

Florida Tobacco Disparities Case Study Tobacco Prevention and Control Program

Florida Department of Health

Florida Tobacco Disparities Coordinator

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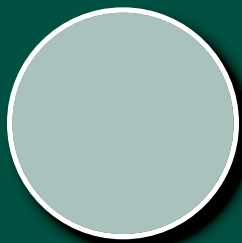
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1. OVERVIEW OF THE DISPARITIES PROJECT

1.1 Purpose and Goals of the Project

In 2006, Florida was one of 13 US States and Territories to be funded by the Centers for Disease Control and Prevention to identify disparities related to tobacco use, exposure and cessation and to develop a statewide strategic plan for reducing and eliminating tobacco-related disparities. The workgroup began the strategic planning process in January of 2007. The goals were:

1. Provide an example for the CDC's national strategic planning project
2. Create a strategic plan for identifying and eliminating tobacco-related disparities in Florida.

This case study provides a detailed description of the strategic planning process in Florida.

1.2 Overview of Tobacco Prevention and Control Activities in Florida

Florida was selected for participation in the third round of Tobacco Use Disparities trainings funded and hosted by the Centers for Disease Control and Prevention. Originally identified as the fourth goal area within CDC's Best Practices for Tobacco Control, tobacco-related disparities remain an essential component of a comprehensive, statewide tobacco control program. The identification and elimination of tobacco-related disparities work in concert with other best practice goal areas to increase programmatic efficacy and to change the social environment.

Florida's involvement in tobacco prevention efforts dates back to 1989 when the Department of Health began receiving federal funding to implement tobacco prevention and control activities. By 1997, Florida successfully settled with the tobacco industry for \$11.3 billion to recoup Medicaid costs incurred by smokers. As part of the settlement agreement, Florida launched the Tobacco Pilot Program targeting tobacco use among underage youth. Five years later, the funding for the tobacco program was cut to \$1 million at which time the program discontinued several key components of its youth tobacco program such as school-based tobacco education, youth development, and counter-marketing efforts, otherwise known as the "truth" campaign.

As the result of a 2006 ballot initiative organized by Floridians for Youth Tobacco Education, Florida voters passed a constitutional amendment requiring the Florida Legislature to fund a comprehensive, statewide tobacco education and prevention program. Annual funding constituted 15 percent of 2005 tobacco settlement payments to Florida, adjusted annually for inflation, with one-third of total annual funding being used for educational and counter-marketing mass media. The constitutional amendment required that the tobacco program conform to the 1999 Centers for Disease Control's Best Practices to target youth and other at-risk Floridians.



The Florida Department of Health's Tobacco Prevention and Control Program currently operates with a total of \$57.7 million in funding allocated from two sources: state funds (\$57 million) and the Centers for Disease Control and Prevention (\$705,000). Approximately \$10 million of the \$57 million have been allocated to the Area Health Education Centers (AHECs) to expand smoking cessation initiatives to every county in the state and tobacco prevention and cessation training to health professionals and health care practitioners.

1.3 Project Team

The Tobacco Disparities Coordinator served as the project team coordinator. Other project team members included a facilitator, epidemiologist and a community member, the Seminole County Tobacco Prevention Specialist.

1.4 Roles and Responsibilities of the Project Team Members

The project team sent for CDC training included the disparities coordinator, the tobacco epidemiologist, and the community member -- all of whom participated in the workgroup meetings in Orlando. All four team members reviewed project documents and meeting minutes.

The Tobacco Disparities Coordinator served as the project coordinator recruiting workgroup members, selecting a facilitator, organizing the work group meetings, providing materials, coordinating all communication, and processing travel reimbursement for all workgroup members. Because she had the added responsibility of taking minutes for the meeting, she was more of a participant observer during the meetings than an active participant.

The epidemiologist provided the workgroup with the data overview of the State of Florida that included sources such as the US Census, Current Population Survey, Behavioral Risk Factor Surveillance Survey, Florida Adult Tobacco Survey, and the Florida Youth Tobacco Survey.

The community member assisted in the recruitment of workgroup members, locating meeting space, and facilitating portions of the meeting.

