

**Case Study Analysis of State Readiness and Capacity:  
Smoking Cessation for People with a Disability**

BY ADRIANE K. GRIFFEN

BS, BA, The George Washington University, Washington, DC, 1996

MPH, The George Washington University, Washington, DC, 1998

DISSERTATION

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**Dissertation Committee**

Kristina Risley, Chair, Community Health Sciences

Michael H. Fox, Associate Director for Science, National Center on Birth Defects and Developmental Disabilities, Division of Human Development and Disabilities, Centers for Disease Control and Prevention

Michael Petros, Environmental and Occupational Health Sciences

Eve C. Pinsker, Community Health Sciences

Christina R. Welter, Community Health Sciences

To my family—my wonderful husband Joe, my “mini-me” son Luc, my sister Alexandra, and Mom. Thank you for your love and support!

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## Abbreviations and Keywords

ACA	Affordable Care Act
ACS	American Community Survey
ADA	Americans with Disability Act
BRFSS	Behavioral Risk Factor Surveillance System
CoP	Community of Practice
LEND	Leadership Education in Neurodevelopmental and Related Disabilities
NACCHO	National Association of County and City Health Officials
NCBDDD	National Center on Birth Defects and Developmental Disabilities
NHIS	National Health Interview Survey
PWD	People with Disability
PCA	Personal Care Assistant
UCEDD	University Center of Excellence in Developmental Disabilities
WHO ICF	World Health Organization's (WHO) International Classification of Functioning (ICF)

## **Summary**

The smoking disparity issue for people living with a disability (PWD) served as an area to examine the concept of including PWD as a demographic in public health efforts. A seven-month case study utilized seven data sources to explore readiness, capacity building, and capacity factors of how Ohio has included PWD in public health efforts, such as smoking cessation. Action research was conducted with a Community of Practice (CoP) to examine the factors needed for public health practitioners to include PWD in state public health efforts. The CoP developed 10 practical action steps for including PWD in public health efforts overall. This study identified 14 readiness, capacity building, and capacity factors that make a state system ready to include PWD in public health efforts, with nine factors being critical.

The CoP experience enhanced 11 factors of readiness, capacity building, and capacity, including the critical factors to include PWD in public health efforts. The CoP offered systematic reflection as a professional development opportunity for leaders at all levels, while emphasizing facilitation as a public health leadership skill. This use of a CoP in public health, along with the essential conditions that must be present as identified by this study, may be a way for leaders to enhance critical reflection and contribute to evidence-based practice.

Including PWD is an important charge for public health professionals to show courage to include everyone living in the community in their efforts. The findings of this study clarify the essential readiness, capacity building, and capacity elements and serve as a framework on how public health practitioners may move forward.



## **I. Background and Problem Statement**

### **A. Study Objectives**

The public health system serves everyone. As a public good, it serves many demographics and allows Americans to live healthy, safe lives. Equitable access and opportunity to experience program and service benefits is an ideal for the public system (Turnock, 2001). People with a disability (PWD) comprise up to 30 percent of the US population (Oreskovich and Zimmerman, 2012) when applying a broad, functional definition of disability. Often public health planners do not see PWD as a demographic or a target audience of their efforts (Iezzoni, 2011), as they often have very little exposure to this demographic group during graduate training (Lollar and Andresen, 2011). However, disability may be considered a major demographic and not merely a negative health outcome (Iezzoni, 2011; Walker, 2011; Alberico and Griffen, 2015). Public health efforts do not always include PWD, even in areas where they experience the most severe disparities, such as emergency preparedness, obesity, diabetes, or smoking. This study examined the factors of readiness, capacity building, and capacity through a case study of a state that already includes PWD in its smoking cessation efforts. The relationship between the constructs of readiness and capacity is dynamic and has a critical intermediary step of capacity building. Understanding the relationship between readiness and capacity building assists with implementation of the change or actually demonstrating the capacity. A facilitated CoP in a case study state offers a unique way to examine these factors of readiness, capacity building, and capacity. In the case of Ohio, available evidence suggests that this state is already demonstrating capacity to include PWD in public health efforts, such as smoking cessation efforts. Therefore, one may hypothesize that this state has already built capacity and attained a certain degree of

readiness for this change of including include PWD in public health efforts, such as smoking cessation.

The smoking disparity issue for PWD is an appropriate area in which to examine the concept of including PWD in public health program design. Public health planners long have viewed smoking and tobacco use as a key public health priority; the *systems change* is to include PWD in these efforts. Smoking cessation offers a lens through which to examine how to include PWD as a demographic in public health efforts. The main proposition is to include PWD anytime a public health planner conceptualizes or designs an effort. A systematic approach with coordinated leadership is needed to include PWD as a demographic in public health practice in a routine manner.

Several studies over the past 15 years report that PWD smoke at least 50% more than people without disabilities (Armour, 2007; Becker, 2008; Borelli, 2013; Brawarsky, 2002; CDC , 2012a; CDC, 2014a; CDC, 2015b; Courtney-Long *et al*, 2014; Drum *et al*, 2009; Hall *et al*, 2013; Mitra *et al*, 2012; US DHHS, 2005; US DHHS, 2012; US DHHS, 2014). In 2012, data from the Behavioral Risk Factor Surveillance System (BRFSS) showed the disparity worsening (CDC, 2012a). More recent estimates continue to show higher cigarette smoking among people with a disability (25%) than among those with no disability (19%) (CDC, 2015d). Regardless of the data source or definition of disability that is applied, the smoking rate remains one of the most significant health disparities for PWD.

States do not consistently collect data on smoking cessation among PWD (Bailey, 2014, personal communication; North American Quitline Consortium, 2009). State-based data may guide future research, programs, and services that can effectively improve health for PWD. States like Ohio that collect data on smoking cessation among PWD have done so by collaborating with partners and making the request of state Quitlines.<sup>1</sup> States which have smaller Quitline operators—such as Ohio, which has National Jewish Health as its Quitline operator—have been more open to include measures to assess smoking rates among PWD (Bailey, 2014, personal communication; National Jewish Health, 2014). There is no national standard for states to collect this data.

Nationally, the Centers for Disease Control and Prevention (CDC), National Center on Birth Defects and Developmental Disabilities (NCBDDD) is a leader in the inclusion of PWD in public health efforts. The Division of Human Development and Disability at this Center currently funds 18 states to develop focused programs on including PWD in public health efforts. Within the priority areas for the currently funded states, smoking is just one example of a health promotion effort that the states may opt to include in their efforts to include PWD in public health efforts (CDC, 2012b). Few state examples of smoking cessation efforts that include PWD are beginning to emerge beyond those in Ohio, including Illinois, Michigan, and New Hampshire (CDC, 2014c.)

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<sup>1</sup> Quitlines are telephone-based tobacco cessation services that help tobacco users quit. Services offered by quitlines include coaching and counseling, referrals, mailed materials, training to healthcare providers, Web-based services and, in some instances, free medications such as nicotine replacement therapy (North American Quitline Consortium, 2010).

This study examined the factors of readiness, capacity building, and capacity present in Ohio. Ohio demonstrated how to include PWD in smoking cessation efforts as a state that secured funding, conducted a needs assessment, and collected data on smoking rates among PWD on smoking. The investigator retrospectively identified these factors that supported Ohio's efforts to include PWD in smoking cessation efforts in 2013 and 2014. A participatory action research design involving a Community of Practice (CoP) prospectively developed recommendations for other states to reach PWD through their public health efforts, and a learning agenda with a supporting action plan to encourage the partners in Ohio to continue collaboration beyond the life of their current CDC grant.<sup>2</sup> The investigator acted as the facilitator of this CoP.

This study has capacity building applications for state and national organizations to address the public health needs of PWD. The findings work toward achieving the public health capacity to serve unreached populations at risk for health disparities.

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<sup>2</sup> Ohio's CDC grant currently ends in June 2016. A competitive application allowed a one-year continuation. (CDC, 2015).

## **B. Background and Context**

The CDC estimates about one in five Americans is a person who has a disability (2012, 2015b). Some public health surveys show up to 30 percent experience a disability, depending on how the survey defines disability (Altman and Bernstein, 2008; Oreskovich and Zimmerman, 2012). Disability may be present from birth or acquired, visible or not visible, identified or not identified. Disability may be experienced anywhere on a spectrum from mild to severe functional limitations (Altman and Bernstein, 2008). People with a disability (PWD) are part of every community, as people may develop a disability at any time in their life, especially as a natural part of the aging process (Brault, 2012; Scommegna, 2013). PWD are more likely to have health issues, including chronic conditions related to being overweight and physically inactive, such as obesity, diabetes, and heart disease (CDC, 2014a; CDC, 2015b), as well as a much higher prevalence of smoking (Armour *et al*, 2007; Borelli *et al*, 2013; CDC 2015b). Additionally, PWD are less likely to report that they receive recommended preventive screening, including mammograms and colorectal cancer screening, or dental care in the past year (CDC, 2011; CDC, 2015b). At the same time, people with disabilities survive and live full lives due to medical treatment advances and benefits from public health approaches tailored to their unique needs across the lifespan (Borrelli, *et al* 2014; Courtney-Long, *et al* 2014; Drum, *et al*; 2009, Hall, *et al* 2013; Lee, *et al* 2014; Mitra, *et al* 2012; US DHHS, 2005). The current public health system does not completely meet the needs of this segment of the US population.

Public health practitioners do not consistently view the disability segment of the US population as a target demographic of their efforts due to a lack of education and awareness (Lollar and Andresen, 2011). This is a shortcoming of the public health system (Drum *et al*,

2009; Krahn *et al*, 2015). A recent survey of 159 local health departments (LHDs) (NACCHO, 2014b) indicates that LHDs do not intentionally exclude PWD from their activities, but many are unaware of the prevalence rates of PWD in their jurisdictions with only 47.8% being “aware/very aware” of the number of people with disabilities in their jurisdictions. PWD may not be seen as a specific demographic group with unique health promotion concerns (Devereux and Bullock, 2011). This lack of perception that PWD are a target population for public health services is a gap that practitioners must address to fully include PWD in programs.

Given the landmark recognition of civil rights for PWD with the passage of the Americans with Disabilities Act (ADA), access to public health programs and services may also be viewed as a civil right (Public law, 1990). These public health and civil rights relate to the application of *Health in All Policies* (ASTHO, 2013), as policymaking across all sectors influences health and has the potential to improve the health of all communities, including PWD. When one views public health as the science and art of preventing disease, prolonging life and promoting health and efficiency through an organized community effort (Winslow, 1920), it presents a potential dichotomy for PWD. Some have viewed the public health system as a tool to prevent the existence of PWD, rather than a tool to promote the health of PWD (Lollar and Crews, 2003). Historically, PWD have not been considered as a demographic typically included in public health programs (U.S. Department of Health and Human Services, 2000; U.S. Department of Health and Human Services, 2005), rather disability has been viewed as a negative health outcome that should be prevented (U.S. Department of Health and Human Services, 2008; Lollar and Crews, 2003). The Surgeon General’s Call to Action to Improve the Health of Persons with Disabilities (2005), and the Healthy People 2010 (U.S. Department of

Health and Human Services, 2000) approach to disability as an important demographic, make it clear that specific public health promotion strategies tailored to the needs of PWD is a growing national priority.

Cigarette smoking is one of the most significant health disparities for PWD. It offers a frame for the current investigation of how state public health systems may become ready and able to include PWD as a demographic. Despite overall population declines in cigarette smoking, PWD still smoke more than people without disabilities (CDC, 2012a; CDC 2014a; CDC 2015b). Public health programs address smoking cessation for the 42.1 million Americans who smoke (CDC, 2014b) and regularly include people with mental illness (National Association of State Mental Health Program Directors, 2010), but not other types of disabilities (Borelli *et al*, 2013; Borelli *et al*, 2014). Over 54 million Americans have a disability (Altman and Bernstein, 2008) and smoke at a significantly higher rate (CDC, 2014a; CDC, 2014b; CDC, 2014c). Ironically, if advised by a physician, PWD are more likely to make a quit attempt (Armour *et al*, 2007). Proven population-level interventions, such as Quitlines, smoke-free laws, and mass media campaigns, are not reaching PWD as widely as the general public (Armour *et al*, 2007; Hall, *et al* 2013).

Although the data on this smoking disparity among PWD varies, all data sources indicate significantly higher rates among PWD than those without disabilities. Several studies report that PWD smoke at least 50% more than people without disabilities (CDC, 2014a; CDC, 2014b; CDC, 2014c; Becker and Brown, 2008; Borrelli, *et al* 2014; Brawarsky, 2002; Courtney-Long, *et al* 2014; Drum, *et al*; 2009, Hall, *et al* 2013; Mitra, *et al* 2012). In 2012, the Behavioral Risk

Factor Surveillance System (BRFSS) showed a worsening disparity (CDC, 2012a). Estimates from the 2013 National Health Interview Survey (NHIS) using the American Community Survey (ACS) disability status questions showed cigarette smoking was higher among PWD (23%) than among those with no disability (17%) (CDC 2014c). Current estimates show that cigarette smoking remains higher among PWD (25%) than among those with no disability (19%) (CDC 2015d).

Opportunities to include PWD in public health efforts exist at national and state levels. The Centers for Disease Control and Prevention (CDC) offers strategies to involve PWD in public health. These strategies are inclusion in public health organizations' programs, policies, and communications for specific issues, like physical access to health care services, physical activity, and emergency preparedness (CDC, 2013). The National Association of County and City Health Officials (NACCHO) has also recently shared strategies for including PWD in health department plans, programs and services (2014a). Viewing disability as a demographic (CDC, 2013; Dixon-Ibarra and Horner-Johnson, 2014; US DHHS, 2005; Borelli, 2010; Walker, 2011; Lollar and Andresen, 2011), it is essential for the public health system to craft tobacco programs for PWD as they are living full lives and need approaches tailored to their unique needs (Hall, *et al* 2013; CDC, 2013; Steinberg, 2009; US DHHS, 2005; Lee, 2014). Approaches based on these unique needs have included adaptation of evidence-based treatments for underserved smokers (Borelli, 2010; Borrelli, *et al* 2014). For example, the cessation strategies suggested for PWD need to be adapted for the functional limitation. Changes in a daily routine may be more difficult for a person with a disability who may work with a personal care attendant (PCA) in their own



home or a residential home for adults with disabilities.<sup>3</sup> Many of these PCAs may also smoke or use other forms of tobacco, thus adding another layer to how smoking cessation strategies must be tailored for PWD (Moorhouse, 2011).

PWD experience many health disparities. Public health practitioners are starting to begin to see PWD as a target audience for specific disparity efforts (Krahn, 2015; NACCHO, 2014a; Alberico and Griffen, 2015). The first CDC Disability and Health Program, which focused on preventing primary disabilities and secondary conditions, was established in 1989. This program shifted focus to preventing secondary conditions and promoting health of people with disabilities in 2000. By 2007, CDC funded 16 State Implementation Projects for Preventing Secondary Conditions and Promoting the Health of People with Disabilities (State Disability and Health Grantees). In 2012, this CDC program invested in 18 State Disability and Health Grantees (CDC, 2012 b). This investigation furthers how PWD could be more widely recognized as a target audience for public health efforts. No other current study has examined how a Community of Practice can establish PWD as a demographic in public health programs, such as smoking cessation efforts.

Ohio has demonstrated inclusion of PWD in smoking cessation efforts through a collaboration of key organizations involved in its CDC grant, specifically the Department of Health, the two University Centers for Excellence in Disabilities in Ohio (Ohio State and University of Cincinnati), and smoking cessation programs (Quitline). These organizations have

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<sup>3</sup> Personal care attendants (PCAs) care for and assist clients with housekeeping tasks, activities of daily living like bathing, organizing a client's schedule, and food preparation, as well as shop for personal items and groceries (Bureau of Labor Statistics, 2014).

also collaborated through the Tobacco Free Ohio Alliance,<sup>4</sup> in essence as a community of practice. They worked together to establish data collection to capture the smoking rates among PWD in Ohio, outreach to PWD, and trained Department of Health staff on how to work with PWD. These organizations collaborate with diverse partners, including advocates, and interests through the Alliance's subcommittee on disparities. Table 1, *Ohio's Disability and Public Health Partnership Timeline*, describes how this community of practice integrated PWD into Quitline efforts with the CDC grant as a catalyst. Table 2, *Tobacco Free Ohio Alliance Partner Interest by Partners Involved in Including PWD in Smoking Cessation*, shows a wide range of complimentary partner interests among this community of practice.

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<sup>4</sup> The Tobacco Free Ohio Alliance is an association of Ohio agencies, organizations, groups and individuals with a commitment to work to prevent the use of tobacco products and to educate Ohioans about the harmful effects of tobacco use and second-hand smoke exposure on all citizens. Alliance members share information on policy, funding, legal and educational issues relating to tobacco use prevention and cessation.

**Table 1. Ohio's Disability and Public Health Partnership Timeline**

<b>2012</b>	
<p>Ohio awarded CDC grant: Establishes OH Disability and Health Program (ODHP), which includes a partnership of the following organizations:</p> <ul style="list-style-type: none"> <li>• Department of Health <ul style="list-style-type: none"> <li>-Bureau for Children with Developmental and Special Health Needs</li> </ul> </li> <li>• University Centers for Excellence in Disabilities in Ohio <ul style="list-style-type: none"> <li>-Ohio State (grant lead)</li> <li>-University of Cincinnati</li> </ul> </li> </ul> <p>The following organizations serve supporting roles:</p> <ul style="list-style-type: none"> <li>• Ohio Colleges of Medicine Government Resource Center</li> <li>• Disability Community Planning Group</li> </ul>	
<b>2013</b>	<b>2014</b>
<p>ODHP conducted Needs Assessment, showing smoking disparity among PWD in OH was the highest disparity in the US</p> <p>Collaboration with Tobacco Use Prevention and Cessation Program (TUPCP) at Ohio Department of Health</p> <p>Reached out to Ohio Tobacco Quitline</p> <p><u>August 2013</u>: Disability identifier added to Quitline intake to monitor utilization by PWD</p>	<p>PWD are a demographic in OH's Quitline intake process</p> <p>ODHP and TUPCP collaborating on promotional materials targeting PWD</p> <p>Fact sheet and social media targeting PWD</p> <p>Focus groups on effective marketing for PWD and subgroups</p> <p>ODHP joins Tobacco Free Ohio Alliance -disparities subgroup</p>

(Publicly Available Document Data Sources: ODHP website (<http://nisonger.osu.edu/odhp>); *Combating Smoking Disparities among Those with and without Disabilities: Using Data to Drive Policy Change*, APHA poster presentation, November 2014; ODHP Needs Assessment; ODHP Collaboration Proposal with OH Department of Health's Tobacco Use Prevention and Cessation Program; CDC grant RFA, 2012; CDC Grantees Orientation Call, July 2012; Yang, personal communication 2014.)

**Table 2: Tobacco Free Ohio Alliance Partner Interest by Partners Involved in Including PWD in Smoking Cessation**

Partners Involved in Inclusion of PWD	Range of Partner Interests						
	Advocacy	Disability program specialist	Community engagement/ programs	Data experts/ epidemiologists	Families	Public Health Practitioners	Health Providers
Department of Health (CDC grant partner)			x	x		x	X
UCEDD – Ohio State (CDC grant lead)	x	x	x	x	x	x	X
UCEDD – University of Cincinnati	x	x	x	x	x	x	X
Ohio Quitline			x			x	

(Publicly Available Document Data Sources: Tobacco Free Ohio Alliance Partner Roster, 2015; Yang, 2015, personal communication).

Ohio’s CDC grant activities aim to improve health outcomes for PWD through focused efforts at the intersection of disability and public health. Ohio conducted a needs assessment in year 1 of their CDC grant, which revealed the high disparity rates of smoking among PWD as compared to those without disabilities. This needs assessment found the smoking rate disparity between people with and without disabilities in Ohio was 17.3%. This was the highest such smoking disparity in the US at the time. This led to the inclusion of tobacco use in Ohio’s efforts to make health promotion more accessible to PWD (Yang, 2015, personal communication). Two other partners affiliated with Ohio State support these efforts: 1. The Ohio Colleges of Medicine Government Resource Center, a public university-based center for health policy, research, and technical assistance that seeks to promote health system transformation, and 2. The Disability Community Planning Group, which is a coalition of over 80 organizations that provides guidance and input for all project activities.

## **C. Problem Statement and Research Questions**

### Dissertation Problem Statement:

People with a disability (PWD) experience significant health disparities. Current data show that PWD smoke more than the general public. Previous studies suggest the promotion of Quitlines and other population-level interventions as specific strategies to reach PWD with smoking cessation efforts. However, these proven population-level interventions do not reach PWD as widely as the general public (Armour *et al*, 2007; Hall, *et al* 2013). Often, public health practitioners do not consider PWD a demographic in the development and delivery of state and national initiatives. As a result, PWD continue to face increasing disparities in health, as compared with those who do not have disabilities. Some states are meeting the public health needs of PWD more effectively than other states.

### **Research Questions**

1. What are the factors that make a state system ready to include PWD as a demographic?
  - What are the process steps that a state system can take to become ready?
  - What are the capacity supports that help make a state system ready?
2. How does partner participation in a community of practice foster the capacity of state systems to include PWD as a demographic in public health efforts?
  - What are the factors that support state capacity to address demographic groups that experience health disparities, such as smoking among PWD?

#### **D. Leadership and Practice Significance**

This study assessed readiness and capacity factors that enabled one state, Ohio, to successfully integrate PWD into its efforts to address the high smoking rates among the citizens in the state. The findings from this study have implications for other states working to integrate PWD into their public health efforts.

Viewing disability as a demographic allows public health practitioners to address similar risk factors among PWD, such as functional limitations of trouble concentrating, in program design and message development. This will help to improve the quality of public health programs for whole communities, including PWD. Public health is for everyone.

There is an unrealized opportunity for public health leaders at a state and national level to initiate and facilitate a strategy to plan accessible public health services, such as smoking cessation services for PWD. This opportunity involves public health practitioners being aware of PWD and having the capacity to incorporate PWD into ongoing smoking cessation efforts, as well as general public health promotion activities. Healthy People 2020 emphasizes the need for public health promotion activities to include PWD (US DHHS, 2010), yet health campaigns are less likely to target them (Armour *et al*, 2007; Courtney-Long *et al*, 2014; Iezzoni, 2000; Mitra *et al*, 2012; US DHHS, 2005). Given that this smoking disparity for PWD has been documented for over 15 years without a systematic, coordinated programmatic response to include PWD in smoking cessation efforts, public health leaders must create a sense of urgency (Kotter, 2012) to address this issue. This will ensure that that public health practitioners view PWD as a

demographic worthy of attention and that PWD receive services from the public health system as any member of the general public would and in accordance with the Americans with Disabilities Act (Public law, 1990) and ASTHO's *Health in All Policies* (2013). PWD need to be able to participate fully in public health services offered to all Americans. Tailored health promotion efforts that target PWD are needed (Brawarsky *et al*, 2002; Becker and Brown, 2008; Courtney-Long *et al*, 2014; Hall *et al*, 2013; Havercamp *et al*, 2004; Iezzoni, 2000; Mitra *et al*, 2012; Steinberg, 2009; Lee, 2014; US DHHS, 2005). Access to tailored smoking cessation efforts for PWD is an example of this need.

Although several previous studies share strategies to reach PWD, no national programmatic efforts actually conduct and evaluate smoking cessation efforts for PWD. Only a few states that received CDC funding dedicated to health promotion for PWD focus on tobacco programming, as this was one of several priority areas for this particular grant (CDC, 2012b). This presents a national and state leadership opportunity to emphasize reaching PWD in all areas of health promotion, especially the many areas in which they experience a health disparity.

The various definitions that public health surveys currently use to describe PWD make it difficult for public health leaders to understand clearly who may be included as a PWD. This variation in how surveys define disability is a major limitation in making public health programming and related materials accessible for PWD. It is difficult to include a particular target audience when one does not know exactly who is included in that audience as based on the existing data. In order to define disability more completely as a demographic, public health practitioners must consider similarities and differences among PWD. Public health practitioners

may not be able to include PWD easily in smoking cessation efforts due to the various definitions of disability that national surveys and research efforts use. A uniform disability definition across population surveillance efforts would improve disability statistic and inclusive program efforts. With the implementation of the Affordable Care Act (ACA), data collection standards are now required in US Department of Health and Human Services surveys (2011). These newly implemented data standards, coupled with viewing public health as a public good and the provisions of the Americans with Disabilities Act, offer an exciting opportunity. This opportunity is to create public health programming, such as smoking cessation, that is accessible to PWD as a demographic. Concentrated attention from practitioners is needed to improve public health opportunities for PWD (Peacock *et al*, 2015). It is important to consider disability as a general population demographic for effective public health programs that will be accessible to everyone.

Knowing more about the strategies that Ohio is using to highlight PWD as a demographic for public health efforts will be critical in positioning PWD as a target for future public health efforts. Utilizing a Community of Practice (CoP) is still a novel concept in public health settings; its application will assist in reflection and identifying the factors of readiness, capacity building, and capacity that have benefited Ohio. This investigation offers the partners in Ohio the opportunity to reflect critically on what they have done well in terms of including PWD, as well as continuing their collaborations beyond the current CDC grant cycle. This represents a peer leadership opportunity, as the recommendations on reaching PWD produced through this CoP in Ohio will have wide application to other states.



The partners in Ohio may be able to utilize this CoP to continue to collaborate and make progress in Ohio through the learning agenda and action plan that were developed as part of this effort. This process helped to renew the partner commitment to include PWD in ongoing public health efforts.

Findings of this study have applications for building the capacity of state and national organizations to address the public health needs of PWD, as well as enhancing the capacity of these organizations to serve unreached populations at risk for health disparities. This is especially relevant as a leadership issue as these populations are simply not visible to public health practitioners. The findings of this effort will help to position PWD as a demographic for public health.

## **II. Conceptual and Analytic Framework**

### **A. Literature Review**

The literature has noted that PWD smoke about 50% more than general public for over 15 years, and recent data shows that PWD are still smoking at higher rates than the general public (CDC, 2014; CDC, 2015b). The current literature review did not find data on inclusion of PWD in smoking prevention efforts. Available data on cigarette smoking was identified; therefore, this investigation focused on how state public health systems may become ready and able to include adults with disability in smoking cessation efforts.

Since no one definition of disability exists, a functional definition is often applied in public health efforts, in which PWD are categorized based on their level of function or ability. The most common functional disability type is a mobility limitation, followed by disability in thinking and/or memory, independent living, vision, and self-care (CDC, 2015b). There is variation of smoking prevalence across these subgroups of the disability population. PWD need cessation efforts tailored according to their disability characteristics, including level of function or ability (Krahn *et al*, 2014, 2014; Krahn *et al*, 2015; Jarrett and Pignataro, 2013).

A recent study utilizing National Health Interview Survey (NHIS) data showed that the prevalence of current smoking for young adults (ages 18-49) was higher for every functional disability type than for adults without a disability (Courtney-Long *et al*, 2014). These disability types were based on six questions identifying functional types of disability from the American Community Survey (ACS) and included: hearing, vision (even when wearing glasses), cognitive

(concentrating, remembering, or making decisions), or ambulatory (walking or climbing stairs); or any limitation with the following: self-care (dressing or bathing) or independent living (e.g., running errands or visiting a doctor's office). The prevalence of smoking was highest among adults who reported a cognitive limitation. Overall men with a disability were more likely to report being a smoker than women; however, when cognitive limitation was the functional disability, women smoked more. Adults who were unemployed or unable to work smoked more. This study helps to paint a picture of the segment of the disability population for whom the smoking disparity is likely worse.

This finding of a higher smoking prevalence among adults with a cognitive limitation is in keeping with findings of college health assessment (Jarrett and Pignataro, 2013), which also found higher smoking rates among students with learning disabilities. Functional disability surveys classify learning disabilities under the category of a cognitive limitation.

Other studies also show that unemployed PWD are more likely to have higher rates of smoking (Wolf *et al*, 2008; Fitzmaurice, 2011). However, a survey of directors at Centers for Independent Living (CIL) estimates that more people with physical disabilities are smoking (33.2%), rather than cognitive disabilities (16.0%) or sensory disabilities (11.2%). According to this CIL survey, about 32% of people with mental health disabilities smoke (Moorhouse, 2011). It may be a combination of conditions, from having different co-occurring disabilities to a lack of opportunities to work, that influence the increased smoking prevalence for PWD.

Many PWD do not work and miss exposure to the current work place culture, which does not allow smoking in the work place (Becker and Brown, 2008; Courtney-Long, 2014). In addition, many residential homes for adults with disabilities do not operate under the current smoke-free workplace ban, as personal care assistants (PCAs) often smoke. Thus, this environment fosters a social norm of smoking (Steinberg, 2009). Tobacco use among PWD adds another stigma in our society as PWD are already marginalized and smoking is socially unacceptable (Lee, 2014; Steinberg, 2009; Wolf *et al*, 2008).

#### *Smoking cessation programming needs for people with a disability*

Despite the high smoking prevalence and potential strategies for reaching PWD suggested by previous studies (Armour *et al*, 2007; CDC, 2013; Becker and Brown, 2008; Borrelli, 2010; Brawarsky *et al*, 2002; Courtney-Long *et al*, 2014; Dixon-Ibarra and Horner-Johnson, 2014; Hall *et al*, 2013; Iezzoni, 2000; Lee, 2014; Mitra *et al*, 2013; Steinberg, 2009; Wolf *et al*, 2008; US DHHS, 2005; US DHHS, 2010) few efforts have examined smoking cessation programming needs for people with a disability. Although quitting regimens are often part of health treatment for people with mental illness (National Association of State Mental Health Program Directors, 2010), people with other disabilities are typically not included. Smoking cessation efforts for all types of disabilities is a critical need as PWD overall have a higher smoking prevalence and many PWD have multiple functional needs due to co-occurring disabilities (Krahn *et al*, 2015; CDC 2015b). Previous studies suggest promotion of Quitlines, Internet, social media, and home-based interventions as specific strategies to reach PWD with smoking cessation efforts (Armour *et al*, 2007; Borrelli, *et al* 2014; Hall *et al*, 2013). Outreach to PWD to use existing mechanisms like Quitline and other quitting resources are needed as resources are often underutilized.

Many Centers for Independent Living (CIL) recognize this need to reach PWD with smoking cessation efforts, yet do not feel adequately prepared to deliver smoking cessation efforts tailored for PWD (Moorhouse, 2011). Health providers may also serve as messengers to PWD as they screen PWD for smoking status and refer to accessible, effective cessation services (Becker and Brown, 2008; Mitra *et al*, 2013).

This lack of preparation and awareness contributes to a lack of smoking cessation efforts, which vary across subgroups of PWD. For example, health providers ask people with mobility impairments less often about their tobacco use than people without any impairment (Iezzoni, 2000), even though they risk exacerbating disability-related medical concerns with tobacco use and exposure (Borrelli, et al 2014; Lee, 2014; Steinberg, 2009). Culturally competent tobacco programs for PWD have also been shown to be critically important (Horner-Johnson and Dobbertin 2014; Horner-Johnson *et al*, 2014). For example, minorities with mobility limitations are less likely to use nicotine replacement therapy than non-Hispanic Whites (Borrelli, et al 2014). Being both a person with a disability and a member of an underserved racial or ethnic group often means worse health care and prevention efforts (Wolf *et al*, 2008; Horner-Johnson and Dobbertin 2014; Horner-Johnson *et al*, 2014). PWD are often not able to participate fully in preventive services (Pharr and Bungum, 2012).

Often motivated to quit smoking, PWD underutilize cessation treatment options (Steinberg, 2009). Adults with more severe disabilities who need assistance in handling routine needs or personal care are more likely to be planning to quit (Brawarsky and Brooks, 2013). People with

mobility impairments have high rates of unassisted quit attempts and low use of psychosocial treatments (Borrelli, 2013).

In summary, a limited number of studies have explored smoking cessation approaches for different types of disabilities. Recognition of the smoking disparity among PWD is still emerging and many professionals do not feel adequately prepared to address the smoking cessation needs of PWD. Smoking cessation efforts tailored for all types of functional disabilities remain a critical need. Prevalence of current smoking for adults is higher for every functional disability type than for adults without a disability (Courtney-Long *et al*, 2014). This literature review identified several studies that show that people with mobility limitations, cognitive issues, personal care needs, and minorities that experience a disability, have a higher smoking prevalence. Factors such as the various definitions of disability, available data sources, and co-occurring disability conditions contribute to limited number of studies examining smoking among PWD.

#### *Data on disability and cigarette smoking*

There are challenges when examining data on disability and cigarette smoking. Few data sources examine the cigarette smoking disparity for PWD. Publicly available data sources on cigarette smoking and disability include the National Health Interview Study and the CDC's Disability and Health Data System (DHDS). The 2009–2011 National Health Interview Study (NHIS) uses six questions identifying functional types of disability from the American Community Survey, which defines disability as functional limitations that affect a person's

participation in activities. A person is considered to have a disability if he or she, or a proxy respondent, answers affirmatively to having at least one of six serious limitations. These disability types are not mutually exclusive as respondents could have more than one type of disability. The six categories of disability were used collectively and individually in the NHIS to define disability and in examining the association between current smoking and disability.

Two questions were used in NHIS to assess smoking status. These questions are: 1) Have you smoked at least 100 cigarettes in your entire life? and 2) Do you now smoke cigarettes every day, some days, or not at all? Current smokers were defined as smoking at least 100 cigarettes during their lifetime and who currently smoke every day or some days.

The CDC's DHDS also assesses the association between current smoking and disability, with the Behavioral Risk Factor Surveillance System (BRFSS) as the data source. Disability is determined using the following two BFRSS questions: "Are you limited in any way in any activities because of physical, mental or emotional problems?" and "Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?" Respondents were defined as having a disability if they answered 'Yes' to either of these questions. Respondents were defined as not having a disability if they answered No to both questions. These questions are consistent with measures in Healthy People 2020 (US DHHS, 2010). To examine cigarette smoking status, respondents were asked: "Have you smoked at least 100 cigarettes in your entire life?" and "Do you now smoke cigarettes every day, some days, or not at all?" Responses were grouped into three categories: *Current Smoker*, *Former Smoker*, and *Never Smoker*. Respondents who reported smoking at least 100 cigarettes

in their lifetime and who, at the time of survey, smoked either every day or some days were defined as Current Smoker. Respondents who reported smoking at least 100 cigarettes in their lifetime and who, at the time of the survey, did not smoke at all were defined as *Former Smoker*. Respondents who reported never having smoked 100 cigarettes were defined as *Never Smoker*.

DHDS offers state profiles based on BRFSS data. This helps to create a map of what states may have higher prevalence of people living with a disability who smoke. Table 3 shows the top 20 states with the highest prevalence of smoking by disability status (CDC, 2012c).

<b><i>Table 3: Prevalence of Smoking by Disability Status-Top 20 States, CDC DHDS State Profiles</i></b>	
1. Kentucky	11. Louisiana
2. Arkansas	12. Alabama
3. West Virginia	13. Indiana
4. Ohio	14. Iowa
5. Tennessee	15. Maine
6. Missouri	16. North Dakota
7. Michigan	17. South Dakota
8. Pennsylvania	18. Oregon
9. Mississippi	19. Nebraska
10. Oklahoma	20. Massachusetts

Public health practitioners may use this geographic information to develop further an audience profile for creating accessible smoking cessation efforts, which PWD may easily attain and use. Similarities among the states identified, such as more rural areas or areas with a lower socioeconomic status, would be important factors to keep in mind when designing smoking cessation efforts. In Ohio, the disability prevalence varied by county, with the highest prevalence in Appalachian counties (Yang *et al*, 2013). Therefore, public health practitioners need to tailor smoking cessation efforts to reach PWD in these areas.



For public health programming to have the greatest benefit for PWD, it is necessary to focus on broad functional definition of disability, rather than specific disabilities or a medical diagnosis. Public health practitioners may use this functional approach to distinguish people living with a disability as a demographic or target audience, which shares broad characteristics, based on how the individual is able to function. For example, people with cognitive limitations, such as concentrating, remembering, or making decisions, have been shown to have a higher prevalence of smoking (Courtney-Long *et al*, 2014). These cognitive limitations relate to how a person is able to function. This cognitive disability functional definition serves as a broad category for many different types of disabilities, such as: intellectual and developmental disabilities; autism spectrum disorders; severe, persistent mental illness; brain injury; stroke; Alzheimer's disease; and other dementias (Braddock, 2013). When public health planners design efforts with cues on how to remember an action step, they strengthen program capacity to serve PWD, as well as anyone in the public who may need to access this information.

In addition to the American Community Survey (ACS) and Behavioral Risk Factor Surveillance System (BRFSS) definitions of disability, the World Health Organization's (WHO) International Classification of Functioning (ICF) framework (WHO, 2011) serves as an example of moving toward a functional approach to examining disability. The WHO ICF framework (WHO, 2011) gives a broad framework for measuring health and disability at both individual and population levels. Health conditions (illness, disease, disorder, injury or trauma), body structures (physical parts of the body), body functions (how body parts and systems work), functional limitations (difficulties completing a variety of basic or complex activities that are associated

with a health problem), activity (doing a task or action), activity limitations (difficulties a person may have in doing activities), participation (being involved in a life situation and fully participating in society), participation restrictions (problems a person may have in life situations), environmental factors (things in the environment that affect a person's life), and personal factors (age, gender, social status, and life experiences) are components of the ICF framework. This broad functional basis includes people with developmental, acquired, health-related, and aging-related disabilities, which may result in an inclusive lifespan approach to public health programs.

#### *Functional approach to disability*

Although different definitions of disability are used across the WHO's ICF, the ACS, and BRFSS, all share a functional approach to describing disability. Therefore, it is important for public health programs to take a similar functional approach when tailoring smoking cessation efforts for groups of PWD with shared characteristics. Functional limitations require specific adaptations regardless of the particular disability that a person may happen to have. Therefore, functional limitations are ultimately more helpful to consider rather than the specific disability or medical diagnosis.

This highlights the need for government data sets to use more consistent parameters when describing disability and related levels of function. With the implementation of the Affordable Care Act (ACA), data collection standards are required and have been designated in US Department of Health and Human Services surveys as: deafness or serious difficulty in hearing, blindness or serious difficulty in seeing, serious difficulty in concentrating, remembering, or

making decisions because of a physical, mental, or emotional condition, serious difficulty walking or climbing stairs, difficulty dressing or bathing, and difficulty doing errands alone (e.g. visiting a doctor's office or shopping) (HHS, 2011). This standardization of data collection assists public health practitioners in knowing the functional needs of PWD in their communities.

This functional approach aligns with the strategy of the Division of Human Development and Disability at CDC's National Center on Birth Defects and Developmental Disabilities, which promotes the inclusion of people with disabilities in programs for the general public wherever possible, the use of cross-disability strategies for issues unique to people with disabilities where necessary, and the use of condition-specific approaches where essential (Krahn *et al*, 2014). CDC defines disability inclusion as the inclusion of PWD in everyday activities and encouraging them to have roles similar to their peers who do not have a disability (2015c). Disability inclusion allows for PWD to take advantage of the benefits of the same health promotion and prevention activities experienced by people who do not have a disability.

### *Public health program design*

When public health practitioners design programs—like Quitline counseling and educational materials—with the needs of PWD in mind, these programs serve everyone better. Considering public health as a good available to all Americans, public health programs designed with the needs of PWD in mind may be thought of as an industry standard. This inclusive program design standard may be applied whether the target audience is a PWD or not, as many who have a disability and functional limitations may not be recognized through current disability surveys. For example, public health practitioners may use low literacy approaches, with

accompanying graphics, to help anyone—regardless of their level of function—be better able to remember and understand details regarding complex medical conditions. This application of universal design principles (Rickerson, 2009) to public health programming is critical to make resources usable by all.

### *Opportunity to shift to action*

A previous study suggested a social marketing approach for reaching health professionals to deliver smoking cessation messages to PWD (Becker and Brown, 2008). However, social marketing remains an unutilized strategy to position PWD as a target audience worthy of attention of the public health system. The application of a social marketing strategy to address the smoking disparity for PWD may be a critical shift toward the inclusion of PWD as target audience for public health efforts. Social marketing strategies are widely used in public health settings to be able to design and deliver health promotion efforts for particular target audiences and may hold promise for inclusive programs for PWD (Gordon *et al*, 2006; Lee and Kotter, 2011; Andreason, 2006; Weinreich, 1999).

The field of public health has an opportunity to transition from study of health disparities for PWD to action that includes PWD in public health programs. Recent efforts recommend workforce capacity building and the explicit inclusion of PWD in public health efforts as broad strategies for taking this action (Krahn *et al*, 2015). An examination of how a state-level Community of Practice includes PWD in smoking cessation efforts offers practical strategies on

the specifics of how to carry this action forward toward inclusion of PWD in public health practice.

### *Community of Practice in Ohio*

The Ohio Disability and Health Program (ODHP) and the Tobacco Free Ohio Alliance has acted as a Community of Practice, with the Department of Health, the two state University Centers on Disabilities, Ohio Colleges of Medicine Government Resource Center, Disability Community Planning Group, and the state Quitline, as members that viewed PWD as a target audience. A Community of Practice (CoP) is a group of people who share a concern, a set of problems, or an interest in a topic, and who enhance their knowledge and expertise in this area by interacting on an ongoing basis (Wenger *et al*, 2002). The CoP framework is a leadership tool to unite people in a common enterprise who share values, beliefs, and interest in a topic (Wenger *et al*, 2002; Drath and Palus, 1994; Maybery, 2012). Leaders may be involved in a CoP in various roles that involve some level of practice or shared activity to create shared knowledge and shared approaches. These various roles may be analogous to performing a musical composition. Each member of the CoP may play a different role that will complement other members of the CoP. Truly, members of a CoP collaborate musically. This study deliberately invites members of the Ohio CoP to a “stage” to examine exactly how each member and organization contributes to the effort to include PWD in public health programs, such as smoking cessation.

