attended a Workgroup meeting. Support from the Secretary of Health was a major accomplishment for the Workgroup and the Implementation Team. The level of support the Workgroup receive from PA DOH and from each other was notable.

Another major accomplishment for Pennsylvania is their participation in the Strategic Planning Training with CDC. The CDC training provided an opportunity for Pennsylvania to finalize its draft Plan with new motivation and to learn from the tobacco-related disparities work of other states.

6.2 Lessons Learned Throughout the Planning Process

Pennsylvania has learned many lessons through the experience of convening a strategic planning group and drafting a plan to eliminate tobacco-related disparities. While developing a strategic plan was the goal of the process, it has been clear through this experience that the process was as important as the endpoint.

"Creating a tapestry in life… this experience is one of my golden threads."

-PA DOH staff

In light of this, the lessons learned by key informants of this case study will be outlined by: A. Lessons learned through the strategic planning process; and B. Lessons learned about drafting a strategic plan. It is imperative to maintain a focus on both the process and the ultimate outcome.

A. Lessons Learned Through the Strategic Planning Process:

1) Preparation is essential. Pull as much information together as possible before you convene a workgroup and provide resources to interpret that information. Not only will this save time, but it will get the group pointed in a unified and informed direction.
2) Create an open and trusting environment. Establish ground rules early so workgroup members feel comfortable and ready to fully engage in the process.
3) Give your workgroup an agenda and expected accomplishments at the beginning of each meeting. The group can get there if you tell them where they are going.
4) Listen. Trust the process and learn from what you hear.
5) Provide your workgroup with opportunities to offer feedback to improve the planning process in real time.
6) Provide leadership. Group involvement and consensus building are important, but it is also imperative to have a leader who knows when it is time to move on.
7) Eliminate participation barriers. Help people to attend and stay focused at meetings. Be sure to have someone who is focused on travel arrangements, accommodations, food and reimbursement.
8) Prioritize documentation and evaluation. Manage records of all key actions and decisions. Always cite data used in discussions. Decide on a process evaluation plan before beginning.
9) Limited time and money frequently challenge planning processes. Prioritize staying on track with your timeline and setting a realistic budget.

B. Lessons Learned About Drafting a Strategic Plan:

1) Discuss and acknowledge the desired result of the strategic planning process from the start. It is not enough to say that a report will be written. Take time to think about the format (length and style), the outline, the intended audiences, the key questions to be answered, the key tables, and the parties responsible for making it happen.
2) Anticipate the limitations of the final product so that opportunities to counter those limitations are acted upon.
3) Set a realistic timeframe and then stick to it. Morale falls as tasks get delayed or forgotten.
4) Buy-in is critical. Be sure you have the commitment you need, from your workgroup, your key staff and committed leadership at the top.
5) Be prepared to build partnerships for plan implementation. Think outside of and within your state. Let the plan grow in all directions.

6) Edit your plan so that it is manageable, and can educate and engage new people. Extensive documentation is needed to write a plan, but the plan itself should not be cumbersome. Offering a concise executive summary will help others to quickly understand the essence of your strategy.

6.3 Recommendations to Enhance Future Strategic Planning

Tobacco-related health disparities affect many more populations than those which Pennsylvania plans to concentrate on over the next four years. The Workgroup was clear in discussions and meetings that the six disparately affected populations chosen for extensive Workgroup discussion were not intended to be an exhaustive list of important groups disparately affected by tobacco. Rather, these six populations were a place to start efforts in eliminating tobacco-related health disparities. Both the Workgroup and PA DOH feel strongly that the final Plan should reflect this notion. Pennsylvania can use this experience and clearly document in this Plan that the disparately affected populations identified here are where efforts in Pennsylvania can begin, rather then where efforts addressing tobacco-related health disparities should remain. The state can use their experience to continue to gain clarity in defining targeted populations in the future.

"You are passing the baton in some ways to the Department (of Health) and we intend to do you justice."

-PA DOH staff

In the future, Pennsylvania may find it beneficial to coordinate timing of Plan release or breadth of Plan with other statewide efforts. For example, in 2006 Pennsylvania began a strategic planning process around statewide tobacco prevention and control programming. PA DOH and CMH decided it would be helpful to have the two complementary plans both reach until 2010.

Finally, prioritizing communication at every stage of the planning process is important. During this strategic planning process, communication was both a strength and a weakness. Maintaining high quality communication throughout the process will help future efforts to stay organized, coordinated, accurate and on time. Both Workgroup discussion and the written plan need to be organized around solid communication goals.