The facilitator provided the tobacco-related disparities overview, conducted the meetings, adhered to the agenda, completed the process evaluation of the individual work group meetings, and de-briefed the project team about the meetings afterwards. Her previous experience facilitating the strategic planning process in other states helped guide the workgroup and push the group forward to complete the strategic plan in a short time frame.

2. Evaluating the Strategic Planning Processes

2.1 Purpose and goals of the evaluation

This case study will serve as a guide for other states undergoing disparities training in the future.

2.2 Evaluation design

Assessing the strategic planning process included reviewing meeting minutes, evaluation reports, agendas and project team members' notes.

2.2.1 Evaluation methods

The facilitator took the lead for developing, administering and tabulating an evaluation check list to assess the overall quality and effectiveness for all five meetings. The survey instrument (four point Likert scale) queried workgroup members about openness, participation, and productivity with additional space for comments at the end. Evaluation surveys were completed at the end of each meeting, following the same format ensuring comparability of results. The project team members along with the Tobacco Program Administrator reviewed and discussed the findings in order to make appropriate adjustments for subsequent meetings.

3. Strategic Planning Processes and Milestones

3.1 Forming the Strategic Planning Workgroup

3.1.1 Workgroup members

The constituencies represented by members of the workgroup included Hispanics/Latinos, Asians, Blacks, American Indians, low socio-economic status, LGBT and youth.

Organizations included on the workgroup:

Alachua County Health Department
Aspira of Florida
Compass Gay and Lesbian Community Center
Gay and Lesbian Community of South Florida
Florida A&M University
Florida Department of Health's Office of Minority Health
Florida Tobacco Prevention and Control Program
Hillsborough County Health Department
JCW Research and Evaluation Group, Inc.
Marion County Health Department
National Cancer Institute's Cancer Information Service - FAMU
Nriya India Dance Academy
University of Florida
Wakulla County Health Department



3.1.2 Workgroup Roles and Responsibilities

Workgroup members were asked to commit to all five all-day meetings conducted monthly from January to May, 2007 in Orlando, FL and to work collaboratively to create a strategic plan for addressing tobacco-related disparities among populations in Florida. Most of the work was completed during the meetings; however, members were asked to review other states' strategic plans, workgroup responsibilities and the data presentation beforehand. Those who were unable to attend the first meeting would be assigned a "mentor" among members present who would subsequently update them.

Workgroup members agreed to remain active after the strategic planning process ended and to meet three times per year to market the implementation of the plan.

3.1.3 Recruitment

Prior to the CDC Tobacco-Related Disparities training, the Disparities Coordinator took the initiative to hold conference calls with potential workgroup members who worked for the state. In the first training, the project team learned that CDC wanted states "to think outside the box" and recruit members from the community and other agencies. The project team learned that the workgroup would have a stronger stake in the process and outcomes if a wider variety of representatives from populations who experience health disparities were included.

Every effort was made to recruit workgroup members associated with populations at disproportionate risk for tobacco-related disparities. Our Disparities Coordinator began recruiting workgroup members from the tobacco program's former Diversity Workgroup. She worked from this list to contact potential recruits over the phone followed by a letter formally inviting them to participate. CDC recommended that she contact the national tobacco networks for the priority populations for whom she did not have a contact. The national networks, in turn, attempted to provide a contact within Florida. Additionally, the community member of the project team assisted the Disparities Coordinator in her search for representative workgroup members among Hispanics, Asians and Haitians.

Florida had a particularly short time line for completing the strategic planning process, which was originally slated for completion in four months. Subsequently, a fifth meeting was added at the last minute at the State's expense. This impacted the time available for pursuing suggested leads for additional constituent representation. During the first workgroup meeting, members volunteered to find constituents representing persons with disabilities, prisoners, straight-to-work and trade school populations, blue and pink collar workers. However, if the person recommended could not attend the second meeting, he/she could not participate as a workgroup member.

3.1.4. Member involvement

Prior to the first meeting, the facilitator sent all members a letter introducing herself, providing a brief overview of the process, meeting dates, and first meeting agenda.

The facilitator felt strongly that if members were going to commit to the group they must attend the second meeting at which the data would be presented; otherwise, the member would be asked to recommend a replacement. Total persons present for any given meeting ranged from 14 to 18, including project staff.