A “champion” is akin to the lead vocalist or musician and is centrally involved in the CoP

and aggressively supports the development of the community by providing guidance, visibility, legitimacy, funds, or other means of support to enable the CoP to achieve results. Typically, champions push for communities to thrive and apply innovative approaches. In the case of Ohio, one may view the champions as the Department of Health and the two state University Centers on Disabilities. A “sponsor” is akin to a backup vocalist or musician and is a willing participant in the CoP that is less central to the development and may not provide the same level of time, attention, and resources as a sponsor, such as the Quitline in Ohio. The CoP benefits from both types of leaders. With a CoP approach, all members contribute to the leadership of the community rather than just one individual. This allows the CoP to be nimble and exist both within an organization and across organizational boundaries.

Portions of the community members are typically “peripheral” and do not actively participate and may just be “listening,” in keeping with the music analogy. These peripheral activities are an essential dimension of communities of practice (Wenger *et al*, 2002). These members may watch the interaction of core and active members, while gaining insights through observation. In Ohio, a peripheral group may be the Disability Community Planning Group.

Community members often move through the levels of participation (core group champions, active sponsors, and peripheral members) depending on availability and interest. The range of Ohio’s Disability and Health Program partner interests within the Tobacco Free Ohio Alliance (Table 1) exemplifies the flexibility of a CoP to include different organizations at different degrees of participation.

Just as musicians may play a particular instrument, CoPs typically have three key elements or “instruments:” 1. *Domain*—the shared interest that provides the incentive and passion for the group to come together, 2. *Community*—the group of people who come together with a common interest, who share their perspectives and knowledge with one another, and 3. *Practice*—the agreed upon ways of formalizing and implementing the collectively developed knowledge and solutions that further the community’s mission. With the case of Ohio, the CoP domain would be an interest in disability and smoking cessation, while the community may be the four organizations that have been involved in the efforts to include PWD in smoking cessation programs and the practice may be the creation of a set of recommendations for other states, as well as a learning agenda to support further collaboration.

People may initiate a CoP for different strategic intents across different teams or locations. This is similar to a group of musicians determining which song they will play with their instruments. Four main strategic intents of “songs” of a CoP are: 1. Solve every day work problems, 2. Develop and disseminate best practices, 3. Develop and steward tools, insights, and approaches needed by colleagues in the field, and 4. Develop highly innovative solutions and ideas. The size of a CoP may vary depending on the purpose of the CoP. The challenge is to make the group large enough to allow new ideas and people, but narrow enough that members will remain interested in the topic. The key community issue is finding people who already network on the topic and helping them to imagine how increased networking and knowledge sharing could be valuable. As the community gets started, the topic needs to be of genuine

interest to all CoP members and align with the organizational priorities overall.

Similar to how a group of musicians may perform a series of songs together in a concert, there are five stages of CoP development: potential, coalescing, maturing, stewardship, and transformation. Each CoP may vary and reach its potential and a different stage, not necessarily in this sequential order. *Stage 1, Potential*, focuses on the discovery that others are passionate about a topic, can contribute data or tools, and that valuable insights can be learned. Imagining where this potential may lead the CoP is a critical component of this stage. *Stage 2, Coalescing*, focuses on officially launching the CoP through hosting community events and activities that allow members to build relationships, trust, and an awareness of common interests and needs (Wenger *et al*, 2002). The CoP needs to see the value in sharing knowledge on a topic of interest, and may begin to commit to a shared learning agenda that motivates contribution to efforts of the community. During *Stage 3, Maturing*, the CoP clarifies the focus, role, and boundaries of how newcomers may be involved as sponsors and/or champions. The CoP's learning agenda continually evolves at this stage. *Stage 4, Stewardship*, focuses on sustaining a mature community and its members, while allowing for new ideas and approaches. *Stage 5, Transformation*, focuses on negotiating the CoP's boundaries so that the topic of interest and approaches are still relevant for the members.

With the case of Ohio, the CoP domain would be an interest in disability and smoking cessation, while the strategic intent may be to develop highly innovative solutions and ideas needed by the field of public health through recommendations for including PWD. CoP members would be the four key members of the Disability and Health Program, who have already



demonstrated progress in including PWD in smoking cessation efforts. These very partners may be able thoughtfully consider the readiness, capacity building and capacity factors that enabled them to be successful, culminating with *Stage 2 Coalescing*. Most importantly, these Ohio partners will put forward recommendations on how other states may be able to include PWD and continuing their own commitment to collaborate through a jointly created learning agenda and action plan.

The CoP model outlines a dynamic framework that may be utilized across organizational boundaries to share knowledge on issues of mutual interest. This model does not describe in detail how to facilitate the conversations, which must take place at each stage of the CoP. It does not tell the members of the CoP what “song” they should play together. The notion is that a series of questions or productive inquiries will generate useful information sharing (Saint-Onge and Wallace, 2003). This productive inquiry helps a CoP generate and create knowledge. Examples of productive inquiry questions are ones that spark discussion, such as: *How do I...?*, *Who else does this...?* *What am I missing here...?*

How one poses these questions is very powerful in terms of engaging group discussion. With a strength-based, affirmative approach, the conversation can be generative and valuable to those involved. Appreciative Inquiry (AI) is a strength-based method of positive questions, which shift the conversation and reflection toward stories of moments when groups and teams were doing their very best work together (Cooperrider and Whitney 2005; Whitney *et al* 2004). These stories may then serve as a basis for analysis and discovery of the core success factors that the group already possesses. This process of discovery is the first phase of AI and focuses on

engaging stakeholders to encourage them to articulate their strengths and best practices. The second AI phase is thinking about what might be and creating a clear results-oriented vision or the dream. The next AI phase, design, focuses on creating and co-constructing the ideal collaboration, which draws from the strengths of the group. The final AI phase is called destiny and explores how to best empower, learn, and adjust ongoing efforts so that momentum may be sustained. The proposed study will utilize all phases of AI style questions to develop the conversation or “song” of the CoP.

The focused conversation Technology of Participation (ToP) method (2000) may serve as a means to facilitate discussions of a CoP as the conversation develops. The ToP focused conversation method follows a natural process of a conversation with the elements slowed down to help the participants connect with the meaning of what is being said and other participants in the conversation. The focused conversation method follows a series of questions that are reflective of a rational aim or practical goal of the conversation and an experiential aim or the mood and tone of communication among the participants. Four series of questions are asked: 1) *Objective* level questions, which elicit facts and data on the topic, 2) *Reflective* level questions that acknowledge emotions and imagination, 3) *Interpretive* level questions that elicit sharing of experiences to identify options and possibilities, and 4) *Decisional* level questions to engage collective opinions on what future actions may be on the topic. These levels of questions allow a facilitator to ask questions that provide an environment for collective thinking to take place within a limited amount of time.

“Well-facilitated, member-driven, and highly participative CoPs are valuable tools for fostering collaboration essential to improving the public health system, and should be used more broadly across public health” (Maybery, 2012). One may view the CoP as a leadership tool to examine what Ohio is doing well, so that other states may replicate their efforts to include PWD in public health efforts. One must consider the challenges associated with the changes necessary at the state level to adopt such inclusive public health programming. Readiness, capacity building, and capacity factors may all influence the shift to more inclusive programs.

### *Readiness, Capacity Building and Capacity Factors*

In order to create the change necessary for enhanced capacity, one must be prepared through a series of readiness factors, which in turn lead to capacity building opportunities. These capacity building opportunities then ultimately lead to realizing the actual capacity. Readiness for change, capacity building, and demonstrating capacity takes place on an organizational as well as an individual level. A facilitated CoP in a case study state offers a unique way to examine these factors of readiness and capacity building, which ultimately lead to capacity. In the case of Ohio, available evidence suggests that this state is already demonstrating capacity to include PWD in public health efforts, such as smoking cessation efforts. Therefore, one may hypothesize that this state has already built capacity and attained a certain degree of readiness for this change.

There are many different terms and ambiguous concepts currently used in the literature to describe readiness for change. Readiness is multidimensional and different models place different emphasis on different supporting factors (Stevens, 2013). Six key factors of readiness

for change among individuals and organizations are evident across the literature: 1. recognition of need to coordinate, 2. contact with other organizations working in this area, 3. understanding the work of other organizations in this area, 4. positive perception of other organizations, 5. commitment to change (adoption of short-term tests and institutionalization of long-term tests), and 6. mutually shared goals, values and interests with other organizations.

In order to increase readiness, organizations and individuals must recognize the need and have an awareness of the issues (Holt, 2007; Edwards *et al*, 2000). Knowing more about the issues and having awareness may allow initial actions to take shape through outreach to other interested groups.

This realization of the need to coordinate leads to contact with other organizations working in the issue area (Edwards *et al*, 2000). This contact allows the individuals working the organizations to introduce new information about the issue through presentations, discussions, and meetings, which leads to an understanding of the scope of work others perform in this area.

The understanding of others work is critical as it goes beyond a cursory contact with others into knowledge of what the groups each do separately and possibly together. Understanding of the work of others is an important step in gathering information to form concrete ideas and action steps to address the issue (Edwards *et al*, 2000).

Understanding of the work of others in the area will often lead to a positive perception of these other organizations and emotional readiness to try to work together on a change effort (Bouckenooghe *et al*, 2009). The positive perception of others in the issue area is a key contextual factor that will help to establish a relationship in the future if the interaction is positive (Weiner *et al*, 2009; Weiner, 2009). Past interactions with others that have been positive are likely to influence positively the way individuals perceive whether the change will really deliver the possible benefits.

An important factor of readiness is the intent to change (Weiner, 2009; Castañeda *et al*, 2012). A series of short-term and long-term tests to determine which strategy is most effective is a demonstration of commitment to change. It takes a combination of support at director and the staff levels to commit to change (Lehman, 2002). These series of tests allow for the individuals and organizations to experiment with innovative approaches and ideas.

The new ideas and strategies must be a good fit with the goals, values and interests of the organizations involved to increase the likelihood of goes from a readiness state to an implementation state of demonstrating capacity (Weiner *et al*, 2009). The concept is that the better the fit of the idea with the goals and values, the more likely that the idea will lead to a strategy that is adopted and implemented.

There is some confusion in the literature on where readiness ends, where capacity building starts, where capacity building ends, and where the attainment of actual capacity begins.

Some research does not include the concept of capacity building, but rather directly connects readiness for change with capacity. CDC broadly defines capacity building as “technical assistance, training, information sharing, technology transfer, materials development, or funding that enables an organization to better serve customers or to operate in a more comprehensive, responsive, and effective manner (2000).” Capacity building may be defined as a series of relationships (Labonte and Laverback, 2001a; 2001b) involving a combination of activities of practical experience, continuing education, engagement in a network (formal or informal), and systematic reflection (McLean *et al*, 2005).

The literature identifies practical experiential training and ongoing continuing education, tailored to the needs of the professional and the community served, more readily (Cooper, 2007; Pettman *et al*, 2013). However, the literature on the integral value of connecting and engaging with a network, either in a formal or informal way, to enhance capacity has received less attention. Even less attention has been dedicated to the value of consistent time to reflect on these experiences. Systematic reflection would include critical thinking methods and facilitation tools. The proposition is that a combination of practical experience, continuing education, engagement in a network, and systematic reflection will lead to enhanced capacity (McLean *et al*, 2005).

The constructs related to notion of capacity also vary in the literature. Capacity relates to organizational, as well as individual, ability to take an action toward a change. Six factors have been identified across the literature as necessary to demonstrate capacity: 1. stakeholder involvement, 2. change efficacy (stakeholders believe group can achieve something by working

together), 3. adaptive ability and support for organizational learning, 4. leadership support and vision, 5. resources (time, people, funds, space), and 6. technical skills and knowledge.

The actions taken toward a change effort must involve the key organizational and individual stakeholders (Labonte and Laverback, 2001a; 2001b; Peirson *et al*, 2012). This involves leaders, program managers, and the communities that they serve. A combination of support at director and the staff levels are involved in taking action (Lehman, 2002).

The concept of change efficacy seems to serve as a bridge between readiness and capacity. Change efficacy refers to the notion that organizations and individuals need to both be ready and able to take action toward change (Weiner *et al*, 2008; Weiner *et al*, 2009; Holt, 2007). The actual demonstration of taking action together is a factor of capacity. Successful collaboration creates momentum for further collaborations (Weiner, *et al* 2009).

Being able to be adaptive and support organizational learning is a critical factor in demonstrating capacity (Brothers and Sherman, 2012). Adaptive learning uses collaboration with individuals and organizations involved in the issue area to learn what is going on in the community and stay current with what is going on in the field. This adaptive learning perspective allows for the organization to learn for successes as well as failures (Marquardt, 2011; Heifetz *et al* 2009) and maintain a perspective of the entire field, as well as the specific area of interest.

Adaptive and organizational learning also relate closely to leadership vision and support, another critical element in the demonstration of capacity. Organizational leaders and individual

leaders must persevere in their ongoing support for a potential change, as well as share a mission-centered vision to inspire their followers (Brothers and Sherman, 2012; Heifetz *et al* 2009; Marcus *et al*, 2005).

Leaders are often able to align the proper resources to demonstrate capacity. Resources may refer to staff time dedicated to a change effort, staff themselves and their relationships and personalities (Geddes, 2005), funding, and space from the physical room to the organizational culture to support the change effort (Brothers and Sherman, 2012). A mix of resources is necessary to help establish capacity.

Likewise, a mix of technical skills and knowledge is needed to establish capacity. This may involve partner outreach, program evaluation, operations management, and effective communication with stakeholders (Brothers and Sherman, 2012; Geddes, 2005; Heifetz *et al* 2009; Marcus *et al*, 2005).

Community assets, strengths, and capabilities of the members of the community influence activities (Pinsker and Lieber, 2005) of capacity building and the demonstration of actual capacity. Exploring these community assets in a systematic way allows a discussion of current activities in a reflective, retrospective manner, as well as a discussion of possible future activities in a prospective manner.

Members of the community may share information on these activities in variety of interactions as they are developing their relationships with each other (Pinsker and Lieber, 2005;



McLean *et al*, 2005). This may include phone conversations, electronic correspondence, in person meetings, social media, sharing sites, websites, or piggybacking on any events already happening, such as a health fair or support group. Quality and frequency of these interactions and how valuable any new information or content that is shared is critical.

Participation in a CoP helps develop leaders and create momentum for change. An increase in capacity has been observed through active participation in these communities in public health settings (Mabery, 2012). The CoP can then encourage systems change as leaders are from different organizations. The CoP becomes the catalyst for learning and experimenting together. These partners in Ohio have already worked together in their collaborations on smoking cessation and data monitoring of smoking among PWD. These partners have fully collaborated in that they had exchanged information and activities, while sharing resources (staff, financial, and technical expertise), and enhanced the capacity of each other for mutual benefit and to achieve the common purpose of including PWD in smoking cessation programs. (Himmelman 1996; 2001; 2002).

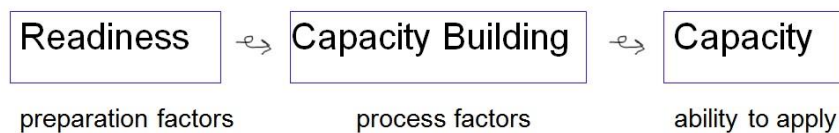
## **B. Conceptual Framework**

The relationship between the constructs of readiness and capacity is dynamic and has a critical intermediary step of capacity building. Understanding the relationship between readiness and capacity building assists with implementation of the change or actually demonstrating the capacity. In order to be ready for the change of including PWD in programs and services, the partners in Ohio needed to demonstrate a series of supporting preparation factors. These

readiness factors may then help to facilitate a capacity building process of key activities. The process factors that support capacity building may then lead to an actual ability to perform and apply a series of supporting capability factors.

**Figure 1: Construct Model – General Overview**

**Construct Model: General Overview**



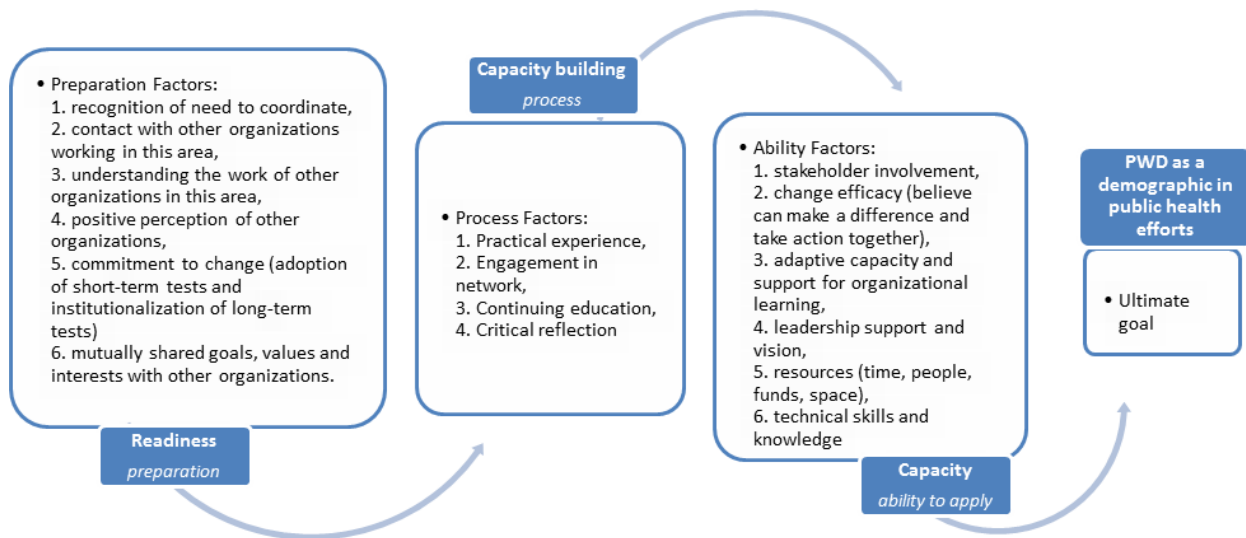
This construct model represents a unique sequencing of factors expressed in the literature, assembled in a sequential order, which may loop back to an earlier set of factors before moving forward to make progress toward the ultimate goal of PWD as a demographic in public health efforts. The readiness factors that this investigation studied were: 1. recognition of need to coordinate, 2. contact with other organizations working in this area, 3. understanding the work of other organizations in this area, 4. positive perception of other organizations, 5. commitment to change (adoption of short-term and long-term tests), and 6. mutually shared goals, values and interests with other organizations.

For purposes of this study, capacity building was defined as a series of relationships (Labonte and Laverback, 2001a; 2001b) involving a combination of activities: 1. practical experience, 2. engagement in a network (formal or informal), 3. Continuing education, and 4. Critical reflection (McLean *et al*, 2005). The process of engaging in activities and relating them to each other is essential to connect the concept of readiness and capacity with the interim step of

capacity building. For the proposed study, practical experiences are public health programs or activities including people with a disability, activities in support of a work plan, or information sharing and materials dissemination. Engagement in a network in either formal or informal ways include collaboration with partners, coworkers, a coalition, or planning teams in Ohio, in addition to any regional connections or national affiliations with other states as fellow CDC grantees. Continuing education includes employee educational opportunities, conferences, or trainings. Critical reflection includes systematic, critical thinking methods and facilitation tools, such as dedicated staff time for thinking and planning, journaling, any retreat opportunity, in addition to participation in the Community of Practice (CoP). The proposition is that a combination of practical experience, continuing education, engagement in a network, and systematic reflection will lead to enhanced capacity (McLean *et al*, 2005).

Six capacity factors were assessed by this study: 1. stakeholder involvement, 2. change efficacy (stakeholders believe they can make a difference and take action together), 3. adaptive ability and support for organizational learning, 4. leadership support and vision, 5. resources (time, people, funds, space), and 6. technical skills and knowledge.

**Figure 2: Construct Model-Detailed View**



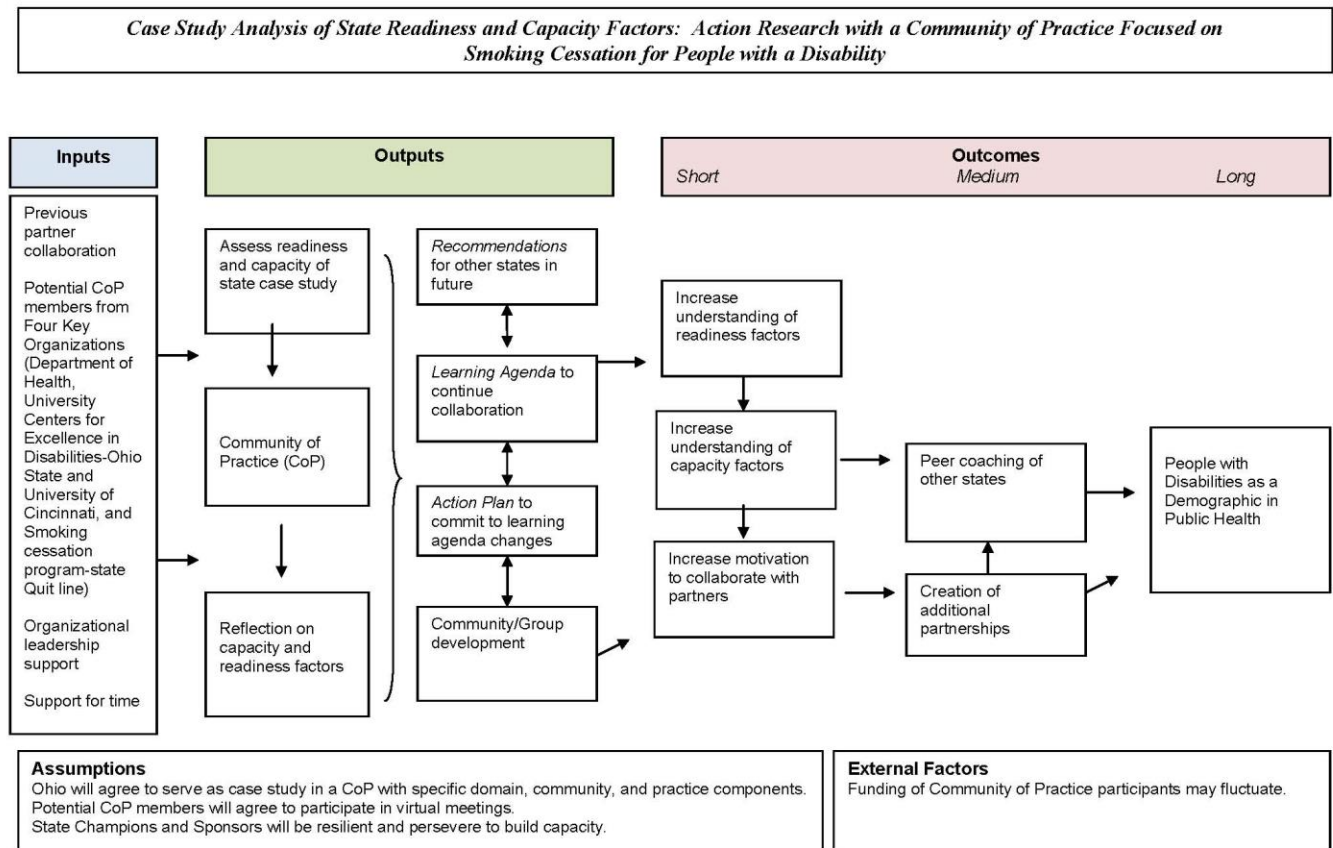
This detailed construct model further represents the unique sequencing of factors in each step. Each set of factors is interconnected and relates to earlier factors, as well as later factors. For example, the capacity building factor of engagement in informal or formal networks connects with the readiness factors. If all six readiness factors are present, then the activity of network engagement will likely be better supported. If some of these factors are missing, it may be necessary to loop back to an earlier set of supporting factors before moving forward to make progress toward the next set of factors in this sequence of readiness leading to capacity building and capacity building leading toward actual capacity. It was hypothesized that each of these sets of factors are present among the key partners in Ohio and that these factors will enable the ultimate goal of PWD being seen as a demographic in public health efforts.

### **C. Logic Model**

This investigation leveraged previous partner collaboration through the Ohio Disability and Health Program (ODHP) as a critical input. Members of the Community of Practice (CoP) were from four key organizations that have actively collaborated in ODHP. Each organization has dedicated support for staff time. The leadership of each organization has supported efforts to enhance capacity and increase work to reduce health disparities among PWD.

An initial output of this study was a capacity and readiness assessment of the state partners involved in integrating PWD into smoking cessation programs. These partners were invited to collaborate in a CoP. The investigator was an outside guest at three CoP meetings, acting as the CoP coordinator. These meetings were facilitated by the investigator with the outcomes of reflection on the findings of the capacity and readiness assessment, as well as the creation of recommendations on reaching PWD with public health efforts like smoking cessation. These recommendations will be helpful for future efforts in other states. Another output of this study was a learning agenda, with a supporting action plan, that the CoP created to facilitate collaboration beyond the life of the current CDC grant, which is currently in a competitive re-application cycle (CDC, 2015a).

**Figure 3: Study Logic Model**



It was hypothesized that development of this CoP would lead to further group development as a community. This community group development, along with the other outputs, may then support an increased understanding of readiness and capacity factors, as well as an increased motivation to collaborate with partners. Peer coaching of other states and creation of additional partnerships may then occur as mid-term outcomes, beyond this investigation's scope.

### **III. Study Design, Data and Methods**

#### **A. Analytical Approach**

This investigation explored the present efforts of Ohio as they relate to including PWD as a demographic in public health efforts. Ohio may serve as a single case study for the proposed investigation as it is a unique state in that its partners have been able to include PWD in smoking cessation efforts, while this is not yet the norm in other states (Yin, 2009). Anecdotally, the organizations that have been collaborating on the CDC grant have been told that they are doing well (Yang, 2014, personal communication); however, the partners involved in these organizations have not yet had a dedicated opportunity to systematically reflect on the factors that may have made their efforts successful. This investigation was such an opportunity.

The research questions were appropriate for a case study investigation as they explored how Ohio has included PWD in public health efforts, such as smoking cessation. A case study approach offered a method to take an in-depth examination of these phenomena and solicit strategies for including PWD that may be helpful to other states.

#### *Case Study Selection*

Ohio is one of a few states that include PWD in smoking cessation efforts (CDC, 2014c). Ohio secured funding for dedicated public health efforts that include PWD, conducted a needs assessment on health promotion needs among PWD, and collected data on smoking rates among PWD on smoking. There is no current national standard for states to collect this data on smoking

rates. States like Ohio that collect data on smoking cessation among PWD have done so by collaborating with multiple partners and making the request of state Quitlines. This unique support of state-based data, along with the ambition to address the high disparity area of smoking cessation among PWD, sets Ohio apart from other states. Therefore, Ohio may be viewed as an exemplary case study. This single state case study can lead the way for other states to follow their recommendations on reaching PWD in public health efforts like smoking cessation.

In the case of Ohio, publicly available evidence suggested that this state was already demonstrating capacity to include PWD in public health efforts, such as smoking cessation efforts. The key publicly available evidence included a needs assessment that identified the smoking rate disparity between people with and without disabilities in Ohio, as well as a poster presentation (APHA 2014) on state Quitline data and Ohio Disability and Health Program partner collaboration. Therefore, the investigator hypothesized that this state had already built capacity and attained a certain degree of readiness for this change of including include PWD in public health efforts, such as smoking cessation. This study uncovered how Ohio was an exemplary case in which public health partners displayed factors of readiness, capacity building, and capacity in the pursuit of including PWD in smoking cessation.

### *Community of Practice and Public Health Phenomena*

In a broad sense the phenomena that this case study examines is public health. Public health, as defined nearly a century ago by CEA Winslow, is “the science and art of preventing



disease, prolonging life and promoting health and efficiency through organized community effort (1920).” The issue of smoking cessation served as a lens through which to view this larger phenomena of public health. The issue of viewing PWD as a demographic in public health efforts refined the focus even further. The use of a Community of Practice (CoP) acted as a stage or a container through which to see the public health system. In this way, the CoP became a proxy for examination of the larger public health system

This single state case study in Ohio utilized a CoP comprised of volunteers from state partners who have included PWD in smoking cessation efforts. This case may serve as an exemplary case example for other states, including other CDC state grantees, as the findings revealed how Ohio has been able to position disability as a demographic of focus for public health efforts, such as smoking cessation.

#### *Analytical Approach to the Case Study: Action Research*

An action research model was applied as the CoP participants were involved and participated in the inquiry, which examined existing smoking cessation efforts (Stringer, 2007; McNiff and Whitehead, 2011). Action research examined the organizational and systems factors and opportunities for reaching PWD with public health efforts, including smoking cessation strategies, such as Quitlines, web, social media, and home-based interventions. The CoP with Ohio partners served as the “stage” for this collaborative inquiry.

A general action research routine consisting of the following steps was used: 1. review of relevant information, 2. explore, analyze, and theorize approaches, and 3. plan, implement and

report updates. As Stringer puts it, this is an action research spiral of three simple steps: look, think, and act (2007). Action research is a collaborative approach to inquiry that engages those involved to take systematic action to resolve a specific problem. An action research cycle moves the participants, including the investigator, through the steps of observation, reflection, action, and evaluation, to moving in new directions (McNiff and Whitehead, 2011). The *action research hypothesis* was that a CoP may be used in a retrospective manner to identify action or process steps and capacity supports to become ready to include PWD in public health efforts, as well as in a prospective manner to build capacity by providing time, space, and opportunity for critical reflection.

Action research was used with a Community of Practice (CoP), which included partners in Ohio, in three cycles to examine the capacity, capacity building, and readiness factors needed for public health practitioners to include PWD. The participants in the CoP were able to co-create the action steps that evolved from the experience of collaboration. This means that the CoP participants were able to contribute to the products of the intervention through their meeting collaborations. The products of this intervention include a set of recommendations on how to reach PWD and include them in public health efforts, such as smoking cessation; in addition to a learning agenda with a supporting action plan that enable the partners in Ohio to continue their commitment to collaboration beyond the current CDC grant.

## **B. Data Sources, Data Collection and Management**

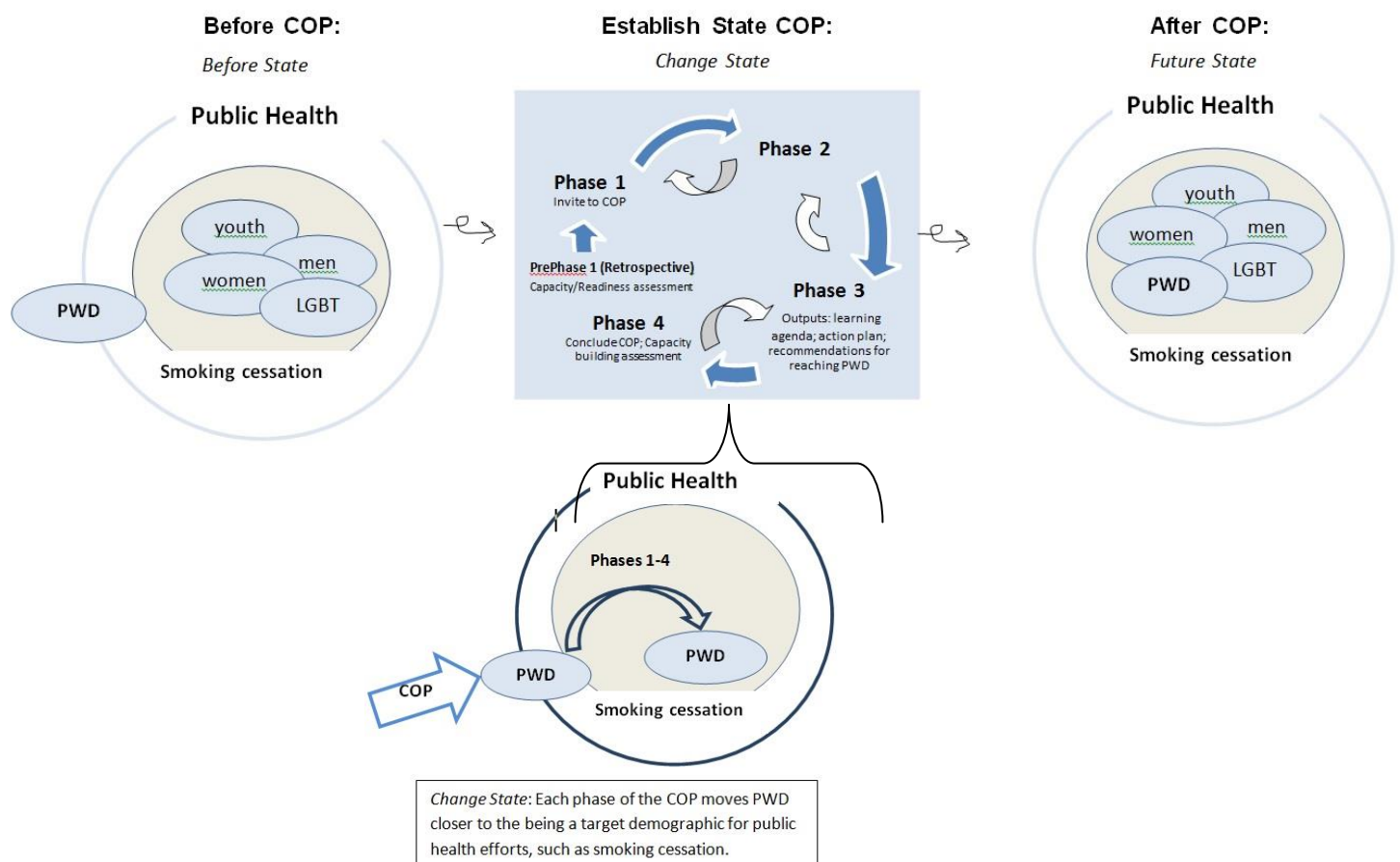
The presence of readiness, capacity building and capacity factors were assessed through a Community of Practice (CoP) with the key partners in Ohio who are including PWD in their smoking cessation efforts. In this way, the CoP served as the intervention. These partners in Ohio have already worked together on smoking cessation and data monitoring of smoking among PWD. This effort involved a retrospective examination to assess the readiness, capacity building, and capacity that was present in Ohio for this change to be successful. This retrospective examination occurred before the CoP took place. Through the CoP, a prospective examination took place in which the investigator guided Ohio CoP participants through a series of collaborative discussions to produce recommendations on how to include PWD and a learning agenda supported by an action plan for the partners to continue collaboration.

According to Connor (1992), change comes very quickly and takes place in three phases of the present state, the transition state, and the desired state. PWD are a growing part of the US population with rights to public health services. This right has been reinforced by the passage of the ADA (Public Law, 1990), ACA provisions that specifically target PWD (Section 4302), and an emerging call for more health practitioners to include PWD (Peacock *et al*, 2015). *In the proposed study, the CoP serves as a “stage” for the transition or Change State.* The ultimate desired future state is the inclusion of PWD as a demographic in public health efforts. The partners in Ohio have already gone from the *Before State* to a *Future State* in that they have been successful in increasing awareness of the need for PWD to be included in public health efforts,

such as smoking cessation.

This investigation concept map depicts how the change between the *Before State* and the *Future State* occurred through re-engaging the partners in Ohio and establishing a dedicated CoP. This process may not be linear and may loop back to an earlier state before making progress toward the Future State. Each phase within the *Change State* was expected to loop back and review the previous phase, as well as continue with the next phase.

**Figure 4: CoP Concept Map**



*Pre-Phase 1 & Phase 4 Capacity Assessment:* Partners in Ohio were invited to participate in the CoP Phases 1-4. A capacity assessment was administered via in depth interviews with each organization, including champion, sponsor and peripheral members, during Pre-Phase 1 and Phase 4. The participants in the CoP were individual representatives of four key organizational entities: 1. Department of Health, 2. Two University Center for Excellence in Developmental Disabilities Education, Research, and Service (UCEDDs) – Ohio State and University of Cincinnati, (disability technical assistance provider), and 3. Smoking cessation programs (state Quitline operator).

A capacity assessment in-depth interview instrument–informed by Interorganizational Relations Theory (IOR) (Butterfoss *et al*, 2008), Lewin (Butterfoss *et al*, 2008), and Connor (1992)–focused on the ability of partners in Ohio to implement change. Key capacity assessment factors included: stakeholder involvement, collective efficacy, adaptive capacity and support for organizational learning, leadership support and vision, resources (time, people, funds, space), and technical skills and knowledge. Capacity building activity efforts were assessed at Pre-Phase 1 and Phase 4 as a nested survey within the capacity assessment. Key capacity building factors included relationships (Labonte and Laverback, 2001a; 2001b) involving a combination of activities such as practical experience, continuing education, engagement in a network, and systematic reflection (McLean, *et al*, 2005).

*Pre-Phase 1 Readiness Assessment:* Partners in Ohio who volunteered to participate in the CoP were asked to complete a readiness assessment survey in preparation for the CoP virtual meeting 1. The readiness assessment instrument was based on IOR (as change in the CoP is happening across organizations), Lewin's Change Management Model, and Connor's Stages of Change Commitment (1992). Key readiness factors included: recognition of need to coordinate, contact with other organizations working in this area, understanding the work of other organizations in this area, positive perception of other organizations, commitment to change (adoption of short-term and long-term tests) and mutually shared goals, values and interests with other organizations.

*Establish State CoP Phases 1-4:* Four phases were facilitated by the investigator in a CoP supported by an initial action research question to examine the organizational and state systems factors that support perceiving PWD as a demographic. Three virtual sessions were facilitated with the CoP (Phases 1-3), with pre-work and post-work through group emails and document exchanges.

To monitor the process of partner interaction during the CoP, a monitoring system was administered as an online survey after each virtual CoP meeting. This online survey used Appreciative Inquiry style questions as a non-judgmental way to solicit true interaction with other CoP members in between the virtual meetings. Therefore, this becomes an Appreciative Inquiry monitoring system. This survey included short process evaluation questions on how the CoP participants are incorporating information learned from the CoP, the impact of the

relationship with CoP members, and satisfaction with the CoP experience itself.

## **C. Methods, Measures and Data Sources**

### *Overview*

A case study investigation explored how Ohio has been able to include PWD in public health efforts, such as smoking cessation. This case study approach offers a method to take an in-depth examination of these phenomena of public health practitioners including PWD in public health efforts, as well as a strategy to solicit practical recommendations for including PWD that may be helpful to other states.

An action research methodology was used in a purposive sampling strategy (Maxwell, 2008) with the partners involved in integrating PWD into smoking cessation efforts, the Ohio Disability and Health Program partners and the Ohio Quitline. The CoP was a leadership tool to support the action research examination of the organizational and systems factors and opportunities for public health practitioners to reach PWD with their efforts. Appreciative Inquiry, a strength-based method of positive questions, which shift the conversation and reflection toward stories of moments when groups were doing their best work, supported the CoP conversations to examine what Ohio is doing, so that other states may replicate their efforts to include PWD in public health efforts.

A seven (7) month protocol (Table 4) tested the *action research hypothesis that a CoP can be used as a tool to: a) identify action and process steps and capacity supports to become ready for change (retrospective examination), and b) build capacity by providing time, space, and*

opportunity of critical reflection (prospective examination). Action research cycle 1 focused on the retrospective examination, while introducing the prospective examination. Action research cycles 2 and 3 focused on the prospective examination.

**Table 4. Methods Summary and Timeline**

	Capacity Assessment $t_1$	Readiness Assessment	CoP virtual meeting 1	Monitoring System Survey (post meeting)	CoP virtual meeting 2	Monitoring System Survey (post meeting)	CoP Virtual meeting 3	Monitoring System Survey (post meeting)	Capacity Assessment $t_2$	
	Month 1	Month 2	Month 3	Month 3	Month 4	Month 5	Month 6	Month 6	Month 7	
	Pre-CoP		Action Research Cycle 1		Action Research Cycle 2		Action Research Cycle 3		Post-CoP	
	Retrospective examination			Prospective examination						
Before State	Pre-Phase 1			Establish CoP Phase 1		Phase 2		Phase 3		Phase 4

## Sampling and Recruitment

Since the receipt of CDC grant funding in 2012, the Ohio Disability and Health Program (ODHP) has acted as a catalyst for a core group of partners to work together to include people with a disability in smoking programming. Therefore, subjects were recruited from the current collaborators of the ODHP. This information is publicly available on the program website at <http://nisonger.osu.edu/ODHP>. A diverse sample included members who were familiar with a broad range of disabilities, represented different ethnic and minority groups, and represented different degrees of participation in the community (champions, sponsors and peripheral members).



Potential CoP champions, sponsors and peripheral members were recruited to participate. Champions were defined as collaborators that receive funds from the CDC grant, while sponsors were collaborators involved in the programming without receiving these funds. This is in keeping with the CoP framework that champions take a lead role in change efforts. Peripheral members were defined as partners that have a basic level of awareness of including people with a disability in smoking programming, but may not believe this is a genuine concern. Champions, sponsors, and peripheral members were identified through the publicly available Ohio Disability and Health Program team roster (<http://nisonger.osu.edu/odhp/team>).

Three different levels of leaders were recruited at each Ohio Disability and Health Program Partner organization. Leaders at the 1. director/administrator, 2. manager/coordinator, and 3. assistant levels that contribute to public health programming at each of these organizations will be recruited. At least two representatives were recruited for each of these four organizations. It was anticipated that there would be a minimum of eight study participants, and up to 15 participants including those at all levels, according to the CoP framework. See Table 5.