6.4 Next Steps in Pennsylvania

The next step for Pennsylvania is to finalize and release the Strategic Plan to Eliminate Tobacco-Related Health Disparities. In order for Pennsylvania's Plan to serve as a guide as it was intended, investments of commitment and in training need to be incorporated into the Plan's release. Once the Plan is released, Pennsylvanians will need to work together to achieve success in eliminating tobacco-related health disparities.

Once the Plan is finalized, the Workgroup will help guide release and marketing plans. As well, there are a variety of ways Workgroup members could remain involved and guide the implementation of this Plan. PA DOH and the 2007

disparities contractor will need to work with Workgroup members to establish their future roles.

Over the four-year period associated with the Plan it will be imperative to discuss funding opportunities. Funding decisions should consider and incorporate the Plan's goals, supporting critical efforts to address health disparities in Pennsylvania. The Plan needs to receive long-term commitment with clear and realistic expectations from decision makers so that success can be measured appropriately. Incorporating the goals, objectives and strategies described by the plan will require sustained funding and efforts.

7. RESOURCES

7.1 LIST OF ACRONYMS USED IN THIS CASE STUDY

BRFSS – Behavioral Risk Factor Surveillance Survey
CDC – Centers for Disease Control and Prevention
CMH – Center for Minority Health at the University of Pittsburgh
DOH – Department of Health
ETS – Environmental Tobacco Smoke
HRSA – Health Resources and Services Administration
LGBTQ – Lesbian, Gay, Bisexual, Transgender, Queer or Questioning
NCHS – National Center for Health Statistics
NCI – National Cancer Institute
PA – Pennsylvania
PHC4 – Pennsylvania Health Care Cost Containment Council
SHIP – State Health Improvement Plan
SWOT – Strengths, Weaknesses, Opportunities, Threats Analysis
TTAC – Tobacco Technical Assistance Consortium
USDA – United States Department of Agriculture
YTS – Youth Tobacco Survey

7.2 WORKS CITED

Centers for Disease Control and Prevention. (1999). *Best Practices for Comprehensive Tobacco Control Programs – August 1999*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

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Zimmerman, R. S. (2002). *State Health Improvement Plan, Special Report on the Health Status of Minorities in Pennsylvania, 2002*. Harrisburg, PA: Pennsylvania Department of Health.

Appendix A

Planning Meeting Evaluation

Self-Assessment Form for the Workgroup

The purpose of this self-assessment is to provide an opportunity for planning group members to provide input into the process and the policies that govern meetings. The results will be summarized by the co-chairs and distributed to all members. Your input is important to the successful and efficient functioning of the workgroup. Thanks!

Directions: Please indicate your agreement or disagreement with the statements below by circling the number on the scale that best represents your experience with the workgroup. We prefer that your responses be anonymous, so please do not include your name.

	Completely Agree				Completely Disagree
1. The atmosphere is friendly, cooperative, and pleasant.	1	2	3	4	5
2. The purpose of each task or agenda item is defined and kept in mind.	1	2	3	4	5
3. Everyone participates in discussions, not just a few.	1	2	3	4	5
4. There is no fighting for status.	1	2	3	4	5
5. There is no fighting for hidden agendas.	1	2	3	4	5
6. The group uses the resources of all, not just a few.	1	2	3	4	5
7. Members stay with the task.	1	2	3	4	5
8. The group adjusts to changing needs and situations.	1	2	3	4	5
9. Members feel safe in speaking out.	1	2	3	4	5
10. Meetings have free discussion.	1	2	3	4	5
11. Interest is generally high.	1	2	3	4	5
12. Meetings run smoothly, without interruptions or blocking.	1	2	3	4	5
13. Meetings start and stop on time.	1	2	3	4	5
14. Members seem well-informed and up-to-date and understand what is going on at all times.	1	2	3	4	5
15. Technical terms and acronyms are clearly defined and understood by all.	1	2	3	4	5
16. Routine matters are handled quickly.	1	2	3	4	5
17. Committee and/or workgroup reports are routinely made to the entire group.	1	2	3	4	5
18. The group advises and makes recommendations to the State and/or local health department.	1	2	3	4	5
19. The roles of professional staff are clearly defined	1	2	3	4	5
20. The roles of the workgroup are clearly defined	1	2	3	4	5
21. Materials for meetings are prepared adequately and distributed in advance (e.g., agendas, minutes, study documents).	1	2	3	4	5
22. Minutes accurately reflect the proceedings of the meeting.	1	2	3	4	5
23. Members have a good record of attendance at meetings.	1	2	3	4	5
24. I am usually clear about my role as a workgroup member.	1	2	3	4	5
25. My assignments are manageable and not overburdening.	1	2	3	4	5
26. Meeting times work well with my schedule.	1	2	3	4	5
27. Notification of meetings is timely.	1	2	3	4	5
28. Location of meetings is convenient.	1	2	3	4	5

29. Do you feel that your expertise or talents are being used well? ____Yes ___No

Appendix A continued

If no, how could they be used more effectively?