At the outset of the first meeting, the facilitator assisted members to develop the workgroup's ground rules, which included silencing all electronic devices, honoring time, respecting one another's opinions, limiting distractions and following professional meeting etiquette. The group decided that a 60% majority of those in attendance would constitute a majority vote.

The facilitator personally followed-up with workgroup members who missed a meeting or who decided that they could no longer participate. She provided feedback to the rest of the workgroup on that particular person's status to keep all informed. However, the group agreed that those who were not in attendance at a particular meeting would not have their opinions or votes included.

Participation in the strategic planning meetings was completely voluntary. Financially, Florida could not provide any additional incentives for participation aside from travel reimbursement (hotel, airline, mileage) and per diem. Government agencies are prohibited from purchasing food, so neither meals nor coffee could be paid by the state and delivered to the hotel conference room. Consequently, members were on their own for lunch, availing themselves of the restaurants in and around the conference hotel. Because most people left the hotel grounds for lunch, many returned late impinging on the relatively short meeting time.

Although all the meetings were purposely held in a centralized location (Orlando, FL), meeting location still impacted workgroup members' attendance. Flights were delayed or cancelled. Several persons traveling by car were delayed by Orlando's considerable commuter traffic.

3.1.5 Workgroup conduct

Based on their individual comments, evaluation results and participant observation, the workgroup appeared eager and cohesive from the beginning. In the first two meetings, no single person monopolized the group discussion and participants reported feeling comfortable expressing their view and concerns. The members all agreed that the group as a whole demonstrated a high level of interest in the meeting proceedings. "Let's roll up our sleeves and get to work at the next meeting!" one member commented. "I feel like the members are passionate and I love it!" said another.

However, by meeting three in which the group was tasked with developing goals and strategies based on the data presentation, differences between group members emerged. In a particularly heated exchange, one member became impatient with a lengthy discussion on evaluation and began to challenge the professional opinion of another group member. The conflict that arose did not advance the planning process by bringing new issues to light, but rather ground the entire discussion to a halt. The unwillingness of the instigator to accommodate another viewpoint disrupted the spirit of mutual respect and tolerance cultivated by workgroup members to that point. When the workgroup broke for lunch, the two persons both left the meeting for the day (the instigator chose not to attend subsequent meetings).

After lunch the facilitator again reviewed the ground rules, which served to diffuse a potentially explosive situation among the remaining members. Once the group had achieved consensus on which goal areas would be included in the strategic plan, the facilitator broke the workgroup into three smaller task groups to work on strategies for (1) prevention and education, (2) capacity building, and (3), funding and sustainability. Members who volunteered to be in one of the small groups helped write goal statements and develop strategies. In this way, the facilitator renewed participation and interest by valuing and respecting members' insight and expertise.

Key to the whole strategic planning process was the perception that each member made a valuable contribution to the workgroup. As a result, members felt personally invested in the outcome and as a result passions ran high regarding the goal areas for the strategic plan. Because the facilitator kept the focus on the higher purpose of the meeting, the workgroup did not dissolve into competing self-interests. Some of the conflict and tension could have been ameliorated had the workgroup had more time for discussion instead of having to move quickly from one agenda item to the next. Despite the tension and conflict, members consistently reported that they respected the process and felt productive after each meeting. The facilitator actively worked to keep the group on task and build consensus.

3.2 Identifying and prioritizing groups at disproportionate risk for tobacco-related disparities

3.2.1. Collection and analysis of data on disparities

At the second meeting the Epidemiologist provided the overview of tobacco use in Florida along with important demographic information from the US Census. Although Florida benefits from a wealth of data sources that include tobacco, none of these sources provides the necessary depth to address the subpopulations of interest to the work group. The Epidemiologist attempted to show how tobacco affects certain populations beyond smoking prevalence and identify gaps in data collection.

Clearly there are many subpopulations about which we know little in Florida. Inferred risk comes from national rates or research literature indicating high risk or disproportionate use (e.g., American Indians, LGBT). In order to determine a relative increase, the Epidemiologist explained that the group needed to use some sort of benchmark. In this case, she proposed using the average rate for all Floridians combined as a measure against which other groups could be assessed.