**Table 5. Ohio Disability and Health Program Partner Organizations Recruited for Study Sample**

<b>Organization</b>	<b>Type / Unit</b>	<b>Degrees of CoP Participation</b>	<b>Website Reference</b>
Ohio State University, Nisonger Center (1 Leader, 2 Managers, 1 Assistant)	Disability / University Center for Excellence in Developmental Disabilities	Champion	<a href="http://nisonger.osu.edu/odhp/team">http://nisonger.osu.edu/odhp/team</a>
Department of Health (2 Leaders, 2 Managers, 2 Assistants)	Public Health / Tobacco Use Prevention and Cessation Program	Champion	<a href="http://nisonger.osu.edu/odhp/resources/healthpromotion">http://nisonger.osu.edu/odhp/resources/healthpromotion</a>
Department of Health (1 Leader)	Public Health / Ohio's Title V Children and Youth with Special Health Care Needs (CYSHCN) program	Sponsor	<a href="http://nisonger.osu.edu/odhp/team">http://nisonger.osu.edu/odhp/team</a>
University of Cincinnati (1 Leader, 1 Manager)	Disability / University Center for Excellence in Developmental Disabilities	Sponsor	<a href="http://nisonger.osu.edu/odhp/team">http://nisonger.osu.edu/odhp/team</a>
Ohio Tobacco Quit Line (1 Manager)	Business (operated by National Jewish Health)/ Contractor of Department of Health Tobacco Use Prevention and Cessation Program	Sponsor	<a href="http://nisonger.osu.edu/odhp/resources/healthpromotion">http://nisonger.osu.edu/odhp/resources/healthpromotion</a> (alternate reference: <a href="http://www.nationaljewish.org/Health-Initiatives/News-Resources-(1)/One-Millionth-Person-Seeking-to-Quit-Tobacco-Contacts-National-Jewish-Health">http://www.nationaljewish.org/Health-Initiatives/News-Resources-(1)/One-Millionth-Person-Seeking-to-Quit-Tobacco-Contacts-National-Jewish-Health</a> )
Disability Community Planning Group (coalition of 80 organizations) (1 Leader)	Disability / Ohio State University, Nisonger Center	Peripheral	<a href="http://nisonger.osu.edu/odhp/infrastructure">http://nisonger.osu.edu/odhp/infrastructure</a>
Ohio Colleges of Medicine Government Resource Center (1 Leader)	Medicine / Ohio State University, Nisonger Center	Peripheral	<a href="http://nisonger.osu.edu/odhp/infrastructure">http://nisonger.osu.edu/odhp/infrastructure</a>

This study did not seeking information from any vulnerable population, such as people with a disability. If the participants had disclosed any personal details regarding having a

disability, the investigator would have discarded those personal details from any recording, notes, or analysis. This study did not collect any personal health information, such as disability status.

The investigator initiated contact with potential study participants via phone call upon approval of the IRB application. (See Appendix L for telephone consent guide.) A claim of exemption was approved by UIC's IRB (Research Protocol #2015-0459). A follow up email with the study information sheet was sent. CoP participants were asked for a verbal confirmation of willingness to participate during the initial telephone contact. This was confirmed during the initial in-depth interviews.

### *Capacity In depth Interviews*

Purposeful sampling (Saldaña, 2013; Creswell, 2014) was used in this case study as Ohio is one of very few states demonstrating capacity in including PWD in public health efforts, such as smoking cessation. The investigator selected potential CoP members from the Ohio Disability and Health Program as these partners all have important information for this study that cannot be attained from other sources. An initial capacity assessment of Ohio CoP potential members was done in a retrospective manner through telephone, in-depth interviews ( $t_1$   $n=11$ ) that ask the partners to recall elements of capacity and capacity building that may have been present at the time in 2013 and 2014, when they were first able to involve PWD in smoking cessation efforts. (See *Appendix A*.) This allowed for a comparison of evidence from document review for case selection to the information gathered during the interviews. This served as an important validity

checkpoint. An organizational representative of each key member of the Ohio CDC grant (n=3) and smoking cessation program partner (n=1) were interviewed. Organizational representatives were sought at a mix of levels to include program director, manager, and associate staff members. The aim was to interview 2-3 organizational representatives for the four organizations involved (Ohio State UCEDD (n=4), University of Cincinnati UCEDD (n=2), Ohio Department of Health Tobacco Program (n=2), and the Ohio Tobacco Quitline (n=1). (See Table 7.)

Representatives from peripheral partner groups were also interviewed. The Ohio Colleges of Medicine Government Resource Center (n=1) was interviewed prior to the initial CoP virtual meeting. The Ohio Center for Independent Living, a member of the Disability Community Planning Group (n=1), initially declined the interview, but was later available and was interviewed between the CoP virtual meetings 2 and 3. In total, eleven (n=11) potential CoP members were interviewed, including a potential future coordinator (OH CDC grant program coordinator). Seven agreed to participate in the CoP sessions, while one organization (Ohio Department of Health Tobacco Program) requested to have an additional staff member involved. Therefore, a total of eight (n=8) partners from Ohio participated in the full CoP experience.

Conducting the capacity assessment interviews as a first step was important as this established investigator contact with the CoP members as the group facilitator (Maybery, 2015, personal communication). This was a critical initial step, especially since the investigator conducted the meetings of the CoP virtually.

After the  $t_1$  interviews were completed, a document review was conducted as an additional way to uncover details of the capacity building activities and capacity demonstrated

by Ohio. Approximately seven (n=7) documents were planned to be reviewed; however, additional relevant documents related to including PWD in smoking cessation efforts were solicited at the conclusion of the interviews. A total of eleven (n=11) documents were reviewed. A document review template is available in Appendix B. The capacity and capacity building measures that were used, along with the data sources are summarized in Table 6.

<b>Table 6: Capacity and Capacity Building Factors, Measures and Data Sources Pre-Community of Practice (CoP)</b>		
<b>Timeline:</b> <b>Pre CoP, Months 1-2</b> <b>Pre-Phase 1</b>	<b>Research questions:</b> <ol style="list-style-type: none"> <li>What are the factors that make a state system ready to include PWD as a demographic in public health efforts? <ul style="list-style-type: none"> <li>➤ What are the capacity supports that help make a state system ready?</li> </ul> </li> </ol>	
<b>Factors</b>	<b>Measures</b>	<b>Data Sources</b>
<u>Capacity:</u> 1. stakeholder involvement, 2. change efficacy (believe group can achieve something by working together), 3. adaptive capacity and support for organizational learning, 4. leadership support and vision, 5. resources (time, people, funds, space), 6. technical skills and knowledge  <u>Capacity building activities:</u> 1. Practical experience, 2. Engagement in network, 3. Continuing education, 4. Critical reflection (CoP participation)	<u>Capacity:</u> 1. Number and type of partners; frequency and type of interaction (meetings, phone calls, activity planning, emails, sharing site) 2. Agreement on question scale in in depth interviews; successful past collaborations 3. Action plans based on needs assessments; Information generation and sharing through trainings, presentations 4. Vision, mission statements; strategic plan; work plan; Partner agreements 5. Competencies-job requirements, job descriptions ; Dedicated funding, staff, space, library access, equipment 6. Needs assessment of community; Employee educational opportunities-continuing education, conferences, trainings <u>Capacity building:</u> 1. Work plan; Information sharing and materials dissemination; Examples of public health programs/activities including people with a disability 2. Collaboration with partners, coalition, planning teams in OH; Connection with other states 3. Employee educational opportunities, conferences, trainings 4. Dedicated staff time for thinking and planning; Journaling; Retreat opportunity; motivation to participate in CoP; goal for participation in CoP	<u>In depth interviews</u> n=5 program staff  <u>Document review</u> n=11 Publicly available a) upon request: 1. Work plan 2. APHA Presentation 3. Needs assessment 4. Collaboration proposal between OH Disability and Health Program and OH Department of Health's Tobacco Program  b) website: 5. Vision, mission statements 6. RFA for CDC funding 7. OH Quit line Promotional Materials (n=3) 8. Policy briefs (n=2)

### *Readiness Survey*

A readiness assessment of the CoP members was conducted through an online survey (n=5) as pre-work with the program staff for the first virtual meeting. (See *Appendix C.*) This survey retrospectively assessed the steps of readiness for change, as well as capacity building. This served as a comparison assessment on steps of capacity building that the CoP members reported using. This was an important step for maintaining internal validity. To strengthen the applicability of the findings, a companion in-depth interview on readiness and capacity building was conducted with the leadership of the Ohio Disability and Health Program (ODHP), which included the two UCEDDs, the OH Colleges of Medicine Government Resource Center, and the Ohio DOH (n=5). (See *Appendix D.*) The readiness and capacity building measures that will be used, along with the data sources are summarized in Table 7.

<b>Table 7: Readiness and Capacity Building Factors, Measures and Data Sources Pre-CoP</b>		
<b>Timeline:</b> <b>Pre CoP, Months 1-2, Prep-work for Virtual Mtg 1</b> <b>Pre-Phase 1</b>	<b>Research questions:</b> <ul style="list-style-type: none"> <li>➤ What are the factors that make a state system ready to include PWD as a demographic in public health efforts?</li> <li>➤ What are the process steps that a state system can take to become ready?</li> <li>➤ What are the capacity supports that help make a state system ready?</li> </ul>	
<b>Factors</b>	<b>Measures</b>	<b>Data Sources</b>
<u>Readiness:</u> 1. recognition of need to coordinate, 2. contact with other organizations working in this area, 3. understanding the work of other organizations in this area, 4. positive perception of other organizations, 5. commitment to change (adoption of short-term tests and institutionalization of long-term tests) 6. mutually shared goals, values and interests with other organizations.  <u>Capacity building activities:</u> 1. Practical experience, 2. Engagement in network, 3. Continuing education, 4. Critical reflection (CoP participation)	<u>Readiness:</u> 1. Examples of program or grant collaboration; Agreement on question scale in survey 2. Frequency and type of interaction (meetings, phone calls, activity planning, emails, sharing site); Agreement on question scale in survey 3. Agreement on question scale in survey; Collaboration with partners in a program (knowledge, value, interest) 4. Agreement on question scale in survey; Collaboration frequency and type of interaction (positive or negative) 5. Examples of short-term and long-term tests to implement new way of doing a program; Agreement on question scale in survey 6. Shared goals, values and interests of partners; Agreement on question scale in survey <u>Capacity building:</u> 1. Work plan; Information sharing and materials dissemination; Examples of public health programs/activities including people with a disability 2. Collaboration with partners, coalition, planning teams in OH; Connection with other states 3. Employee educational opportunities, conferences, trainings 4. Dedicated staff time for thinking and planning; Journaling; Retreat opportunity; motivation to participate in CoP; goal for participation in CoP	<u>Online survey instrument (n=5)</u>  <u>In depth interviews (n=6)</u>

### *Community of Practice: “Stage” for Conducting Action Research*

At end of capacity assessment in-depth interviews for program staff and the readiness assessment interviews for leadership, the interviewees were invited to join the Community of Practice (CoP). Potential members were informed of the commitment to participate in this CoP and provided an information overview sheet on the study. (See *Appendix F*.) Eight partners in

Ohio accepted the invitation to volunteer their participation in the CoP.

The CoP commitment involved three (3) virtual meetings by conference call, each with pre- and post-work shared via an email group, for a total of 9 commitments. Each virtual meeting lasted approximately 60 minutes, as this was the amount of time the volunteers were available. See *Appendix H: Community of Practice Summary* for a summary of the discussions that took place during these meetings. In keeping with the action research method, the investigator developed the agenda for these meetings based on the findings of the initial capacity assessment interviews, document review, and the readiness assessment interviews and survey.

During Month 3, the first virtual meeting of the CoP took place. The meetings with the CoP took place via a free conference call, with a meeting agenda and relevant slides disseminated in advance of each meeting. Each meeting was recorded for investigator use in note taking, with all recordings being destroyed upon completion of the study.

This first meeting during Month 3 was critical in that it established and launched the CoP as a dedicated group to develop recommendations for reaching and including PWD in public health efforts like smoking cessation, as well as a learning agenda with a supporting action plan to continue collaboration beyond the CoP experience. Roles and relationships of the CoP members were assessed and defined during this “Potential Stage.” The initial meeting reviewed retrospective information discovered during the capacity and readiness assessments. Productive Facilitation, along with Appreciative Inquiry and ToP facilitation questions, were used to



encourage group reflection and idea generation, shifting into the prospective examination of advice that Ohio may give to other states.

Within two weeks following each virtual meeting, the CoP members were solicited to complete an online monitoring survey to monitor their interaction with each other in between the virtual meetings. These Appreciative Inquiry style questions served as a non-judgmental way to solicit true activity levels. Therefore, this served as an Appreciative Inquiry monitoring system. (See *Appendix E*.) The CoP factors and measures used, along with the data sources are summarized in Table 8.

**Table 8: CoP Factors, Measures and Data Sources –Virtual Meeting 1/Action Research Cycle 1**

<b>Timeline:</b> <b>CoP (Stage 1),</b> <b>Month 3</b> <i>Virtual Mtg 1,</i> <b>Action Research Cycle 1</b> <b>Phase 1</b>	<b>Research Questions:</b> 2. How does partner participation in a modified community of practice foster the capacity of state systems to include PWD as a demographic in public health efforts? ➤ What are the factors that support state capacity to address demographic groups that experience health disparities, such as smoking among PWD?	
Factors	Measures	Data Sources
1. <u>Domain:</u> Smoking Cessation for People with disabilities; Motivation and passion for group to have shared interest (based on in depth interview findings)  2. <u>Community:</u> Representatives from DOH, UCEDDs, OH Quit line  3. <u>Practice:</u> Recommendations, learning agenda, action plan	<u>During CoP Meeting:</u> Factors 1-3. Participation of all in group; Information shared <u>Post CoP:</u> Factors 2-3: <i>A) Incorporate information learned from CoP into ...</i> 1 practical experience 2 continuing education 3 systematic reflection 4 involvement with a network (formal or informal) <i>B) Impact of relationship with CoP members...</i> Interactions... 1 Phone conversations (individual or conference call) 2 Email correspondence (individual or group listserv) 3 Meetings (with individual or group) 4 social media 5 sharing site 6 website (add any content or links) 7 piggybacking on any events already happening (health fair or support group) Quality of interactions... -positive interactions? -new information or content-rich? -frequency? <i>C) Satisfaction with CoP experience itself;</i> How well did the CoP meeting meet 1. Goals for CoP participation 2. Ability to contribute and share information	<u>CoP discussion</u> -Documents: slides, meeting agenda, discussion notes  <u>Monitoring System</u> <u>Survey t<sub>1</sub> (post meeting 1, n=8 (goal))</u> - Appreciative Inquiry style questions with short blanks for process evaluation questions on A. Incorporate information learned from CoP B. Impact of relationship with CoP members C. Satisfaction with CoP experience itself

During the second virtual meeting, the conversation shifted as the CoP prospectively created information through the drafting of recommendations for including PWD in public health efforts, along with their own state learning agenda with a supporting action plan. This type of visioning represented a change from the CoP Stage 1 “Potential” to the beginning of CoP Stage 2

“Coalescing.” The CoP factors and measures used, along with the data sources are summarized in Table 9.

<b>Table 9: CoP Factors, Measures and Data Source: Action Research Cycles 2 and 3 (Virtual Meetings 2 &amp; 3)</b>		
<b>Research Questions:</b> 1. What are the factors that make a state system ready to include PWD as a demographic in public health efforts? ➤ What are the process steps that a state system can take to become ready? ➤ What are the capacity supports that help make a state system ready? 2. How does partner participation in a modified community of practice foster the capacity of state systems to include PWD as a demographic in public health efforts? ➤ What are the factors that support state capacity to address demographic groups that experience health disparities, such as smoking among PWD?		
<b>Virtual Meeting 2/Action Research Cycle 2, Timeline: CoP (Stages 1&amp;2), Months 4-5, Virtual Mtg 2</b>		
<b>Virtual Meeting 3/Action Research Cycle 3, Timeline: CoP (Stage 2), Month 6, Virtual Mtg 3</b>		
<b>Factors</b>	<b>Measures</b>	<b>Data Sources</b>
1. <u>Domain:</u> Smoking Cessation for People with disabilities; Motivation and passion for group to have shared interest (based on in depth interview findings)  2. <u>Community:</u> Representatives from DOH, UCEDDs, OH Quit line  3. <u>Practice:</u> Recommendations, learning agenda, action plan	<u>Before CoP Meeting 2 &amp; 3: Factors 1-3</u> Information & recommendations shared <u>During CoP Meeting 2 &amp; 3: Factors 1-3</u> Participation of all in group; Information & recommendations shared <u>Post CoP Meeting 2 &amp; 3:</u> A) <i>Incorporate information learned from CoP into... (Factors 1-3)</i> 1 practical experience 2 continuing education 3 systematic reflection 4 involvement with a network (formal or informal) B) <i>Impact of relationship with CoP members... Interactions... (Factors 2-3)</i> 1 Phone conversations (individual or conference call) 2 Email correspondence (individual or group listserv) 3 Meetings (with individual or group) 4 social media 5 sharing site 6 website (add any content or links) 7 piggybacking on any events already happening (health fair or support group) Quality of interactions... -positive interactions? -new information or content-rich? -frequency? C) <i>Satisfaction with CoP experience itself;</i> How well did the CoP meeting meet...(Factors 1-3) 1. Goals for CoP participation 2. Ability to contribute and share information	<u>CoP discussion</u> -Documents: slides, meeting agenda, discussion notes, recommendations, learning agenda, action plan  <u>Monitoring System Survey t<sub>2</sub> &amp; t<sub>3</sub> (post meeting 2 &amp; 3, n=8 (goal))</u> - Appreciative Inquiry style questions with short blanks for process evaluation questions on A. Incorporate information learned from CoP B. Impact of relationship with CoP members C. Satisfaction with CoP experience itself

By the time of the third virtual meeting, all research questions were addressed. Although the second meeting touched on aspects of all research questions, the third meeting allowed the CoP participants the opportunity to review and finalize recommendations for including PWD in public health efforts, learning agenda, and supporting action plan. The third meeting continued to develop the CoP Stage 2 of Coalescing. The CoP participants considered what they would like to do in their future collaborations together. The CoP factors and measures used, along with the data sources are summarized in Table 8.

After the three virtual meetings of the CoP concluded, a follow up capacity assessment of CoP participants was conducted via in-depth interviews. This assessed any changes in capacity and capacity building. This follow up interview also assessed any changes in the factors of readiness as a set of readiness assessment questions were nested within the capacity assessment interview. Telephone in-depth interviews ( $t_2$ ,  $n=7$ ) were conducted with the CoP participants, as well as the potential future coordinator. (See Appendix F.) The goal was to interview all CoP participants ( $n=8$ ); however, the OH DOH participants requested to combine their interview. In addition, any updated documents were solicited to assess any documented changes in capacity; however, none were shared by the participants. The CoP factors and measures used, along with the data sources are summarized in Table 10.

**Table 10: Post-CoP Factors, Measures and Data Sources**

<b>Timeline:</b> <b>Post-CoP,</b> <b>Month 7</b> <i>Phase 4</i>	<b>Research Questions:</b> 1. What are the factors that make a state system ready to include PWD as a demographic in public health efforts? ➤ What are the process steps that a state system can take to become ready? ➤ What are the capacity supports that help make a state system ready? 2. How does partner participation in a modified community of practice foster the capacity of state systems to include PWD as a demographic in public health efforts? 2. What are the factors that support state capacity to address demographic groups that experience health disparities, such as smoking among PWD?		
<b>Factors</b>		<b>Measures</b>	<b>Data Sources</b>

<p><u>Capacity:</u></p> <ol style="list-style-type: none"> <li>1. stakeholder involvement,</li> <li>2. change efficacy (believe group can achieve something by working together),</li> <li>3. adaptive capacity and support for organizational learning,</li> <li>4. leadership support and vision,</li> <li>5. resources (time, people, funds, space),</li> <li>6. technical skills and knowledge</li> </ol> <p><u>Capacity building:</u></p> <ol style="list-style-type: none"> <li>1. Practical experience,</li> <li>2. Engagement in network,</li> <li>3. Continuing education,</li> <li>4. Critical reflection (CoP participation)</li> </ol> <p><u>Readiness:</u></p> <ol style="list-style-type: none"> <li>1. recognition of need to coordinate,</li> <li>2. contact with other organizations working in this area,</li> <li>3. understanding the work of other organizations in this area,</li> <li>4. positive perception of other organizations,</li> <li>5. commitment to change (adoption of short-term tests and institutionalization of long-term tests)</li> <li>6. mutually shared goals, values and interests with other organizations.</li> </ol>	<p><u>Capacity:</u></p> <ol style="list-style-type: none"> <li>1. Number and type of partners; frequency and type of interaction (meetings, phone calls, activity planning, emails, sharing site)</li> <li>2. Agreement on question scale in in depth interviews; successful past collaborations</li> <li>3. Action plans based on needs assessments; Information generation and sharing through trainings, presentations</li> <li>4. Vision, mission statements; strategic plan; work plan; Partner agreements</li> <li>5. Competencies-job requirements, job descriptions ; Dedicated funding, staff, space, library access, equipment</li> <li>6. Needs assessment of community; Employee educational opportunities-continuing education, conferences, trainings</li> </ol> <p><u>Capacity building:</u></p> <ol style="list-style-type: none"> <li>1. Work plan; Information sharing and materials dissemination; Examples of public health programs including people with a disability</li> <li>2. Collaboration with partners, coalition, planning teams in OH; Connection with other states</li> <li>3. Employee educational opportunities, conferences, trainings</li> <li>4. Dedicated staff time for thinking and planning; Journaling; Retreat opportunity; motivation to participate in CoP; goal for participation in CoP</li> </ol> <p><u>Readiness:</u></p> <ol style="list-style-type: none"> <li>1. Examples of program or grant collaboration; Agreement on question scale in survey</li> <li>2. Frequency and type of interaction (meetings, phone calls, activity planning, emails, sharing site); Agreement on question scale in survey</li> <li>3. Agreement on question scale in survey; Collaboration with partners in a program (knowledge, value, interest)</li> <li>4. Agreement on question scale in survey; Collaboration frequency and type of interaction (positive or negative)</li> <li>5. Examples of short-term and long-term tests to implement new way of doing a program; Agreement on question scale in survey</li> <li>6. Shared goals, values and interests of partners; Agreement on question scale in survey</li> </ol>	<p><u>In depth interviews</u> n=7</p> <p><u>Document review</u> Investigator solicited any additional recommendations from participants.</p>
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## C. Analysis

The types of data in each phase of the investigation varied. Therefore, the analyses varied according to the kind of data available. The analysis involved the following strategies:

<b>Table 11: Analysis Plan Summary</b>	
<b>Data Source</b>	<b>Analysis Strategy</b>
1. Document Review (n=11)	Theme the data (manual review, Atlas.ti) Pattern matching analysis (Atlas.ti)
2. Capacity In-depth Interviews (t <sub>1</sub> n=5; t <sub>2</sub> n=7)	Simultaneous analysis (manual review, second coder) Theme the data (manual review, Atlas.ti, second coder) Pattern matching analysis (Atlas.ti) Construct table (Atlas.ti) Member checking (CoP sessions)
3. Readiness In-depth Interviews with Leadership (n=6)	Simultaneous analysis (manual review, second coder) Theme the data (manual review, Atlas.ti, second coder) Pattern matching analysis (Atlas.ti) Construct table (Atlas.ti) Member checking (CoP sessions)
4. Readiness Survey with Program Staff (n=5)	Descriptive, percentage summaries of responses Member checking (CoP session t <sub>1</sub> )
5. Online Survey (Appreciative Inquiry Monitoring System) (t <sub>1</sub> n=5, t <sub>2</sub> n=5, t <sub>3</sub> n=7)	Descriptive, percentage summaries of responses Member checking (CoP sessions)
6. Action Research Cycles (t <sub>1</sub> , t <sub>2</sub> , t <sub>3</sub> ) (8 participants)	Theme the data (manual review) Member checking (CoP sessions) Recommendations and learning agenda with supporting action plan
7. CoP Virtual Meetings (t <sub>1</sub> , t <sub>2</sub> , t <sub>3</sub> ) (8 participants)	Theme the data (manual review) Member checking (CoP sessions)

### *1. Document Review*

Documents were reviewed prior to the Community of Practice (CoP) to ascertain whether the case study state selection (Ohio) has demonstrated capacity in including PWD in public

health efforts, like smoking cessation. Five publicly available documents were reviewed (n=5): an Ohio Disability and Health Program (ODHP) poster presentation from the 2014 American Public Health Association (APHA) meeting, Disability and Health in Ohio needs assessment, Ohio partner vision and mission statements, ODHP collaboration proposal, and the Request for Application (RFA) for CDC Disability and Health grant. CoP participants were asked during the initial interview to share any documents that demonstrated their capacity to include PWD in smoking cessation. Six publicly available documents (n=6) were reviewed: the ODHP CDC Disability and Health grant work plan, OH quit line promotion mock ups (n=3), and Health Policy Institute of Ohio policy briefs (n=2).

The investigator themed the data manually and coded the documents with the revised Capacity and Readiness codebooks (as described in the interview section). This allowed the investigator to examine patterns that emerged. The investigator then performed a pattern matching analysis using Atlas.ti (Version 7.5.9).

## *2. Capacity In-depth Interviews and 3. Readiness In-depth Interviews*

The Capacity In-depth Interviews (n=5, t<sub>1</sub>; n=7, t<sub>2</sub>; *Appendices A and F*) and the Readiness In-depth Interviews (n=6; Appendix D) with partners in Ohio were conducted by phone and recorded for ease of transcribing notes for use in analyzing emerging themes. A descriptive coding filter was used (Saldaña, 2013) as a wide range of participant responses were categorized and documented. The unit of analysis for the coding was once per paragraph or question response. The investigator developed an initial provisional codebook, with codes



derived from the theoretical constructs of readiness, capacity and capacity building.

Simultaneous analysis occurred during the data collection in an open coding construction period.

After the first two Capacity interviews were conducted, the investigator and a second coder tested the provisional codes (Saldaña, 2013) with manual coding and then updated the codebook with new codes that emerged. A similar test was performed after the first Readiness interview. The second coder has a background in disability issues, qualitative research, and health policy. In this way, the second coder was able to serve as a peer examiner (Creswell, 2014).

The investigator and second coder tested the Readiness codebook with manual coding of the first interview with leaders and tested the Capacity codebook with the manual coding of the first two interviews with program staff. After this codebook testing, the codes in the draft code books were all found to be relevant, but *four additional codes* were added:

1. *Communication technology* was added as a particular resource *capacity* factor in order to capture the participant mentions of integrating and applying technology to enhancing and maintaining open communication with partners or stakeholders.

Based on practical experiences mentioned by the participants but not present in the capacity building factor codes, two codes were added to the *capacity building* factor codes:

2. *Inclusion*, or the concept of inclusion of people with disabilities as a priority or a component of a strategy, and
3. *Disability Identifier*, the concept of identifying PWD as a target demographic of public health programs and surveillance through asking a series of questions about functioning and

daily living, such as the battery of six disability questions in ACS.

4. *Involvement of a Disability Organization* was added as a collaboration capacity factor in order to capture any emphasis or priority to include organizations that have direct contact with people living with a disability.

All test interviews were then recoded with the revised codebooks (readiness assessment and capacity assessment). (See *Appendices L and M.*) A revised codebook (*Appendix N*) which combined the readiness and capacity assessment protocols was used to code the follow up ( $t_2$ ) interviews as both capacity and readiness factors were assessed.

The investigator then developed a refined, updated version of the Capacity and Readiness codebooks. (See *Appendices I and J.*) The investigator and a second coder then coded all interviews manually based on the revised codebooks. The investigator then used Atlas.ti to code all interviews. The second coder reviewed the interview coding in Atlas.ti. Inter-coder reliability was tracked for consistency of coding. Overall, inter-coder reliability was high, with the investigator and second coder in agreement on all codes after the initial codebook tests.

A follow up interview ( $t_2$ ) to assess any changes in the factors of capacity was conducted with each participant after the CoP virtual meetings ( $n=7$ ). The entire team from the Nisonger UCEDD participated including, their PI, program manager, policy manager, and program coordinator. The Cincinnati UCEDD program manager and a business manager from the OH quitline operator, National Jewish Health, also participated. The participants from the Ohio DOH (Tobacco Team Lead and a Lead Epidemiologist) requested to combine their interview.

Therefore, a total of seven follow up interviews were conducted (n=7).

The investigator transcribed notes for each interview and listened to the interview recordings to code each interview. The second coder reviewed the interview notes and codes after listening to each interview. One readiness interview with a leader was conducted by the investigator in person, rather than by phone, and no recording was made. The investigator took notes during the interview and coded themes from these notes. The second coder reviewed these notes.

Once the first cycle of interview coding was done, the investigator themed the data. This allowed the investigator to elaborate on themes that emerged during the analysis and examine any patterns that emerge. The investigator wrote memos to aid in analysis, observations that may be surprising, and new pattern coding (Miles and Huberman, 1994). The investigator performed a pattern matching analysis, supported by a construct table (Miles, 2014). Pattern matching analysis is a qualitative method that will measure degree to which there is a match with the *expected hypotheses that the CoP will be able to identify the action and process steps and capacity supports to become ready for the change of including PWD, and that the CoP will build capacity*. The construct table enabled the investigator to code themes that emerged and link them back to specific comments shared during the individual interviews and compare themes between the interviews. This enabled the investigator to do pattern coding to look for relationships between the codes.

The investigator examined two levels of codes by identifying co-occurring codes and then

those that related all initially identified co-occurring codes. The investigator used Atlas.ti to examine these two layers of co-occurring codes.

#### *4. Readiness Assessment Survey*

The Readiness Assessment Survey (*Appendix C*) was an online survey of closed ended, short open ended, and Likert scale questions, soliciting the CoP participants to rate the presence of the readiness factors. This survey yielded categorical responses (e.g. Strongly Agree, Agree, Don't Know, Disagree, and Strongly Disagree), according to how the respondents rated the presence of the readiness factors. The small  $n$  was best suited for an aggregate summary of percentage by category. This allowed an estimate of the most widely recognized readiness factors.

#### *5. Appreciative Inquiry Monitoring System*

The Appreciative Inquiry Monitoring System ( $t_1, t_2, t_3$ ) (*Appendix E*) was used in between the CoP meetings to monitor (Fawcett, 1995) how the CoP participants interact with each other. It was anticipated that the Appreciative Inquiry Monitoring System would yield enough data points in each category (1. incorporate information learned from CoP, 2. impact of relationship with other CoP members by type of and quality of interaction, and 3. satisfaction with the CoP experience itself) to be able to document a cumulative effect over time. The investigator had planned to produce a matrix that lists the different types of interactions over time or an ordering by time with event-listing matrix, according to Miles (2014). However, a low response was

achieved; there was insufficient data to calculate these measures. For the satisfaction questions on the CoP experience itself, descriptive, percentage summaries of responses were calculated. This served as a feedback loop to make any adjustments necessary to the ongoing facilitation of the CoP. The Appreciative Inquiry Monitoring System overall helped to measure degree to which there was a match with the *expected hypothesis that the CoP will be able to identify the action and process steps and capacity supports to become ready to include PWD*.

#### 6. Community of Practice (CoP) Virtual Meetings and 7. Action Research Cycles

During each Community of Practice (CoP) virtual meeting ( $t_1$ ,  $t_2$ ,  $t_3$ ), an action research cycle was completed. The CoP virtual meeting referred to the dialogue and conversation occurring among the partners at the sessions. The Action Research Cycles referred to the group inquiry to explore actual strategies and process steps that states may take to include PWD in public health efforts. At the beginning of each meeting, findings of surveys and interviews to date were reviewed by the investigator with the CoP participants. These findings were then member checked with these participants. Then there was information sharing and facilitated group discussion. (See Appendix L.) Each session ended with a recap of the next steps and action plan to support future work together. These sessions guided participants through the *CoP Stage 1, Potential*, which focuses on the discovery that others are passionate about a topic, and *CoP Stage 2, Coalescing*, which focuses on activities that allow members to build relationships, trust, and an awareness of common interests and needs. Given the time constraints of the current study, the CoP sessions ended during the beginning of this *Stage 2*.

During the first virtual meeting of the CoP, the investigator reviewed findings of the capacity interview, the readiness interviews, and the readiness survey with the participants. This member checking (Saldaña, 2013; Creswell, 2014) served as a way to validate the findings thus far. The participants of the CoP themselves served as a checkpoint to ensure that the investigator's perceptions accurately portrayed their reality. This was an important step in the analysis as the next two meetings of the CoP built upon a shared understanding of readiness and capacity factors as the group created recommendations for including PWD in public health efforts, like smoking cessation, and the learning agenda for ongoing collaboration.

The creation of the recommendations and the learning agenda themselves served as an analysis of the conversations of the CoP. Creation of the recommendations and a learning agenda served as test of the *expected hypotheses that the CoP will be able to identify the action steps and capacity supports to include PWD, and that the CoP will build capacity.*

The themes analysis of the findings from the Appreciative Inquiry Monitoring System, along with member checking during the CoP meetings, were used to develop the recommendations and learning agenda with a supporting action plan. The investigator wrote memos after each CoP meeting to aid in themes analysis and documenting any observations that may be surprising (Miles and Huberman, 1994). The investigator coded the CoP meeting notes with Atlas.ti and captured themes of the group conversation in the writing of the recommendations, learning agenda and action plan. This development took place in three waves: a draft outline ( $t_1$ ), draft documents ( $t_2$ ), and consensus documents ( $t_3$ ).

## IV. Results and Analysis

This single state case study of Ohio utilized a Community of Practice (CoP) with individuals representing a range of partner groups that was actively involved in including PWD in smoking cessation efforts. Ohio was identified as a state demonstrating this ability to include PWD through an initial document review. The investigator facilitated three virtual meeting sessions with eight CoP volunteers from Ohio. An action research cycle was completed during each virtual meeting session. A summary of the methods used in this study (based on Elliot's action research model (1991) is presented in Figure 5. The CoP served as a means to gather partners who had been collaborating on public health efforts that include PWD. Action research was used to allow the CoP participants and the investigator to explore the factors of readiness, capacity building, and capacity that contributed to successful inclusion of PWD in a public health effort, smoking cessation. In other words, this study explored what a state system must consider to be ready to take on such an effort, what capacity must be present among partner groups, and what capacity must be enhanced in order to include PWD. The study questions explored were:

- 1. What are the factors that make a state system ready to include PWD as a demographic?*
- 2. How does partner participation in a community of practice foster the capacity of state systems to include PWD as a demographic in public health efforts?*

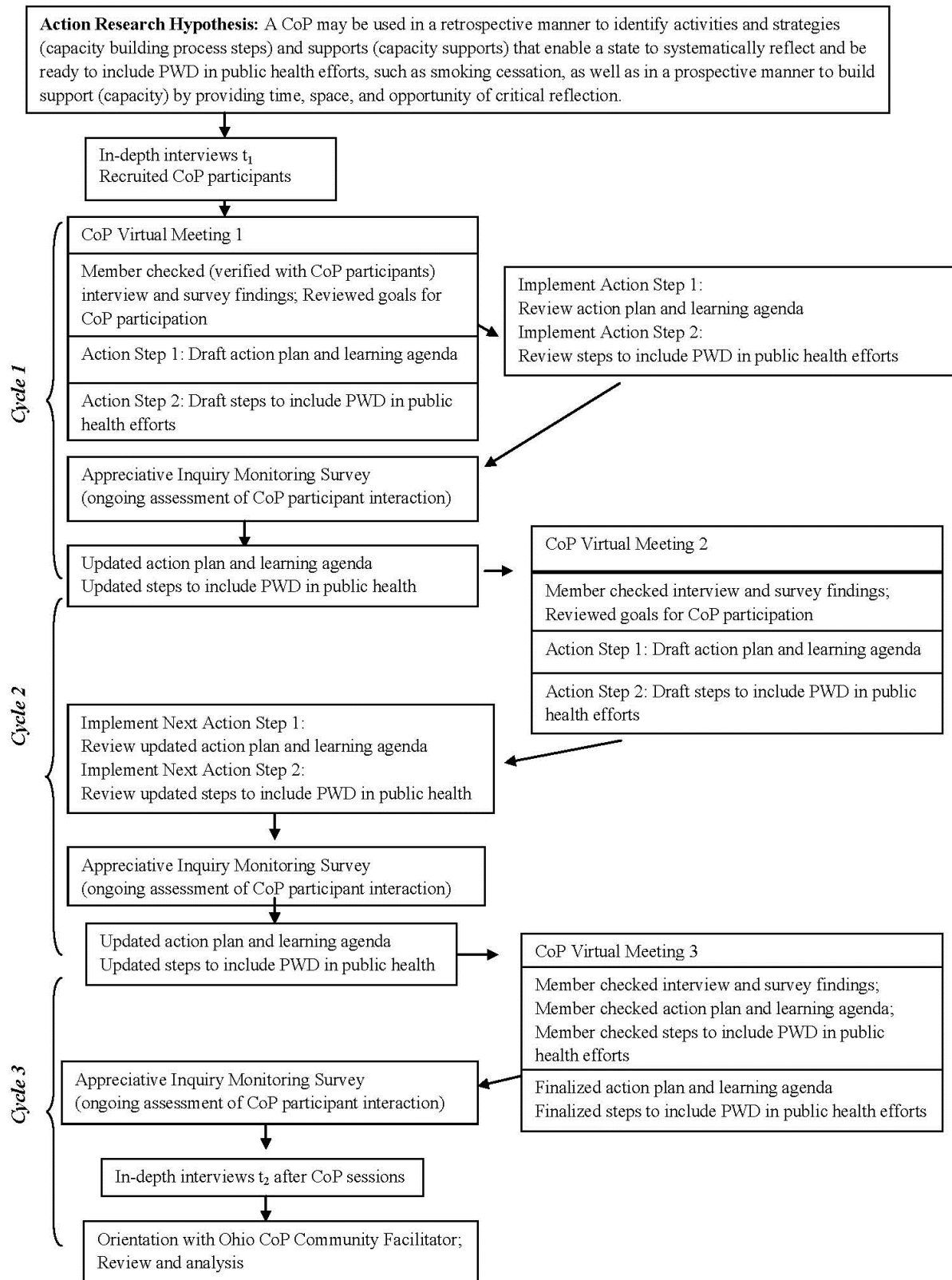
Data sources included: 1. Document Review, 2. Capacity In-depth Interviews with Program Staff (t<sub>1</sub>) and CoP participants (t<sub>2</sub>), 3. Readiness In-depth Interviews with Leadership of partner organizations, 4. Readiness Survey with Program Staff, 5. Online Survey/Appreciative Inquiry Monitoring System with CoP participants, 6. Action Research Cycles, and 7. CoP Virtual Meetings. Appreciative Inquiry and Topics of Participation Facilitation methods were used

during the group inquiry and discussion, interviews, and surveys.

This study identified 14 factors of readiness, capacity building, and capacity demonstrated by partners in Ohio in their work to include PWD in a public health smoking cessation effort (Section A). These factors can be applied to other public health efforts to include PWD. The CoP experience identified several of these factors (Section B). The CoP virtual meeting sessions showed that partnerships and facilitation were critical in including PWD (Section C). Action research cycles with the CoP identified activities and strategies (capacity building process steps) that states may take to include PWD in public health efforts (Section D). Findings from this study have implications for a larger, national dialogue that highlights the importance of explicitly including PWD and appropriate stakeholder groups and organizations in all statewide public health efforts. The CoP supported by Appreciative Inquiry and Topics of Participation Facilitation was a useful leadership tool to help state partners systematically reflect on their successes and identify activities and strategies to include PWD in public health efforts. The following are results that discuss the presence of these factors in Ohio's efforts to include PWD in smoking cessation efforts.



**Figure 5: Action Research Cycles**



## **A. Factors of State Systems that Include People with Disabilities in Public Health Efforts**

The primary study question for the current investigation was: *What are the factors that make a state system ready to include people with disabilities as a demographic in public health efforts?*

Sixteen readiness, capacity building, and capacity factors were explored. Fourteen factors (n=14) were observed. A summary of these factors, along with the data sources, are available in Table 12.

This study defined these readiness, capacity building, and capacity factors as:

1. *readiness factors* – preparation factors needed before a program that includes PWD takes place, e.g. awareness of other partners in an area of interest,
2. *capacity building factors* - factors related to the actual activities, strategies, and process steps that take place during a program that includes PWD, e.g. attending a training to learn about a particular target audience, and
3. *capacity factors* - factors needed to be able to perform and apply support toward inclusion of PWD in public health efforts, e.g. leadership support or dedicated resources.

Multiple data sources have been used to identify these factors. Seven data sources were used for this study:

1. Document Review (n=11) prior to the CoP and after t<sub>1</sub> In-depth Interviews, based on suggestions received from participants,
2. Capacity In-depth Interviews (t<sub>1</sub> prior to the CoP (n=5); t<sub>2</sub> after the CoP (n=7) to assess changes in capacity factors resulting from the CoP experience,
3. Readiness In-depth Interviews with Leadership of partner organizations (n=6) prior to the CoP,



Measures were used to define each of the factors. For instance, the Readiness Factor, *recognition of the need to coordinate* was defined by the current study in two ways, one as an awareness and knowledge of stakeholder efforts or an increase in awareness of stakeholder efforts, and two as coordinating joint efforts. If either of these measures were ever coded, this readiness factor of *recognition of the need to coordinate* was observed. See Table 13 for measures of the factors investigated in the current study and the respective data sources where these measures were observed.