30. What changes would make the workgroup more effective?

31. What changes would make serving on the workgroup more enjoyable?

32. Other comments/suggestions:

Note: Adapted with permission from Minnesota Department of Health, 1990. and the Centers For Disease Control and Prevention (2002) *Pilot Training Program on Tobacco Use Among Population Groups*

Appendix B

Workgroup Feedback, 10th Workgroup Meeting

<u>What was the best or most interesting part of the planning process for you?</u>

- Meeting tobacco control partners from throughout the state and learning from their experiences and knowledge.

- To see the transformation from strangers and "agenda guards" to an open atmosphere of friends and teammates working together. The food was good too!

- Enhancing my understanding of other disparate pops. And also fellowship with other to bacco advocates.

- As a person who is not a minority, but one who had extensive experience with racial health disparities, I felt that I was already sensitive to the issues. This helped me to broaden my perspective, and to understand other points of view and concerns. I have come to really care about the people who represent those other points of view, and accept them as they are.

- It was extremely valuable to meet other health professionals from all over the state, representing various groups of disparately affected people. I learned so much!

- The process was developed and facilitated in a manner that made me believe our input and work will actually make a difference. That's rare.

- Seeing the dedication of all working together to achieve a common goal. It takes a great deal to remain focused.

<u>What was the most challenging part of the planning process for you?</u>

- Streamlining the communication and excellent ideas from the diverse partners into one comprehensive plan.

- The learning curve for me personally; I was relatively new to this field (from corporate America).

- Staying involved in the face of changing position (careers).

- This was a diverse and broad issue. It was a challenge to think broadly and not narrow my perspective. It was tough to see the whole picture.

- At the point where we were getting to the heart of the matter, funding was used up. I feel like we stopped short.

- I wasn't part of the work group.

- Knowing that I/we didn't have enough time to share all of our thoughts and ideas (knowing this was not feasible).

- Finding my tie-into the direct subject material.

Please share any recommendations you have for this Plan or future strategic planning efforts?

- Bringing the partners together for work on this plan once a month was a good idea. If would be nice in the future to have a few meetings outside of Harrisburg for logistic purposes.

- The ability to create an open and safe environment so that you can benefit from the experiences of all.

- Members from community are part of strategic planning.

- With limited time, you need to keep a very disciplined approach. Everyone has a right to be heard, but not drone on. You need an agenda, with goals, for every meeting.

- Continue to use a nomination process for planning committee members – raises bar. Reconvene group periodically to monitor and update plan – please don't let this collect dust on a shelf!

- Share this plan with other entities in PA that it may become a collaborative document.

- Definition and methodology of work plan. How you arrive to a consensus (case study – Jenn) good Job! Under evaluation? What base-line data are we working off of?

Overall reflections of this strategic planning experience?

- Having PaDOH at the table and present throughout the process demonstrated their commitment to seeing the plan through planning, implementation and dissemination.

- Outstanding! Educating! Growth!

- A wonderful, meaningful experience. I feel like I really made a difference to make sure these populations aren't "lost".

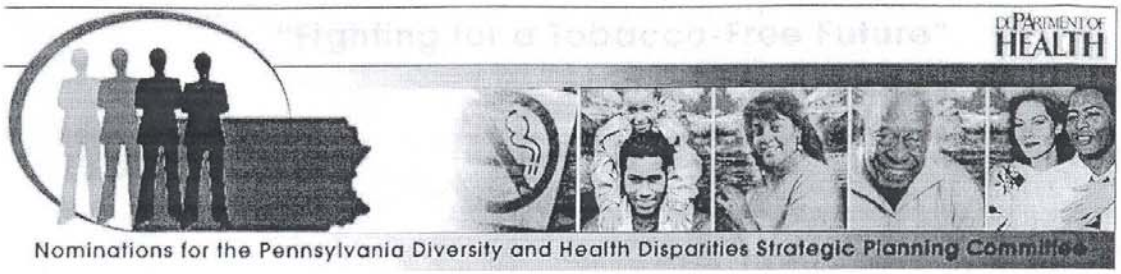
- This was a great experience. This is reflected by a great output and the large volume of work produced.

- It was beneficial to work on a state-level project. The knowledge and lesson are directly transferable to my local-level work. The leadership of Ray Howard and support of Judy Ochs were very helpful to the process.

- I thought it was a great planning meeting, even if I wasn't at the beginning.

- Most valuable I've been a part of.