In the next 25 years, data from the U.S. Census indicate that Florida is poised to surpass New York in population size, thereby becoming the third largest state in the nation. The 2000 census showed that Florida exceeded the national averages for persons ages 65 and older, of Latino/Hispanic race, of Black/African-American race, and with a disability. Florida also has a greater proportion of persons who speak a language other than English at home than other states. Although we have significant subpopulations in Florida such as Haitians, persons who identify as LGBT, and migrant and seasonal workers, we presently lack the resources to capture state-specific survey data.

The sharpest decline in youth smoking occurred between 1998 and 2001 during the height of the funding for youth tobacco prevention. Although rates continued to decline from 2002 to 2005, these reductions have been less dramatic among both middle and high school students. As of 2006, Florida had exceeded the Healthy People 2010 goal for high school smoking with a current prevalence of 15.3%. However, the trend among youth was not reflected among adults where nearly one out of every five currently smokes cigarettes.

3.2.2. Identifying critical issues from the data presentation

Using data from the Florida Adult Tobacco Survey, overall smoking prevalence in Florida appears lower than for the national US average.

Groups for whom the trend in tobacco use is NOT declining include:

- **Persons with less than a high school diploma**
- **Persons who are 18 to 44 years old**
- **Persons without health insurance**
- **Men**

Tobacco use is highest among:

- **Men (significantly higher than women regardless of race/ethnicity)**
- **Persons with total household incomes below \$50,000**
- **Persons with less than a high school diploma**
- **18 to 24 year olds (highest smoking prevalence of any age group)**
- **Non-Hispanic Whites**

The workgroup agreed that the Florida Tobacco Prevention Program must continue to broaden and to strengthen data collection efforts in order to keep pace with the shifting diversity in our state. The Epidemiologist suggested that gaps in data collection might be redressed using qualitative data collection methods or by adding questions to existing surveys.

3.2.2. Identifying critical issues from population assessments

The group reviewed strategic plans from three other states, looking particularly at their data goals and strategies/objectives. During the second meeting, the workgroup decided to formulate a data goal and to outline four strategies to achieve that goal.

Goal: Increase and enhance data and information related to specific populations

Strategy 1. Use traditional and non-traditional methods of collecting community level data.



Strategy 2. Prioritize data gathering among specific groups: communities with Black, Hispanic/Latino and Asian populations; and, LGBT communities.

Strategy 3. Begin the process of engaging American Indian tribes and organizations to develop data gathering strategies.

Strategy 4. Develop partnerships with other states and with county agencies, organizations and institutions to facilitate data gathering.

As a corollary to developing the data goal and strategies, the group emphasized the need to include members from those communities in the data collection and dissemination process. They developed a set of overarching guiding principles to inform the planning process:

- 1.) Specific population groups will participate in all levels of strategic planning and data collection initiatives**
- 2.) All data collection methods will be culturally competent and appropriate**
- 3.) We acknowledge the negative language of disparities and the different ways in which communities may define themselves**

3.3 Developing the strategic plan

3.3.1 Identification and prioritization of critical issues

Following the presentation and discussion of the populations at highest risk for tobacco use, the workgroup expressed concern over creating a strategic plan before having reliable data on the populations of interest. Consequently, the workgroup decided to move ahead knowing that redressing data gaps would be a priority in the first year of the plan's implementation.

The workgroup brainstormed 11 goal areas that were subsequently reduced to three by a vote using the 60% consensus rule. Workgroup members broke into smaller groups for each of the three (capacity building, interventions and awareness) in order to write goal statements and to create strategies. After a lunch break the three break out groups reconvened to work on three more goal areas (prevention, data and information, and funding and sustainability). For each of the six goal areas, the break out groups generated at least three strategies for achieving each.

Goals for the strategic plan:

- 1.) Increase the awareness of tobacco-related issues of specific populations**
- 2.) Facilitate the development of infrastructures so that communities can create their own tobacco prevention and control programs**
- 3.) Increase and enhance data and information related to specific populations**
- 4.) Identify and secure funding to sustain programs for the reduction and elimination of tobacco-related disparities**
- 5.) Identify, develop and implement culturally competent interventions targeting tobacco use, exposure to secondhand smoke and tobacco policies for specific populations**

6.) Develop and implement tobacco prevention strategies for specific populations.