<b>Table 13: Study Factors, Measure/Meaning, and Data Sources</b>	
<b>Factor</b>	<b>Measure/Meaning</b>
<i>Readiness Factors</i>	
Recognition of the need to coordinate	Measure 1: Awareness and knowledge of stakeholder efforts + <sup>1 a</sup> ~ <i>This referred to being familiar with partner examples of program or grant collaboration and knowledge of related efforts.</i>
	Measure 2: Coordination of joint efforts+* <i>This referred to doing a program or grant together or pursuing funding together.</i>
Contact with other organizations in this area	Measure: Frequent interactions with co-workers as well as outside organizations and stakeholders+ <sup>i a c</sup> <i>This referred to how other organizations were seen, either positively or negatively, and how contact happened and how often contact occurred.</i>
Understanding the work of other organizations in this area	Measure: Collaboration with partners in a program, including knowledge, value, interest ^ <sup>i</sup> <i>This referred to being familiar with partner knowledge, values, and interests through working together.</i>
Positive perception of other organizations	Measure: Quality interactions with partners +*^ <sup>i c</sup> <i>This referred to how interaction with other organizations was seen, either positively or negatively.</i>
Mutually shared goals, values, and interests with	Measure: Shared goals, values, and interests of partners +

other organizations	<i>This referred to how closely ideas, goals, values or interests were common among the partners.</i>
<b>Capacity Building Factors</b>	
Practical experience	Measure 1: Including people with disabilities in a work plan for public health efforts <sup>^ i</sup> <i>This referred to the concept of specific inclusion of PWD as a priority or a component of a strategy.</i>
	Measure 2: Disability identifier to describe people with a disability as a demographic <sup>^ a i</sup> <i>This referred to any references to the concept of PWD as a target of public health programs and surveillance.</i>
	Measure 3: Collaboration with partners <sup>a ~</sup> <i>This referred to any actual activities with partners, such as planning, needs assessments, trainings, or presentations.</i>
	Measure 4: Work plan, Information sharing and materials dissemination <sup>a •</sup> <i>This referred to any references of activities that include PWD in planning, information sharing or materials dissemination.</i>
Engagement in network	Measure: Being part of a team or planning group <sup>^ i a</sup> <i>This referred to any references of ongoing connections with groups in state and region or a sense of belonging.</i>
Continuing education	Measure: Access to educational opportunities <sup>i • ~</sup> <i>This referred to any references to employee conference or trainings where co-workers and staff learn, such as conferences or trainings.</i>
Critical reflection	Measure: Systematic reflection, thinking and planning time <sup>* • ~</sup> <i>This referred to dedicated staff time for thinking and planning, such as journaling, a retreat opportunity, or CoP participation.</i>
<b>Capacity Factors</b>	
Stakeholder involvement	Measure 1: Number and type of partners; frequency and type of interaction+ i <i>This referred to any coalition member, grant partner, or stakeholder, the type of contact, and the timeframe of the contact.</i>
	Measure 2: Activity planning ~ <i>This referred to any planning for collaboration such as information sharing, materials dissemination, planning, needs assessments, training or presentations.</i>
Adaptive capacity and support for organizational	Measure: Organizational learning; information generation and

learning	sharing <sup>i*</sup> <i>This referred to the concept of new ideas, tests, or experiments toward learning.</i>
Leadership support and vision	Measure: Vision, mission, strategic plan <sup>^i</sup> <i>This referred to any reference to the idea of vision or mission statements, or a strategic approach.</i>
Resources	Measure 1: Job requirements on partner and stakeholder involvement* <sup>a i</sup>  <i>This referred to any references to competencies, job requirements, job descriptions, or staffing.</i>  Measure 2: Dedicated funding <sup>i*~</sup> <i>This referred to any references to dedicated funds, budgets or grants.</i>
Technical skills and knowledge	Measure: Disability knowledge as a critical technical skill <sup>^ i a ~</sup> <i>This referred to any mention of information about PWD, through a needs assessment, or employee continuing education to include conferences or training, as a technical skill.</i>
Data sources: <sup>a</sup> Action Research Cycles <sup>^</sup> Document Review <sup>*</sup> Readiness In depth Interviews with Leaders <sup>c</sup> CoP Virtual Meetings	
<sup>*</sup> Appreciative Inquiry Monitoring System <sup>i</sup> Capacity In depth Interviews <sup>+</sup> Readiness Survey with Program Staff <sup>~</sup> In depth Interview: Follow Up t <sub>2</sub>	

Seven data sources were used to identify the factors of readiness, capacity building, and capacity present in Ohio's smoking cessation efforts, which included PWD. This study defined multiple data sources as a factor having been identified in at least three out of these seven data sources. All factors identified are reported in the following results narrative.

The Readiness Factor-*Mutually shared goals, values, and interests with other organizations*, as measured by the mention of shared goals, values, and interests of partners, was identified in only one data source, the readiness survey with program staff. Conversely, the Readiness Factor-*Positive perception of other organizations*, as measured by the mention of

quality interactions with partners, was identified by the most data sources, including: 1. document review, 2. online survey/Appreciative Inquiry Monitoring System, 3. readiness survey with program staff, 4. CoP virtual meetings, and 5. capacity in depth interviews.

Two factors that were investigated were not observed in study data sources: 1. Readiness Factor, *commitment to change*, which was measured by the mention of adoption of short-term tests and institutionalization of long-term tests, and 2. Capacity Factor, *change efficacy or the belief that the group can achieve something by working together*, which was measured through the mention of successful past collaborations. These two factors did not surface in the aggregate data summary, as they were only mentioned by an individual participant. Data were captured in the aggregate for this study as a way to maintain confidentiality due to the small number of study participants.

### **Interconnected Factors**

The following sections present the findings of the study by Readiness Factors (A1), Capacity Building Factors (A2), and Capacity Factors (A3). Factors were found to occur together, even if a specific data source was intended to specifically identify a particular set of factors. For example, Capacity Building factors were found within the readiness survey. The readiness, capacity building, and capacity factors with supporting data sources are reported, along with factors that occurred simultaneously, even if not the original intent and focus of the particular data source.

### **A1) READINESS FACTORS**

The readiness factors identified by the current study included the following:

1. Recognition of the need to coordinate, which was present if either 1. Awareness and knowledge of stakeholder efforts or an increase in this awareness or 2: Coordination of joint efforts, were mentioned,
2. Contact with other organizations in the area of interest through frequent interactions with co-workers as well as outside organizations and stakeholders,
3. Understanding the work of other organizations in this area through collaboration with partners in a program, including knowledge, values, and interests,
4. Positive perception of other organizations through quality interactions with partners, and
5. Mutually shared goals, values, and interests with other organizations through shared goals, values, and interests among partners.

These factors are not in rank order, but are the factors that emerged throughout the current study. Readiness factors emerged through the following: 1. readiness survey with program staff, 2. readiness interviews with leadership, 3. capacity in depth interviews, 4. document reviews, 5. the online survey/appreciative inquiry monitoring system, and 6. the process steps of activities and strategies to include PWD in public health that were developed during the action research cycles.

**Readiness Survey with Program Staff identified four key areas:** CoP Participants who held staff positions (n=5) at the four organizations that took part in the CoP sessions (1. Nisonger UCEDD, 2. Cincinnati Children's Hospital UCEDD, 3. the Ohio Department of Health, and 4. National Jewish Health, the quitline operator) were asked to participate in a survey which assessed the factors of readiness that were present in Ohio before the CoP began. These surveys were administered to staff prior to the CoP sessions as a retrospective assessment of what factors



may have impacted readiness to include PWD in smoking cessation. A table summary was used to analyze the survey due to the small *n*. (See Table 16.)

The key areas of readiness that the staff reported as most important (in rank order) are:

1. *Positive perception of other organizations*, measured through quality interactions with partners,
2. *Contact with other organizations in this area*, measured through frequent interactions with co-workers, as well as outside organizations and stakeholders,
3. *Recognition of the need to coordinate*, measured through awareness and knowledge of stakeholder efforts or increase in awareness of partner interests, and
4. *Mutually shared goals, values, and interests with other organizations*, measured through mentions of shared goals, values, and interests among partners.

These areas represent readiness strategies that were identified as preparing the partners in Ohio to include PWD in public health efforts. Each of these areas triangulated with findings of the readiness in depth interviews with leadership. As participants shared:

*“We raised their awareness of this disparity and then asked them to partner with us on programs to include people with disabilities in smoking cessation efforts.”*

*“We do pre-work including making sure that our team comes prepared with their homework so that there is a take-away factsheet with relevant data. Then we do a face-to-face meeting.”*

*“Absolutely, we have shared values! You get there, but you may not in the beginning....Sometimes they [staff] may experience frustrations with the questions they would get. And I would say let’s figure out why they are asking those questions. An example is that relationship with the health equity world and the disability... I’ve personally encouraged everybody to not give up...We just have to keep at it. So when there are opportunities to come to a meeting and present, we do it, even if they don’t totally get it yet. We don’t want to write them off. We need them.”*

**Readiness in depth Interviews with Leadership identified factors of readiness, capacity building and capacity:** Potential CoP participants who served as team leads or in oversight leadership positions (n=6) were interviewed to assess the factors of readiness present among the partners in Ohio before the CoP began. Interviews were completed by members of the Ohio Disability and Health Program (ODHP); the state-level Center for Independent Living (CIL), a member of the Disability Community Planning Group; the OH Colleges of Medicine Government Resource Center; and the OH Department of Health Tobacco Program. These interviews were completed prior to the CoP virtual meeting sessions, with the exception of the CIL interview, which was completed in between sessions two and three, as this individual was originally not available at the time of the interviews, but had later availability.

The most frequently mentioned factors in the leader interviews included readiness factors, as well as capacity building factors and capacity factors, even though this interview was not seeking other factors. (See Table 14.) The most frequently identified readiness factor was

*recognition of need to coordinate*, which was designated by the code *joint effort*. This was assessed through a mention of program or grant collaboration. The importance of *contact with other organizations in this area; recognition of the need to coordinate; mutually shared goals, values, and interests with other organizations; and understanding the work of other organizations in this area* were also identified. These findings triangulated with findings of the readiness survey with program staff. This indicated close alignment with the readiness factors staff and leaders perceived as necessary to include PWD in public health efforts, such as smoking cessation.

<b>Table 14: Readiness In Depth Interviews with Leadership: Top Mentions</b>	
<b>Factors (Codes)</b>	<b>Mentions</b>
<b>1. Readiness Factor, <i>recognition of need to coordinate</i> (joint effort)</b>	23
<b>2. Capacity Building Factor, <i>practical experience</i> (work)</b>	23
<b>3. Capacity Factor, <i>adaptive capacity and support for organizational learning</i> (information generation)</b>	23
4. Readiness Factor, <i>contact with other organizations in this area</i> (perception of partners)	20
5. Readiness Factor, <i>recognition of the need to coordinate</i> (awareness)	19
6. Capacity Factor, <i>stakeholder involvement</i> (type of interaction)	19
7. Readiness Factor, <i>mutually shared goals, values, and interests with other organizations</i> (teams)	18
8. Readiness Factor, <i>understanding the work of other organizations in this area</i> (shared values)	16
9. Capacity Factor, <i>stakeholder involvement</i> (frequency)	14
10. Capacity Building Factor, <i>continuing education</i> (educational opportunities)	13

These findings indicate that leaders in Ohio’s partner organizations thought that factors

across the constructs of readiness, capacity building, and capacity were crucial to be prepared to include PWD in public health efforts. These factors were interconnected and discussed simultaneously by these leaders. As leaders shared:

*“Just getting the data out to people to show how many people with a disability live in the community and the different health disparities they have – it’s been pretty eye-opening for them...It’s about raising awareness on both sides. Our organizations give us some room to be innovative to show that we are having an impact on health broadly.*

*“My vision is for the go-to people with disabilities [in the community] to be trained on smoking cessation. I think you need to bring it to the group....I would love for disability to be integrated into a larger effort...it would be nice to have a peer-to-peer component.”*

*“We’ve had conversations with the Centers for Independent Living. They have expressed interest...we’ve applied for funding to provide cessation programming through their organization. We have not been successful yet. I would really like to pursue it again. We’ve got a terrible smoking rate in our state for people with a disability and I’d really like to be part of the solution.”*

*“In the latest awareness campaign, we met with program partners several times...we designated a staff person to participate more meaningfully in active projects and that’s been really key.”*

The survey findings from the staff survey complimented the findings mentioned by the leaders during the readiness interviews. (See Table 15.)

<b>Table 15: Readiness In depth Interview with Leadership in Partner Organizations and Survey with Program Staff - Most Mentioned Codes</b>	
<b>Readiness In Depth Interviews with Leadership (n=6)</b> Readiness Factor (Codes in order of mentions)	<b>Readiness Survey with Program Staff (n=5)</b> Readiness Question Topic and Response
1. Readiness Factor, <i>recognition of need to coordinate</i> (Joint effort-23 mentions)	1. <i>Interaction with partners</i> All (5/5) collaborated with partners
2. Readiness Factor, <i>contact with other organizations in this area</i> (Perception of partners-20 mentions)	2. <i>Positive perception of partners</i> All (5/5) strongly agree or agree
3. Capacity Factor, <i>stakeholder involvement</i> (Type of interaction-19 mentions)	3. <i>Meeting with partners</i> All (5/5) prefer meeting in person or by phone with partners
4. Readiness Factor, <i>recognition of need to coordinate</i> (Awareness-19 mentions)	4. <i>Awareness</i> Most (4/5) agree they have awareness of partner interests
5. Readiness Factor, <i>Mutually shared goals, values, and interests with other organizations</i> (Teams-18 mentions)	5. <i>Mutually shared effort</i> All (5/5) agree that they collaborate on mutually shared efforts

Both the leaders and the staff that worked on disability and health efforts had a shared sense of the factors that made them prepared to include PWD in their public health efforts. The factors included both readiness and capacity factors.

**Capacity in depth Interviews with Program Staff found that awareness of partners, positive interactions, and dedicated funding critical:** Prior to the CoP, in depth interviews were conducted with potential participants to assess the factors of capacity already present among the partners in Ohio. This also served as a baseline measure to assess if any factors changed as a

result of the CoP experience. Program staff (n=5) were given a capacity assessment interview (t<sub>1</sub>) prior to the CoP. Interviews were completed by members of the Ohio Disability and Health Program (ODHP), including the Nisonger Center UCEDD (n=3); the Cincinnati Children's Hospital UCEDD (n=1); and the Ohio quitline vendor, National Jewish Health (n=1).

Readiness and capacity building factors were identified by the capacity in depth interviews, even though these interviews sought to identify capacity factors. The following Readiness Factors were identified: 1. *Recognition of the need to coordinate*, 2. *Contact with other organizations in this area of interest*, 3. *Understanding the work of other organizations in the area*, and 4. *Positive perception of other organizations*. (See Table 16.)

Table 16: Capacity In Depth Interviews: Readiness, Capacity Building, and Capacity Factors		
Readiness Factor	Capacity Building Factor	Capacity Factor
1. <i>Positive perception of other organizations</i> : 45 mentions	1. <i>Practical experience</i> : 37 mentions	1. <i>Adaptive capacity and support for organizational learning</i> : 35 mentions
2. <i>Contact with other organizations in this area of interest</i> : 29	2. <i>Engagement in network</i> : 31 mentions	2. <i>Technical skills and knowledge</i> : 31 mentions
3. <i>Recognition of the need to coordinate</i> : 19 mentions	3. <i>Continuing education</i> : 30 mentions	3. <i>Stakeholder involvement</i> : 29 mentions
4. <i>Understanding the work of other organizations in the area</i> : 12 mentions		4. <i>Resources</i> : 12 mentions

The importance of *positive perception of other organizations* was a key finding as its measure, *quality interactions with partners*, was the most frequently mentioned (n=45) measure across the t<sub>1</sub> interviews. As one participant shared:

*“I think these interactions have been quality interactions. I’d prefer in person, but when it’s hectic, I’ll take what I can get. Plus with email, you can go back and reference the thought process. You can use this as a starting point for in person meetings going forward.”*

Others mentioned the importance of interactions and awareness as it related to activities:

*“It’s new to many in public health to think about people with a disability as a demographic, just like race or ethnicity...A lot of times our partners have no idea that there are people with disabilities in their communities and are surprised to learn that they comprise almost 20% of the population...a lot of awareness raising.”*

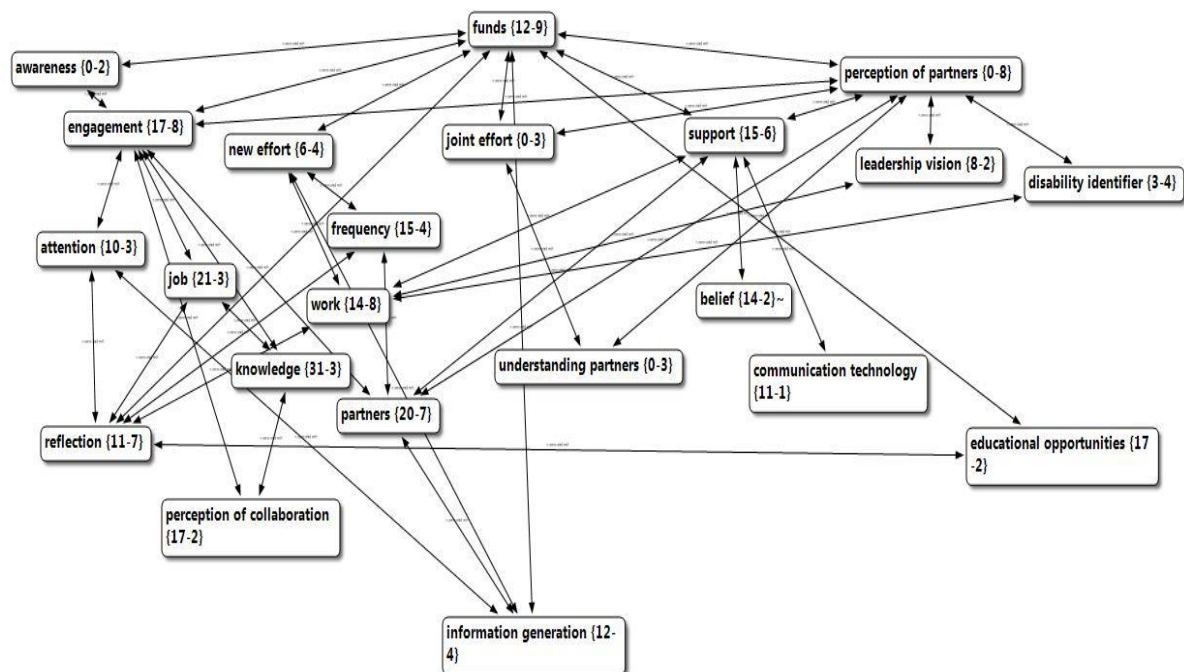
*Positive perception of partners* co-occurred with the measure *funding*, which was associated with the Capacity Factor, *resources*, as well as *awareness*, which was associated with the Readiness Factor, *recognition of need to coordinate*. Measures were found to be connected across the factors of readiness, capacity building, and capacity. (See Figure 6.) Given that the measure of *quality interactions with partners* was the most frequently mentioned measure for *positive perception of other organizations*, ***awareness of partners and positive interactions were integral for pursuing dedicated funding***. These factors appeared to be occurring simultaneously to facilitate the pursuit of dedicated funding. Several participants mentioned funding as it relates

to perception of partners:

*“We need money to implement a [smoking cessation] program with the CILs [Centers for Independent Living]. Then [other partners] responded that they have an upcoming funding opportunity.”*

*“We collaborated on a grant with the OH Office on Health and Disability – on a grant that they applied for. We were in support of it and provided data in support of their application. We participated in developing outreach materials as part of that grant.”*

**Figure 6: Funds-Capacity In depth Interview with Program Staff (t1) Co-Occurring Codes**



**Key:** Code (1<sup>st</sup> number=grounding/mentions—2<sup>nd</sup> number=density/co-occurring networks)  
Arrows represent co-occurring networks among the codes.



**Document review showed understanding of partners and positive perception:** Documents were reviewed prior to the Community of Practice (CoP) to ascertain whether the case study state Ohio has demonstrated capacity in including PWD in public health efforts, like smoking cessation. Participants were also asked to recommend documents during the initial in depth interviews. A total of eleven (n=11) documents were reviewed. (See Appendix O for content summary of the document review.) The document review found: *1. Understanding the work of other organizations in this area* through partner collaborations, including knowledge, values, and interest, as exemplified in a needs assessment and APHA Poster on smoking cessation efforts in Ohio; and *2. Positive perception of other organizations* through quality interactions with partners, seen in a partner collaboration proposal. The document review showed the diverse group of partners in Ohio valued involvement of disability organizations and partners, and placed a priority on including PWD in public health programs through collaborative activities.

The OH quitline and the OH Department of Health have served as partners in the effort to add disability identifiers, such as self-identification questions on any limitations in daily activities, to surveillance questions to better describe PWD who smoke. The organizations of the CoP participants all held a similar health focus, as identified in the vision and mission document review. This was also demonstrated during the follow up interviews. As one participant shared:

*“We all have something to do with health. If it’s about health, we [OH Disability and Health Program] should be involved.”*

The document review did not identify data that describes the specific segments of the disability population who may be smoking. This connected with the CoP session finding that the participants emphasized the need for disability identifiers to learn more about PWD who may also smoke. Additional disability identifiers were described by CoP participants as potential modifications and additions to current surveillance questions in the state Behavioral Risk Factor Surveillance System (BRFSS) survey. This issue has been discussed by the group of partners in Ohio in the past, as exemplified by this participant quote:

*“Our collaboration is successful, but it took a while...about a year to add the disability qualifier [quitline question]. They had to be careful with the addition of the question to the intake form to not make it too long...We compromised to not ask the full BRFSS questions [6 questions].”*

Participants did not recommend additional documents for review at the end of the CoP sessions.

**Appreciative Inquiry Monitoring System found quality interactions among partners:**

The goal of the Appreciative Inquiry Monitoring Survey was to assess any changes that may occur in the factors of readiness, capacity building, and capacity among the CoP participants in between the virtual meetings via an online survey. A full response rate was not achieved (t<sub>1</sub>, 5/8, 62.5%; t<sub>2</sub>, 5/8, 62.5% t<sub>3</sub>, 7/8, 87.5%). A bar graph was used to show the relative sizes of the results due to the small *n*. (See Figure 8 *Appreciative Inquiry Survey CoP Participant Summary*.)

Team leaders and staff CoP participants held similar views in that they all learned new information in the CoP and preferred meeting in person, followed by phone contact. All reported that their goals for CoP participation were met and that they were able to share and contribute information. Goals included using the CoP as an opportunity for sharing, strengthening collaboration, and an opportunity to expand current work. (See Appendix L.)

***Quality interactions with partners were reported overall.*** One participant reported contacting other CoP members, with whom he would not have otherwise spoken, in between meetings. Some participants felt that the survey administration timings were too soon to report changes, as one participant shared at end of interviews:

*“I was not sure how to respond to the survey because our team has had so many participants...I feel like I communicate with the ODHP team regularly. Those have stayed the same.”*

**Action and Process Steps developed during Action Research Cycles emphasized awareness and contact with partner organizations:** An outline of activity steps and strategies that states could use to include PWD in public health efforts were developed by the CoP participants during the action research cycles. These action steps were based on a retrospective examination of past efforts and prospective experience of partners during the CoP. Factors of readiness, capacity building, capacity were associated with these action steps. (See Table 23 in Section D: Action Research Cycles.) Readiness factors identified included *recognition of the need to coordinate*

and *contact with other organizations in this area*. This triangulated with the findings of the capacity in depth interviews, the readiness interviews with leadership in partner organizations, and the readiness survey of program staff.

## **A2) CAPACITY BUILDING FACTORS**

The capacity building factors identified by this study included:

1. Practical experience through mentions of activities that:

1. included PWD in a work plan for public health efforts, or
2. a disability identifier to describe PWD as a demographic, or
3. collaborated with partners, or
4. had work plan which noted information sharing and materials dissemination;

2. Engagement in network through mentions of being part of a team or planning group;

3. Continuing education through mentions of access to educational opportunities; and

4. Critical reflection through mentions of systematic reflection, thinking and planning time.

These factors are not in rank order, but are the factors that emerged throughout the current study.

Capacity building factors were identified during the readiness interviews with leaders, capacity in depth interviews, document reviews, and the Appreciative Inquiry Monitoring System; and emerged through the action steps developed during the action research cycles.

All measures for *practical experience*, or activities, were found and triangulated through four data sources: 1. capacity interviews, 2. document review, 3. readiness in depth interviews with leaders, and 4. action research cycles. The factor *engagement in a network* was found in

three supporting data sources: 1. capacity in depth interviews, 2. document review, and the 3. action research cycles, which suggests strong support for this factor as well.

**Capacity In depth Interviews with Program Staff showed that practical experience and engagement in a network are critical:** A key finding of the capacity in depth interview with program staff (t<sub>1</sub>) was that one member of the Ohio Disability and Health Program (ODHP) team, housed within the policy team at ODH, had received specialized leadership and disability training. This was associated with the capacity building factors *practical experience* and *engagement in a network*, even though the interview was intended to identify capacity factors.

This member of ODHP's team was dedicated to serving as a liaison between the ODH and ODHP teams. Originally, a former Leadership Education in Neurodevelopmental and Related Disabilities (LEND) trainee was in a key leadership role at ODH and pivotal in brokering the relationship with the tobacco program and ODHP, as well as arranging and overseeing this staff position.<sup>5</sup> As one interview participant put it:

*“My supervisor was a LEND trainee – she gets it. I was actually a LEND trainee too, so that’s helpful.”*

Disability training was seen as an asset for the work ODHP undertook with the DOH.

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<sup>5</sup> LEND programs are one type of member of the Association of University Centers on Disabilities (AUCD), which is a national network that advances policies and practices that improve the health, educational, social, and economic well-being of all people with disabilities. Some LENDS are co-located with University Centers of Excellence on Developmental Disabilities (UCEDDs).

**Follow up In Depth Interview identified changes in perception of educational opportunities and practical experience:** A follow up in depth interview ( $t_2$ ) to assess any changes in the factors of capacity, capacity building, and readiness was conducted with each participant ( $n=7$ ) after the CoP virtual meetings. The entire team from the Nisonger UCEDD participated, along with the Cincinnati UCEDD program manager, and a business manager from the OH quitline operator, National Jewish Health. Two participants from the Ohio DOH requested to combine their interview. Therefore, a total of seven follow up interviews were conducted ( $n=7$ ).

The follow up interviews identified two aspects of the *practical experience* through including PWD in a work plan and using a disability identifier to describe PWD as a demographic. From the initial capacity in depth interviews ( $t_1$ ) to the follow up interviews ( $t_2$ ) after the CoP experience, the greatest increase was in *practical experience*, specifically the importance of having a disability identifier that describes PWD as a demographic, with 7 mentions at  $t_1$  and 11 mentions at  $t_2$ . This supported the importance of the capacity building factor *practical experience* and showed that a key activity for partners is to include PWD in their work plan and collaborate with partners to explicitly include PWD as a target population.

*Continuing education* was mentioned most frequently. *Educational opportunities*, the code for this factor, was most frequently mentioned ( $n=16$ ) in the follow up interview.

*Educational opportunities* were identified through specific opportunities for employee education,

learning, or trainings. See Table 17. Educational opportunities related to staff trainings and future learning activities.

<b>Table 17: In Depth Interviews – Comparison of Mentions</b>			
<i>Readiness Interviews with Leaders/ Capacity Interviews with Program Staff t<sub>1</sub></i>		<i>Follow Up Interview t<sub>2</sub></i>	<i>Mentions</i>
Factor (code)		Factor (code)	
1. Capacity (knowledge)	31	1. Capacity Building (educational opportunities)	16
2. Capacity (type of interaction)	26	2. Capacity (partners)	15
3. Capacity (accountability)	23	3. Readiness (awareness)	15
4. Capacity (activities)	22	4. Capacity (funds)	14
5. Capacity (job)	21	5. Capacity Building (reflection)	14
6. Capacity (partners)	20	6. Capacity Building (attention)	14
7. Capacity Building (educational opportunities)	17	7. Readiness (understanding partners)	14
8. Capacity Building (engagement)	17	8. Capacity (activities)	13
9. Capacity (perception of collaboration)	17	9. Capacity (knowledge)	13
10. Capacity (support)	15	10. Capacity building (work)	12
11. Capacity Building (disability identifier)	7	11. Capacity building (disability identifier)	11

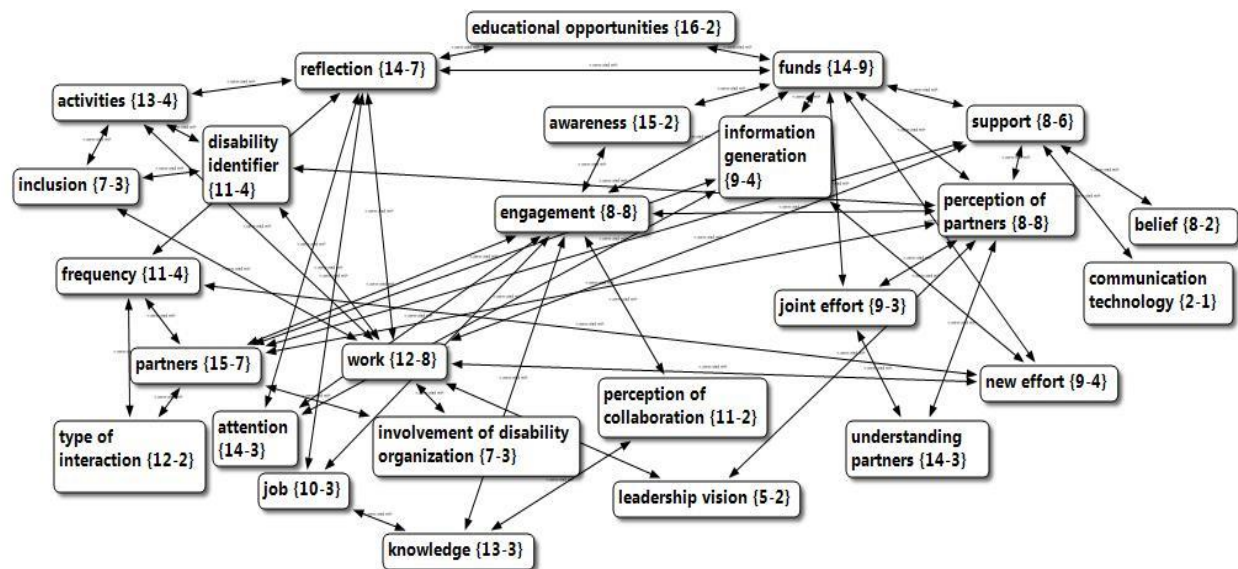
Perceptions around *educational opportunities* changed after the CoP experience, as did . stakeholder involvement (designated by the code partners) and recognition of the need to coordinate (designated by the code awareness). The initial readiness interviews (t<sub>1</sub>) showed that technical skills and knowledge were mentioned most, whereas *educational opportunities* were mentioned less frequently. However, *education opportunities* were mentioned most (n=16) during the t<sub>2</sub> interviews. See Figure 7. As one CoP participant explained:

*“The opportunity to have disability training for our staff has been the number one exciting thing to come out of this. One of the CoP members even offered to fund it.”*

This kind of educational opportunity for training was seen as a future activity by a few participants:

*“We have not had the opportunity to provide educational opportunities yet. Perhaps in the future...we’ve been meeting for a fairly short time, so the conversations would need to continue to make progress.”*

Figure 7: Educational Opportunities  $t_2$  Co-Occurring Codes



**Key:** Code (1<sup>st</sup> number=grounding/mentions—2<sup>nd</sup> number=density/co-occurring networks)  
Arrows represent co-occurring networks among the codes.



*“Since the CoP we have not given any significant training events, but we did use our work as a highlight on disparities in a recent stakeholder newsletter. So that’s one way we’re educating people.”*

*“Based on the conversations that we’ve had, we’re more connected. We’ve pointed out and identified ways that we can work together in the future. We have not yet had the opportunity to do shared activity planning. But based on our conversations, I think there will be some headway there.”*

CoP participants recognized the importance of educational opportunities, not just their existing technical skill and knowledge.

Educational opportunities co-occurred with funds (a code for designated funding) and reflection (a code for critical reflection). Reflection and educational opportunities appeared to be occurring at the same time to facilitate pursuit of dedicated funding. (See Figure 6.) This represented a shift in the CoP participant perception around the importance of reflection as a way to prepare for the change of incorporating PWD into public health programs. The participants reported that they had dedicated meetings to discuss ideas, which may serve as a space for reflection. As one participant put it:

*“We have dedicated time. Our team meets formally weekly and we’ve discussed the specifics that have come up on the CoP.”*

The interest of the CoP participants in educational opportunities demonstrated that readiness, capacity building, and capacity factors were present simultaneously or that the constructs of these factors were closely related and perhaps not defined in a distinct manner.

**Document review identified practical experience and engagement in network:**

*Practical experience*, through including PWD in a work plan for public health efforts or use of disability identifier to describe PWD as a demographic, was shown in seven documents. (See Appendix O.) This triangulated with findings of the capacity in depth interviews with staff, the follow up in depth interviews with CoP participants, and the action research cycles. This supported the overall importance of explicitly including PWD in public health efforts.

*Engagement in network*, through being part of a team or planning group, was identified in the work plan during the document review. This showed that the partners in Ohio valued being part of a team and have included PWD in their work plan. Involvement of disability organizations in a work plan, inclusion of PWD in the public health planning groups, and collaboration teams, were present in Ohio's efforts to include PWD in smoking cessation efforts. *Engagement in a network* was identified during the initial capacity in depth interviews with program staff and the action research cycles, which suggests strong support for this factor being relevant for Ohio's efforts in including PWD in smoking cessation efforts.

**Appreciative Inquiry Monitoring System identified changes in four capacity building factors:** The Appreciative Inquiry Monitoring System was an online survey, which assessed changes in the factors of readiness, capacity building, and capacity among the CoP participants

in between the virtual meetings. In examining the aggregate changes overall for the group, the CoP participants showed changes in 1. *practical experience*, through mentions of incorporating information from the CoP into updates to work plans, information sharing and materials dissemination; 2. *continuing education*, through mentions of access to educational opportunities as a learner; 3. *critical reflection*, through mentions of systematic reflection, thinking and planning time; and 4. *engagement in network*, through mentions of being part of a team or planning group. See Figure 8.

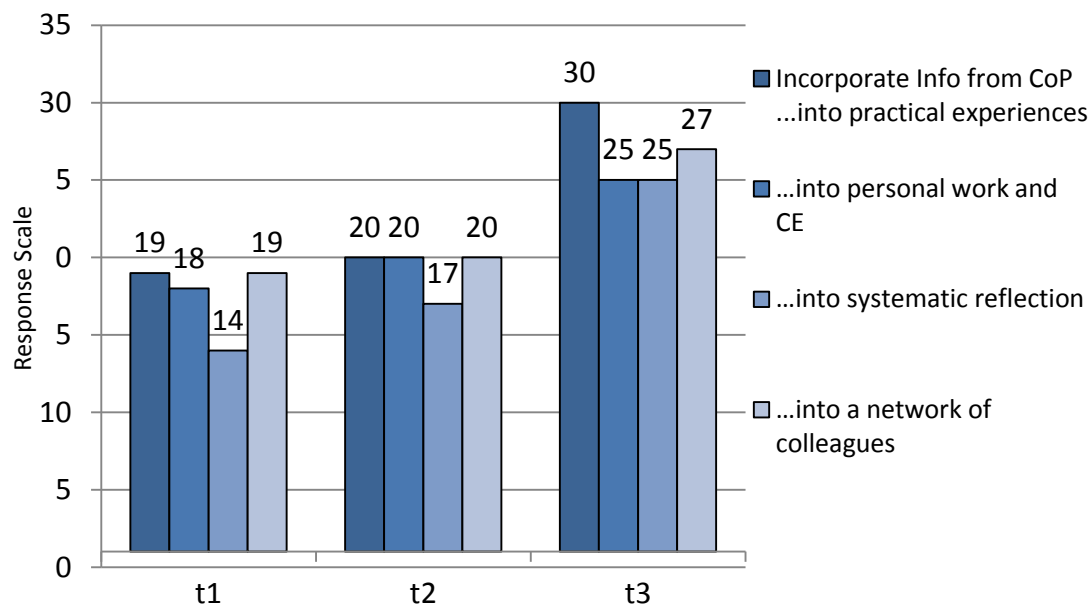


Figure 8: Appreciative Inquiry Survey CoP Participant Summary

Incorporation of information from the CoP into practical experiences, personal work and continuing education (CE), systematic reflection, and work with a network of colleagues was monitored after each CoP session.

During  $t_1$  and  $t_2$  the maximum possible response value was 25 as there were 5 respondents and the highest possible value for the responses was 5. At  $t_3$  the maximum response was 35 as there were 7 responses, with the highest possible value for the responses being 5. No statistical

test of significance was performed due to the low *n*.

Having *dedicated staff* to focus on various aspects of the disability and health project *was essential for moving efforts forward*. The CoP participants began their experience in the current study with a solid understanding of partnership building and exhibited factors of capacity building. This finding was triangulated through the readiness in depth interviews with leaders and follow up in depth interviews. As participants shared:

*“We absolutely have dedicated staff. It is spelled out in my coordinator’s time to be dedicated to this.”*

*“The CoP served as a catalyst for us. It was an excuse to talk more...The CoP was really helpful for our partnership.”*

Participants shared that they were incorporating the information from the discussions into their own practical experiences and in work with their network of colleagues.

The *levels of systematic reflection remained low* throughout the survey administrations.

However, through this CoP experience, the participants developed a greater appreciation for partners and valued the group discussion time and space. This finding was triangulated through the follow up in depth interviews. As one participant shared:

*“We have dedicated time for reflection...We’ve discussed the specifics that have come up in the CoP.”*

**Readiness in depth Interviews with Leaders in Partner Organizations identified importance of**

**practical experience:** Potential Community of Practice (CoP) participants who served in leadership positions in partner organizations (n=6) were given an interview, which assessed the factors of readiness for integrating PWD into public health efforts like smoking cessation. Even though this interview was intended to investigate the readiness factors that enabled Ohio to include PWD in public health efforts like smoking cessation, the Capacity Building factor of *practical experience* was mentioned. The most frequently mentioned factors found in the leader interviews were equally among capacity, readiness, and capacity building factors. (See Table 15.)

The Capacity Building factor of *practical experience* was assessed through mentions of a work plan with examples of public health programs and activities including PWD, as well as information sharing and materials dissemination. The code for this was *work*. This presence of *practical experience* connected with a finding in the follow up interviews. As one shared:

*“In my mind the work plan is expanded...if we get permission to review data...if we get funding first.”*

This further emphasized that the factors of readiness, capacity building, and capacity occurred simultaneously in Ohio’s efforts to include PWD in public health efforts.

### **A3) CAPACITY FACTORS**

The capacity factors identified by this study included:

Stakeholder involvement, through mentions of frequent interactions with co-workers as well as outside organizations and stakeholders,

Adaptive capacity and support for organizational learning, through mentions of organizational learning and information generation'

Leadership support and vision, through mentions of vision, mission, or a strategic plan,

Resources, through mentions of job requirements on partner and stakeholder involvement, or dedicated funding, or

Technical skills and knowledge, through mentions of disability knowledge being a critical technical skill within public health.

These factors are not in any rank order, but are the factors that emerged throughout the current study. Capacity Factors were identified in the following data sources: 1. capacity in depth interviews with program staff, 2. readiness survey with program staff, 3. readiness interviews with leadership in partner organizations, 4. document reviews, 5. Appreciative Inquiry Monitoring System, and 6. through the activity process steps developed during the action research cycles. *Technical skills and knowledge* had the strongest support as it was identified through three data sources: 1.capacity in depth interviews, 2. document review, and 3. during the action research cycles.

**Capacity In depth Interviews with Program Staff showed importance of dedicated staff and funding:** A capacity in depth interview with program staff (t<sub>1</sub>) finding was the importance

of *dedicated staff*. This complimented comments that other participants shared about job competencies and descriptions. As an interview participant shared:

*“It is my job—It’s my entire job. It’s my job to be sure that people with disabilities are included.”*

This was associated with the Capacity Factor of *resources*, which referred to time, people, funds, or space needed to support an effort.

*Resources* was also measured by *dedicated funding*, which was not as frequently mentioned (12 mentions). However, *dedicated funding* was connected with the most factors across the constructs of readiness, capacity building, and capacity. (See Figure 6.) *Awareness of partners and positive interactions were integral for pursuing dedicated funding.*

**Readiness Survey of Program Staff identified stakeholder involvement, a Capacity Factor:**

Surveys were administered to staff (n=5) prior to the CoP sessions to staff as a retrospective assessment of factors of readiness already present among program staff. The key area that the staff reported as most important was *stakeholder involvement*, which was a Capacity Factor, measured through mention of frequent interactions with co-workers, as well as outside organizations and stakeholders. Even though this survey was intended to identify Readiness Factors, this Capacity Factor emerged. This showed that these factors were closely connected and perhaps not defined in a distinct manner.

The staff indicated taking action to collaborate with partners, whereas the leaders shared during the interviews that they prepared to collaborate with partners by thinking about joint efforts. This showed that the staff were engaged in carrying out the plans of the leadership regarding involving stakeholders in public health efforts to include PWD.