Appendix C



Section II: Nomination submitted by:

Name: [redacted]
City/State/Zip: [redacted]
Phone: [redacted]
Fax: [redacted]
Email: [redacted]

Section III: Nominee Name and Contact Information

Name: [redacted]
Title: [redacted]
Organization: [redacted]
Address: [redacted]
City/State/Zip: [redacted]
County of Residence: [redacted]
Phone: [redacted]
Fax: [redacted]
Email: [redacted]

Section IV: Nominee should have expertise

Population of Expertise:	
African Americans	1
Hispanic/Latino	1
Asian Pacific Islanders	0
American Indians / Alaskan Natives	0
Adolescent and Youth	1
Amish Residents	0
Rural Residents	1
People with Low Incomes	1
Gay/Lesbian/Bisexual/Transgender	1

Section V: Describe expertise of nominee and your reason for the nomination.

[redacted] works with all populations - rural, urban and suburban - in [redacted] County. He heads the funding agency for the [redacted] project and works with prevention as well as treatment. He is a visionary and community change agent.

Appendix D

GUIDELINES FOR COMMUNICATION, CONFLICT RESOLUTION AND DECISION MAKING:

Who: The **Pennsylvania Diversity and Health Disparities Strategic Planning Committee** - an Ad Hoc committee of experienced tobacco prevention and control health advocates who represent the groups likely to be affected by tobacco-related disparities.

Process Mission: Develop a strategic plan for identifying and eliminating tobacco-attributable health disparities in Pennsylvania through an inclusive, representative, equitable, participatory, and collaborative process.

Purpose of these Guidelines: Provide information to ensure the strategic planning process is clear and acceptable to all committee members, and consistent with the mission statement (above). Adherence to these Guidelines will be monitored and enforced by the facilitator, committee staff and committee members.

Time frame for the strategic planning process on-site meetings: March 12, 2004 – July 30, 2004

The Diversity and Health Disparities Committee is composed of the organizations and individuals on the membership list. The total number of the Diversity Committee will not exceed 30 members. In those cases where more than one member is from the same organization, only 1 member from the organization votes.

1. The following meeting **ground rules** will be practiced by all committee members:
   - Begin and adjourn on time
   - Follow an agreed upon agenda
   - Concentrate on one subject at a time
   - Have one speaker at a time
   - Conversation is open to all committee members and is balanced among them
   - Wait for your turn to speak
   - Be concise when speaking
   - Listen attentively to whoever has the floor-consider participants' feelings and ideas
   - It is OK to disagree...please do so respectfully
   - Use differences as an opportunity to learn, to teach, to create something new and inclusive
   - Follow a clear and agreed upon process for communicating, problem solving, decision- making, and conflict resolution.

2. **Committee decisions** will be made by consensus. Consensus means that all committee members who are present support the adoption of the proposal under consideration, although there may be very different levels of enthusiasm for the proposal. At least one-third of the Committee membership must be present at the time any committee decision is made. **NOTE:** due to the time constraints of the planning session, every effort will be made to expeditiously come to an agreement.

3. **If the committee** is unable to reach consensus on an issue during a meeting, the committee will consider whether the issue is critical to completing the strategic plan on time and requires a final decision on that day. If the committee decides by consensus that the issue is critical to completing the strategic plan on time and requires a final decision on that day, then the committee may vote to reach closure on the critical issue. In such votes, support by a super-majority (2/3 of the Diversity and Health Disparities

Appendix D continued

Committee members in attendance) is required for a decision. If the committee decides by consensus that a final decision on the issue is not required on that day, then the issue will be deferred after committee member preferences regarding the issue and the reasons for those preferences are recorded. Issues that are deferred during a meeting will be placed on the agenda of the committee's next meeting, unless by an explicit decision of the committee the issue is referred to a committee meeting.

4. **All committee meetings** are open to the public. The public (anyone outside the Diversity and Health Disparities Committee member's list) attends as observers but does not participate in decision making of the Diversity and Health Disparities Committee.

5. **A caucus may be held** at any time during a committee meeting upon request by any members of the committee or by the facilitator. The purpose of a caucus is to allow a self-defined subset of the committee to confer privately, or to allow the facilitator to confer privately with a subset of committee. The decision of the caucus will be brought to the whole committee.

6. **If conflicts arise,** the Diversity Committee members agree to:
   - maintain acceptance of one another as fellow committee members
   - understand the conflict from each other's perspective
   - create mutually satisfying solutions.

7. The directly affected parties will confront conflicts that arise between committee members with clarity and mutual respect. Committee members will promote resolution even when they are not the direct parties to a dispute through thoughtful non-involvement, careful listening, or prudent advice to the parties consistent with the conflict resolution goals. If the issue in question directly pertains to the strategic planning process, time will be set aside to address the conflict. Committee members requiring assistance in addressing a conflict will seek it from a designated mediator agreeable to the directly affected parties to the dispute.