Although the workgroup formulated the goals and attendant strategies in short order, deciding the form they should take sparked considerable debate. Perhaps feeling the pressure of the short time frame, members argued passionately about which goal areas they felt were appropriate to include in the strategic plan. As the facilitator noted in her meeting summary, group members were exceptionally engaged in the process and as a result the discussion became combative at times. There was not time enough to address the issues causing tension and achieve consensus on the direction of the plan.

3.3.3. Developing action steps to support the implementation of the strategic plan

In order to maximize the precious face-to-face meeting time, the facilitator sent out action step charts on which members could review and comment for purposes of developing the Year One Implementation Plan. Upon re-convening in the fourth meeting, the facilitator once again reviewed the strategies and then broke the group into three smaller groups to work on three sets of actions steps in the morning and the next three in the afternoon. The workgroup understood that implementing the strategic plan would require being realistic about how many action steps could be accomplished the first year, particularly the first quarter. The facilitator took the completed action steps charts generated for each of the six strategies, combining them into a single document for review before the fifth and final meeting. During the fifth meeting, the members re-evaluated and refined their action steps in order to match a more realistic first year implementation timeline.

3.3.4. Developing a marketing plan and safeguarding the strategic plan

Again members broke into three smaller workgroups to develop marketing plans for the following audiences:

- 1) Florida Department of Health and the Tobacco Advisory Council**
- 2) American Heart Association, American Cancer Society, American Lung Association, the Area Health Education Councils, Legislators and other elected officials**
- 3) Florida Association of City and County Health Officials and the Florida Public Health Association**

The workgroup decided that the Disparities Coordinator would be responsible for writing the strategic plan that would span three years, starting in fiscal year 2008. Everyone present agreed to be part of the monitoring process and to meet three times a year to review the strategic plan's implementation. Conference calls would be scheduled as needed between meetings.

4. Major Assets For Strategic Planning

4.1 Factors facilitating planning processes

Preparatory steps: Without the grant provided by CDC, the Florida Tobacco Prevention and Control Program would have been unable to undertake the strategic planning process. The funding permitted Florida to hire a facilitator, to reimburse workgroup members' travel expenses, and to pay for hotel meeting space.

CDC training: The CDC training itself provided our program team with the fundamentals of understanding, defining and addressing tobacco-related disparities. The training helped to clarify members' roles, the scope of work and the process by which the work would get done.

Leadership: Florida was fortunate enough to have a full-time Disparities Coordinator to lead and coordinate the disparities strategic planning process. Having a facilitator well acquainted with disparities strategic planning was essential to keeping the group on task and moving forward.

Dedicated members: Florida was fortunate to have a group of highly committed individuals, all of whom took time away from their jobs to devote to the strategic planning process.

Ownership: Although implicit in the process, the strategic planning outcomes are not predetermined by the state, CDC or any other entity. Having control and ownership over the final goals was essential to keeping the members engaged in the planning process.

In their evaluation forms completed after each meeting, members made the following comments on the planning process:

- **I feel like I am leaving satisfied**
- **Great facilitation**
- **I think we finally know what we're doing and are flowing as a workgroup**
- **Great process**
- **It was great to have CDC representatives present**
- **I learned a lot!**

5. Challenges To Strategic Planning

5.1 Challenges to successful planning: steps 1-5

Under-representation: A consistent theme throughout the planning process was the lack of representation from groups whom the workgroup members felt strongly should be present. Despite the vigorous effort to recruit members, the workgroup lacked representation from blue/pink collar occupations, military, Haitians, and disabled, to name a few. Without persons who could represent these interests, the resulting strategic plan would be limited in its inclusivity. Moreover, workgroup members needed more lead time to develop the relationships needed to locate prospective recruits than the one month between the first and second meetings.

Staff limitations: Another major obstacle was the demand on tobacco project staff time from both every day work responsibilities coupled with the additional work demands stemming from the constitutional amendment. The Disparities Coordinator could not reasonably expect to participate in the meeting and take meeting minutes simultaneously. The Tobacco Prevention and Control Program like most state tobacco programs was already over-taxed and understaffed in completing routine, work much less handling additional work duties. Additional administrative assistance with meeting planning logistics, note-taking and travel reimbursement would be beneficial.