**Readiness in depth Interviews with Leaders in Partner Organizations identified information**

**generation:** Potential CoP participants who served in leadership positions (n=6) were given an interview (t<sub>1</sub>) to assess the Readiness Factors needed for integrating PWD into public health efforts like smoking cessation. The Capacity Factor of *adaptive capacity and support for organizational learning* was observed through the *information generation* measure, which was present if action plans based on needs assessments or information generation and sharing through trainings and presentations were mentioned. (See Table 15.) This triangulated with the follow up interview findings. As one participant shared:

*“I think we generated new information. Definitely new ideas were generated and what may come of them. One example is furthering the data collection so that we better understand how people with disabilities are using the quitline...I think there were tons of information sharing generated in those [CoP] meetings.”*

**Follow up in depth Interview identified importance of educational opportunities,**

**stakeholder involvement, and partner awareness:** A follow up interview (t<sub>2</sub>) to assess any changes in the factors of readiness, capacity building, and capacity was conducted with each participant after the CoP virtual meetings. *Educational opportunities*, which was the code for the



Capacity Building factor of continuing education, was the most frequently mentioned. However, the Capacity Factor of *stakeholder involvement*, as designated by the code *partners* closely followed. (See Table 18.) This demonstrates that the CoP participants placed value on stakeholder involvement in public health efforts that include PWD, in addition to continuing education opportunities. As one participant shared:

*“As long as other agencies that are more mainstream are interested in providing resources for people with disabilities, we can provide that expertise. I think it makes a great partnership...my job focus is to teach professionals to reach people with disabilities - with health promotion...My employee continuing education trainings are coming up.”*

The follow up interview also showed that the CoP participants increased in *awareness* of *understanding the work of other organizations* and *recognition of the need to coordinate*, both of which are Readiness Factors. This indicated that the CoP experience enhanced these factors among the participants. The change in partner awareness and recognition was mentioned:

*“It [disability] is still a little bit new to them [partners] ...it’s progressed from I have no idea about this to this is pretty important. From the CoP conversations, I sense that they [partners] think this is worth their priority, worth their resources...our role is to assess and equip programs with the ability to better serve people with disabilities.”*

**Document review – importance of disability knowledge and leadership support and vision:** The document review identified the importance of disability knowledge as a technical skill within public health through an examination of vision and mission statements, OH quitline

promotional materials, and policy briefs. Leadership support and vision was identified through the vision and mission statements. (See Appendix O.) These findings showed that Ohio was a relevant case to investigate as this state had a diverse group of partners with technical knowledge of disability, who actively engaged in strategies and programs to include PWD in public health efforts, and had leadership support. These findings were triangulated in the capacity in depth interviews with program staff, follow up interviews, and the action research cycles. As some put it:

*“One of our partners has the disability expertise and can offer technical assistance in this area.”*

*“We’ve started the conversation on making materials more easily accessible. Because of the CoP, we were able to have more conversation about this in general and with the health equity area, reaching the disability population in all the health efforts the department of health oversees.”*

*“The connections from the CoP fit in very well with our vision and mission. Improving the health of people with disabilities is something that everyone on the CoP seemed focused on and was receptive to. It obviously fits in with our core mission and it fits with others too.”*

### ***Secondary Research Questions***

One secondary study question was: *What are the capacity supports that help make a state system ready?* All of the readiness, capacity building, and capacity factors identified by the study would apply as the factors have been found to be closely interconnected and occurring

simultaneously throughout the effort to include PWD in public health efforts.

Another secondary question was: *What are the process steps that a state system can take to become ready?* The Capacity Building factors identified by the study would apply to this question as this study defined these factors as the actual process happening and the associated activities. All of the Capacity Building factors identified by the study would also apply. This study referred to Capacity Building factors as those that related to the actual steps during the change process of including PWD in public health efforts. These Capacity Building factors have been identified in multiple data sources and suggest that the priority factors may be *practical experience* and *engagement in a network*, as these have the most evidence in the data sources.

#### **Summary: Nine Critical Factors Identified**

Although 14 factors were found to be present in Ohio's efforts to include PWD in public health efforts, nine were found to be critical as they were identified through multiple data sources. This study defined multiple data sources as at least three data sources. These nine critical factors with multiple data sources included:

1. Recognition of the need to coordinate (4 data sources),
2. Contact with other organizations (3 data sources),
3. Positive perception of other organizations and quality interactions (5 data sources),
4. Practical experience of collaboration with partners and direct involvement of the target audience (6 data sources),
5. Engagement in a network, team or planning group (4 data sources),
6. Continuing education (4 data sources),

7. Critical reflection (3 data sources),
8. Resources of dedicated staff and funds (5 data sources), and
9. Knowledge of the target audience as a technical skill (4 data sources).

These critical factors represented the most essential aspects of readiness, capacity building, and capacity that were found to be present in Ohio's efforts to include PWD in public health efforts, such as smoking cessation.

## B. Community of Practice Fostered Readiness, Capacity Building, and Capacity Factors

The second question posed by the current study was: *How does partner participation in a Community of Practice foster the capacity of state systems to include people with disabilities as a demographic in public health efforts?* This study identified 10 factors of readiness, capacity building, and capacity that were found more often in the data sources after the CoP. (See Table 18.) **The CoP was as a “stage” that enhanced factors of readiness, capacity building, and capacity toward including PWD in public health efforts.** The Readiness Factors included:

1. Recognition of the need to coordinate, through awareness and knowledge of stakeholder efforts or an increase in this awareness,
2. Contact with other organizations working in this area, through collaboration frequency or the type of interaction,
3. Positive perception of other organizations, through mentions of quality interactions with partners, and
4. Understanding the work of other organizations in this area, through mentions of collaboration with partners in a program, including knowledge, values, or interest.

The Capacity Building Factors included:

1. Practical experience, through mentions of using a disability identifier to describe PWD as a demographic, or activities and collaboration with partners,
2. Continuing education, through mentions of access to educational opportunities,
3. Critical reflection, through mentions of systematic reflection, thinking and planning time, and
4. Engagement in network through mentions of being part of a team or planning group.

The Capacity Factors included:

1. Stakeholder involvement, through mentions of partners and activity planning,
2. Resources, through mentions of having dedicated funding, and

3. *Technical skills and knowledge*, through mentions of disability knowledge being a critical technical skill within public health.

These readiness, capacity building, and capacity factors were found to be enhanced after the CoP experience, as assessed by the follow up in depth interview (t<sub>2</sub>) (Tables 14 and 17), the CoP virtual meeting discussion analysis (Section C), and the action research cycles (Section D). Multiple data sources identified that the CoP participants increased their recognition of the need to coordinate, as well as practical experience through discussions with partners on tactics to include disability screener questions in state public health surveillance. This means that recognition of the need to coordinate and the opportunity for practical experience were key factors impacted by CoP participation.

***In depth Interview Follow Up identified enhanced activity planning and importance of facilitation:*** A follow up interview (t<sub>2</sub>) to assess any changes in the factors of readiness, capacity building, or capacity was conducted after the CoP virtual meetings (n=7). The follow up interviews revealed that the CoP participants were poised to pursue new efforts together.

Table 18: Summary of Results-Study Question 2		
<i>Study Question 2) How does partner participation in a community of practice foster the capacity of state systems to include people with disabilities as a demographic in public health efforts?</i>		
Readiness Factors	Capacity Building Factors	Capacity Factors
1. Recognition of the need to coordinate <sup>a</sup> ~ 2. Contact with other organizations working in this area <sup>c</sup> 3. Positive perception of other organizations <sup>c</sup> 4. Understanding the work of other organizations in this area~	1. Practical experience <sup>a</sup> ~ 2. Continuing education~ 3. Critical reflection ~ 4. Engagement in network *~	1. Stakeholder involvement <sup>c</sup> ~ 2. Resources~ 3. Technical skills and knowledge~
Data Sources: <sup>a</sup> Action Research Cycles <sup>c</sup> CoP Virtual Meetings		
~ In depth Interview: Follow Up t <sub>2</sub> * Appreciative Inquiry Monitoring System		

Although not doing these efforts yet, the participants were engaged in *activity planning*, which is a measure of the Capacity Factor *stakeholder involvement*. Some CoP participants were already demonstrating capacity toward these efforts. As one participant put it:

*“At our national tobacco conference, I gave a presentation on evaluation of surveillance in terms of best practices. I used disparate populations as an example and I mentioned this CoP as part of that presentation. I did have the data that our epidemiologist pulled on people with disabilities having higher smoking rates.”*

Most of the participants reported being well-positioned to continue collaborative efforts and were already committed to doing so. The *activity planning* measure for the Capacity Factor, *stakeholder involvement*, was identified during the follow up interviews:

*“No changes are happening yet, but there’s definitely ideas on how we can move forward...The groundwork is being laid.”*

*“I feel like this group (CoP) made partners more interested in understanding why know more about those different groups [of people with disabilities] would be helpful. That is another big progress area.”*

***Facilitation was found to help with activity planning.*** The Topics of Participation (ToP) facilitation, a focused conversation method, was used as a tool to support the CoP discussions. Several of the participants mentioned seeing value of facilitation for their discussions and activity planning:

*“This CoP aligned with our program goals, so that piqued my interest...Participating was great. Each of the meetings were incredibly productive. I’m not sure that the progress and the speed of the progress would have happened without the facilitation.”*

*“Having these regularly scheduled calls helped us and I feel like it was fruitful.”*

*“The regular meetings helped us think more about what we can do in preparation for the next meeting and how we can also contribute to the conversation.”*

*“The facilitation was really helpful for us to bring up these different things and move them forward.”*



*“This CoP helped to accelerate and define [our work together] more rapidly than it would have happened without it.”*

This ToP facilitation tool helped the CoP participants utilize this CoP experience in a productive fashion as it kept the goals of the participants elevated throughout the study. This complemented the CoP virtual meeting finding that the participants indicated the value of facilitation and CoP as a “stage” for working with partners.

The follow up interviews and the Appreciative Inquiry Monitoring Survey showed that the CoP experience enhanced ***engagement in a network***. This factor increased over the course of the CoP experience. (See Figure 8.) CoP participants reported incorporating information learned from the discussions into a network of colleagues. As several of the participants shared:

*“ We’re already partners through our other collaboratives with the Disability Community Planning Group. Our Tobacco Free Ohio Alliance is a potential connection. This work could be related to that, but it is not yet.”*

*“Our efforts are not connected to other states, but we connected through that National Tobacco Grantees Conference actually...we shared our media work with [another state] and now they are looking into doing a similar campaign there.”*

*“Once we have this disability training, we’ll be connecting with other states. I think it will be wide-spread once that happens...that means many millions of people we could potentially reach.”*

Many of the CoP participants were already connected and engaged with each other through state coalitions. This CoP experience built on and enhanced these connections. The sense of feeling networked with colleagues positioned the partners in Ohio to take on future projects together.

Other findings of the follow up interviews, such as enhancements to recognition of the need to coordinate, understanding the work of other organizations in this area, collaboration with partners, continuing education, critical reflection, stakeholder involvement, dedicated funding, and disability knowledge as a technical skill have already been discussed in Section A.

**CoP Virtual Meetings found enhanced contact with other organizations, positive perception:** Analysis of the CoP virtual meeting discussion revealed enhanced contact with other organizations, positive perception of other organizations, stakeholder involvement, and engagement in a network. Enhance stakeholder involvement was also identified in the follow up interviews through the importance of partners in efforts to include PWD in public health efforts like smoking cessation. See section C for CoP virtual meeting discussion analysis.

**Action and Process Steps developed during Action Research Cycles emphasized recognition of partners and importance of practical experience of using disability identifier:** An outline of activity steps and strategies that states could use to include PWD in public health efforts were developed by the CoP participants during the action research cycles. (See Table 23 in Section D: Action Research Cycles.) Factors identified included *recognition of the need to coordinate* and importance of the *use of a disability identifier*. This triangulated with the findings

of the follow up in depth interviews and the CoP virtual meetings.

### ***Secondary Study Question***

A secondary study question was: *What are the factors that support state capacity to address demographic groups that experience health disparities, such as smoking among people with disabilities?* All factors identified by the study would apply. This is due to the highly interconnected nature of the readiness, capacity building, and capacity factors, as identified through the study findings.

### ***CoP Summary: Recognition of Need to Coordinate and Practical Experience***

Participation in the CoP provided the partners in Ohio with an opportunity to gain practical experience of collaboration with partners through discussion of tactics for implementing a disability identifier that would include PWD in public health surveillance efforts. Recognition of the need to coordinate with partners was enhanced by participation in the CoP. *Recognition of the need to coordinate, practical experience, stakeholder involvement and engagement in a network*, were found in multiple data sources. Therefore, *these are four key factors that were enhanced by participation in the CoP.*

## **C. Community of Practice (CoP) Virtual Meetings**

### *CoP Definition and Application to Study*

The Community of Practice (CoP) was used as a “stage” to investigate the factors of readiness, capacity building, and capacity, which were present in Ohio’s efforts to include people with disabilities in public health efforts, such as smoking cessation. A CoP is a group of people who share a concern, a set of problems, or an interest in a topic, and who enhance their knowledge and expertise in this area by interacting on an ongoing basis (Wenger *et al*, 2002). The CoP participants were united in a common enterprise and shared values, beliefs, and interest in a topic (Wenger *et al*, 2002; Drath and Palus, 1994; Maybery, 2012). Each member of the CoP may play a different role that will complement other members of the CoP.

Eight interview participants (n=8) committed to participate in the CoP sessions (n=3). Several of the Ohio Department of Health (ODH) staff were not permitted to participate in research due to how their position was funded. Two of the organizations that participated in the initial interviews declined to participate in the CoP sessions.

The ODH Tobacco Team Lead (CoP champion) and a Lead Epidemiologist (CoP peripheral) participated. The entire team from the Nisonger University Center of Excellence for Developmental Disabilities (UCEDD) participated, including, their Ohio Disability and Health Program (ODHP) PI (CoP supporter), program manager (CoP champion), policy manager (CoP champion), and program coordinator (CoP supporter). The Cincinnati UCEDD program manager

(CoP supporter) and a business manager (CoP peripheral) from the quit line operator, National Jewish Health, also participated.

Before the CoP, some of the participants knew each other from other efforts in support of Ohio's CDC Disability and Health Grant. This included the Nisonger UCEDD, the Cincinnati UCEDD, and the Tobacco Team Lead at DOH. Others were familiar with each other through administration of the quitline service, including National Jewish Health and the Tobacco Team and DOH.

*A range of staff of different leadership levels participated at various CoP levels.* (See Table 19.) Leaders at all staff levels were involved in supporting the change of including PWD in public health efforts, such as smoking cessation.

<b>Table 19: Community of Practice (CoP) participants</b>		
<b>Organization</b>	<b>CoP Level</b>	<b>Staff Position</b>
1. Ohio Department of Health	Champion	Tobacco Team Lead
2. Ohio Department of Health	Peripheral	Lead Epidemiologist
3. Nisonger UCEDD	Supporter	ODHP PI
4. Nisonger UCEDD	Champion	Program Manager
5. Nisonger UCEDD	Supporter	Policy Manager
6. Nisonger UCEDD	Supporter	Program Coordinator
7. Cincinnati UCEDD	Supporter	Program Manager
8. National Jewish Health	Peripheral	Business Manager

The CoP levels included Champions, Supporters, and Peripheral members. Champions most actively contributed to the group discussions and suggested the idea of pursuing funding, as well as key partners. Supporters also contributed to the group discussions, shared ideas, and gave more specific examples of past partner collaborations. In keeping with the CoP literature (Wenger *et al*, 2002), peripheral members often listened to the group discussions with minimal original contributions.

There were eight (n=8) participants throughout the CoP sessions. Each session was attended by seven participants in the live session, with one participant sharing information by email and following up with the group afterwards due to a family emergency (n=1 participant in Cycle 1), previously planned vacation (n=1 participant in Cycle 2), and an incorrect calendar notation of the session time (n=1 participant in Cycle 3).

### *Process and Key Conditions*

*1. Timespan* – In keeping with the length of other successful learning collaboratives (IHI, 2003), three sessions were held with the CoP volunteers over a 15-week period, with a session every 4-5 weeks by conference call. Originally, the study protocol specified three 90-minute sessions. Based on feedback received during the initial interviews, the investigator structured the three 60-minute sessions, as this fit the participants' availability. Slide decks were prepared to support the discussions and were shared in advance of each call. (See Appendix L: CoP Session Slides and Notes.) Condensing the length of the sessions helped maintain study participation.

*2. Systematic Reflection and Facilitation* – The CoP model does not describe in detail how

to facilitate conversations that take place at each stage of the CoP. This model only outlines a very broad series of questions or “productive inquiries” in an effort to generate useful information sharing (Saint-Onge and Wallace, 2003). This study employed the use of Appreciative Inquiry (AI), which is a strength-based method of positive questions that shift the conversation and reflection toward stories of moments when groups and teams were doing their very best work together (Cooperrider and Whitney 2005; Whitney *et al* 2004). AI informed the CoP session questions and discussion with the participants. The focused conversation Technology of Participation (ToP) method (2000) further served as a means to facilitate CoP discussions.

These facilitation techniques helped greatly to maintain participation in discussions in a manner that encouraged systematic reflection. Each of the sessions were informed by Topics of Participation (ToP) facilitation. The investigator served as a facilitator during each CoP session.

In keeping with the ToP facilitation methods, the investigator utilized a series of four questions over the course of the CoP meetings:

- 1) *Objective* level questions, which elicit facts and data on the topic, which was used during the first virtual meeting,
- 2) *Reflective* level questions that acknowledge emotions and imagination, which was used during the end of the first virtual meeting,
- 3) *Interpretive* level questions that elicit sharing of experiences to identify options and possibilities, which was used at the end of the first virtual meeting and during the second virtual meeting in more detail, and

4) *Decisional* level questions to engage collective opinions on what future actions may be on the topic, which was used at the end of the second virtual meeting and during the third virtual meeting in more detail.

These levels of questions allowed an environment for collective thinking to take place within a limited amount of time. Other types of facilitation could also likely have worked as well.

3. *Supported* – The CoP participants from Ohio who volunteered had sufficient resources to dedicate staff and leadership to this effort. The organizations were collaborators in Ohio’s CDC Disability and Health Grant and saw value in staff and leadership participation, as well as had the ability to support staff time needed to participate. Further, the facilitation of the group discussion also provided a means to help participants make connections and meaning (Moore, 2004; Drath and Palus 1994).

4. *Personal Interest and Commitment of Participants* – All of the CoP participants were highly engaged throughout the virtual meetings. Member checking of findings to date took place at the start of each session. This engaged the CoP participants in the inquiry and served as a critical validity checkpoint throughout the study, as it ensured that the CoP participants agreed with the emerging findings. With each session building on the information shared during the previous session, as well as findings of the online survey, member checking was critical. This was a successful validation technique in the current study because of the personal interest and commitment of the participants to actively contribute during the CoP discussions.



## CoP Lifespan

Each of the three CoP sessions achieved key milestones, typical in the lifespans of these communities (Wenger *et al*, 2002). (See Table 20.) These sessions guided participants through the *CoP Stage 1- Potential*, which focused on the discovery that others are passionate about a topic, and *CoP Stage 2-Coalescing*, which focused on activities that allow members to build relationships, trust, and an awareness of common interests and needs. These two stages of CoP development were the focus of the current study in an effort to establish an environment in which partners could share strategies that have been effective in including PWD in public health efforts, such as smoking cessation. Given the 7-month duration of the current study, the CoP sessions ended during the beginning of this *Stage 2*.

<b>Table 20: Community of Practice Milestones</b>	
<b>Study Phase</b>	<b>Milestones</b>
<b>Pre-Phase 1</b>	Readiness in-depth interviews with Leaders in Partner Organizations Readiness survey with Program Staff Capacity in-depth interviews with Program Staff
<b>1</b>	<i>Stage 1-Potential:</i> Goal-Set Domain, Community, and Practice issues Defined CoP relationships and roles Reviewed strategies to reach PWD and build outline for recommendations for reaching PWD Began to create learning agenda
<b>2</b>	Reviewed Phase 1 discussion Continued to develop recommendations for reaching PWD and learning agenda Recruited CoP community coordinator
<b>3</b>	<i>Stage 2-Coalescing:</i> Goal-Deliver value for CoP participants with development of documents Reviewed Phase 2 discussion Developed process steps and recommendations for reaching PWD, learning agenda, and action plan
<b>4</b>	Concluded CoP Follow up capacity assessment in-depth interview Conducted orientation with CoP community coordinator from Ohio

The participants set their goals for CoP participation at the time of the initial ( $t_1$ ) in depth interview (either capacity interview or readiness interview) and reported how well their goals were met in the follow up interviews ( $t_2$ ). Goals for participation ranged from strengthening collaborations to providing insights and learning about what others are doing. (See Appendix L.) Each CoP participant shared that their goals for the CoP sessions were met, as assessed during the follow up interviews ( $t_2$ ).

The CoP participants developed a short summary of action steps for a process that other states may take in order to include PWD in health programs, like smoking cessation. A version for disability and health partners, as well as a version for public health partners was created. (See Appendices M and N.)

The CoP developed an action plan to support continued work together and a learning agenda to support the action plan. (See Table 21.) The CoP participants began with concrete potential action steps. The investigator then facilitated discussion on a learning agenda needed to support these action steps.

<b>Table 21: CoP Action Plan and Learning Agenda</b>	
<b><u>Action plan</u></b> 1. Funding for more collaboration with the Centers for Independent Living (CILs) to adapt a smoking cessation program used in another state 2. Training for Quit line Coaches 3. Sharing data and looking at it together	<b><u>Learning agenda</u></b> 1. Focus on disability data, including who with a disability smokes 2. Support referral to smoking cessation services (talk with Centers for Independent Living, direct service providers) 3. Communications to promote referral services 4. Disability awareness, by functional type of disability 5. Know which staff interested/available

The investigator approached a member of the CoP after the second session to serve as an ongoing CoP community coordinator. The selected member was put forward by the CoP participants and had initiated contact with another CoP participant between sessions 2 and 3. The investigator conducted an additional training on CoP theory and ToP facilitation strategies with this individual after the third session. The CoP reported planning to continue to their work with the guidance of this CoP community coordinator.

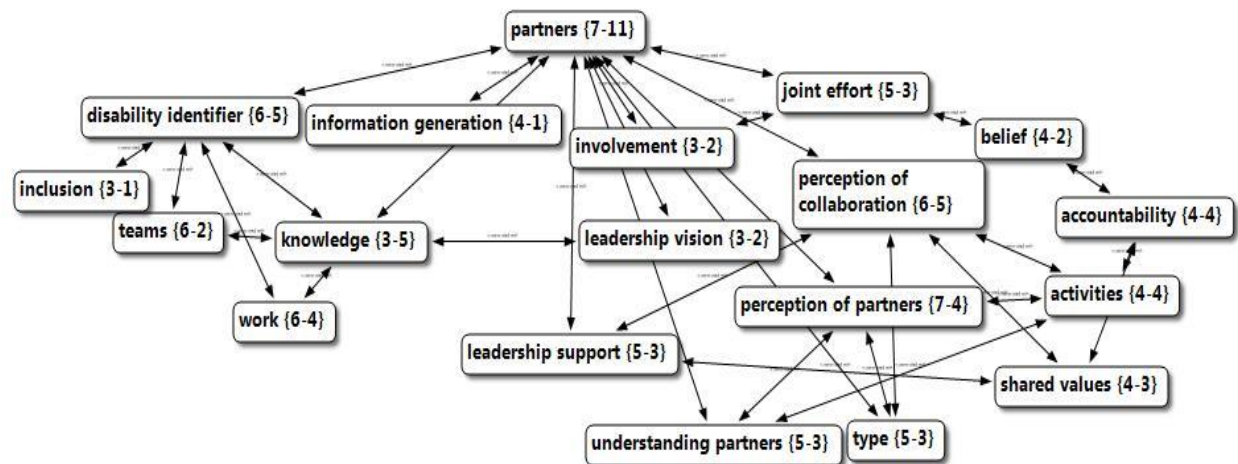
**CoP Virtual Meeting Discussions identify Readiness, Capacity Building and Capacity**

**Factors:** The discussion notes from the three CoP sessions were coded by the investigator using the code book used for the in depth interviews. (See Appendix K.) Notes were coded manually and with Atlas.ti (Version 7.5.9). A key finding is that ***partnership supported all of the factors of readiness, capacity building, and capacity***. *Partners* was a measure of the Capacity Factor, *stakeholder involvement*. *Partners* were integral in everything the group did and were important across all factors. This was demonstrated through partners being the most frequently mentioned and most connected with other code designations for other factors (mentions n=7; connected codes n=11). *Partners* co-occurred with 11 codes across readiness, capacity building, and capacity factors. See Figure 9. ***Partners were integral in all the activities discussed by the CoP***. This Capacity Factor supported all of the factors of readiness, capacity building, and capacity.

The CoP participants highlighted the importance of *partners* during the sessions, as exemplified by the following quotes:

*“Strategies to get people to quit may need to be adapted to the different disability conditions.  
Partners may need some general disability awareness and sensitivity skills.”*

Figure 9: CoP Code Map-Partners



**Key:** Code (1<sup>st</sup> number=grounding/mentions—2<sup>nd</sup> number=density/co-occurring networks)

Arrows represent co-occurring networks among the codes.

*“For smoking cessation among people with disabilities, we need to bring partners to the table. It depends on the scope of impact you want to make. We approached the Department of Health to make a state-wide impact.”*

This emphasis on the importance of *partners* was consistent with the interview finding that there was an increase in awareness and knowledge of related stakeholder efforts. As participants shared during the follow up interviews:

*“Yes, we’re poised to work together. We already were working together, but this community of practice helped to accelerate and define it more rapidly than it would have happened without it.”*

*“It’s been exciting to hear partners talk about the importance of adding disability identifiers and understand the importance. That is definitely a sign that they are recognizing how important this topic is. The groundwork is being laid.”*

This work with partners was critically important and connected with efforts to have a *disability identifier* that describes PWD as a demographic and a target of public health surveillance and programs.

#### *CoP Virtual Meeting Sessions Analysis*

During the CoP, the participants became better acquainted with one another and each other’s work. As a result of being more familiar with each other as individuals and having an increased awareness and knowledge of each other’s related efforts, the **CoP participants’ positive perception of each other’s organizations increased** by the end of the sessions, as identified in the follow up interviews and the CoP virtual meetings. *Partners* was code for the Capacity Factor, *stakeholder involvement*, and related to efforts that are done jointly, having involvement of organizations which directly serve people with disabilities, organizational learning and information generation, as well as having a disability identifier that describes PWD as a demographic and a target of public health surveillance and programs.

**Partners were critical.** The importance of *partners* became more emphasized over the course of the CoP sessions as the participants got to know one another, developed a shared action plan and learning agenda for future efforts together, and began to share resources and information. As several of the participants shared:

*“I do feel like we have a core group of partners. We do want our services to reach all states. It was great that the ODH Tobacco Team Lead was involved...I absolutely believe that the group can do something together. Between the group of diverse partners and the passion they have and the knowledge around disabilities, they will be able to do something together for people with disabilities.”*

*“I loved being in a group with many different stakeholders; I really gained disability awareness.”*

*“Based on our interactions, we’ve had a lot of good ideas and a lot of actionable steps have resulted from them.”*

*“I feel like it’s been positive and the doors are open. Being able to spend time together and getting to know one another over the past few months has been really positive. It’ll be easier now. Everything helps us to work together more productively.”*

This group of partners in Ohio indicated that this CoP experience was beneficial and wanted it to continue. The CoP participants reported enjoying the experience and indicated the desire to

continue meeting as a group.

**Facilitation was a helpful accelerant for the CoP participant collaboration.** During the follow up in depth interviews, half (4/8) of the CoP participants shared that the **facilitated discussion helped move the group forward more quickly than it would have otherwise.** The CoP participants intend to use facilitation in future discussions. One participant shared:

*“The facilitation was really helpful for us to bring up these different things and move them forward.”*

**As a result of the CoP experience, the participants valued facilitation and saw the CoP as a model for working with partners in the future.** As one participant shared during the follow up interview:

*“The CoP helps focus our conversations...then the conversations went to where we can go moving forward. The conversations that we have had have been good and I’d like to see them continue.”*

Several of the participants shared that this CoP model supported with facilitation helped the group work together more quickly. The investigator conducted an additional technical assistance session with the facilitator of the CoP on ToP and the CoP model at the request of the group. As another participant shared during the follow up interview:

*“With this CoP opportunity and the facilitation, it was an opportunity to solidify that partnership and build off of it. The new ideas that were generated is a success to me. It makes for a more formal establishment of this collaboration.”*

This interest in generating new ideas relates to the Capacity Factor of adaptive capacity and organizational learning. This showed that the CoP participants used this experience to enhance their partnerships and collaborations. These CoP participants may have recognized the importance of facilitation in moving public health projects forward because they were also facilitative leaders (Moore, 2004) themselves. CoP participants shared how they brainstormed during their staff and team meetings to continue to discuss topics that were raised during the CoP. There was a value of the collective wisdom of the group.

***CoP participants considered engagement in a network to be part of their future efforts.***

Although not reported in the aggregate analysis of the measures of engagement in a network, several individual participants reported feeling more connection with each other during the follow up interviews. As one participant put it:

*“I just feel like we’re more on the radar... We’re more collegial now.”*

This same participant went on to explain:

*“Instead of being an outside party asking for this and that, we can think together about it.”*

As another participant explained:

*“For every barrier that came up, the group brainstormed a potential solution together.”*

**The CoP offered participants an opportunity to consider how they might expand their**



**efforts**, such as tailoring a smoking cessation training, which was developed by another state, for the needs of Ohioans living with a disability. As one participant shared in the follow up interview:

*“Right now there are no changes to the written work plan, but in my mind, it is expanded...”*

As a result of the CoP experience, the participants are poised to go beyond the deliverables noted in the work plan and continue to take action toward including PWD in general in smoking cessation efforts together.

The two OH UCEDDs shared that they operate as a joint entity in their disability work in the state. They did not report that they are networked with other states, yet *a connection with the CO UCEDD happened as a result of the interest of the CoP to conduct disability awareness training with the OH quitline staff* at National Jewish Health (Havercamp, 2015, personal communication; Friedman, 2015, personal communication).

**By the end of the CoP experience, participants had a shared sense of responsibility to continue their collaborations.** As one participant put it during the follow up interview:

*“We’ll follow up on the data. We’ll follow up on the funding. We’ll work with counselors on disability training.”*

### **CoP Virtual Sessions Summary: Partners are critical**

With the CoP experience, participants increased in their perception that partners are critical.

Leaders at different staff levels are needed to develop partnerships and supporting networks and teams. Facilitated discussions of the CoP assisted in moving the group forward and accelerating work together.

## **D. Action Research Cycles**

At the beginning of each CoP meeting, findings of surveys and interviews to date were reviewed by the investigator with the CoP participants (Stringer's action research step, "look"). These findings were then member checked with the group of CoP participants. This served as a critical validation check point. Member checking was followed by facilitated group discussion, which prompted group information sharing (Stringer's action research step, "think"). (See Appendix L for summary of facilitated group discussion.) Each session ended with a recap of the next steps and action plan to support future work together (Stringer's action research step, "act") (Stringer, 2007).

### ***Action Research Cycle 1: Community of Practice Session One***

During the initial CoP session, the investigator member checked the participants' goals for participation. Goals for participation included an opportunity for sharing, a mechanism to provide insights and hear about what others are doing, a means to strengthen collaboration, a way to interact with each other and get different perspectives, and an opportunity to expand work beyond what was already happening.

At the initial CoP, the findings from the capacity assessment ( $t_1$ ) and readiness assessment survey were reviewed. Findings included a retrospective summary of accomplishments, as well as the key partner organizations involved in those accomplishments. The key accomplishments included:

1. *State needs assessment*, which showed smoking as a disparity for PWD (CoP members

involved: OH University Centers of Excellence on Developmental Disabilities (UCEDDs) and OH Department of Health (DOH),

2. *Inclusion of a disability identifier* in the intake data from the quitline screening questions (CoP members involved: all),

3. *Recently launched media campaign* to reach PWD to encourage them to call the quitline (CoP members involved: all), and

4. *Adaptation of another state's train the trainer model for tobacco cessation for PWD* (CoP members involved: OH UCEDDs).

All of the key accomplishments of the CoP participants were informed through interaction with the Ohio Disability and Health Program's Disability Community Planning Group (DCPG). The main partners involved in the state smoking cessation efforts for PWD included the DCPG, the two state University Centers on Developmental Disabilities (UCEDDs) at the Ohio State Nisonger and Cincinnati Children's Hospital, the OH Department of Health (DOH), and the OH Centers for Independent Living (CIL). It was noted that the CIL needed to have dedicated funding to continue to collaborate. A past grant application developed by some of the CoP participants and the state CIL was not funded; therefore, the CIL involvement was limited.

Key findings from the survey and interviews were reviewed at the beginning of the meeting. With regard to Readiness Factors, the CoP participants preferred in person interactions and meeting as needed. *Persistence was seen as a key in achieving the past accomplishments.* Participants shared that a good understanding of partner values and interests was essential. With regard to the factor of Capacity Building, ongoing training and *continuing education*

*opportunities* were valued. Most participants shared that they had dedicated time to plan and reflect. With regards to the Capacity Factor of *leadership vision*, opportunities for leadership were reported at all levels—senior, mid-level, and junior staff were all engaged in the past accomplishments. Because of this shared leadership, all staffers reported being able to look for opportunities to align with other organizations and to be innovative and creative.

A summary of these past accomplishments (Appendix L), as well as survey and interview findings, was member checked. The members of the CoP agreed with the summary as presented by the investigator. Then the investigator facilitated a discussion on a prospective of examination of how the CoP participants might work together on future efforts to include PWD in smoking cessation efforts.

During the initial meeting the CoP, participants drafted recommendations for other states to include PWD in their smoking cessation efforts. *Initial recommendations* included:

1. *knowing your goals and considering what is feasible,*
2. *finding an ally at the department of health,*
3. *knowing where disability resources are in your state,*
4. *having a good information base in order to make the case for including people with disabilities and public health efforts, and*
5. *having a needs assessment with disability identifiers.*

UCEDDs were mentioned as a good resource for disability information. The *initial action plan* developed by the CoP participants included:

- 1. further development of these recommendations and future efforts around pursuing training for quit line coaches,*
- 2. exploring new grant opportunities for the CILs to do smoking cessation,*
- 3. using another state's tobacco cessation program and adapting it for use in Ohio, and*
- 4. sharing quitline data.*

## **Action Research Cycle 2: Community of Practice Session Two**

The second session of the CoP began with a review of the initial meeting and survey findings to date. Survey findings included that most participants met someone new or became better acquainted with a colleague, and that most felt that they were able to contribute and share information during the last meeting. Goals for participation and the purpose of the CoP were reviewed. The investigator then member checked the initial meeting and survey findings, as well as the goals for participation. All CoP participants agreed that the summary accurately portrayed their conversations to date.

The initial recommendations were reviewed and discussed. The group determined that two versions of the recommendations were needed—one for public health practitioners in general and a second for disability and health practitioners to persuade general public health practitioners to include PWD in their efforts. Participants in the CoP shared that spelling out the steps for other programs could be very helpful. This was the first time participants had written how they included PWD in smoking cessation efforts. As one participant put it:

*“I had never conceptualized our work like this before, but I see how it would be very helpful for other partners.”*

The group also determined that it is important to pick a specific project with a short-term goal, *“in order to cement the relationship with partners,”* as another participant shared.

During the second session, the action plan drafted during the first session was reviewed. The group felt that getting funding for collaboration with the CILs was critical, as well as training for people to do cessation work with specific populations like people with disabilities. The participants committed to begin sharing data as one participant put it:

*“Sharing of data can happen now.... We can look at current questions and our intake items...We can also continue to look at the data together.”*

At this time, the group began to develop a learning agenda in order to accomplish these action steps. The investigator facilitated this learning agenda discussion. Participants determined that more focus was needed on disability data including more information on who was using the quitline. As a result of this discussion, the OH Department of Health indicated that they may be able to add disability identifiers questions to the next Behavioral Risk Factor Surveillance System (BRFSS) survey. Modifications of current surveillance questions for different populations and adaptation for different needs were discussed as a learning agenda priority. Supporting referrals to smoking to cessation services was also a learning agenda priority. The participants determined that they needed to have someone who is knowledgeable about the

communications of how to promote referral services. The participants discussed the need to think about how to create messages for each disability subpopulation, as well as healthcare providers.

The investigator recruited an ongoing facilitator from the Ohio CoP to continue the CoP discussions once the current study ended. The participants indicated that they would consider which member would be able to serve as a CoP facilitator.

### **Action Research Cycle 3: Community of Practice Session Three**

The third session of the CoP began with a reflection on the second community of practice meeting, as well as the interviews and surveys done to date. Most participants reported that their goals are being met and that they were able to contribute and share information. More indicated incorporating information that they learned into their job and efforts with partners. One participant indicated that he initiated contact with another CoP participant between sessions 2 and 3. The investigator then member checked the initial meeting and survey findings, as well as the goals for participation. All CoP participants agreed that the summary accurately portrayed their conversations to date.

The CoP reviewed **10 key process steps** that a state system can take to become ready to include PWD in public health efforts like smoking cessation and confirmed through member checking that the summary was an accurate reflection of their conversations. See Table 22.



These process steps were based on a retrospective examination of past efforts and prospective experience of partners during the CoP. A version for disability and health partners, as well as a version for public health partners was created. (See Appendices M and N.) The investigator categorized these process steps by the factors of readiness, capacity building, and capacity. Readiness, capacity building, and capacity factors were found to occur simultaneously.

<b>Table 22: Action and Process Steps for State System Readiness to Include People with a Disability</b>	
<b>Action and Process Steps</b>	<b>Readiness, Capacity Building, Capacity Factors</b>
1. Use state-level needs assessment data with disability identifiers	Capacity building factor-Practical experience
2. Know what your goal or “ask” is and craft your message in a way that would speak to partners	Capacity building factor-Practical experience
3. Take time to create and practice a compelling presentation to get partner and leader attention to these messages	Capacity building factor-Practical experience
4. Do your homework and create a list of potential partners	Readiness factor-Recognition of the need to coordinate
5. Request a meeting with a specific partner	Readiness factor-Contact with other organizations in this area
6. Establish a relationship and stay in touch your colleagues	Capacity building factor-Practical experience
7. Dedicate a staff member to facilitate and connect disability experts and public health programs to provide encouragement to establish the relationship	Capacity factor-Resources
8. Pick one project to do together	Capacity building factor-Practical experience
9. Feel connected with public health programs	Capacity building factor-Engagement in network
10. Keep going and encourage your partners to make an investment of their time and resources to provide guidance.	Capacity factor-Technical skills and knowledge

*Step 1: Use state-level needs assessment data with disability identifiers.*

A key finding from the development of this list of process steps was **use of data from a state-level needs assessment with disability identifiers is critical to support inclusion of PWD in public health efforts**. This was critical as disability identifiers are not currently administered in a uniform way across state surveillance systems. The CoP discussions with the state Department of Health connected members with the BRFSS survey and offered an opportunity to include more specific disability identifier questions to the screener protocol in an effort to describe PWD as a demographic.

*Step 2: Know what your goal or “ask” is and craft your message in a way that would speak to partners.*

Information sharing and materials dissemination was noted as a key activity. Members shared that it was important to first know the specific “ask” and then develop the message and related materials so that it aligned with the partner expertise. If the partner had disability expertise, it was important to educate on public health and surveillance efforts. If the partner had a public health expertise, it was important to provide disability background information. As one participant shared:

*“They had a subject matter expert on disability and two centers our state with disability expertise. We had public health expertise but were very thin on disability experience...Now we have that connecting with public health... I see my role as being that trusted person—because people do know who I am and I am seen as a leader. I was able to help develop the relationship and bring validity to the disability message within public health.”*

*Step 3. Take time to create and practice a compelling presentation to get partner and leader attention to these messages.*

Delivery of the message to partners and leaders was emphasized during the CoP discussions. CoP members shared that they tailored information for the specific audience and sought out in person meetings with partner groups, including key leaders and decision-makers. As one participant shared:

*“We did an infographic toward the beginning of our work. We used this in addition to our needs assessment to be a compelling presentation – to get partners’ attention to these messages.”*

*Step 4. Do your homework and create a list of potential partners.*

Awareness and knowledge of stakeholder efforts were seen as critical. This allowed members of the CoP to have an understanding of which partner relationships may be most fruitful in achieving the goal or “ask.” As one participant put it:

*“We think of the best potential leads that we have...we can’t do it all but we want to take advance of the ones where we think we’ll be fruitful.”*

*Step 5. Request a meeting with a specific partner.*

The CoP members shared that frequent interactions with organizations and stakeholders that can help achieve the goal and share your vision is critical. The CoP strongly felt that it was

important to interact in person as much as possible, with a timely email follow up. As one shared:

*“I always prefer to meet in person – that is always better.”*

*Step 6. Establish a relationship and stay in touch your colleagues.*

The CoP members shared that new partners were important colleagues. The establishment of this relationship takes time and it was critical to stay in touch to develop the connection. The CoP discussion indicated that most colleagues are interested and that persistence is critical, as some may not respond immediately. Several members of the CoP shared that it is important to continue to follow up and stay in touch.

*Step 7. Dedicate a staff member to facilitate and connect disability experts and public health programs to provide encouragement to establish the relationship.*

Having a dedicated staff member ensured that it was a job requirement to spend time on partner and stakeholder involvement. Several CoP members shared that it is ideal to have a dedicated staff member who has an understanding of disability, as well as public health, to manage the relationship and be sure that partners have appropriate expectations. As one participant put it:

*“I was a connector for the Ohio Disability and Health Program to the Tobacco Program...I introduced the people in disability to the tobacco people, making sure they understood who they were.”*

*Step 8. Pick one project to do together.*

The CoP members set specific project goals initially to get a clear perspective of what a possible early success could be. As one CoP participant put it:

*“This helps to cement the relationship.”*

Establishing and utilizing partners in a project that achieved success was critical for the CoP.