8. The role of the committee member includes the following responsibilities and commitments to the "Guidelines" and:
   - Attend all Diversity Committee meetings or designate substitutes for meetings they cannot attend
   - Arrive at meetings on time and prepared to work, allow no interruptions of their attention during meetings and remain for the entire scheduled time of the meeting.
   - Identify areas in which data are missing or lacking
   - Assist with the environmental scan portion of the strategic planning process
   - Share all relevant information about the project, organization, or community they represent
   - Share all relevant information from the strategic planning process with the organizations and constituents they represent
   - Identify individuals and agencies that can help with the plan
   - Participate in priority setting portion of the strategic planning process
   - Help draft strategies and goals for the strategic plan
   - Support the formal positions of the committee
   - Advise on and monitor implementation of the strategic plan.

9. **Resource persons are individuals** whose expertise and/or linkages to outside groups are requested on an as needed basis by the committee. They are not committee members. They participate in meetings at the invitation of the committee, within limits defined by the committee. At the invitation of the committee they may provide presentations, answer questions of interest to committee members, provide advice to the committee, and/or participate in committee discussions. At other points in the meeting they function as observers. Resource persons do not participate in committee decision-making.

Appendix D continued

10. **Observers at committee** meetings include members of the news media and other people interested in watching and listening to the meeting. They are not committee members. Observers may not communicate with other meeting participants during the meeting.

11. **The Implementation Team** – Ray Howard of Center for Minority Health and Serina Gaston of Pennsylvania Department of Health, Tobacco Prevention and Control shall serve as committee staff to provide technical assistance. They will fulfill the following responsibilities:
    - Clarify roles of the individuals participating in the strategic planning process
    - Provide support to all committee members during the strategic planning process
    - Provide resources to support the committee's efforts
    - Monitor and oversee the committee budget and the expenditure of committee funds
    - Provide for relevant technical data
    - Guide the environmental scan
    - Manage all meeting logistics
    - Serve as committee liaison with the committee's facilitator
    - Notification to members of upcoming meetings
    - Disseminate information and materials to committee members
    - Keep meeting minutes
    - Draft meeting agenda
    - Write the strategic plan

12. **Standing and ad hoc workgroups** may be formed by the committee to fulfill specific assignments or fulfill certain functions. Workgroup membership may include people who are not committee members. Workgroup decisions must be made by consensus. Unless otherwise authorized by the Committee, workgroup are not authorized to make decisions for the Health Disparities Committee. Committee members will be notified of all workgroup meetings, and all workgroup meetings will be open to all committee members. For example, the **Evaluation Workgroup** plans the Data Forum, reviews data and gives input, and provide ongoing group process evaluation.

13. **Following each committee meeting,** the committee staff will prepare and distribute to all of the committee members a simple record of the meeting indicating at least the meeting date, location, timeframe, names and an affiliation of all attendees (including observers and resources persons), relevant information raised during the meeting, and all decisions made by the committee.

14. **The facilitator will operate** free of favoritism or bias toward any committee member in her professional relationship with them, and will maintain a professional position of impartiality toward all substantive issues under consideration by the committee.

15. **The committee may change** its "Guidelines"at any time through an explicit committee decision.

Appendix E

Population Assessment

The following instrument can be used to conduct the population assessment. An important point to remember is that the intent is *not* to conduct an exhaustive assessment, but to acquire information quickly to guide the planning process.

Committee member name:_____

Attributes of Population Groups With Identified Tobacco-Related Disparities

(to be completed by committee members)

A. Population group being addressed :

B. Nature of the specific population group:

- Is the population group a "community" in that it shares its own history, context, and culture?
- Is the population group a stratum (e.g. low socioeconomic status or rural) rather than a community (e.g. African Americans or college students)?
- Is the population group a subpopulation of a larger group (Puerto Rican women)?
- What is the geographic dispersion of the population group/community?

Communication Channels (to be asked of the population group leaders)

1. How do members of the population group/community relate with one another and the larger community? (language, social life, religion)

2. Which entities influence the population group/community? (churches, political leaders, community-based organizations, media, workplace, other)

3. Where do you get your news?

4. What would be the best way to communicate tobacco prevention within your community? Are there barriers?

Tobacco-Related Norms and Attitudes:

5. What is known about the social norms of the population group/community regarding tobacco use (e.g. positive/negative, men/women, role in socializing, role in spirituality)?
    - Do a lot of people smoke or chew? Is it accepted?