Resolving conflict: The conflict that arose during the planning process could not be adequately addressed in the timeframe allotted. As a result, the evaluations reflected the feeling that conflicts were not resolved to the satisfaction of the parties involved. The workgroup needed more time.

Attendance: Attendance fluctuated slightly from month to month based on scheduling conflicts and the meeting location (Orlando), although the solution may be to rotate the meetings around the state to equalize the burden of traveling. On the other hand, some members appreciated the consistency in the meeting space. If possible, members should appoint an alternate in the event they may be absent.

Being “outed”: One of the project team members was approached by a few women interested in joining the workgroup representing the LGBT community. One woman in particular had recently begun a new job and worried about the repercussions of disclosing her sexual orientation to her new employer if she were to join the workgroup.

Strategies to overcoming challenges

Having an experienced facilitator was the most critical factor to Florida’s success in completing the strategic planning process. However, time was still a major issue because the Florida group only had five meetings in which to complete the entire process. If a free meeting space had been found, roughly \$5,000 would have been saved and possibly funded an additional workgroup meeting. The fifth meeting was added only at the last minute, using Florida Department of Health funds.

With highly invested and hardworking members, emotions can run high at times. Having more time to bond at the outset of the process might have helped ameliorate some of the animosity that arose. Furthermore, reviewing the ground rules at the beginning of every meeting would serve to reinforce appropriate meeting behavior.

Again, the workgroup discussed the issue of recruiting additional members from important population groups as they prepared to conclude the final meeting. The members volunteered to recruit from eleven more population groups during the first year of implementation.

CONCLUSION

In the future, states may reconsider the inclusion of the epidemiologist on the project team as Wisconsin did. After the initial data presentation that included US Census data, the group decided to focus upon collecting further data on persons with Caribbean ancestry, LGBT and Asians. One of the difficulties of identifying tobacco-related disparities is the inability to move past disparities as necessarily defined by non-white race and ethnicity. In Florida, tobacco use is greater among men, Whites, low income, and low education.

At the same time the tobacco-related disparities workgroup convened to develop the strategic plan, the Florida Legislative session commenced to debate the fate of the tobacco constitutional amendment. This served as the backdrop against which the strategic planning took place. The Florida Senate Health Care Subcommittee was tasked with writing the implementing language determining the direction and manner of the tobacco amendment funding. The legislature made clear that Florida Department of Health was in no way guaranteed to be the managing entity for the funding and began holding hearings to entertain possible alternatives.

Operating against a backdrop of uncertainty, the tobacco disparities workgroup moved forward with developing its strategic plan. The tobacco program staff had to manage the demands of meeting legislative requests and preparing for contingencies with completing routine work demands.

An effective tobacco prevention and control program coordinates programs, activities, policy efforts, and partnerships at the state level. With the 2007 update to CDC's Best Practices, community interventions (formerly known as community programs) should be tailored to address tobacco-related disparities through education and training programs, mass media campaigns, policy adoption, and surveillance and evaluation outcomes.

5.2 Strategies to Overcome Challenges

The CDC training provided a much needed overview of how the strategic planning process works.

Strategies for sustaining regular attendance:

- **Meet at regularly scheduled intervals (no longer than a month between meetings)**
- **Maintain email and/or phone contact with members between meetings**
- **Make all materials available prior to the meetings**
- **Follow up with members who were absent to keep them involved**
- **Rotate the meeting location to share the burden of traveling**
- **Provide meals, sugar, and caffeine**

6. CONCLUSIONS

6.1 Major planning accomplishments

- **Recruitment and maintenance of a highly committed and knowledgeable workgroup**
- **Process evaluation administered at the end of every workgroup meeting**
- **A completed draft of the tobacco strategic plan with six goals and accompanying strategies and action steps**
- **A completed marketing plan with identified leads, communication channels, intended audience(s) and benchmark measures.**

6.2 Lessons learned

Priority populations: Recruitment of disparate population members takes considerable time. Members cannot be expected to find constituent representatives in a month.