*Step 9. Feel connected with public health programs.*

Being part of a team or a state coalition was an important factor in including PWD in smoking cessation efforts. CoP members mentioned that they got to know each other through some of the state planning groups and then were able to include each other in subsequent meetings and make introductions to other players.

*Step 10. Keep going and encourage your partners to make an investment of their time and resources to provide guidance.*

The CoP members viewed disability knowledge as a critical technical skill. In the CoP sessions, the members emphasized the importance of considering disability knowledge as an essential part of public health knowledge overall.

**Action plan and learning agenda emphasized the importance of using a disability identifier.** The draft action plan and learning agenda items were reviewed and finalized during the third CoP session. The survey findings action plan and learning agenda were member checked with the participants. The CoP members indicated that the summary was accurate. Specific feedback and edits were made to the recommendations for other states to include PWD

in public health programs, such as spelling out all acronyms and giving realistic examples for the steps that partners can take to include PWD in public health programs. The *action plan* was discussed by the group and developed into three distinct plans, with a *learning agenda* supporting each of these action plans. (See Table 22.) The action plan and the learning agenda were member checked with the group by the investigator. The CoP participants confirmed that this summary was accurate.

Between the second session and the third session the investigator was able to interview the state CIL executive director. Findings from this interview were shared and reviewed with the group. This CIL leader shared that the CILs needed more details on what a PWD would get by calling to quitline. Dedicated funding was needed by the CILs to make smoking cessation efforts a priority. For some CILs in the state, smoking related to other health promotion priorities and funding. The group reflected on this and indicated that this connected with their action plan to secure funding to collaborate with the CILs.

The investigator asked one of the champion members, who was recommended by the CoP participants, between the second session and the third session to continue to serve as the facilitator for ongoing CoP efforts. This champion member is a mid-level staff member, had expressed interest in facilitation, and agreed to continue to facilitate. The investigator held one training session with this individual, with the offer to do one additional session as needed.

In response to a suggestion to link local UCEDD resources with the National Jewish Health quit line coaches serving Ohio (who are actually based in Denver), the investigator

connected the Nisonger UCEDD and the National Jewish Health CoP participants with the Colorado UCEDD immediately following the third session. The Colorado UCEDD director and the National Jewish Health CoP participant indicated that they would be interested in exploring options for a general disability awareness training for quitline coaches and will follow up with each other, with support as needed from the Nisonger UCEDD (Havercamp, 2015, personal communication; Friedman, 2015, personal communication).

### **Action Research Analysis**

The *action research hypothesis*—that a CoP may be used in a retrospective manner to identify process steps and capacity supports to become ready for change, as well as in a prospective manner to build capacity by providing time, space, and opportunity of critical reflection—was shown to have support through the CoP discussion analysis and the action research cycles. Ten key process steps on how a state system can take to become ready to include PWD in public health efforts like smoking cessation emerged from the discussion with CoP participants. These process steps were based on a retrospective examination of past efforts and prospective experience of partners during the CoP.

These action research findings indicated that the CoP valued and involved *partners* in their efforts. These findings compliment the follow up interview findings, which highlighted increases in the Readiness Factor of *recognition of the need for coordination*, measured through an increase in awareness and knowledge of stakeholder efforts; and the Capacity Factor of *technical skills and knowledge*, measured through the importance of having a disability identifier to describe PWD as a demographic. **Partners and their expertise were critical to including**

## **PWD in smoking cessation efforts.**

The capacity factor of *technical skills and knowledge* was highlighted through the action research cycles. The CoP members viewed disability knowledge as a critical technical skill to include PWD in public health efforts. This is in keeping with the key finding of the document review—the OH Disability and Health Program partners possess content knowledge expertise in disability. During the CoP sessions, the group described the **importance of considering disability knowledge as an essential part of public health knowledge overall** as it relates to populations surveillance. The CoP participants indicated that the disability community is not a separate community, but a demographic that is part of every community everywhere.

### **Action Research Cycles Summary: Development of 10 Action Steps**

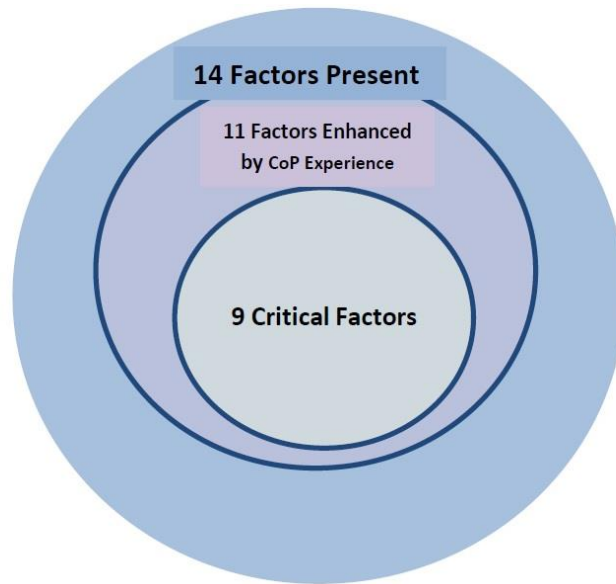
Three action research cycles with the CoP participants identified 10 action steps that states may take to include PWD in public health efforts. *Disability knowledge was identified as an essential part of public health knowledge overall.*



## Results Summary

A seven-month case study explored readiness, capacity building, and capacity factors of how Ohio has included PWD in public health efforts, such as smoking cessation. This study identified 14 readiness, capacity building, and capacity factors that make a state system ready to include PWD in public health efforts. Nine factors were critical as they were identified in multiple data sources. Action research was conducted with a Community of Practice (CoP) to examine the factors needed for public health practitioners to include PWD in state public health efforts and developed practical action steps. The CoP experience enhanced 11 factors, including the critical factors to include PWD in public health efforts. Therefore, CoPs are a critical tool for to include PWD in public health efforts. See Table 23 and Figure 10.

<b>Table 23: Factors Present, Factors Enhanced, and Critical Factors</b>		
14 Factors of Readiness, Capacity Building, and Capacity Present	11 Factors Enhanced by CoP Experience	9 Critical Factors to Include PWD in Public Health Efforts
1. Recognition of need to coordinate 2. Contact with other organizations in area 3. Understanding work of other organizations in area 4. Positive perception of other organizations and quality interactions 5. Mutually shared goals, values, interests 6. Practical experience of collaboration with partners and direct involvement of the target audience 7. Engagement in a network, team or planning group 8. Continuing education 9. Critical reflection 10. Stakeholder involvement 11. Adaptive capacity and organizational learning 12. Leadership support and vision 13. Resources (staff, funds) 14. Knowledge of the target audience as a technical skill	1. Recognition of need to coordinate 2. Contact with other organizations in area 3. Understanding work of other organizations in area 4. Positive perception of other organizations and quality interactions 5. Practical experience of collaboration with partners and direct involvement of the target audience 6. Continuing education 7. Critical reflection 8. Stakeholder involvement 9. Engagement in network, team or planning group 10. Resources (dedicated staff and funds) 11. Knowledge of PWD as a target audience as a technical public health skill	1. Recognition of the need to coordinate 2. Contact with other organizations in area 3. Positive perception of other organizations and quality interactions 4. Practical experience of collaboration with partners and direct involvement of the target audience 5. Engagement in a network, team or planning group 6. Continuing education 7. Critical reflection 8. Resources (dedicated staff and funds) 9. Knowledge of the target audience as a technical skill



***Figure 10: Communities of Practice: A Critical Tool to Include PWD in Public Health***

## V. Discussion

This study builds on the existing literature, which includes calls for action (Krahn et al, 2015; Peacock et al, 2015) to include PWD in public health efforts. No previous effort has examined the readiness, capacity building, and capacity factors that enable a state public health system to include PWD. The findings of this study show how a state might move forward in building capacity to include PWD, utilizing smoking cessation programs as a specific example.

Despite the limitation of the current study being a single case study, the most critical factors of readiness, capacity building, and capacity are applicable to any state with the aim of including PWD in public health efforts. Further, these factors may be applicable for including any group that experiences health disparities in state public health efforts.

Fourteen factors that make a state system ready to include PWD as a demographic in public health efforts were identified through interviews, document review, AI survey in between CoP sessions, interviews before the CoP, and interviews after the CoP. While all factors identified by this study are important for achieving this change of including PWD in public health, nine factors may perhaps be even more critical and they were observed in multiple data sources. (See Section A; Table 12.) *States that aim to include PWD in public health efforts need to work toward enhancing these critical factors.*

The factors identified were highly interconnected. Readiness was found as an ongoing factor that supported the factors of capacity building and capacity. Readiness was not a precursor in a linear, stage-like model, but a continuous process (Stevens 2013). This study builds a further

understanding of readiness as a supporting factor throughout a change process, such as viewing PWD as a demographic in public health efforts.

The CoP experience enhanced 11 key factors of readiness, capacity building, and capacity. (See Section B; Table 18.) The CoP served as a means to gather a diverse group of program staff and leaders and increase these factors among the participants (Maybery 2012). Therefore, *CoPs are an important tool for public health leaders to utilize in moving efforts forward*. The CoP experience offered a space for engagement so that the participants could collaborate.

These factors are critical for sustained work toward including PWD in public health efforts. Member checking was used by the investigator to verify the findings of the interviews, sessions, and surveys with the CoP participants. The potential limitation of telling the investigator what she wants to hear or reactivity (Maxwell, 2008), was addressed by the fact that the investigator held no current work relationship with the CoP participants. Member checking also brought the group together as it created a shared activity for the CoP participants to do together.

The sense of value in *partnerships* was expressed by CoP participants. This may be due to an increased awareness and knowledge of each other's efforts and the existing appreciation for a facilitative style of leadership (Moore 2004; Drath and Palus 1994). A sense of value of partners and facilitation was already held by the participants; otherwise they would not have been active across all three CoP sessions or put forward another CoP member to serve as a facilitator beyond the current study. However, their activity and positive engagement with each

other during the CoP sessions enhanced their value of partners. Given this sense of connection, along with the value of partnerships found in the CoP themes analysis, one may hypothesize that this group will continue to collaborate with one another in productive ways in the future.

The collaboration among the CoP participants was likely a good fit due to the similar health focus held by all of the participant organizations, as identified by the document review and interviews. The ongoing CoP facilitator from the group also initiated contact with another CoP member that would not have happened otherwise. The UCEDD in Ohio reached out to another UCEDD in Colorado to coordinate a potential disability awareness training with the National Jewish Health Quitline staff. There may be opportunities to strengthen the sense of connection with other states through additional partner collaborations.

The online, Appreciative Inquiry Survey was not able to completely monitor changes in participant readiness, capacity building, and capacity, as a result of the CoP sessions. Some participants shared that the surveys were premature to assess these changes. In addition, the participants did not always complete this survey after the CoP sessions, thus limiting the ability to examine changes. However, the survey did identify an opportunity for *systematic reflection* to build capacity toward inclusion of PWD in public health efforts.

Another opportunity exists around *engagement in a network*, team or planning group, as this was as a critical factor for including PWD in public health efforts. Although the follow up interviews, CoP sessions, and action research cycles did not specifically identify the enhancement of this factor, engagement in a network increased by the end of the CoP experience

as shown by the survey. This lack of support around engagement in a network or team may be because this particular CoP served as a stage for the investigation, rather than coming organically from the group itself.

The CoP participants indicated that they valued the facilitated discussions and that they felt the facilitation aided them in moving forward more quickly. The fact that the group had a fellow member express interest in continuing to serve as the facilitator of future CoP sessions indicates that the group values facilitation as a tool to advance the collaborations and planning to include PWD in public health efforts, like smoking cessation. Facilitation of the CoP sessions was informed by Appreciative Inquiry (AI) and ToP methods that were adjusted for the timeframe and format of virtual meetings. This study demonstrates that “productive facilitation” (Saint-Onge and Wallace, 2003), given more specific form through the application of AI (Cooperrider and Whitney 2005; Whitney *et al* 2004) and ToP (2000), helped group collaboration and progress. This was shown through the survey and follow up interview findings. Therefore, *facilitation emerged as an important leadership skill to encourage inclusion of PWD in public health efforts.*

Having *dedicated staff* to focus on different aspects of the disability and health project *was essential for moving efforts forward*, as was found in the survey and interviews. It is important to consider disability knowledge as an essential part of public health knowledge overall. The CoP participants felt that the disability community is not a separate community, but a demographic that is part of every community everywhere. This sentiment was shared during

CoP sessions and evolved during the action research cycles.

***Training matters for integrating PWD into public health.*** Leadership training helps with adaptive approaches to problems, such as the strategy exhibited by the Ohio Department of Health (DOH) leader who spearheaded housing a policy manager at the DOH. Participants in the CoP acknowledged this leader's LEND training as a helpful factor and an important asset in executing this strategy.

***Leaders may be adaptive without knowing it.*** One may be going through elements of an overarching reflection process without realizing it. Reflection may take more time than this survey afforded the CoP participants. The team still learns from a general approach that embodies organizational learning and is then able to apply adaptive approaches to problems. Within a CoP context, some participants may be champions, sponsors, or supporters, depending on the project, regardless of whether the individual is a leader or a staff member of the team. As each action research cycle evolved, there was a shift in these roles. Successful efforts allow these role shifts. Based on the CoP virtual meeting discussion, it seems that this freedom for shifting in these roles is afforded to partners. Having a shared understanding between leaders and staff of the readiness factors made Ohio prepared to build capacity in including PWD in public health efforts. Other states may benefit from enhancing their readiness in the key areas identified in the readiness assessment in order to be poised to take on similar efforts.

### ***Revised Concept Model***

Based on the findings of this study, the constructs of readiness, capacity, and capacity building are highly interconnected. The investigator attempted to examine unique factors for each construct. Measures are like interim assessments to link the factors of each construct studied to the code. The factors of readiness, capacity, and capacity building were found to be occurring simultaneously in the work toward including PWD in smoking cessation efforts. The nine critical factors observed in multiple data sources are likely key influencers of the increases observed in readiness, capacity building, and capacity. These influencing factors include:

1. Recognition of the need to coordinate (Readiness Factor),
2. Contact with other organizations in area (Readiness Factor),
3. Positive perception of other organizations and quality interactions (Readiness Factor),
4. Practical experience of collaboration with partners and direct involvement of the target audience (Capacity Building Factor),
5. Engagement in a network, team or planning group (Capacity Building Factor),
6. Continuing education (Capacity Building Factor),
7. Critical reflection (Capacity Building Factor),
8. Resources including dedicated staff and funds (Capacity Factor), and
9. Knowledge of the target audience as a technical skill (Capacity Factor).

Therefore, a revised concept model has evolved. Originally, the investigator conceived of the process capacity building in more of a linear fashion, but due to the highly networked, dense codes that were found, one may conclude that the concept model is more interactive between readiness, capacity building, and capacity factors.



With this revised concept model, the construct definitions are now revised and better defined. Readiness factors are now preparation steps required in advance for a change to happen. These Readiness factors support the development of capacity building and capacity factors throughout a change process, such as the phenomena studied here—inclusion of PWD in public health efforts. Capacity building factors are activities and practice steps toward change. These factors support the development of readiness, as well as capacity during a change process. Capacity factors are ongoing requirements for achieving and maintaining change. These capacity factors support the development of capacity building and readiness factors.

The presence of the nine critical factors identified by this study to include PWD in public health efforts become influencing factors which may encourage the development of readiness, capacity building, and capacity factors overall. If these critical factors are present, then the likelihood of observing the phenomena of inclusion of PWD in public health efforts, and the factors of readiness, capacity building, and capacity, increases.

Facilitation was identified as a critical public health leadership skill in this study. With the presence of facilitative leadership in a Community of Practice setting, these critical factors may be enhanced. Systematic reflection and action research contributed to these factors overall.

Given this interconnected nature of readiness, capacity building, and capacity as identified by this study, it is reasonable for there to be a gap in the literature with regard to how these constructs are woven together. The definitions currently in the literature are sometimes confusing, with aspects of the constructs that are not specific to one factor. This revised concept

model acknowledges this complexity, while attempting to more specifically define the specific aspects of readiness, capacity building, and capacity.



*Figure 11: Revised Concept Model for Including PWD in Smoking Cessation*

### ***Implications for Replication***

#### *Conditions Present*

This study identified four essential conditions that must be present in order for a CoP model to foster readiness, capacity building, and capacity among public health state partners to include PWD in efforts:

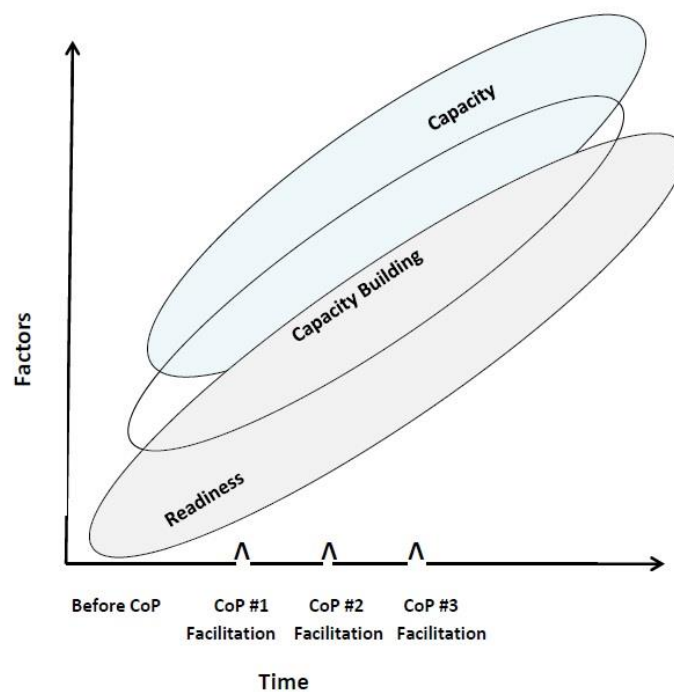
1. *Timespan* – The CoP must be an appropriate length given the interest, support, and commitment of the participants. The length should not be too long in order to sustain commitment over time to address an issue.
2. *Systematic Reflection Process* – Use of a facilitation technique, such as Appreciative Inquiry (Cooperrider and Whitney 2005; Whitney et al 2004) or ToP facilitation (2000), may help the conversations in the CoP be productive and address the issues of interest to the participants.
3. *Supported* – CoP participants must have sufficient resources in order to dedicate staff to participate. Staff may not be facilitative leaders themselves, but must appreciate facilitative leadership and actively engage in the group process.
4. *Personal Interest and Commitment of Participants* –Use of ongoing member checking during the CoP discussion is a critical strategy to actively engage the participants.

The CoP model may be generalizable to other states beyond Ohio if all four of these conditions are present. These factors must be taken into consideration when recruiting CoP participants.

#### *Facilitation-Accelerant for Change*

Generally, CoPs do not have a specific facilitation technique associated with them. During the current study, Appreciative Inquiry (Cooperrider and Whitney 2005; Whitney et al 2004) and ToP facilitation (2000) were used to lead the discussions of the CoP. Other facilitation techniques may also work well.

Each of the facilitated CoP virtual sessions utilized these facilitation tools. This allowed the group to move forward more quickly in time to make progress toward efforts to include PWD, such as development of action steps for others embarking upon similar efforts and encouraging other partners to conduct disability training. Each CoP session enhanced factors of readiness, capacity building and capacity. Readiness factors supported the other factors over the course of the current study. As the factors increased, so did the overlap between readiness, capacity building, and capacity. See Figure 12.



***Figure 12 Facilitation – Accelerant for change***

It is important to incorporate facilitation training in future public health efforts targeting PWD. This study found that facilitation acted as an accelerant toward change. This was

triangulated in the follow up interviews.

### ***Triangulation***

A mix of data types from multiple sources of peripheral community members, sponsors, and champions were used in this investigation in an effort to triangulate findings (Yin, 2009). Original data collection was conducted through the qualitative in-depth interviews and online surveys. The document reviews performed prior to and at the beginning of the investigation served as another means to triangulate the findings.

### ***Evidence and Phenomena of Including PWD***

The different sources of data flowed toward a convergence of evidence and reinforced the central findings around this phenomena of including PWD in public health efforts, such as smoking cessation. Different types of data served as a check for methodological triangulation. Data were collected through multiple sources, including interviews, document reviews, surveys, and observations.

Overall, there is triangulation with the themes that emerged from the action research cycles and other data sources. The importance of the group and partners was similar to the CoP discussion finding of the value placed on *partners* outside their own individual organizations, including the *perception of partners* and *perception of collaboration*. The evidence found during this case study is supported by multiple sources of evidence and multiple types of analyses. (See

Tables 12 and 13.)

### *Validity Considerations*

Validity generally means how the results and conclusions may be wrong (Maxwell, 2008). The methods used were self-report in nature. During the retrospective examination phases of the CoP, recall bias was a threat to construct validity. One way that the proposed investigation controlled for recall bias was through multiple sources of data collection (Yin, 2009). For instance, CoP members had the opportunity to share thoughts on capacity factors information through an initial capacity assessment interview, the discussions during the CoP meetings, the Appreciative Inquiry Monitoring System, as well as the follow up capacity assessment interview. The CoP members themselves also helped to address this threat by being involved in the ongoing review and development of the recommendations and learning agenda documents. This is a form of respondent validation (Maxwell, 2008) as the CoP structure of meetings systematically solicited feedback about the findings and emerging themes from the CoP participants. Member checking in the virtual meetings of the CoP also helped as a verification of evolving findings. This involvement of the CoP participants helped the investigator interpret the meaning of the group discussions.

### *Case Study Implications*

A general threat to the validity of this study is that the findings may be unique to Ohio and not as widely applicable to other states. Given that Ohio is one of several CDC grantees focused on health promotion for PWD, the findings of this investigation indeed have some applicability

to other states. The extent to which the findings are applicable to other states hinges on how similar or different other states are from Ohio in terms of their current readiness, capacity building, and capacity factors. It may be possible to repeat the proposed investigation in other states with the same results. The public health system at a state level has many commonalities in terms of health promotion programming. Therefore, the findings of this study are likely applicable in a very practical way.

One key finding of the study was how the public health partners in Ohio displayed facilitative leadership. The results may be generalizable in other state systems where this type of leadership is valued and used.

### *Reactivity*

Another threat to validity during the prospective and retrospective examination phases of the CoP is telling the investigator what she wants to hear. This is reactivity (Maxwell, 2008), in that the effect of the researcher herself may affect the findings. This potential validity concern is addressed by the fact that the investigator holds no programmatic authority over the CoP participants and is distant from the day-to-day work happening in Ohio. The investigator serves as a project director of a CDC cooperative agreement housed at the national membership organization of which the two university centers (Ohio State and Cincinnati Children's) are a part, the Association of University Centers on Disability. She has worked in the field of disability and health since 2000. For the past four years, the investigator has had no direct programmatic responsibility or oversight of the technical assistance provided to other states like Ohio that receive a CDC grant for health promotion efforts for PWD. This allowed the

investigator to maintain objectivity as a facilitator during the CoP.

To address this bias further, the investigator spent dedicated time reflecting (Maxwell, 2013) after each phase of the project in an effort to remain interested and focused on supporting the CoP participants in their information sharing and knowledge creation. The investigator wrote memos to aid in analysis, observations, and new pattern coding (Miles and Huberman, 1994). Another way that the study addressed this particular threat to validity is through the application of the Appreciative Inquiry Monitoring System and member checking. This type of monitoring helped to get true picture of interaction between meetings and removed pressure from the CoP participants to report stellar interactions.

### *Timeframe*

Reliability concerns having to do with the actual operations of the case study (Yin, 2009) are also inherent design flaws. One may have expected a decline in interest and participation of the CoP participants over a seven-month period, as they are volunteers for this effort and may develop study fatigue. This seven-month period is similar in length to other learning collaboratives where participation remains consistent over time (Institute for Healthcare Improvement, 2003). There was no financial incentive or stipend available to the participants. Even so, leadership of the UCEDD's CDC grant and the Department of Health remained committed to collaborate with the investigator on this study (Yang, 2015, personal communication). The main incentive for partners in Ohio to participate in the CoP was to document the work done in the state. The in-depth interviews, document reviews, and surveys



are of value in getting a clearer picture of which readiness and capacity factors were present for a successful collaboration in Ohio. The timeline of the proposed effort aligned with the final phase of Ohio's current CDC grant. The products of this CoP, the recommendations and a learning agenda supported by an action plan, will be especially relevant to continue collaboration among this group of passionate, dedicated public health practitioners. While this study had no budget for participant incentives, the non-financial benefits of meeting new partners, opportunity for creative collaboration, and a shared value of working together served as sufficient incentives to sustain these participants.

### *Internal validity*

The investigator ensured internal validity of the proposed study in a number of ways. The CoP "stage" allows for a participatory mode of research, with involved CoP members from Ohio. These CoP members verified emerging data through member checking. The second coder has a background in qualitative research, disability issues, and health policy. In this way, the second coder served as a peer examiner; thus, helping with ensuring internal validity. Finally, the reflection on the findings of each stage of the study was critical to ensuring internal validity.

### *Survey Methodology*

A survey methodology may not have been the best match for assessing changes in between the CoP participation for these particular participants. Future survey administration may be improved by pre-testing the survey in advance with a small sample of potential study

participants or colleagues with similar knowledge and experience. Future studies may also benefit from tracking individual responses pre- and post- CoP experience, rather than aggregate responses, as a way to assess any changes in the factors of readiness, capacity building, or capacity.

### *Assessment Methodology*

Another general threat to validity was that the leaders participating in this study did not have an initial capacity assessment, but rather a readiness assessment. However, this flaw was minimized through the fact that program staff and leaders shared many characteristics as seen in the readiness survey completed by program staff and the readiness assessment completed by these leaders. In examining the aggregate change overall for the group, this study likely captures the main changes.

## VI. Recommendations

This study highlighted the opportunity for more systematic inclusion of PWD as a demographic in public health efforts, such as smoking cessation, by enhancing key factors of readiness, capacity building, and capacity. A CoP model was successfully used to invite an exchange of knowledge and expertise between disability and public health state-level experts. **A CoP model may be used as a tool by public health leaders to encourage collaboration with other states working on public health efforts.** This builds on the findings of previous efforts to apply a CoP model to improve the capacity public health system (Maybery, 2012). The CoP is a nimble tool that may be adjusted to fit the participants' availability and specific topic of interest.

### *Community of Practice – Strategy for Public Health Capacity*

The CoP experience of this study offered a successful strategy for group inquiry and working together. This study identified four essential conditions that must be present in order for a CoP model to foster readiness, capacity building, and capacity among public health state partners:

3. *Timespan - not too long in order to sustain commitment*
4. *Systematic Reflection Process - use a facilitation technique*
3. *Supported - sufficient resources to dedicate staff who appreciate facilitative leadership*
4. *Personal Interest and Commitment of Participants –use ongoing member checking*

The CoP model may be generalizable to other states beyond Ohio if all four of these conditions are present.

### ***Opportunity for State Systems***

There is an opportunity for state-level experts to be networked and connected through shared CoP experience. Workforce development through continuing education efforts may be ideal occasions to integrate the readiness, capacity building, and capacity factors identified by this study. Continuing education in areas of disability training (Lollar and Andresen, 2011), facilitation (Cooperrider and Whitney 2005; Whitney et al 2004) or ToP facilitation (2000), and action research (Stringer, 2007; McNiff and Whitehead, 2011) would enhance the public health workforce. This state-level network may then be used for peer support, sharing of lessons learned, and further capacity building. This application of a CoP presents an opportunity to develop a state capacity building model. The CoP may serve as a catalyst for learning, experimenting together, and further development of state networks.

**Future efforts toward including PWD in public health efforts, such as smoking cessation, should focus on the key areas of readiness, capacity building, and capacity as identified by this study.** Smoking cessation was a lens for focusing this study, but the findings may be applicable to other health disparities encountered by PWD, such as physical activity, diabetes, or cancer screenings (Iezzoni, 2011; Krahn *et al*, 2015). Specifically, states need to enhance their competency in 14 readiness, capacity building, and capacity factors as exhibited by the partners from Ohio. States that wish to include PWD in public health efforts would benefit from focusing on using this as a list of work force development priorities. If a state is pressed for time or has limited resources, the nine critical factors identified by this study should serve as a

focus, as these factors had additional evidence and may be most critical for including PWD in public health efforts, like smoking cessation. Alternatively, the findings of this study may also be applicable to other underserved populations, beyond PWD.

### ***Public Health Disability Training Needs***

This study highlights the need for more public health trainees with disability awareness across the life span. This study also shows a need for disability and health experts to gain a deeper perspective of the public health system. The factors identified by this study could serve as the basis for a training curriculum. This would be very valuable to state public health partners as it would give specific guidance on how to include PWD in public health efforts. There may also be applicability to address groups that experience health disparities in general.

***Public health leaders would benefit from specific skills and training in systematic reflection and facilitation.*** The CoP participants indicated how productive the facilitation was in moving their work forward. Appreciative Inquiry (Cooperrider and Whitney 2005; Whitney *et al* 2004) and ToP facilitation (2000) may be important tools to incorporate in future training efforts to prepare leaders to navigate change efforts. The use of the CoP as a stage for the investigation also served as a dedicated space for systematic reflection. The CoP offered systematic reflection as a professional development opportunity for leaders at all levels. This use of a CoP in public health may be a way for leaders to enhance critical reflection and contribute to evidence-based practice. The practical strategies developed by the CoP participants show the benefit and importance of systematic reflection.

The CoP enhanced 11 of the 14 factors of readiness, capacity building, and capacity that were identified by this study. Additional dedicated training for public health professionals in a safe, encouraging space is needed to enhance the factors that were not increased by the CoP experience: 1. Mutually shared goals and values or partners and organizations, 2. Adaptive capacity and support for organizational learning, and 3. Leadership support and vision. These factors *should be the focus of more specialized, dedicated training efforts for public health practitioners*. This is an opportunity to enhance networks to support inclusion of any underserved population and build capacity. Network engagement efforts, such as a CoP, would need to be tailored for each specific population in an effort for the connections to come organically from the members of the community themselves (Block 2009).

**A dedicated, safe space for public health practitioners to practice and reflect is needed** *so that they are armed with the tools they need to reach every demographic with the information and services that they need when they need it*. One might think of this as a “Public Health Shokunin<sup>6</sup>Academy.” A public health shokunin would know how to use these tools artfully to influence positive change for partners or for the target audience. A public health shokunin may nimbly move around barriers and utilize tools to create change. This person would be able to adapt practical reflection strategies (Turner, 2013) and facilitation tactics (Technology

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<sup>6</sup> The Japanese word shokunin means craftsman or artisan, but there is a deeper meaning. A shokunin means not only having technical skills, but also implies an attitude of social consciousness and obligation to work his/her best for the general welfare of the people. (Learning the Craft: ‘Medicine Is Not Just a Job.’ *Medscape*. July 1, 2015; [http://www.medscape.com/viewarticle/847178\\_print](http://www.medscape.com/viewarticle/847178_print), accessed July 8, 2015.)

of Participation, 2000) for public health challenges. The partners who are collaborating in the state of Ohio to include PWD in public health efforts like smoking cessation are truly public health shokunin. Their wisdom needs to be harnessed by public health practitioners to create the systems change of including PWD in all public health efforts in the future. ***Public health practitioners should use the 10 action steps developed by the CoP participants.*** These are practical strategies for public health practitioners to explicitly include PWD in their programs. By working together as public health shokunin, practitioners will be on the path to cultivating their own network, team, or planning group with expertise in reaching underserved populations, such as PWD, who are at risk for health disparities, such as higher rates of smoking.

#### *Future Study Efforts*

Capacity building, being an iterative process, takes practice and time. Future studies should employ a longer protocol timeframe to more fully examine the capacity building process. Facilitation of the CoP sessions acted as an important accelerant for moving toward capacity.

Future efforts should use carefully defined constructs and measures in an effort to know better which factor may be taking place. Further testing of these factors and measures should be pursued with other states.

## **VII. Conclusion**

This study identified 14 capacity, capacity building, and readiness factors that help make a state system prepared to include PWD in public health efforts, such as smoking cessation. These factors were triangulated through seven data sources and can serve as a framework for other states wishing to serve other underserved populations at risk for health disparities. Nine factors had more evidence and were most critical for a state system to become ready to include PWD as a demographic in public health efforts. Findings from this study have implications for a larger, national dialogue on the importance of explicitly including PWD and appropriate stakeholder groups and organizations in all statewide public health efforts. One particular opportunity is the inclusion of disability in health equity efforts.

Partner participation in a CoP was found to foster the capacity of state systems to include PWD as a demographic in public health efforts. Specifically, the CoP experience enhanced 11 factors of readiness, capacity building, and capacity. Future public health efforts that aim to address demographic groups that experience health disparities, such as PWD, should use a CoP model to keep partner focus on key factors identified by this study.

Additional dedicated training in a safe, encouraging space is needed to enhance the three factors that were not increased by the CoP. A specialized effort is needed for strengthening facilitation as a public health leadership skill, as this was identified a critical factor for including PWD in public health efforts. Additional training may focus on these areas in creative ways that capitalize on other fields, beyond public health, such as the business and educational sectors,



such as Presencing Institute's Theory U (Scharmer, 2009), Leadership in Motion's reflection and action tools (Turner, 2013), or the LUMA Institute's human centered design (2012). This dedicated training would potentially build on the resources used in these sectors, while tailoring them for public health professionals.

This work to include PWD is an important charge for public health professionals to show courage to include everyone living in the community in their efforts. The findings of this study clarify the essential readiness, capacity building, and capacity elements and serve as a framework on how public health practitioners may move forward.

## Appendices

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## **Appendix A: Capacity Assessment In-Depth Interview Protocol, t<sub>1</sub>**

### *Introduction:*

Thanks for making the time for this conversation. I am a DrPH candidate at the University of Illinois at Chicago's School of Public Health and this interview is part of my dissertation process. I am interested in speaking with you about how you work with other partners to address the smoking cessation needs for people with a disability. First, I'd like to review the study information sheet with you. *[Read sheet. Ask if there are any questions.]*

Thanks - I am interested in your thoughts – there are no right or wrong answers. Everything you say will remain confidential and only aggregate findings will be used for purposes of my dissertation. This conversation should take about 60-90 minutes. I want to make sure that I capture all of your responses, so I will also be recording our interview for ease in themes analysis. Do I have your permission to continue?

*[If yes, continue.]*

*[If no, thank and terminate interview.]*

The interview protocol for each interview is included below:

*First, I'd appreciate it if you could tell me who are the people in your state who give of their time or resources to support integrating people with disabilities into smoking cessation efforts?*

*How did you meet these people in your state? [Probe: Were you already in a partnership with these people?]*

*How are you involved? What role(s) do you play? [Probe if not mentioned: What organization are you affiliated with?]*

*Would you say that you do/do not have any of the following:*

....A core group of partners?

If so, who are the partners? [Probe: if mention individuals, ask if they are organizational representatives and which organizations they represent]

Next, I'd like to ask you about how do you interact and connect with partners.  
Do you ...

meet in person [Probe: one-on-one, group meetings]

How often? [Probe: monthly, quarterly etc.]

How would you describe the quality of this interaction?

Highest quality

Quality

Not Sure

Not quality

Not at all a quality interaction

have phone calls [Probe: one-on-one, group conference calls]

How often? [Probe: monthly, quarterly etc.]

How would you describe the quality of this interaction?

Highest quality

Quality

Not Sure

Not quality

Not at all a quality interaction

share activity planning

How often? [Probe: monthly, quarterly etc.]

How would you describe the quality of this interaction?

Highest quality

Quality

Not Sure  
Not quality  
Not at all a quality interaction

communicate electronically [Probe: emails, listserv, text]

How often? [Probe: daily, weekly etc.]

How would you describe the quality of this interaction?

Highest quality  
Quality  
Not Sure  
Not quality  
Not at all a quality interaction

contribute to a partner sharing site [Probe: Google docs, Sharepoint]

How often? [Probe: daily, weekly, monthly, quarterly etc.]

How would you describe the quality of this interaction?

Highest quality  
Quality  
Not Sure  
Not quality  
Not at all a quality interaction

*How successful would you say these past collaborations have been:*

Very Successful  
Successful  
Can't really say  
Not Successful  
Definitely not successful

*How strongly do you agree or disagree with this statement: I believe that my partners and I can achieve something together.*

Strongly Agree  
Agree  
Not Sure  
Disagree  
Strongly Disagree

*What makes you say this?*

*What have you actually been able to accomplish with your partners? [Probe: What supports and processes got you there?]*

*How do partnerships connect with your organization's vision and mission? How about any connections with your strategic plan?*

*Do you have any agreement with these partners?*

*[If Yes – Ask how they are created? How are they shared? How are they tracked?]*

*[Follow Up If Needed:] Who was involved in the change effort in OH to include PWD in smoking cessation efforts?*

*What capabilities do these different partners have?*

*Have you conducted any needs assessments of the disability community in Ohio? If so, how did you share the findings? [Probe: trainings, presentations, action plans] Is the data available? Were partners involved in this effort? If so, what role did they play?*

*How else do you generate or share information? Would you say that you have the opportunity to give any employee educational opportunities, like continuing education, conferences, or trainings? Do you have the opportunity to attend these educational opportunities as learner?*

*Thinking about the employee educational opportunities available to you at your organizations, what educational opportunities, conferences, or trainings, if any, relate to your efforts to include PWD in public health efforts like smoking cessation?*

*[Follow Up If Needed:] Does your work with partners in disability and health connect with your formal job description at all? [Probe: job requirements, job descriptions] If not, how did you get into this kind of work?*

*Does your organization support you in this work? How? [Probe: Dedicated funding, staff, space, library access, equipment]*

Next, I want to ask you some questions about capacity building.

*Do you have a written action plan or work plan that includes your disability and health efforts? If so, what activities does it specify? [Probe for information dissemination, examples of public health programs/activities including people with a disability.] May I have a copy of the plan?*

*[Follow Up If Needed:] Would you say that you are part of any partner collaborations that support including people with disabilities in smoking cessation? Which ones? What coalitions? How are planning teams involved in Ohio's efforts?*

*Are your efforts to include people with disabilities in smoking cessation connected with other states? If so, how?*

*Would you say that you have dedicated staff time for thinking and planning public health efforts that include people with disabilities? In what ways? [Probe: Journaling; Retreat opportunity]*

*[Follow Up If Needed:] How do you think your state public health partners view people with disabilities in terms of programming? What data supports your collaborations with your state public health partners?*

Thank you so much! Those are all the questions that I have for you today. Are you still interested in being involved in this dissertation project and being in a Community of Practice (CoP) with others in Ohio?

[If yes, ask about motivation to participate and provide details on readiness assessment.]

[If no, thank and terminate interview.]

*What is your motivation to participate in this CoP? What is your goal for participation?*

One of the next steps to prepare for our first virtual meeting is to complete a short online survey. May I verify your email address so that I may send you the link?

[Confirm email address.]

Many thanks again for your time and I look forward to speaking with you at our first meeting!

## Appendix B: Document Review Template

Document:				
Capacity and Capacity Building Factors				
If Present x	Code	Definition	When to use	When Not to use
	PARTNERS	Topics around the concept of partners to include stakeholders grant partners, or coalition members	Apply to all references to people or organizations that have acted as stakeholders grant partners, or coalition members	Don't use to refer to internal co-workers or staff
	INTERACTION	Any meetings, phone calls, activity planning, emails, web or sharing site exchange	Apply to all references to people or organizations that have had any of these exchanges	Don't use to refer to internal co-workers or staff exchanges
	FREQUENCY	Topics around the concept of timeframe to include: <input type="checkbox"/> High: multiples times a day, daily, or weekly <input type="checkbox"/> Medium: monthly <input type="checkbox"/> Low: quarterly	Apply to all references to people or organizations that have had any of these exchanges with these timeframes	Don't use to refer to internal co-workers or staff exchanges
	ACTIVITIES	Any collaboration such as information sharing, materials dissemination, planning, needs assessments, training or presentations.	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges
	PERCEPTION OF COLLABORATION	Topics around the concept of perception to include: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges
	BELIEF	Topics around the concept of believing that the group can achieve something together	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges
	INFORMATION GENERATION	Topics around the concept of new ideas, tests, experiments or learning	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
	LEADERSHIP VISION	Any reference to the idea of vision or mission statements, but not specifically these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a leadership role
	LEADERSHIP SUPPORT	Any reference to the idea of strategic plan or partner agreements, but not specifically these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a leadership role



	TIME	Any reference to the idea of a work plan or accountability, but not specifically these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
	PEOPLE	Any references to competencies, job requirements, job descriptions, or staffing, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
	FUNDS	Any references to dedicated funds, budgets or grants, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
	SPACE	Any references to dedicated work space, equipment, resources like library access, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
	KNOWLEDGE	Technical skills, such as information about people with disabilities through a needs assessment, or employee continuing education to include conferences or training, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
	WORK	Any references to activities to include people with disabilities in a work plan, information sharing or materials dissemination, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
	TEAMS	Any references to a planning group, Ohio coalitions, Ohio Disability and Health Program, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
	EDUCATIONAL OPPORTUNITIES	Any references to employee conference or trainings where co-workers and staff learn, such as conferences or trainings, but not necessarily these terms	Apply to all references of collaborations with co-workers and staff	Don't use to refer to people or organizations beyond co-workers and staff
	REFLECTION	Dedicated staff time for thinking and planning, such as journaling, a retreat opportunity, or CoP participation	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
<b>Readiness Factors</b>				
	<b>Code</b>	<b>Definition</b>	<b>When to use</b>	<b>When Not to use</b>
	COORDINATION AWARENESS	Topics around the concept of join programs, grants, or funding, but not necessarily these terms	Apply to all references to people or organizations that have acted as stakeholders grant partners, or	Don't use to refer to internal co-workers or staff

			coalition members	
	INTERACTION	Any meetings, phone calls, activity planning, emails, web or sharing site exchange	Apply to all references to people or organizations that have had any of these exchanges	Don't use to refer to internal co-workers or staff exchanges
	FREQUENCY	Topics around the concept of timeframe to include: <input type="checkbox"/> High: multiples times a day, daily, or weekly <input type="checkbox"/> Medium: monthly <input type="checkbox"/> Low: quarterly	Apply to all references to people or organizations that have had any of these exchanges with these timeframes	Don't use to refer to internal co-workers or staff exchanges
	PERCEPTION OF PARTNERS	Topics around the concept of how other organizations are seen, to include: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges
	UNDERSTANDING PARTNERS	Topics around the concept of knowing partner's goals, values or interests, but not necessarily these terms	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges
	TEAMS	Any references to a planning group, Ohio coalitions, Ohio Disability and Health Program, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
	NEW EFFORT	Topics around the concept of committing to implement new ideas, tests, experiments or learning, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
	SHARED	Topics around the concept that ideas, goals, values, or interests are mutually share among partners, but not necessarily these terms.	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges

## Appendix C: Readiness Assessment Survey Protocol

The following questions will be offered in an online survey using Survey Monkey:

*Thank you for your participation in the Community of Practice focused on smoking cessation for people with a disability! Please answer the following questions based on your most recent meeting. This survey is estimated to take about 10 minutes to complete. Thanks again!*

Thinking of your work to include people with disabilities into your state smoking cessation efforts...