6. What is the most valuable information one should know about your community relating to tobacco use?

Assets/challenges – Tobacco Prevention and Control Issues:

7. What barriers exist in reaching this specific population group/community (e.g. lack of support from community leaders for tobacco control, poor communication channels)?

8. Are there any groups that stand out as being a good fit for dong tobacco use prevention?

Appendix F

S.W.O.T. analysis questions

Pennsylvania Department of Health
June 11, 2004

Important note

The potential list of questions to assess strengths, weaknesses, opportunities, and threats is quite large. There are probably no right or wrong questions; however, the better informed the planning process becomes, the more likely it is that the plan will be highly effective.

Determining relevant strengths and weaknesses

The following questions will help the workgroup determine relevant strengths and weaknesses that affect capacity to address identified population disparities (e.g., workgroup, State health department, collaborative organizations):

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

- The workgroup is comprised of community-based organizations who have access to specific population groups across the Commonwealth. These linkages will help in the implementation of the strategic plan.
- Experienced facilitator who has gone through the strategic planning process with another state agency.

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

- Due to the lack of best practices in the disparate population there are no evidence-based programs that the workgroup can utilize in the strategic plan.
- Historical lack of trust of state government to address disparate population issues/concerns.

(2)What tobacco prevention and control successes have we had in our State? What have we learned from those successes?

Successes:

- Master Settlement dollars were appropriated 100% to health initiatives, including 12% directed to Tobacco Prevention and Cessation program
- Comprehensive planning, development, and implementation followed CDC's Best Practices
- Community-based tobacco control programs exist in all 67 counties and receive 70 percent of the 12 percent appropriation annually
- Statewide programs have been implemented including 24/7 quitline, counter-marketing, youth movement, technical assistance and support to community based partners and ethnic/racial minority populations
- Youth tobacco use/initiation has decreased
- Youth access to tobacco rates of illegal sales have decreased from 50 percent in 1996 to 10.8 percent in 2003

Appendix F continued

Lessons Learned:

- Extremely important to establish external partnerships (ACS, ALA, AHA) that are able to be pro-active advocates for Tobacco Prevention and Cessation program
- Tobacco Prevention and Cessation programs must be comprehensive to work – no component (school, community, chronic disease program; cessation, enforcement, counter-marketing, surveillance/evaluation) is stand alone – nor is the issue of tobacco use a stand alone issue. Systematic approach with focus on integrated components is key.

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

Failures:

- The timing of the funding legislation affected timely linkages between activities that should be complimentary. For example, the statewide quitline was launched before a marketing campaign to support the quitline could be implemented
- PA has not implemented population specific media campaigns
- PA has not always appropriately represented PA's diverse populations in media campaigns (i.e., campaigns to promote quitline, youth campaigns)

Lessons learned

- DOH staffing turnover and available workforce has a major impact on core function
- Restraints in contracting process remain a barrier to program implementation
- Critical to obtain input from minority community for effective program planning and implementation

(5) How effective is our leadership in the workgroup and the department of health?

- Administration continues to maintain commitment to effective tobacco prevention and cessation programs, adhering to best practices and addressing disparities
- As a member of the workgroup, the Department continues to support the efforts by providing statistical data, special minority reports, etc that will assist the workgroup in framing out its goals and objectives.
- The Division of Tobacco Prevention and Control has taken the lead, agency-wide to develop and implement a strategic plan that will identify and eliminate tobacco-related disparities.

(6) Do communication processes within our State (i.e., within, between, and beyond the workgroup, the department of health, and collaborative organizations) lend themselves to effective planning? Do they lend themselves to eliminating tobacco-related disparities?

- Communication processes appear to be improving at the state agency and national level
- National and state attention to eliminating health disparities has had a positive impact on addressing the issue of eliminating tobacco-related disparities
- Currently, the Division of Tobacco Prevention and Control has access to 51 primary contractors that focus on CDC's four goal areas through the implementation of CDC's Best Practices (nine components), the

Division conducts monthly conference calls, quarterly technical assistance conferences and maintains a listserv for electronic communication. These 51 primary contractors service all 67 counties within the Commonwealth and will be very instrumental in the implementation of the strategic plan.

(7) In terms of representation on our workgroup, do we have sufficient representation? If not, what groups should be either included or considered?

- Non-profit organizations such as but not limited to American Lung Association, American Cancer Association are not members of the workgroup. These organizations offer many resources, knowledge, and expertise in the area of disparities. It will be very important to include these organizations as the process continues.

(8) How strong is the health department's commitment to eliminating tobacco-related disparities?

- Very strong
- The Secretary of Health has included the elimination of disparities as one of the agency-wide goals.