Uncertain expectations: As the Florida workgroup met, the fate of the tobacco program was being decided by the legislature. Program staff could not guarantee the certainty of funding for implementation and marketing upon the strategic plan's completion. No one wanted the workgroup to feel as though their hard work would be overlooked or ignored.

Data quandary: Florida has an abundance of tobacco use, exposure and cessation data. From the perspective of the Epidemiologist, even presenting data related to the demographic characteristics of Florida and smoking use can take too much valuable meeting time and bores the audience. The epidemiologist should give careful consideration about which kinds of data are presented and the detail in which it will be presented.

Timeline: Although hardly optimal, the Florida experience demonstrates that with dedicated workgroup members and an experienced facilitator that a strategic plan can be created in a relatively short span of time (five months).

6.3 Recommendations to enhance future strategic planning

- 1.) **Hire a seasoned facilitator well-acquainted with the tobacco-disparities strategic planning process**
- 2.) **If possible, have a tobacco staff person dedicated to tobacco-related disparities**
- 3.) **Out of respect for members' time, adhere to a strict meeting schedule.**
- 4.) **Provide all materials ahead of time**
- 5.) **Provide longer lead time if members are to identify and recruit representatives from priority population**
- 6.) **Take the time before each meeting to review the ground rules for meeting behavior.**
- 7.) **Begin with an ice breaker activity to ease tension and provide another opportunity for interaction**
- 8.) **Minimize distractions to the extent possible (e.g., fire alarm drills, temperature, noise, side conversations)**
- 9.) **Find free meeting space so that the CDC grant money can go towards additional meetings and not a hotel.**

Appendix 1: National Tobacco Networks

National African American Tobacco Prevention Network

www.naatpn.org

National Association of African Americans for Positive Imagery

www.naaapi.org

National Latino Council on Alcohol and Tobacco Prevention

www.nlcatp.org

Asian Pacific Partners for Empowerment and Leadership

www.appealforcommunities.org

National Coalition for LGBT Health

www.lgbthealth.net

National Tribal Tobacco Prevention Network

www.tobaccoprevention.net

National Network on Tobacco Prevention and Poverty

www.nntpp.org

Additional Information

Tobacco Intervention Strategies and Initiatives

- **Implementing the Tobacco Prevention and Control Program according to CDC's Best Practices;**
- **Launching a statewide mass media campaign to address smoking initiation, smoking cessation and secondhand smoke exposure;**
- **Developing community-based tobacco prevention and control partnerships to promote tobacco-free norms;**
- **Developing a strategic plan to reduce tobacco related disparities;**
- **Supporting youth advocacy activities to promote smoke-free policies and local ordinances and**
- **Promoting the 1-888 Florida Quit-for-Life Line to assist smokers who want to quit.**

Expanding tobacco surveillance and evaluation activities that include the administration of the Florida Youth and Adult Tobacco Surveys.

Enacted by Section 381.84 of the Florida Statutes, s.27, Art. X of the State Constitution mandates

funding of a comprehensive, statewide tobacco education and prevention program consistent with the Centers for Disease Control and Prevention's 1999 Best Practices for Comprehensive Tobacco Control Programs. The Florida Legislature determined that the primary goals of the program are to reduce the prevalence of tobacco use among youth, adults and pregnant women; reduce per capita tobacco consumption; and, reduce exposure to environmental tobacco smoke. In order to achieve the goals outlined by the Legislature, the program will contain the following components: counter-marketing and advertising; cessation programs, counseling and treatment; local community-based programming; and surveillance and evaluation.

The Department will conduct an independent evaluation of the statewide tobacco use prevention and control program under 2(c) of this amendment. The purpose of this evaluation is to ensure that state resources devoted to tobacco education and cessation have been efficiently allocated to maximize the outcomes in preventing and reducing tobacco use among youth, adults and pregnant women.

Footnote:

We subsequently received guidance that the BRFSS smoking prevalence estimate should be used rather than the FLATS smoking prevalence. Florida, like many other states that employ the two surveys, consistently reports a lower smoking estimate in FLATS than the BRFSS. Because the national BRFSS is used to report smoking in the US as a whole, we will use the Florida BRFSS to report smoking prevalence in order to ensure comparability.

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