1. Have you ever collaborated on a program or a grant to fund a program on smoking cessation efforts for people with disabilities, either on your own or through a partnership?

Yes (*Continue*)

What are some examples? [short text box answer]

To what extent have you collaborated:

Very much

A lot

About the same as we had before

Very little

Not at all

Not Sure (*Go to Question 2.*)

No (*Go to Question 2.*)

2. Do you interact with any partners on smoking cessation efforts for people with disabilities?

Yes (*Continue*)

Check all that apply:

meetings

How frequently: daily, weekly, monthly, quarterly

phone calls

How frequently: multiple times a day, daily, weekly, monthly, quarterly

activity planning

How frequently: daily, weekly, monthly, quarterly

emails/listserv

How frequently: multiple times a day, daily, weekly, monthly, quarterly

sharing site/website

How frequently: daily, weekly, monthly, quarterly

What are some other ways that you interact? [short text box answer]

To what extent have you interacted:

Very much

A lot

About the same as we had before

Very little

Not at all

Not Sure (*Go to Question 3.*)

No (*Go to Question 3.*)

3. *Would you say that you have an understanding or knowledge of the goals, values and interests of our smoking cessation and disability partners.*

Strongly agree

Agree

Not sure

Disagree

Strongly disagree

What are some other ways that you have this understanding? [short text box answer]

4. *Have you collaborated with partners in a smoking cessation program for people with disabilities?*

Yes (*Continue a*)

To what extent have you interacted:

Very much

A lot

About the same as we had before

Very little

Not at all

Yes (*Continue b*)

I have a positive perception of other partners with whom I have collaborated:

Strongly agree

Agree

Not sure

Disagree

Strongly disagree

Not Sure (*Go to Question 5.*)

No (*Go to Question 5.*)

5. *Would you say that you have mutually shared goals, values and interests with your smoking cessation and disability partners?*

Strongly agree

Agree

Not sure

Disagree

Strongly disagree

What are some other ways that you have this understanding? [short text box answer]

6. Would you say that your work culture supports new and innovative ideas?

Strongly agree

Agree

Not sure

Disagree

Strongly disagree

7. Would you say that you have tests (either short-term or long-term) to implement new way of doing a program?

Yes

What are some ways that you do these tests? [short text box answer]

Not Sure (*Go to Question 8.*)

No (*Go to Question 8.*)

Please rate your agreement with the following statements:

*8. We have a written action plan or work plan that includes our state disability and health efforts.*

Strongly agree  
Agree  
Not sure  
Disagree  
Strongly disagree

*9. We have connections with informal or formal networks, such as coalitions or partner groups that include our state disability and health efforts.*

Strongly agree  
Agree  
Not sure  
Disagree  
Strongly disagree

*10. I have dedicated staff time for employee educational opportunities, like conferences or trainings.*

Strongly agree  
Agree  
Not sure  
Disagree  
Strongly disagree

*11. I have dedicated staff time for thinking and planning public health efforts that include people with disabilities.*

Strongly agree  
Agree  
Not sure  
Disagree  
Strongly disagree

12. Are you still interested in being involved in this dissertation project and being in a Community of Practice with others in Ohio?

Yes

During the Community of Practice, your ideas and thoughts will be collected for the purposes of the dissertation project. Do I have your permission to record and take note of information that you may share?

Yes – Continue and thank

No – Thank and remove from CoP roster.

No – Thank and remove from CoP roster.

Why not? [short text box answer]

Many thanks again for your time and I look forward to speaking with you at our first meeting on [date and time].

## **Appendix D: Readiness Assessment In-Depth Interview Protocol for ODHP Leaders**

### *Introduction:*

Thanks for making the time for this conversation. I am a DrPH candidate at the University of Illinois at Chicago's School of Public Health and this interview is part of my dissertation process. First, I'd like to review the study information sheet with you. *[Read sheet. Ask if there are any questions.]*

Thanks - I am interested in speaking with you about how you work with other partners to address the smoking cessation needs for people with a disability. I am interested in your thoughts – there are no right or wrong answers. Everything you say will remain confidential and only aggregate findings will be used for purposes of my dissertation. This conversation should take about 45-60 minutes. I want to make sure that I capture all of your responses, so I will also be recording our interview for ease in analysis. Do I have your permission to continue?

*[If yes, continue.]*

*[If no, thank and terminate interview.]*

The interview protocol for each interview is included below:

Thank you for your organization's participation in the Community of Practice focused on smoking cessation for people with a disability!

Thinking of your work to include people with disabilities into your state smoking cessation efforts...

*Who are people in your state who have given of their time or resources to support integrating people with disabilities into smoking cessation efforts? What organizations do you think of as partners in this work?*

Again, thinking of your work to include people with disabilities into your state's smoking



*cessation effort, have you or any partners collaborated on a program or a grant to fund a program on smoking cessation efforts for people with disabilities? What are some examples?*

*Have you collaborated with partners in a smoking cessation program for people with disabilities? To what extent would you say that you have collaborated with these partners?*

*How do you interact with partners on smoking cessation efforts for people with disabilities? Do you have meetings, phone calls or activity planning sessions? How about electronic communication? [Probe: How frequently do these interactions occur? daily, weekly, monthly, quarterly] What are some other ways that you interact?*

*[If not yet mentioned]: To what extent have you interacted?*

*Would you say that your work culture supports new and innovative ideas? In what ways?*

*Would you say that you have tests (either short-term or long-term) to implement new way of doing a program? If so, what are some ways that you do these tests?*

Next, I'd like you to rate your agreement with the following statements:

*5. I have an understanding or knowledge of goals, values and interests of our smoking cessation and disability partners. Do you...*

Strongly agree

Agree

Not sure

Disagree

Strongly disagree

*6. We have a written action plan or work plan that includes our state disability and health efforts. Do you...*

Strongly agree

Agree

Not sure

Disagree  
Strongly disagree

*7. We have connections with informal or formal networks, such as coalitions or partner groups that include our state disability and health efforts. Do you...*

Strongly agree  
Agree  
Not sure  
Disagree  
Strongly disagree

*8. I have dedicated staff time for employee educational opportunities, like conferences or trainings. Do you...*

Strongly agree  
Agree  
Not sure  
Disagree  
Strongly disagree

*9. I have dedicated staff time for thinking and planning public health efforts that include people with disabilities. Do you...*

Strongly agree  
Agree  
Not sure  
Disagree  
Strongly disagree

Thank you so much! Those are all the questions that I have for you today.

Many thanks again for your time and I look forward to speaking with your colleagues at our first meeting. Please feel free to join the CoP meetings if you like.

## Appendix E: Appreciative Inquiry Monitoring System (t<sub>1</sub>, t<sub>2</sub>, t<sub>3</sub>)

The following questions will be offered in an online survey using Google Forms:

Thank you for your participation in the Community of Practice focused on smoking cessation for people with a disability! Please answer the following questions based on your most recent meeting. This survey is estimated to take about 10 minutes to complete. Thanks again!

*Section A) These questions are to assess your experience of the most recent meeting. Please select one of the following options:*

- I learned new information in this meeting. (Continue with Questions 1-4.)*
- I did not learn any new information in this meeting. (Skip to Section B.)*

*1. I have been able to incorporate information learned from the Community of Practice into my practical experiences, like my job and efforts with partners...*

- Very much
- A lot
- About the same as before
- Very little
- Not at all

*2. I have been able to incorporate information learned from the Community of Practice into my own personal work and continuing education...*

- Very much
- A lot
- About the same as before
- Very little
- Not at all

*3. I have been able to take time in my work to regularly reflect:*

- Strongly agree
- Agree
- Not sure
- Disagree
- Strongly disagree

*4. I have been able to incorporate information learned from the Community of Practice into my systematic reflection, like critical thinking or journaling...*

- Very much
- A lot
- About the same as before
- Very little

Not at all

5. *I have been able to incorporate information learned from the Community of Practice into my involvement with a network of colleagues, either formal or informal, like partner in a coalition, coworkers, or regional or national groups).*...

Very much

A lot

About the same as before

Very little

Not at all

*Section B) The following questions assess how you have connected with other Community of Practice members. Please select all that apply:*

*--- I met someone new at the most recent meeting. (Continue with Questions 1-8.)*

*--- I did not meet someone new. (Continue with Questions 1-8.)*

*I became better acquainted with someone I met previously. (Continue with Questions 1-8.)*

*The following questions are about the impact of your relationship with other Community of Practice members...*

*Since the most recent meeting, I have not had any contact with other Community of Practice members. (Skip to Section C.)*

*Since the most recent meeting, I have had contact with other Community of Practice members. (Continue with Questions 1-8.)*

Please select any that apply to your contact with other Community of Practice members:

1. Phone conversations

individual calls

conference calls

How often? multiple times a day, daily, weekly, monthly, quarterly

2. Electronic correspondence

individual emails

group listserv

texts

How often? multiple times a day, daily, weekly, monthly, quarterly

3. Meetings in person

individual meetings

group meetings

How often? daily, weekly, monthly, quarterly

4. Connected through social media  
How often? multiple times a day, daily, weekly, monthly, quarterly
5. Sharing site, like a document sharing site  
How often? daily, weekly, monthly, quarterly
6. Website contact, like through the addition of any content or links  
How often? weekly, monthly, quarterly
7. Piggyback on any events already happening, such as health fair or support group  
How often? weekly, monthly, quarterly
8. How would you rate the quality of these interactions...Check any that apply:
  - The interactions were positive.
  - I gained new information or the interaction was content-rich.
  - The frequency of interaction was good for me.
  - The frequency of interaction seemed good for others.

*Section C) The following questions are about your satisfaction with your Community of Practice experience itself.*

How well did the Community of Practice meeting ...

1. Meet your goals for Community of Practice participation?

Very much met my goals  
A lot of my goals were met  
I'm not sure if my goals were met  
Not many of my goals were met  
None of my goals were met

2. Give you the ability to contribute and share information?

I was very much able to contribute and share information.  
I was able to contribute and share information a lot of the time.  
I'm not sure I was able to contribute and share information.  
I was not able to contribute and share as much information as I wanted to.  
I was not able to contribute and share information at all.

*Many thanks again for your time and I look forward to speaking with you next time!*

## Appendix F: Capacity Assessment In-Depth Interview Protocol, t<sub>2</sub>

### *Introduction:*

Thanks for making the time for this conversation. I am interested in checking in with you about how your work with other partners to address the smoking cessation needs for people with a disability may or may not have changed over the course of the Community of Practice. As you know, I am a DrPH candidate at the University of Illinois at Chicago's School of Public Health and this interview is part of my dissertation process. First, I'd like to review the study information sheet with you. *[Read sheet. Ask if there are any questions.]*

Thanks - I am interested in your thoughts – there are no right or wrong answers. Everything you say will remain confidential and only aggregate findings will be used for purposes of my dissertation. This conversation should take about 60-90 minutes. I want to make sure that I capture all of your responses, so I will also be recording our interview for ease in themes analysis. Do I have your permission to continue?

*[If yes, continue.]*

*[If no, thank and terminate interview.]*

The interview protocol for each interview is included below:

Thinking about your experience in this Community of Practice...

*What was your motivation to participate in this CoP? [Probe: What was your goal for participation?] How well did your actual experience meet your goals?*

*Thinking about people in your state who give of their time or resources to support integrating people with disabilities into smoking cessation efforts...*

*Would you say that you do/do not have any of the following:*

....A core group of partners?

If so, who are the partners? [Probe: if mention individuals, ask if they are organizational representatives and which organizations they represent]

Next, I'd like to ask you about how do you interact with partners.  
Do you noticed any changes in how you...

meet in person [Probe: one-on-one, group meetings]

How often? [Probe: monthly, quarterly etc.]

How would you describe the quality of this interaction?

Highest quality

Quality

Not Sure

Not quality  
Not at all a quality interaction

have phone calls [Probe: one-on-one, group conference calls]  
How often? [Probe: monthly, quarterly etc.]  
How would you describe the quality of this interaction?  
Highest quality  
Quality  
Not Sure  
Not quality  
Not at all a quality interaction

share activity planning  
How often? [Probe: monthly, quarterly etc.]  
How would you describe the quality of this interaction?  
Highest quality  
Quality  
Not Sure  
Not quality  
Not at all a quality interaction

communicate electronically [Probe: emails, listserv, text]  
How often? [Probe: daily, weekly etc.]  
How would you describe the quality of this interaction?  
Highest quality  
Quality  
Not Sure  
Not quality  
Not at all a quality interaction

contribute to a partner sharing site [Probe: Google docs, Sharepoint]  
How often? [Probe: daily, weekly, monthly, quarterly etc.]  
How would you describe the quality of this interaction?  
Highest quality  
Quality  
Not Sure  
Not quality  
Not at all a quality interaction

*How successful would you say these past collaborations have been:*

Very Successful  
Successful

Can't really say  
Not Successful  
Definitely not successful

*How strongly do you agree or disagree with this statement: I believe that the partners in the Community of Practice can achieve something together.*

Strongly Agree  
Agree  
Not Sure  
Disagree  
Strongly Disagree

*What makes you say this?*

*How do the partnerships you gained in the Community of Practice connect with your organization's vision and mission? How about any connections with your strategic plan?*

*Do you have any agreement with these partners as a result of the Community of Practice?  
[If Yes – Ask how they are created? How are they shared? How are they tracked?]*

*[Follow Up If Needed:] After the Community of Practice, who was involved in the change effort in OH to include PWD in smoking cessation efforts?*

*What capabilities do these different partners in the Community of Practice have?*

*Have you conducted any needs assessments of the disability community in Ohio? If so, how did you share the findings? [Probe: trainings, presentations, action plans] Is the data available? Were partners involved in this effort? If so, what role did they play?*

*As a result of the Community of Practice did you generate or share information? Would you say that you had the opportunity to give any employee educational opportunities, like continuing education, conferences, or trainings? Based on your Community of Practice experience, did you have the opportunity to attend any educational opportunities as learner?*

*Thinking about any employee educational opportunities available to you at your organization, have there been any changes in conferences or trainings that relate to your efforts to include PWD in public health efforts like smoking cessation? Which ones?*



*[Follow Up If Needed:] As a result of the Community of Practice, how did your work with partners in disability and health connect with your formal job description? [Probe: job requirements, job descriptions]*

*Have you noticed any changes in how your organization supports you in this work? [Probe: Dedicated funding, staff, space, library access, equipment]*

Next, I want to ask you some questions about capacity building.

*Since your participation in the Community of Practice, have there been any changes to your written action plan or work plan that includes your disability and health efforts? If so, what activities does it specify? [Probe for information dissemination, examples of public health programs/activities including people with a disability.] May I have a copy of the plan?*

*[Follow Up If Needed:] Would you say that this Community of Practice is part of any partner collaborations that support including people with disabilities in smoking cessation? Which ones? What coalitions? How is the Community of Practice connected to any planning teams involved in Ohio's efforts?*

*As a result of your participation in the Community of Practice, are your efforts to include people with disabilities in smoking cessation connected with other states? If so, how?*

*Would you say that you have dedicated staff time for thinking and planning public health efforts that include people with disabilities? In what ways? [Probe: Journaling; Retreat opportunity]*

*[Follow Up If Needed:] How do you think your state public health partners now view people with disabilities in terms of programming? What data supports your collaborations with your state public health partners now?*

Thank you so much! Those are all the questions that I have for you today.

Many thanks again for your time and I look forward to sharing a copy of my dissertation findings with you!

## Appendix G

### Telephone/Verbal Consent Documentation for Participation

**The following written consent serves as signed documentation for oral informed consent for the protection of the participant. Federal requirements mandate that informed consent shall be documented by the use of a written consent form and in the case of oral presentation must also be witnessed.**

**SUBJECT: *Case Study Analysis of State Capacity Building Factors: Action Research with a Community of Practice Focused on Smoking Cessation for People with a Disability***

Hello, I am Adriane Griffen, a DrPH candidate at the University of Illinois at Chicago. As part of my dissertation study I am conducting research on state capacity building. You are being contacted as a possible participant because you are part of a group in Ohio that has been demonstrating capacity in including people with disabilities in public health efforts, such as smoking cessation. I would like to ask you questions about your activities and work with others in the state in this topic area. May I review some background on the study with you now? It will take about 5 minutes. You will also be given a written copy of this information to keep for your records.

[If agree to hear background on study, continue. If not, thank and close.]

If you agree to be in this study, I would ask you to do the following things: Take part in a Community of Practice (CoP) with others in your state. I would facilitate this CoP. Before the CoP, you would participate in an in-depth interview about 60 minutes in length and after the CoP you would participate in a similar follow up interview. The CoP commitment will involve three (3) virtual meetings by conference call. Each virtual meeting will last approximately 60-90 minutes and be scheduled on a convenient day and time. Each virtual meeting call will have pre- and post-work to be shared via an email group. The pre-work and post-work would take approximately 15-20 minutes to complete. With the virtual meetings and the pre-work and post-work, this study includes a total of 9 commitments.

We will be taping the conversation using online digital audio recording software, but will not use your last name during the conversation.

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a subject. Research records will be stored securely and only researchers will have access to the records. The recorded materials will be used by only by me for purposes of this dissertation study. The recordings will be deleted in 90 days after they are made.

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relationships with me as the investigator. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting this relationship.

Do you have any questions about the research project? [Respond to any questions.]

Are you able to participate?

[if yes]: I will be documenting your consent to participate.

[if no: thank and close]

May we look at your calendar now to schedule the first in-depth interview?

Many thanks. If you have questions later, I encourage you to contact me on my cell: 202-210-1546 or email: [agriff27@uic.edu](mailto:agriff27@uic.edu). You will be given a written copy of this information to keep for your records. Thanks again!

---

This consent serves as documentation that the required elements of informed consent have been presented orally to the participant or the participant's legally authorized representative by using the below telephone consent script.

Verbal consent to participate in this telephone survey has been obtained by the below investigator on the below date documenting the participant's willingness to continue with the research study.

---

Investigator's Name (Printed)

---

Investigator's Signature

---

Date

## **Appendix H: Information Sheet on Research Study**

### ***Case Study Analysis of State Capacity Building Factors: Action Research with a Community of Practice Focused on Smoking Cessation for People with a Disability***

You are invited to be in a research study of state capacity building. You were selected as a possible participant because you are part of a group that has been demonstrating capacity in including people with disabilities in public health efforts, such as smoking cessation. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Adriane Griffen, a DrPH candidate at the University of Illinois at Chicago, as part of her dissertation study.

#### **Procedures:**

If you agree to be in this study, we would ask you to do the following things: Take part in a facilitated Community of Practice (CoP). Before the CoP, you would participate in an in-depth interview about 60 minutes in length and after the CoP you would participate in a similar follow up interview. The CoP commitment will involve three (3) virtual meetings by conference call. Each virtual meeting will last approximately 60-90 minutes. Each virtual meeting call will have pre- and post-work to be shared via an email group. The pre-work and post-work would take approximately 15-20 minutes to complete. With the virtual meetings and the pre-work and post-work, this study includes a total of 9 commitments.

We will be taping the conversation using online digital audio recording software, but will not use your last name during the conversation.

#### **Confidentiality:**

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a subject. Research records will be stored securely and only researchers will have access to the records. The recorded materials will be used by only by Adriane Griffen for purposes of this dissertation study. The recordings will be deleted in 90 days after they are made.

#### **Voluntary Nature of the Study:**

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relationships with the investigator. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting this relationship.

#### **Contacts and Questions:**

The researcher conducting this study is: Adriane Griffen. You may ask any questions you have now. If you have questions later, you are encouraged to contact her at: cell: 202-210-1546 or email: [agriff27@uic.edu](mailto:agriff27@uic.edu). You will be given a copy of this information to keep for your records.

## Appendix I: Capacity Assessment In-depth Interviews (*Provisional Codebook*)

### Research Questions:

1. What are the factors that make a state system ready to include PWD as a demographic in public health efforts? READINESS CONSTRUCT, CAPACITY BUILDING CONSTRUCT, CAPACITY CONSTRUCT
  - What are the process steps that a state system can take to become ready? READINESS CONSTRUCT
  - What are the capacity supports that help make a state system ready? CAPACITY BUILDING CONSTRUCT
2. How does partner participation in a modified community of practice foster the capacity of state systems to include PWD as a demographic in public health efforts? CAPACITY CONSTRUCT
3. What are the factors that support state capacity to address demographic groups that experience health disparities, such as smoking among PWD? CAPACITY BUILDING CONSTRUCT

Factors	Measures	Code Listing ( <i>Factor</i> )
<b>Capacity:</b> 1. stakeholder involvement, 2. change efficacy (believe can achieve something by working together), 3. adaptive capacity and support for organizational learning, 4. leadership support and vision, 5. resources (time, people, funds, space), 6. technical skills and knowledge	<b>Capacity:</b> 1. Number and type of partners; frequency and type of interaction (meetings, phone calls, activity planning, emails, sharing site) 2. Successful past collaborations (belief group can achieve) 3. Action plans based on needs assessments; Information generation and sharing through trainings, presentations 4. Vision, mission statements; strategic plan; work plan; Partner agreements 5. Competencies-job requirements, job descriptions; Dedicated funding, staff, space, library access, equipment 6. Needs assessment of community; Employee educational opportunities- continuing education, conferences, trainings	<b>Category 1: Interaction (<i>Capacity 1</i>)</b> CODE 1: PARTNERS CODE 2: TYPE OF INTERACTION CODE 3: FREQUENCY  <b>Category 2: Collaboration (<i>Capacity 2, 3</i>)</b> CODE 1: ACTIVITIES CODE 2: PERCEPTION CODE 2: BELIEF  <b>Category 3: Adaptive capacity (<i>Capacity 3</i>)</b> CODE 1: INFORMATION GENERATION  <b>Category 4: Leadership (<i>Capacity 4</i>)</b> CODE 1: VISION CODE 2: SUPPORT  <b>Category 5: Resources (<i>Capacity 5</i>)</b> CODE 1: TIME CODE 2: PEOPLE ( <i>Capacity 6</i> ) CODE 3: FUNDS CODE 4: SPACE  <b>Category 6: Technical skills (<i>Capacity 6</i>)</b> CODE 1: KNOWLEDGE  <b>Category 7: Practical experience (<i>Capacity Building 1</i>)</b> CODE 1: WORK  <b>Category 8: Network (<i>Capacity Building 2</i>)</b> CODE 1: TEAMS  <b>Category 9: Employee Continuing Education (<i>Capacity Building 3</i>)</b> CODE 1: EDUCATIONAL OPPORTUNITIES
<b>Capacity building activities:</b> 1. Practical experience, 2. Engagement in network, 3. Continuing education, 4. Critical reflection (CoP participation)	<b>Capacity building:</b> 1. Work plan; Information sharing and materials dissemination; Examples of public health programs/activities including people with a disability 2. Collaboration with partners,	

	coalition, planning teams in OH; Connection with other states 3. Employee educational opportunities, conferences, trainings 4. Dedicated staff time for thinking and planning; Journaling; Retreat opportunity; motivation to participate in CoP; goal for participation in CoP	<b>Category 10: Thinking/Planning time</b> ( <i>Capacity Building 4</i> ) <b>CODE 1: REFLECTION</b>	
Code	Definition	When to use	When Not to use
PARTNERS	Topics around the concept of partners to include stakeholders grant partners, or coalition members	Apply to all references to people or organizations that have acted as stakeholders grant partners, or coalition members	Don't use to refer to internal co-workers or staff
INTERACTION	Any meetings, phone calls, activity planning, emails, web or sharing site exchange	Apply to all references to people or organizations that have had any of these exchanges	Don't use to refer to internal co-workers or staff exchanges
FREQUENCY	Topics around the concept of timeframe to include: <input type="checkbox"/> High: multiples times a day, daily, or weekly <input type="checkbox"/> Medium: monthly <input type="checkbox"/> Low: quarterly	Apply to all references to people or organizations that have had any of these exchanges with these timeframes	Don't use to refer to internal co-workers or staff exchanges
ACTIVITIES	Any collaboration such as information sharing, materials dissemination, planning, needs assessments, training or presentations.	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges
PERCEPTION OF COLLABORATION	Topics around the concept of perception to include: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges
BELIEF	Topics around the concept of believing that the group can achieve something together	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges
INFORMATION GENERATION	Topics around the concept of new ideas, tests, experiments or learning	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role

LEADERSHIP VISION	Any reference to the idea of vision or mission statements, but not specifically these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a leadership role
LEADERSHIP SUPPORT	Any reference to the idea of strategic plan or partner agreements, but not specifically these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a leadership role
TIME	Any reference to the idea of a work plan or accountability, but not specifically these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
PEOPLE	Any references to competencies, job requirements, job descriptions, or staffing, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
FUNDS	Any references to dedicated funds, budgets or grants, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
SPACE	Any references to dedicated work space, equipment, resources like library access, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
KNOWLEDGE	Technical skills, such as information about people with disabilities through a needs assessment, or employee continuing education to include conferences or training, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
WORK	Any references to activities to include people with disabilities in a work plan, information sharing or materials dissemination, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
TEAMS	Any references to a planning group, Ohio coalitions, Ohio Disability and Health Program, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role

EDUCATIONAL OPPORTUNITIES	Any references to employee conference or trainings where co-workers and staff learn, such as conferences or trainings, but not necessarily these terms	Apply to all references of collaborations with co-workers and staff	Don't use to refer to people or organizations beyond co-workers and staff
REFLECTION	Dedicated staff time for thinking and planning, such as journaling, a retreat opportunity, or CoP participation	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role



## Appendix I: Codebook-Capacity Assessment In-depth Interview (Final version)

### Research Questions:

1. What are the factors that make a state system ready to include PWD as a demographic in public health efforts? READINESS CONSTRUCT, CAPACITY BUILDING CONSTRUCT, CAPACITY CONSTRUCT

➤ What are the process steps that a state system can take to become ready? READINESS CONSTRUCT

➤ What are the capacity supports that help make a state system ready? CAPACITY BUILDING CONSTRUCT

2. How does partner participation in a community of practice foster the capacity of state systems to include PWD as a demographic in public health efforts? CAPACITY CONSTRUCT

What are the factors that support state capacity to address demographic groups that experience health disparities, such as smoking among PWD? CAPACITY BUILDING CONSTRUCT

Factors	Measures	Code Listing (Factor)
<b>Capacity:</b> 1. stakeholder involvement, 2. change efficacy (believe can achieve something by working together), 3. adaptive capacity and support for organizational learning, 4. leadership support and vision, 5. resources (time, people, funds, space), 6. technical skills	<b>Capacity:</b> 1. Number and type of partners; frequency and type of interaction (meetings, phone calls, activity planning, emails, sharing site) 2. Successful past collaborations (belief group can achieve) 3. Action plans based on needs assessments; Information generation and sharing through trainings, presentations 4. Vision, mission statements; strategic plan; work plan; Partner agreements 5. Competencies-job requirements, job descriptions; Dedicated funding, staff, space, library access, equipment 6. Needs assessment of community; Employee educational opportunities-	<b>Category 1: Interaction (Capacity 1)</b> CODE 1: PARTNERS CODE 2: TYPE OF INTERACTION CODE 3: FREQUENCY  <b>Category 2: Collaboration (Capacity 2, 3)</b> CODE 1: ACTIVITIES CODE 2: PERCEPTION CODE 2: BELIEF  <b>Category 3: Adaptive capacity (Capacity 3)</b> CODE 1: INFORMATION GENERATION  <b>Category 4: Leadership (Capacity 4)</b> CODE 1: VISION CODE 2: SUPPORT  <b>Category 5: Resources (Capacity 5)</b> CODE 1: TIME CODE 2: PEOPLE (Capacity 6) CODE 3: FUNDS CODE 4: SPACE

and knowledge  <u>Capacity building activities:</u> 1. Practical experience, 2. Engagement in network, 3. Continuing education, 4. Critical reflection (CoP participation)	continuing education, conferences, trainings  <u>Capacity building:</u> 1. Work plan; Information sharing and materials dissemination; Examples of public health programs/activities including people with a disability 2. Collaboration with partners, coalition, planning teams in OH; Connection with other states 3. Employee educational opportunities, conferences, trainings 4. Dedicated staff time for thinking and planning; Journaling; Retreat opportunity; motivation to participate in CoP; goal for participation in CoP	<p><b>Category 6: Technical skills</b> (<i>Capacity 6</i>) CODE 1: KNOWLEDGE</p> <p><b>Category 7: Practical experience</b> (<i>Capacity Building 1</i>) CODE 1: WORK</p> <p><b>Category 8: Network</b> (<i>Capacity Building 2</i>) CODE 1: TEAMS</p> <p><b>Category 9: Employee Continuing Education</b> (<i>Capacity Building 3</i>) CODE 1: EDUCATIONAL OPPORTUNITIES</p> <p><b>Category 10: Thinking/Planning time</b> (<i>Capacity Building 4</i>) CODE 1: REFLECTION</p>
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Code	Definition	When to use	When Not to use	Mentions During Interview/Exemplary Quotes
<b>Interaction: (-- mentions)</b>				
PARTNERS (--)	Topics around the concept of partners to include stakeholders grant partners, or coalition members	Apply to all references to people or organizations that have acted as stakeholders grant partners, or coalition members	Don't use to refer to internal co-workers or staff	
TYPE (--)	Any meetings, phone calls, activity planning, emails, web or sharing site exchange; and quality of these exchanges	Apply to all references to people or organizations that have had any of these exchanges	Don't use to refer to internal co-workers or staff exchanges	

FREQUENCY (--)	Topics around the concept of timeframe to include: <input type="checkbox"/> High: multiples times a day, daily, or weekly <input type="checkbox"/> Medium: monthly <input type="checkbox"/> Low: quarterly <input type="checkbox"/> As Needed	Apply to all references to people or organizations that have had any of these exchanges with these timeframes	Don't use to refer to internal co-workers or staff exchanges	
<b>Collaboration:</b> (-- mentions)				
ACTIVITIES (--)	Any collaboration such as information sharing, materials dissemination, planning, needs assessments, training or presentations.	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges	
PERCEPTION OF COLLABORATION (--)	Topics around the concept of perception to include: <input type="checkbox"/> Positive overall <input type="checkbox"/> Negative	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges	
BELIEF (--)	Topics around the concept of believing that the group can achieve something together	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges	
INVOLVEMENT OF DISABILITY ORGANIZATION	Any emphasis or priority to include organizations that have direct contact with people living with disabilities	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges	
<b>Adaptive Capacity:</b> (-- mentions)				
ORGANIZATIONAL LEARNING (--)	Topics around the concept of new ideas, tests, experiments or learning	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	

<b>Leadership: (-- mentions)</b>				
LEADERSHIP VISION (--)	Any reference to the idea of vision or mission statements, but not specifically these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a leadership role	
LEADERSHIP SUPPORT (--)	Any reference to the idea of strategic plan or partner agreements, but not specifically these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a leadership role	
<b>Resources: (-- mentions)</b>				
Accountability (--)	Any reference to the idea of a work plan or accountability, but not specifically these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
Job (--)	Any references to competencies, job requirements, job descriptions, or staffing, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
FUNDS (--)	Any references to dedicated funds, budgets or grants, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
Support (--)	Any references to dedicated work space, equipment, resources like library access, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers	Don't use to refer to people or organizations not in a partner role	

		and staff		
Communication Technology (--)	Any references to integrating and applying technology to enhancing and maintaining open communication with partners or stakeholders, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
<b>Technical Skills: (-- mentions)</b>				
KNOWLEDGE (--)	Technical skills, such as information about people with disabilities through a needs assessment, or employee continuing education to include conferences or training, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
<b>Practical Experience: (-- mentions)</b>				
WORK (--)	Any references to activities to include people with disabilities in a work plan, information sharing or materials dissemination, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
INCLUSION	Any references to concept of inclusion of people with disabilities as a priority or a component of a strategy, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and	Don't use to refer to people or organizations not in a partner role	

		staff		
DISABILITY IDENTIFIER	Any references to concept of identifying people with disabilities as target of public health programs and surveillance, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
<b>Network: (-- mentioned)</b>				
TEAMS (--)	Any references to a planning group, Ohio coalitions, Ohio Disability and Health Program, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
Engagement	Any references to ongoing connections with groups in state and region or sense of belonging, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
<b>Employee Continuing Education: (-- mentions)</b>				
EDUCATIONAL OPPORTUNITIES (--)	Any references to employee conference or trainings where co-workers and staff learn, such as conferences or trainings, but not necessarily these terms	Apply to all references of collaborations with co-workers and staff	Don't use to refer to people or organizations beyond co-workers and staff	

<b>Thinking/Planning Time: (-- mentions)</b>				
REFLECTION (--)	Dedicated staff time for thinking and planning, such as journaling, a retreat opportunity, or CoP participation	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
ATTENTION (--)	Motivation for CoP participation, such as dedicated time or focus, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	

## Appendix J: Readiness and Capacity Building In-Depth Interviews (Provisional Codebook)

### Research question:

1. What are the factors that make a state system ready to include PWD as a demographic in public health efforts?  
 READINESS CONSTRUCT, CAPACITY BUILDING CONSTRUCT, CAPACITY CONSTRUCT
  - What are the process steps that a state system can take to become ready? READINESS CONSTRUCT
  - What are the capacity supports that help make a state system ready? CAPACITY BUILDING CONSTRUCT

Factors	Measures	Code (Factor)	
<u>Readiness:</u> 1. recognition of need to coordinate, 2. contact with other organizations working in this area, 3. understanding the work of other organizations in this area, 4. positive perception of other organizations, 5. commitment to change (adoption of short-term tests and institutionalization of long-term tests) 6. mutually shared goals, values and interests with other organizations.	<u>Readiness:</u> 1. Examples of program or grant collaboration; 2. Frequency and type of interaction (meetings, phone calls, activity planning, emails, sharing site); 3. Collaboration with partners in a program (knowledge, value, interest) 4. Collaboration; Frequency and type of interaction; Perception (positive, negative) 5. Examples of (short-term and long-term) tests/experiments to implement new way of doing a program; 6. Shared goals, values and interests of partners;	<b>Category 1: Coordination (<u>Readiness 1</u>)</b> CODE: COORDINATION AWARENESS  <b>Category 2: Contact (<u>Readiness 2, 4</u>)</b> CODE 1: INTERACTION CODE 2: FREQUENCY CODE 3: PERCEPTION OF PARTNERS ( <u>Readiness 4</u> )  <b>Category 3: Collaboration (<u>Readiness 3</u>)</b> CODE 1: UNDERSTANDING PARTNERS CODE 2: TEAMS ( <u>Capacity Building 2</u> )  <b>Category 4: Program implementation (<u>Readiness 5</u>)</b> CODE 1: NEW EFFORT  <b>Category 5: Partners (<u>Readiness 6</u>)</b> CODE 1: SHARED  <b>Category 6: Practical experience (<u>Capacity Building 1</u>)</b> CODE 1: WORK  <b>Category 7: Employee Continuing Education (<u>Capacity Building 3</u>)</b> CODE 1: EDUCATIONAL OPPORTUNITIES  <b>Category 8: Thinking/Planning time (<u>Capacity Building 4</u>)</b> CODE 1: REFLECTION	
<u>Capacity building activities:</u> 1. Practical experience, 2. Engagement in network, 3. Continuing education, 4. Critical reflection (CoP participation)	<u>Capacity building:</u> 1. Work plan; Information sharing and materials dissemination; Examples of public health programs/activities including people with a disability 2. Collaboration with partners, coalition, planning teams in OH; Connection with other states 3. Employee educational opportunities, conferences, trainings 4. Dedicated staff time for thinking and planning; Journaling; Retreat opportunity; motivation to participate in CoP; goal for participation in CoP		
Code	Definition	When to use	When Not to use
COORDINATION AWARENESS	Topics around the concept of join programs, grants, or funding, but not necessarily these terms	Apply to all references to people or organizations that have acted as stakeholders grant partners, or coalition members	Don't use to refer to internal co-workers or staff



INTERACTION	Any meetings, phone calls, activity planning, emails, web or sharing site exchange	Apply to all references to people or organizations that have had any of these exchanges	Don't use to refer to internal co-workers or staff exchanges
FREQUENCY	Topics around the concept of timeframe to include: <input type="checkbox"/> High: multiples times a day, daily, or weekly <input type="checkbox"/> Medium: monthly <input type="checkbox"/> Low: quarterly	Apply to all references to people or organizations that have had any of these exchanges with these timeframes	Don't use to refer to internal co-workers or staff exchanges
PERCEPTION OF PARTNERS	Topics around the concept of how other organizations are seen, to include: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges
UNDERSTANDING PARTNERS	Topics around the concept of knowing partner's goals, values or interests, but not necessarily these terms	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges
TEAMS	Any references to a planning group, Ohio coalitions, Ohio Disability and Health Program, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
NEW EFFORT	Topics around the concept of committing to implement new ideas, tests, experiments or learning, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
SHARED	Topics around the concept that ideas, goals, values, or interests are mutually share among partners, but not necessarily these terms.	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges
WORK	Any references to activities to include people with disabilities in a work plan, information sharing or materials dissemination, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role
EDUCATIONAL OPPORTUNITIES	Any references to employee conference or trainings where co-workers and staff learn, such as conferences or trainings, but not necessarily these terms	Apply to all references of collaborations with co-workers and staff	Don't use to refer to people or organizations beyond co-workers and staff
REFLECTION	Dedicated staff time for thinking and planning, such as journaling, a retreat opportunity, or CoP participation	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role

## Appendix J: Codebook-Readiness and Capacity Building In-Depth Interviews (Final version)

<b>Research question:</b> 1. What are the factors that make a state system ready to include PWD as a demographic in public health efforts? READINESS CONSTRUCT, CAPACITY BUILDING CONSTRUCT, CAPACITY CONSTRUCT <ul style="list-style-type: none"><li>➤ What are the process steps that a state system can take to become ready? READINESS CONSTRUCT</li><li>➤ What are the capacity supports that help make a state system ready? CAPACITY BUILDING CONSTRUCT</li></ul>		
<b>Factors</b>	<b>Measures</b>	<b>Code (<i>Factor</i>)</b>

<p><u>Readiness:</u></p> <ol style="list-style-type: none"> <li>1. recognition of need to coordinate,</li> <li>2. contact with other organizations working in this area,</li> <li>3. understanding the work of other organizations in this area,</li> <li>4. positive perception of other organizations,</li> <li>5. commitment to change (adoption of short-term tests and institutionalization of long-term tests)</li> <li>6. mutually shared goals, values and interests with other organizations.</li> </ol> <p><u>Capacity building activities:</u></p> <ol style="list-style-type: none"> <li>1. Practical experience,</li> <li>2. Engagement in network,</li> <li>3. Continuing education,</li> <li>4. Critical reflection (CoP participation)</li> </ol>	<p><u>Readiness:</u></p> <ol style="list-style-type: none"> <li>1. Examples of program or grant collaboration;</li> <li>2. Frequency and type of interaction (meetings, phone calls, activity planning, emails, sharing site);</li> <li>3. Collaboration with partners in a program (knowledge, value, interest)</li> <li>4. Collaboration; Frequency and type of interaction; Perception (positive, negative)</li> <li>5. Examples of (short-term and long-term) tests/experiments to implement new way of doing a program;</li> <li>6. Shared goals, values and interests of partners;</li> </ol> <p><u>Capacity building:</u></p> <ol style="list-style-type: none"> <li>1. Work plan; Information sharing and materials dissemination; Examples of public health programs/activities including people with a disability</li> <li>2. Collaboration with partners, coalition, planning teams in OH; Connection with other states</li> <li>3. Employee educational opportunities, conferences, trainings</li> <li>4. Dedicated staff time for thinking and planning; Journaling; Retreat opportunity; motivation to participate in CoP; goal for participation in CoP</li> </ol>	<p><b><u>Category 1: Coordination (Readiness 1)</u></b> CODE: COORDINATION AWARENESS</p> <p><b><u>Category 2: Contact (Readiness 2, 4)</u></b> CODE 1: INTERACTION CODE 2: FREQUENCY CODE 3: PERCEPTION OF PARTNERS (<u>Readiness 4</u>)</p> <p><b><u>Category 3: Collaboration (Readiness 3)</u></b> CODE 1: UNDERSTANDING PARTNERS CODE 2: TEAMS (<u>Capacity Building 2</u>)</p> <p><b><u>Category 4: Program implementation (Readiness 5)</u></b> CODE 1: NEW EFFORT</p> <p><b><u>Category 5: Partners (Readiness 6)</u></b> CODE 1: SHARED</p> <p><b><u>Category 6: Practical experience (Capacity Building 1)</u></b> CODE 1: WORK</p> <p><b><u>Category 7: Employee Continuing Education (Capacity Building 3)</u></b> CODE 1: EDUCATIONAL OPPORTUNITIES</p> <p><b><u>Category 8: Thinking/Planning time (Capacity Building 4)</u></b> CODE 1: REFLECTION</p>		
Code	Definition	When to use	When Not to use	
COORDINATION				