(9) What are the relative strengths and weaknesses of technical expertise and access to resources in the workgroup, the department of health, and collaborative organizations?

Strengths:

- DOH – technical assistance/networking from CDC and other national organizations has significantly increased in the last two years
- PA's successes have provided opportunities to participate with other states and national organizations.
- Currently, the division has established partnerships with a variety of organizations across the Commonwealth at a statewide and grass-roots level. (approx 8 statewide and 51 grass-roots)

Weaknesses:

- Additional staff is needed to expand networking and working relationships at the state and national level

(10) Do we have access to decision-makers? Is the political savvy of the workgroup, the department of health, and collaborative organization sufficient for eliminating tobacco-related disparities? Why or why not?

- DOH Administration is knowledgeable of disparities and supportive of effectives to address this issue. The creation of Pennsylvania Alliance to Control Tobacco (PACT) through the non-profits has been beneficial in accessing decision-makes (legislators), providing advocacy training, and providing technical assistance/education

SWOT - continued

Determining external opportunities and threats

More questions will help the workgroup determine external opportunities and threats that may affect capacity to address identified population disparities (e.g., political environment, economic conditions, culture, the educational system, environmental stress/current events):

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

- Bureau of Chronic Diseases and Injury Prevention emphasizes coordinated efforts to address underlying causes of death and disability. Involvement of workgroup representatives as we identify population based disease burden and develop grants/funding opportunities/programs or technical assistance to address health disparities that may be affected by tobacco (heart disease and stroke, diabetes, oral health, asthma)
- STEPS grant – PA has applied and will implement initiatives in three counties with potential to expand annually
- Expansion of existing surveys (i.e. BRFSS)
- Implementation of new surveys (i.e. Adult Tobacco Survey)
- Strong ongoing and new partnerships who can engage the community in addressing tobacoo-related disparities (faith-based initiative)
- Additional funding opportunities by CDC to enhance the Quitline efforts by expanding outreach to populations experiencing tobacco-related disparities.
- Collaboration with other states and national partners who are working to reduce tobacco disparities.
- Train all newly-funded primary contractors how to address disparate populations.

(2) What threats might the workgroup experience during the strategic planning process?

- New partners – new ideas may distract from workgroup's mission
- Loss of leadership, turnover, burnout
- Legislative efforts to re-direct tobacco program funding.
- The tobacco industry continues to be a strong adversary , marketing its product to disparate populations and countering efforts to reduce tobacco use
- Current primary contractors contract will end April 2005 and the transition of new contractors may impede upon the implementation of the plan.

(3) What threats might exist in the State that would impact the identification and elimination of tobacco-related disparities?

- Loss of program funding
- Change of leadership that shifts the focus away from this issue
- New emerging disease prevention initiatives

(4) Describe the nature of political relationships, prevailing perspectives on tobacco use prevention, and political power in the community, State, and country. Do these present either opportunities or threats?

- States are always challenged to prove the success of tobacco prevention and control programs, especially in the short-term (1-5 years)
- PACT has become a major resource in improving political relationships at the local level, which is key to changing policy, protecting the tobacco prevention and cessation program, and changing social norms around tobacco use
- Emerging recognition by the general public of the value of smoke free policies

(5) With regard to election cycles and incumbency, are there changes in the community, State, or country that are relevant to planning or the elimination of population disparities?
- 2002 State Health Improvement Plan Special Report on the Health Status of Minorities in Pennsylvania is used to guide program planning for minority populations
- The current Secretary of Health has expressed his commitment to address health disparities
- Department of Health does not have a single focal point to coordinate minority health issues.

(6) How does the current and projected economy affect our efforts? What about standards of living?
- Budget issues may make the tobacco prevention/cessation dollars much more vulnerable

(7) What are current norms and trends that might have bearing on planning or the elimination of tobacco use disparities? Are there particular role models in the community, State, or Nation that are relevant to our effort?
- National interest in eliminating disparities continues to help PA
- Expanded partnership with CDC around disparities has been extremely helpful
- Dr. Stephen Thomas and the Center for Minority Health and their partners have become state leader in addressing health disparities
- Community-based (primary contractors) provide opportunities to identify role models

(8) What is the state of the educational system with regard to its ability to support the elimination of tobacco use disparities? What is its capacity, funding, and trends?
- The education system in PA is one of the current Governor's top priorities
- At the tobacco program level, school programs (K-12) are one of the best practice components – funding is provided at the county level
- DOH has expanded tobacco prevention and cessation programs to college level through the state system of higher education
- DOH is implementing tobacco cessation interventions into medical school curricula.
- The Youth Tobacco Survey is conducted every two years (PA has completed to surveys to date) and data is collected

(9) Are there current affairs that have implications on the planning process or its aims? How does the September 11 terrorist attack or economic recession affect them?

	• When MSA dollars were received for Tobacco Prevention and Cessation, the existing program was expanded to a division and eight new positions were created. The event of September 11th required states to address the issue of terrorism and unfilled positions were removed from the tobacco program.
Resources	American Cancer Society's *Communities of Excellence in Tobacco Control: A Community Planning Guide* *Communities of Excellence in Tobacco Control: Community Planning Guide,* California Department of Health Services, Tobacco Control Section in partnership with the American Cancer Society,2000 *HIV Prevention Community Planning: Tools for Community Planning Group Members,* Center for Community-Based Health Strategies, Academy for Educational Development, January 1999.

Appendix G

Exhibit B-4

Strategic Planning Work Group Summary Results of SWOT Analysis for Statewide Tobacco Prevention and Control

Strengths

Group 1:

- Established community Partnerships – relationships
- To do N. established credibility and respect
- Good access to data and people
- Sharing resources
- Access to funding
- History of doing outreach and services to community
- Large population base and geographic distribution
- Expertise in conducting research education and clinical services

Group 2:

- Each population represented
- Commitment
- Diversity
- Expertise
- Leadership
- Community-based
- One-stop shop
- Networking
- Existing programs in the community (Hx)
- Population "friendly" to each specific group
- Community support

Group 3:

- Connections with schools

Group 4:

- Money – strong funding
- Experience working with many special populations/ CBOs
- Trust of community served
- Hx of tobacco intervention
- Strong leadership

Appendix G continued

Weaknesses

Group 1:

- Not enough support/ no back-up
- Not an organizational priority (competing priorities)
- Community resistance
- Cultural/linguistic barrier
- Distrust of partnering with others
- Administrative hurdles
- Lack of funds
- Lack of trained staff
- High rate of turnover
- Lack of readiness
- Communication barriers
- Inability to lobby or advocate

Group 2:

- Breakdown of communication
- Everyone has their own agenda
- Staff turnover – lack of diversity
- Population may be overlooked
- Lack of appropriate use of data
- Inability to advertise
- Smokeless tobacco – not addressed
- Lack of information/ materials/ training to represent populations
- Lack of funding (equal) to certain populations
- Language barriers / cultural
- Lack of access to decision makers
- Social and cultural acceptance of tobacco use

Group 3:

- Funding cycle limits long-range planning
- Collaboration with state media campaigns

Group 4:

- Money – lack of it, lack of sustainability (better you serve, more change, less money)
- Inertia
- Trouble with political support
- Not enough programs to keep up with need (also materials – culturally competent)
- Not enough representation at the table (local decision making table)

Opportunities

Group 1:

- Existence of partnerships – interagency collaboration
- Technology – data – expertise
- Good practice models exist
- Established existing venue to promote venue
- National and state priority
- Various funding streams create larger pool for more effective strategies
- More awareness and less tolerance
- More access to education through health care providers
- More knowledge of cultural issues and norms

Group 2:

- This committee – strategic planning
- Impact on community
- Increased awareness of disparities
- Research at local and state level
- Faith-based organization
- Networking and collaboration
- Access to decision makers on state and local level
- Behavioral changes at community level
- District justices for policy violators
- Some funding
- Improve quality of life
- Reduce/ eliminate disparities
- Increase work in disparate population

Group 3:

- Reach out to organizations with experience with disparate populations
- Use existing events to reach populations directly
- Data – state can gather and share

Group 4:

- Collaborate to share information and drive change
- State-wide organization educating CBOs to advocate legislature
- Having direct contact with community served increase awareness of community need
- Having more global approach to eliminate tobacco related disparities
- To make a difference in the lives of each group represented here and not represented

Threats

Group 1:

- Funding uncertain
- Not enough current funding
- Community resistance
- Political adversity
- Administrative hurdles at various levels
- Distrust of working with others
- Lack of autonomy
- Lack of cultural competency at higher administrative levels
- Tobacco industry
- Lack of opportunity for advocacy

Group 2:

- Weight control issues
- Transportation
- Lack of medical and dental facilities
- Health programs
- Political / election
- Lack of knowledge
- Stereotyping of populations
- Lack of collaboration of agencies
- Lack of common language (urban vs. rural)

Group 3:

- Settlement funds could be used for non-tobacco purposes
- Programs may be too centralized
- Mass media not effective in some populations
- Shifting demographics – hard to get a handle on the population

Group 4:

- Funding
- Collaboration with other CBOs threatened due to competition for money
- Decision makers not addressing or acknowledging the importance of health disparities or that they exist
- Fear of retaliation