<b>(- mentions)</b>				
JOINT EFFORT (- MENTIONS)	Topics around the concept of joint programs, grants, or funding, but not necessarily these terms	Apply to all references to people or organizations that have acted as stakeholders grant partners, or coalition members	Don't use to refer to internal co-workers or staff	
AWARENESS (- MENTIONS)	Topics around knowledge of related efforts	Apply to all references to people or organizations that may be potential stakeholders grant partners, or coalition members	Don't use to refer to internal co-workers or staff	
<b>CONTACT</b>				
<b>(- mentions)</b>				
INTERACTION (- mention)	Any meetings, phone calls, activity planning, emails, web or sharing site exchange	Apply to all references to people or organizations that have had any of these exchanges	Don't use to refer to internal co-workers or staff exchanges	
FREQUENCY (- mentions)	Topics around the concept of timeframe to include: <input type="checkbox"/> High: multiples times a day, daily, or weekly <input type="checkbox"/> Medium: monthly <input type="checkbox"/> Low: quarterly	Apply to all references to people or organizations that have had any of these exchanges with these timeframes	Don't use to refer to internal co-workers or staff exchanges	
PERCEPTION OF PARTNERS (- mentions)	Topics around the concept of how other organizations are seen, to include: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges	
<b>COLLABORATION</b>				
<b>(-- mentions)</b>				
UNDERSTANDING PARTNERS (- mentions)	Topics around the concept of knowing partner's goals, values or interests, but not necessarily these terms	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges	

TEAMS (- mentions)	Any references to a planning group, Ohio coalitions, Ohio Disability and Health Program, or a network, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
Involvement of Disability Organization (- mentions)				
<b>PROGRAM IMPLEMENTATION</b>				
ORGANIZATIONAL LEARNING	Topics around the concept of committing to implement new ideas, tests, experiments or learning, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
<b>Common Interests (- mentions)</b>				
SHARED VALUES (- mentions)	Topics around the concept that ideas, goals, values, or interests are mutually shared among partners, but not necessarily these terms.	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges	
<b>Practical Experience (- mentions)</b>				
WORK (- mentions)	Any references to activities to include people with disabilities in a work plan, information sharing or materials dissemination, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
<b>Employee Continuing Education (- mentions)</b>				
EDUCATIONAL OPPORTUNITIES (- mentions)	Any references to employee conference or trainings where co-workers and staff learn, such as conferences or trainings, but not necessarily these terms	Apply to all references of collaborations with co-workers and staff	Don't use to refer to people or organizations beyond co-workers and staff	

Thinking/Planning Time (- mentions)				
REFLECTION (- mentions)	Dedicated staff time for thinking and planning, such as journaling, a retreat opportunity, or CoP participation	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	

## Appendix K: Codebook-Capacity Assessment In-depth Follow Up Interview

<b>Research Questions:</b> 1. What are the factors that make a state system ready to include PWD as a demographic in public health efforts? READINESS CONSTRUCT, CAPACITY BUILDING CONSTRUCT, CAPACITY CONSTRUCT ➤ What are the process steps that a state system can take to become ready? READINESS CONSTRUCT ➤ What are the capacity supports that help make a state system ready? CAPACITY BUILDING CONSTRUCT 2. How does partner participation in a community of practice foster the capacity of state systems to include PWD as a demographic in public health efforts? CAPACITY CONSTRUCT What are the factors that support state capacity to address demographic groups that experience health disparities, such as smoking among PWD? CAPACITY BUILDING CONSTRUCT		
Factors	Measures	Code Listing (Factor)
<u>Capacity:</u> 1. stakeholder involvement, 2. change efficacy (believe can achieve something by working together), 3. adaptive capacity and support for organizational learning, 4. leadership support and vision, 5. resources (time, people, funds, space), 6. technical skills and knowledge  <u>Capacity building activities:</u> 1. Practical experience, 2. Engagement in network, 3. Continuing education,	<u>Capacity:</u> 1. Number and type of partners; frequency and type of interaction (meetings, phone calls, activity planning, emails, sharing site) 2. Successful past collaborations (belief group can achieve) 3. Action plans based on needs assessments; Information generation and sharing through trainings, presentations 4. Vision, mission statements; strategic plan; work plan; Partner agreements 5. Competencies-job requirements, job descriptions; Dedicated funding, staff, space, library access, equipment 6. Needs assessment of community; Employee educational opportunities-continuing education, conferences, trainings  <u>Capacity building:</u> 1. Work plan; Information sharing and materials dissemination; Examples of public health programs/activities including people with a disability	<b>Category 1: Interaction (Capacity 1)</b> CODE 1: PARTNERS CODE 2: TYPE OF INTERACTION ( <i>Readiness 2, 4</i> ) CODE 3: FREQUENCY ( <i>Readiness 2,4</i> )  <b>Category 2: Collaboration (Capacity 2, 3)</b> CODE 1: ACTIVITIES CODE 2: PERCEPTION CODE 3: BELIEF CODE 4: INVOLVEMENT OF DISABILITY ORGANIZATION  <b>Category 3: Adaptive capacity (Capacity 3)</b> CODE 1: INFORMATION GENERATION  <b>Category 4: Leadership (Capacity 4)</b> CODE 1: VISION CODE 2: SUPPORT  <b>Category 5: Resources (Capacity 5)</b> CODE 1: ACCOUNTABILITY CODE 2: JOB(Capacity 6) CODE 3: FUNDS CODE 4: SUPPORT CODE 5: COMMUNICATION TECHNOLOGY

<p>4. Critical reflection (CoP participation)</p> <p><u>Readiness:</u></p> <ol style="list-style-type: none"> <li>1. recognition of need to coordinate,</li> <li>2. contact with other organizations working in this area,</li> <li>3. understanding the work of other organizations in this area,</li> <li>4. positive perception of other organizations,</li> <li>5. commitment to change (adoption of short-term tests and institutionalization of long-term tests)</li> <li>6. mutually shared goals, values and interests with other organizations.</li> </ol>	<ol style="list-style-type: none"> <li>2. Collaboration with partners, coalition, planning teams in OH; Connection with other states</li> <li>3. Employee educational opportunities, conferences, trainings</li> <li>4. Dedicated staff time for thinking and planning; Journaling; Retreat opportunity; motivation to participate in CoP; goal for participation in CoP</li> </ol> <p><u>Readiness:</u></p> <ol style="list-style-type: none"> <li>1. Examples of program or grant collaboration;</li> <li>2. Frequency and type of interaction (meetings, phone calls, activity planning, emails, sharing site);</li> <li>3. Collaboration with partners in a program (knowledge, value, interest)</li> <li>4. Collaboration; Frequency and type of interaction; Perception (positive, negative)</li> <li>5. Examples of (short-term and long-term) tests/experiments to implement new way of doing a program;</li> <li>6. Shared goals, values and interests of partners;</li> </ol>	<p><b>Category 6: Technical skills</b> (<i>Capacity 6</i>) CODE 1: KNOWLEDGE</p> <p><b>Category 7: Practical experience</b> (<i>Capacity Building 1</i>) CODE 1: WORK CODE 2: INCLUSION CODE 3: DISABILITY IDENTIFIER</p> <p><b>Category 8: Network</b> (<i>Capacity Building 2</i>) CODE 1: TEAMS CODE 2: ENGAGEMENT</p> <p><b>Category 9: Employee Continuing Education</b> (<i>Capacity Building 3</i>) CODE 1: EDUCATIONAL OPPORTUNITIES</p> <p><b>Category 10: Thinking/Planning time</b> (<i>Capacity Building 4</i>) CODE 1: REFLECTION CODE 2: ATTENTION</p> <p><b>Category 11: Coordination</b> (<i>Readiness 1</i>) CODE 1: JOINT EFFORT CODE 2: AWARENESS</p> <p><b>Category 12: Contact</b> (<i>Readiness 2, 4</i>) CODE 1: PERCEPTION OF PARTNERS (<i>Readiness 4</i>)</p> <p><b>Category 13: Collaboration</b> (<i>Readiness 3</i>) CODE 1: UNDERSTANDING PARTNERS CODE 2: TEAMS (<i>Capacity Building 2</i>)</p> <p><b>Category 14: Program change implementation</b> (<i>Readiness 5</i>) CODE 1: NEW EFFORT</p> <p><b>Category 15: Common interests</b> (<i>Readiness 6</i>) CODE 1: SHARED VALUES</p>
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Code	Definition	When to use	When Not to use	Mentions During Interview/Exemplary Quotes
<b>Interaction: ( mentions)</b>				
PARTNERS ( )	Topics around the concept of partners to include stakeholders grant partners, or coalition members	Apply to all references to people or organizations that have acted as stakeholders grant partners, or coalition members	Don't use to refer to internal co-workers or staff	
TYPE OF INTERACTION (Readiness sub) ( )	Any meetings, phone calls, activity planning, emails, web or sharing site exchange; and quality of these exchanges	Apply to all references to people or organizations that have had any of these exchanges	Don't use to refer to internal co-workers or staff exchanges	
FREQUENCY (Readiness sub) ( )	Topics around the concept of timeframe to include: <input type="checkbox"/> High: multiples times a day, daily, or weekly <input type="checkbox"/> Medium: monthly <input type="checkbox"/> Low: quarterly <input type="checkbox"/> As Needed	Apply to all references to people or organizations that have had any of these exchanges with these timeframes	Don't use to refer to internal co-workers or staff exchanges	
<b>Collaboration: ( mentions)</b>				
ACTIVITIES ( )	Any collaboration such as information sharing, materials dissemination, planning, needs assessments, training or presentations.	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges	
PERCEPTION OF COLLABORATION (Readiness sub) ( )	Topics around the concept of perception to include: <input type="checkbox"/> Positive overall <input type="checkbox"/> Negative	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges	

BELIEF ( )	Topics around the concept of believing that the group can achieve something together	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges	
INVOLVEMENT OF DISABILITY ORGANIZATION (Readiness sub) ( )	Any emphasis or priority to include organizations that have direct contact with people living with disabilities	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges	
<b>Adaptive Capacity: ( mentions)</b>				
ORGANIZATIONAL LEARNING ( )	Topics around the concept of new ideas, tests, experiments or learning, but not specifically these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
<b>Leadership: ( mentions)</b>				
LEADERSHIP VISION ( )	Any reference to the idea of vision or mission statements, but not specifically these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a leadership role	
LEADERSHIP SUPPORT ( )	Any reference to the idea of strategic plan or partner agreements, but not specifically these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a leadership role	
<b>Resources: ( mentions)</b>				

Accountability ( )	Any reference to the idea of a work plan or accountability, but not specifically these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
Job ( )	Any references to competencies, job requirements, job descriptions, or staffing, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
FUNDS ( )	Any references to dedicated funds, budgets or grants, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
Support ( )	Any references to dedicated work space, equipment, resources like library access, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
COMMUNICATION TECHNOLOGY ( )	Any references to integrating and applying technology to enhancing and maintaining open communication with partners or stakeholders, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
<b>Technical Skills: ( mentions)</b>				
KNOWLEDGE ( )	Technical skills, such as information about people with disabilities through a needs assessment, or employee continuing education to include conferences or training, but	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	

	not necessarily these terms			
<b>Practical Experience: ( mentions)</b>				
WORK ( )	Any references to activities to include people with disabilities in a work plan, information sharing or materials dissemination, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
INCLUSION ( )	Any references to concept of inclusion of people with disabilities as a priority or a component of a strategy, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
DISABILITY IDENTIFIER ( )	Any references to concept of identifying people with disabilities as target of public health programs and surveillance, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
<b>Network: ( mentioned)</b>				
TEAMS (Readiness sub) ( )	Any references to a planning group, Ohio coalitions, Ohio Disability and Health Program, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers	Don't use to refer to people or organizations not in a partner role	

		and staff		
Engagement ( )	Any references to ongoing connections with groups in state and region or sense of belonging, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
<b>Employee Continuing Education: ( mentions)</b>				
EDUCATIONAL OPPORTUNITIES ( )	Any references to employee conference or trainings where co-workers and staff learn, such as conferences or trainings, but not necessarily these terms	Apply to all references of collaborations with co-workers and staff	Don't use to refer to people or organizations beyond co-workers and staff	
<b>Thinking/Planning Time: ( mentions)</b>				
REFLECTION ( )	Dedicated staff time for thinking and planning, such as journaling, a retreat opportunity, or CoP participation	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
ATTENTION ( )	Motivation for CoP participation, such as dedicated time or focus, but not necessarily these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
<b>COORDINATION ( mentions)</b>				
JOINT EFFORT ( MENTIONS)	Topics around the concept of joint programs, grants, or funding,	Apply to all references to people or	Don't use to refer to internal co-workers or staff	

	but not necessarily these terms	organizations that have acted as stakeholders grant partners, or coalition members		
AWARENESS ( MENTIONS)	Topics around knowledge of related efforts	Apply to all references to people or organizations that may be potential stakeholders grant partners, or coalition members	Don't use to refer to internal co-workers or staff	
<b>CONTACT</b> ( mentions)				
PERCEPTION OF PARTNERS ( mentions)	Topics around the concept of how other organizations are seen, to include: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges	
<b>COLLABORATION</b> ( mentions)				
UNDERSTANDING PARTNERS (mentions)	Topics around the concept of knowing partner's goals, values or interests, but not necessarily these terms	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges	
<b>Program Change Implementation</b>				
NEW EFFORT ( )	Topics around the concept of implementing new ideas, based on tests, experiments or learning, but not specifically these terms	Apply to all references of collaborations with people or organizations, as well as co-workers and staff	Don't use to refer to people or organizations not in a partner role	
<b>Common Interests</b> ( mentions)				

SHARED VALUES ( mentions)	Topics around the concept that ideas, goals, values, or interests are mutually shared among partners, but not necessarily these terms.	Apply to all references of collaborations with people or organizations	Don't use to refer to internal co-workers or staff exchanges	
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## Appendix L: Community of Practice (CoP) Session Slides and Notes

### Session 1:



#### Ohio Community of Practice Focus=Smoking Cessation for People with a Disability

##### **6/22/15 Agenda (60 minute discussion)**

Introductions – 5 mins (all)

Share Community of Practice Theory Background and Steps (Set domain, community, and practice issues) – 5 mins (AG)

Review findings of the interviews and surveys – 5 mins (AG)

Review retrospective information and check in – 15 mins (all)

Begin prospective information creation together-25 mins (all)

Start idea generation:

start recommendations (today and next meeting)

learning agenda, action plan to support learning agenda (next two meetings)

Wrap up and next steps – 5 mins (AG)

1



#### Ohio Community of Practice Focus=Smoking Cessation for People with a Disability

##### **6/22/15 Agenda (60 minute discussion)**

✓ Introductions – 5 mins (all)

***Share Community of Practice Theory Background and Steps (Set domain, community, and practice issues) – 5 mins (AG)***

Review findings of the interviews and surveys – 5 mins (AG)

Review retrospective information and check in – 15 mins (all)

Begin prospective information creation together-25 mins (all)

Start idea generation:

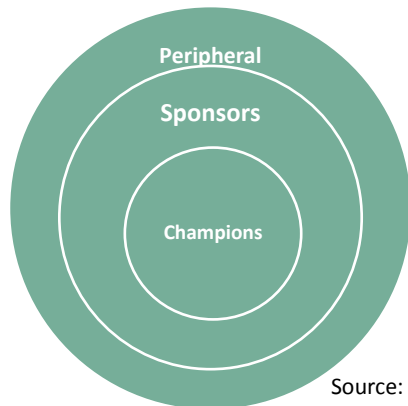
start recommendations (today and next meeting)

learning agenda, action plan to support learning agenda (next two meetings)

Wrap up and next steps – 5 mins (AG)

3





## ***What is a Community of Practice?***

Source: *Communities of Practice*, Wenger

### **Roles:**

**Adriane:** Facilitate discussion and share findings (note taking supported by telephone recording)

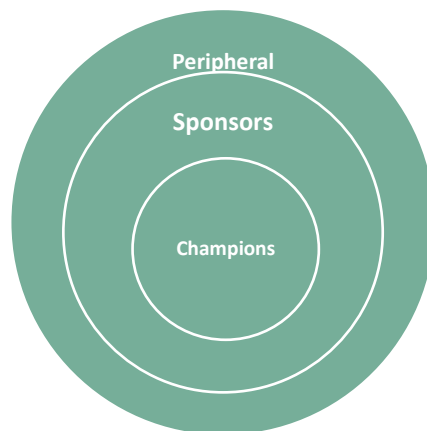
**Members of the Ohio Community of Practice:** Share your perspectives and knowledge with one another

**Practice:** formalizing and implementing the collectively developed knowledge and solutions; what you do together

=1. recommendations for others states; 2. learning agenda to support further collaboration

3

***You can decide where you want to be in a  
Community of Practice.***



Source: *Communities of Practice*, Wenger

3

***Review findings of the interviews and surveys – 5 mins (AG)***

**Accomplishments**

State needs assessment showing smoking disparity for people with a disability  
Disability screening question/Intake data from quitline  
Media campaign to reach people with a disability  
Forming and interacting with the Disability Community Planning Group  
Train-the-Trainer (Living Independently from Tobacco – LIFT)

**Key partners**

CILs – need to have dedicated funding; past grant application  
ODH  
Nisonger  
DCPG

3

***Review findings of the interviews and surveys – 5 mins (AG)***

**Interactions**

In person is best  
As needed conversations  
Relationship management and open discussions  
Persistence is key  
Good understanding of partner goals, values, and interests

**Capacity Building**

Ongoing training and continuing education opportunities  
Most have dedicated time to plan and reflect  
Leadership and looking for opportunities (alignment, innovation)  
Mix of levels of leaders (senior, mid-level, and junior)

3

**6/22/15 Agenda (60 minute discussion)**

✓ Introductions – 5 mins (all)

✓ Share Community of Practice Theory Background and Steps – 5 mins (AG)

✓ Review findings of the interviews and surveys – 5 mins (AG)

***Review retrospective information and check in – 15 mins (all)***

Begin prospective information creation together-25 mins (all)

Start idea generation:

start recommendations (today and next meeting)

learning agenda, action plan to support learning agenda (next two meetings)

Wrap up and next steps – 5 mins (AG)



3

***Review retrospective information and check in – 15 mins (all)***

*Is this summary true for you?*

*Are there any other things that you would emphasize in your work to date?*

*Is there anything else that you want to share?*

3

**6/22/15 Agenda (60 minute discussion)**

- ✓ Introductions – 5 mins (all)
- ✓ Share Community of Practice Theory Background and Steps – 5 mins (AG)
- ✓ Review findings of the interviews and surveys – 5 mins (AG)
- ✓ Review retrospective information and check in – 15 mins (all)

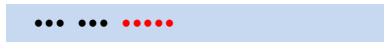
**Begin prospective information creation together-25 mins (all)**

Start idea generation:

start recommendations (today and next meeting)

learning agenda, action plan to support learning agenda (next two meetings)

Wrap up and next steps – 5 mins (AG)



3

***Begin prospective information creation together-25 mins (all)***

***Start idea generation:***

***-start recommendations (today and next meeting)***

***-learning agenda, action plan to support learning agenda (next two meetings)***



***Begin prospective information creation together-25 mins (all)***

Supporting questions:

*Who should be involved in the change effort in other states? What would you advise others?*

*What capabilities do different members of your group in Ohio have? Do you need any other capabilities?*

*Who should be involved in the change effort in other states?*

*What would you advise others?*

3

***Begin prospective information creation together-25 mins (all)***

Supporting questions:

*What lessons do you think there are for other public health efforts? How does this connect to your work?*

*Knowing what you know now, what would you recommend to other states that may be just starting this work?*

*How do you want to interact with this community of practice of colleagues from your state? How does this connect to your work?*

3

***Begin prospective information creation together-25 mins (all)***

Supporting questions:

*Thinking back on your experiences, what do you think were the most important things that you did to get ready?*

*Imagine that you were advising another state on how to do this work of including PWD in smoking cessation efforts. What would you say are the key steps in building capacity to do this work?*

*How has your state demonstrated enhanced capacity in this area of including PWD in smoking cessation efforts? What do you think would be helpful for other states to know?*

3

***6/22/15 Agenda (60 minute discussion)***

✓ Introductions – 5 mins (all)

✓ Share Community of Practice Theory Background and Steps – 5 mins (AG)

✓ Review findings of the interviews and surveys – 5 mins (AG)

✓ Review retrospective information and check in – 15 mins (all)

✓ Begin prospective information creation together-25 mins (all)

Start idea generation:

start recommendations (today and next meeting)

learning agenda, action plan to support learning agenda (next two meetings)

***Wrap up and next steps – 5 mins (AG)***

... ..

3

*Wrap up and next steps – 5 mins (AG)*

- Follow up survey:  
<https://www.surveymonkey.com/s/PY2SFCY>
- Schedule our next Community of Practice discussion  
---now or via poll
- Send me any additional resources that this  
conversation brought to mind for you
- I'll draft recommendations based on your input  
-review before and during next discussion



4

*Wrap up and next steps – 5 mins (AG)*

you either need to start  
being more productive with  
your time, or figure out how  
to get paid to pace around  
the house and periodically  
look in the fridge



5

*Wrap up and next steps – 5 mins (AG)*

***Questions?***

*Adriane Griffen*  
*Work 240-821-9374*  
*Cell 202-210-1546*  
*[agriff27@uic.edu](mailto:agriff27@uic.edu)*

*Thank you!!!!!!*





## **Ohio Community of Practice Meeting 1: 6.22.15 NOTES**

### ***Attendees:***

Ohio Community of Practice Members: Ohio Community of Practice Members

Guest and facilitator: Adriane K. Griffen, MPH, MCHES, 2012 Cohort DrPH Candidate: [agriff27@uic.edu](mailto:agriff27@uic.edu)

### ***Focus of this Community of Practice=Smoking Cessation for People with a Disability***

This group will be dedicated to:

1. developing recommendations for reaching people with disabilities and including them in public health efforts like smoking cessation
2. learning agenda and action plan to support further collaboration

### ***Goals for participation:***

opportunity for sharing  
provide insights and hear about what others are doing  
learn more about community of practice and how to use to advantage  
help strengthen collaboration  
way to interact with academic and services to enhance reach and get different perspectives  
building a community of practice on smoking cessation for people with disabilities work with people across the state and enhance efforts  
opportunity to expand work already doing and continue to move forward

### ***Background on Community of Practice – included in slides and follow up documents***

### ***Findings of the interviews and surveys so far:***

#### **Accomplishments**

State needs assessment showing smoking disparity for people with a disability

Disability screening question/Intake data from quitline

Media campaign to reach people with a disability

Forming and interacting with the Disability Community Planning Group

Train-the-Trainer (Living Independently from Tobacco – LIFT)

### Key partners

CILs – need to have dedicated funding; past grant application  
ODH  
UCEDDs - Nisonger  
DCPG

### Interactions

In person is best  
As needed conversations  
Relationship management and open discussions  
Persistence is key  
Good understanding of partner goals, values, and interests

### Capacity Building

Ongoing training and continuing education opportunities  
Most have dedicated time to plan and reflect  
Leadership and looking for opportunities (alignment, innovation)  
Mix of levels of leaders (senior, mid-level, and junior)

*The group felt that this summary was accurate.*

### Action Plan-

*Do more with LIFT program, make it more available to people with disabilities across the state*

Background:

- developed by Dr. Jamie Pomeranz, University of Florida
- AHEC tobacco cessation program that was adapted for people with disabilities
- designed as a 4-week program, meeting 2x per week
- had worked on a grant proposal with the CILs so that they would be able to have dedicated staff time; there's will currently in Ohio to focus on tobacco cessation

*Would like to pursue new grant opportunities for the CILs to do smoking cessation*

- New ODH tobacco funding coming to address health disparities and demonstration projects
- people with disabilities will be included as a demonstration project, look for more details once available

Use this group community of practice to pursue LIFT program and funding

ODH not historically doing much on disability

- had nice concrete projects to work on with the media campaign and the outreach brochures and materials, specific projects with discrete timeframes, get some success stories – good way to start things off!

OH Disability and Health Program Used ODH to share findings, build relationships, and make things happen

#### *Training for Quit Line Coaches*

- Guidelines on how Quit line coaches should work with people with disabilities
- Need to have training; often have someone from that population come and does training
- would like to have the train-the-trainer work with the Quit line coaches
- not sure that the coaches have had a general physical disability training
- have has mental health and deaf training
- would need to look at subcategories of disability type
- sharing LIFT curriculum within the group and YouTube link

#### *Sharing Quitline retention data*

- Quitlines have retention rate data by the population (a 5 call program)
- would be interested in knowing how many people with disabilities follow through beyond the initial call
- can look at follow up survey data for specific populations and can work with ODH on sharing that

#### ***Recommendations:***

*for smoking cessation among people with disabilities-more general*

*Bring partners to table*

- depends on scope of impact you want to make
- approach Department of Health for a state-wide impact

*for smoking cessation through the quit lines-more specific*

- OH Disability and Health Program reached out to quit line for state-wide impact
- Bring these partners to table for quit line efforts:
- Department of Health
  - provider of services
  - marketing and media firm because you are trying to reach these people before you provide quitting services to them

*Consider what is feasible*

- know what programs and resources you can work with
- local impact (may consider hospitals or regional programs) or state-wide impact (may consider state entities)
- know where the gaps are,
- consider which things you feel you can improve to improve efforts for people with disabilities

*Consider the decision-making processes*

- think about who can help with that

*Needs assessment is critical*

- use data to hold partner interest and frame action
- makes a platform for the work
- use to identify partners you want to involve and at what level
- use to assess where gaps are and who to approach

*Find an ally at Department of Health*

- like a relationship broker to link disability with other teams
- advise and guidance on who to talk to, when, and what approach
- full time person grant funded, but housed at the Department of Health

*Need Disability resources:*

UCEDDs can be a good resource for this type of work

*Need to have good information base to make case*

- many traditional surveillance methods don't include people with disabilities
- surveillance is starting to monitor, but not yet by different type of disability
- treating disability as a demographic
- just as you look at a racial group
- many subcategories within that
- any indicator within that demographic may vary by other characteristics; It would be great if we knew more about the characteristics of people with disabilities who smoke.
- eg. BRFSS are move from 2 disability identifiers to 5
- SC did a more an analysis of this data for their state and know more about the different types of characteristics of people with disabilities who smoke
- helpful for guiding intervention and targeting health promotion; data not yet available in Ohio
- also a lag time when data is available
- in Ohio there is a general screener question and not breaking out by specific disability types
- Quit line intake process does break out mental health needs and behavioral health characteristics, but this has increase the length of time of the intake process
- possible for Quit line to break out; just need to know what goal is
- eg tailored information for different audiences

Next Community of Practice: Monday, July 27, 11:30amET 866-951-1151, code 7307522

## Session 2:



Ohio Community of Practice  
Focus=Smoking Cessation for People with a Disability

### **7/27/15 Agenda (60 minute discussion)**

Introductions – 5 mins (all)

Review findings of initial Community of Practice meeting and surveys – 5 mins (AG)

Review prospective information creation together-45 mins (all)

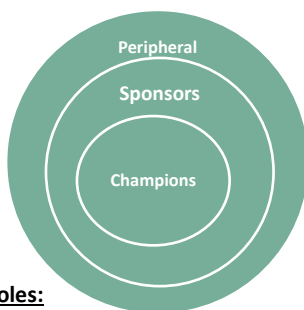
Recommendations (today and next meeting)

Action plan to support working together (today and next meeting)

Learning agenda to support action plan (today and next meeting)

Wrap up and next steps – 5 mins (AG)

1



### ***What is a Community of Practice?***

Source: *Communities of Practice*, Wenger

#### **Roles:**

**Adriane:** Facilitate discussion/share findings (note taking supported by telephone recording)

**Members of OH Community of Practice:** Share your perspectives/knowledge with each other

#### ***Your Goals for participation:***

- \*opportunity for sharing    \*help strengthen collaboration
- \*opportunity to expand work already doing and continue to move forward
- \*provide insights and hear about what others are doing
- \*learn more about community of practice and how to use to advantage
- \*way to interact with academic and services to enhance reach and get different perspectives
- \*building a community of practice on smoking cessation for people with disabilities work with people across the state and enhance efforts

**Practice:** 1. recommendations for others states; 2. learning agenda to support further collaboration

2

***Review findings of initial Community of Practice meeting and surveys– 5 mins (AG)***

*Community of Practice Update*

*7 participants in live phone meeting (7/8)*

*Reviewed retrospective information on how you included people with a disability in smoking cessation efforts*

*Brainstormed on recommendations for other states and possible action steps to take together as a group*

2

***Review findings of initial Community of Practice meeting and surveys– 5 mins (AG)***

*Survey Update*

*6 participated (6/7)*

*Met someone new or became better acquainted with a colleague*

*Most prefer meeting in person*

*Most were able to contribute and share information during the last phone meeting*

2

**7/27/15 Agenda (60 minute discussion)**

- ✓ Introductions – 5 mins (all)
- ✓ Review findings of initial Community of Practice meeting and surveys – 5 mins (AG)
- Review prospective information creation together-45 mins (all)**
  - Recommendations (today and next meeting)
  - Action plan to support working together (today and next meeting)
  - Learning agenda to support action plan (today and next meeting)
- Wrap up and next steps – 5 mins (AG)

2

***Review Recommendations 15 minutes (all)***

***2. Needs assessment is critical***

- use data to hold partner interest and frame action
- makes a platform for the work
- use to identify partners you want to involve and at what level
- use to assess where gaps are and who to approach

***3. Find an ally at Department of Health***

- like a relationship broker to link disability with other teams
- advise and guidance on who to talk to, when, and what approach
- full time person grant funded, but housed at the Department of Health

***4. Need Disability resources***

- UCEDDs can be a good resource for this type of work
- LEND trainees “get it”

4

***Review Recommendations 15 mins (all)***

***5. Need to have good information base to make case***

- many traditional surveillance methods don't include people with disabilities
- surveillance is starting to monitor, but not yet by different type of disability
- treating disability as a demographic
- just as you look at a racial group
- many subcategories within that
- any indicator within that demographic may vary by other characteristics;
- Quit line intake process does break out mental health needs and behavioral health characteristics, but this has increase the length of time of the intake process
- possible for Quit line to break out; just need to know what goal is
- eg tailored information for different audiences

3

***Review Recommendations 15 mins (all)***

***1. Know your goals:***

*for smoking cessation among people with disabilities-more general*

*for smoking cessation through the quit lines-more specific*

***2. Needs assessment is critical***

***3. Find an ally at Department of Health***

***4. Need Disability resources***

***5. Need to have good information base to make case***

6



**7/27/15 Agenda (60 minute discussion)**

- ✓ Introductions – 5 mins (all)
- ✓ Review findings of initial Community of Practice meeting and surveys – 5 mins (AG)
- Review prospective information creation together-45 mins (all)**
  - ✓ Recommendations (today and next meeting)
    - Action plan to support working together (today and next meeting)*
    - Learning agenda to support action plan (today and next meeting)*
- Wrap up and next steps – 5 mins (AG)

7

**Action Plan– 15 mins (all)**

1. *Do more with LIFT program, make it more available to people with disabilities across the state*
  - work with CILs so that they would have dedicated staff time
2. *Would like to pursue new grant opportunities for the CILs to do smoking cessation*
  - Use this group community of practice to pursue LIFT program and funding
3. *Training for Quit Line Coaches*
  - Guidelines on how Quit line coaches should work with people with disabilities
  - Need to have training; often have someone from that population come and does training; would like to have the train-the-trainer work with the Quit line coaches
  - would need to look at subcategories of disability type

8

**Action Plan– 15 mins (all)**

*4. Sharing Quitline retention data*

- would be interested in knowing how many people with disabilities follow through beyond the initial call
- can look at follow up survey data for specific populations and can work with ODH on sharing that

9

**Action Plan– 15 mins (all)**

- 1. Do more with LIFT program, make it more available to people with disabilities across the state*
- 2. Would like to pursue new grant opportunities for the CILs to do smoking cessation*
- 3. Training for Quit Line Coaches*
- 4. Sharing Quitline retention data*

10

***Learning agenda and check in – 15 mins (all)***

*Is this summary true for you?*

*What do we have to learn in order to accomplish your plans? What else do you need to know to get there?*

*What steps do you need to take? What steps can you take now? What will take more time?*

*Who else needs to be involved?*

11

***Learning agenda and check in – 15 mins (all)***

*Possible Opportunities...*

Intentional about organizational learning  
-small tests, discuss learnings, retest/reflect (action learning)

Marketing the concept of people with a disability as a demographic to public health professionals  
-how to guide; ideas from interviews with Jessica/David

Marketing smoking cessation services to people with a disability, including subgroups  
-how to guide; ideas from interviews from Cindy and ODH

12

**7/27/15 Agenda (60 minute discussion)**

- ✓ Introductions – 5 mins (all)
- ✓ Review findings of initial Community of Practice meeting and surveys – 5 mins (AG)

Review prospective information creation together-45 mins (all)

- ✓ Recommendations (today and next meeting)
- ✓ Action plan to support working together (today and next meeting)
- ✓ Learning agenda to support action plan (today and next meeting)

**Wrap up and next steps – 5 mins (AG)**

13

**Wrap up and next steps – 5 mins (AG)**

- Follow up survey:  
<https://www.surveymonkey.com/s/PY2SFCY>
- Schedule our next Community of Practice discussion  
---now or via poll
- Send me any additional resources that this conversation brought to mind for you
- I'll draft recommendations based on your input  
-review before and during next discussion



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*Wrap up and next steps – 5 mins (AG)*

***Questions?***

*Adriane Griffen*  
*Work 240-821-9374*  
*Cell 202-210-1546*  
[agriff27@uic.edu](mailto:agriff27@uic.edu)

***Thank you!!!!!!***

***Steps for People with a Disability to be Included in Public Health Programs***

Prepared by: Adriane K. Griffen, MPH, MCHES, 2012 Cohort DrPH Candidate, [agriff27@aucd.org](mailto:agriff27@aucd.org)

Based on findings from Ohio's Community of Practice on Smoking Cessation and People with a Disability

1. Use of data from a state-level needs assessment is critical. The more you can show that data that are from surveys that have broad based support, the better able you will be to talk articulately about this data, while acknowledging any limitations.
2. Craft your message in a way that would speak to the public health program. Use your message to convey the vision that public health programs should be addressing people with disabilities and making sure that their work is accessible to everyone.
3. Take time to create and practice a compelling presentation to get partner attention to these messages. Infographics in addition to a needs assessment convey the background data in a meaningful way.
4. Do your homework and think about which relationships are critical. You will want to focus your efforts on the potential leads that you think will be most fruitful. Look for areas where you may already have buy-in. We all have limited time and resources, so focus and make your efforts count.
5. Request a meeting with a specific public health program. Initially meet face-to-face. Use email to follow up on the meeting, express thanks, and highlight the take-aways and action steps. You are looking for partners that share your vision that public health programs should be addressing people with disabilities and making sure that their work is accessible to everyone.
6. Know you are not bothering your public health colleagues, even if they do not respond right away. It is important to stay in touch. Your colleagues in public health are interested. It is a lot of work to establish the relationship.
7. Dedicate a staff member to facilitate and connect disability experts and public health programs to provide encouragement to establish the relationship. It is important to make sure that there is a shared understanding so that partners we have appropriate expectations. It is critical to have somebody thinking about this all the time to set up check in meetings to plan and review.
8. Once the relationship is established and strong, then the rest of it happens because the public health program feels connected with disability and health, knows the people and the players, and brings them to the meetings and the coalitions going on in the state.
9. Ask for disability to be included in the health equity definitions when speaking about disparity and to be included in cultural competency efforts so that people with disabilities are engaged in that work.

10. Keep going! Encourage your public health partners to make an investment of their time and resources to learn more about how to include people with disabilities across programs. Establish and utilize a planning group comprised of disability community leaders from around the state to get input. This is an essential part of making sure that public health is for everyone.



## **Ohio Community of Practice Meeting 2: 7.27.15 NOTES**

**Attendees:** ✓ Ohio Community of Practice Members

Guest and facilitator: ✓ Adriane K. Griffen, MPH, MCHES, 2012 Cohort DrPH Candidate: [agriff27@uic.edu](mailto:agriff27@uic.edu)

### ***Reviewed Focus of this Community of Practice=Smoking Cessation for People with a Disability***

This group will be dedicated to:

1. developing recommendations for reaching people with disabilities and including them in public health efforts like smoking cessation
2. learning agenda and action plan to support further collaboration

### ***Your Goals for participation:***

*Share:*

- \*opportunity for sharing*
- \*help strengthen collaboration*
- \*opportunity to expand work already doing and continue to move forward*
- \*provide insights and hear about what others are doing*

*Learn:*

- \*learn more about community of practice and how to use to advantage*

*Increase Reach:*

- \*way to interact with academic and services to enhance reach and get different perspectives*
- \*building a community of practice on smoking cessation for people with disabilities work with people across the state and enhance efforts*

### ***Findings of the interviews and surveys so far:***

#### **Community of Practice Update**

7 participants in live phone meeting (7/8)

Reviewed retrospective information on how you included people with a disability in smoking cessation efforts

Brainstormed on recommendations for other states and possible action steps to take together as a group



### Survey Update

6 participated (6/7)

Met someone new or became better acquainted with a colleague

Most prefer meeting in person

Most were able to contribute and share information during the last phone meeting

### **Review recommendations**

#### **1. Know your goals:**

*for smoking cessation among people with disabilities-more general*

*Bring partners to table*

- depends on scope of impact you want to make
- approach Department of Health for a state-wide impact

*for smoking cessation through the quit lines-more specific*

- OH Disability and Health Program reached out to quit line for state-wide impact

Bring these partners to table for quit line efforts:

- Department of Health
- provider of services
- marketing and media firm because you are trying to reach these people before you provide quitting services to them

#### **2. Needs assessment is critical**

- use data to hold partner interest and frame action
- makes a platform for the work
- use to identify partners you want to involve and at what level
- use to assess where gaps are and who to approach

#### **3. Find an ally at Department of Health**

- like a relationship broker to link disability with other teams
- advise and guidance on who to talk to, when, and what approach
- full time person grant funded, but housed at the Department of Health

#### **4. Need Disability resources**

- UCEDDs can be a good resource for this type of work
- LEND trainees "get it"

#### **5. Need to have good information base to make case**

- many traditional surveillance methods don't include people with disabilities

---surveillance is starting to monitor, but not yet by different type of disability  
---*treating disability as a demographic*  
----just as you look at a racial group  
----many subcategories within that  
----any indicator within that demographic may vary by other characteristics;  
----Quit line intake process does break out mental health needs and behavioral health characteristics, but this has increase the length of time of the intake process  
----possible for Quit line to break out; just need to know what goal is  
-----eg tailored information for different audiences

Reviewed draft *Steps for People with a Disability to be Included in Public Health Programs*

*The group felt that this summary was accurate. The following suggestions and thoughts were shared:*

Spelling out the steps for other programs could be very helpful

Merge these five recommendations with *Steps for People with a Disability to be Included in Public Health Programs*

The needs assessment may be a barrier as this assumes that we have disability identifiers. Disability identifiers are limited. Getting disability on surveys needs to be raised.

Important to pick a specific project or short term goal to begin with to cement the relationship. In our case it was to develop a media outreach campaign centered around people with disabilities and smoking cessation. Do not make it nebulous, like “include in health equity.” Be concrete so that you can have an early success in a partnership collaboration. Revised this in #9.

Making sure that we have good disability measures in state level needs assessments. It can be difficult to get the right geographic scale. It’s hard to do smaller areas like counties because you cannot then report it because the numbers are too small. Then there are challenges with attempting to evaluation the effectiveness of the intervention because of the smaller numbers.

-work arounds – if a local surveillance tool is implemented it can include disability identifiers, but it’s a challenge

-need to be creative to get better data on disability at a local level and ideas on how to get better data for evaluating efforts

----could be another purpose for this community of practice

----share CDC data release on state level disability data

#### Action Plan-

1. Do more with LIFT program, make it more available to people with disabilities across the state

-work with CILs so that they would have dedicated staff time

*2. Would like to pursue new grant opportunities for the CILs to do smoking cessation*

*-Use this group community of practice to pursue LIFT program and funding*

*3. Training for Quit Line Coaches*

*-Guidelines on how Quit line coaches should work with people with disabilities*

*-Need to have training; often have someone from that population come and does training; would like to have the train-the-trainer work with the Quit line coaches*

*--would need to look at subcategories of disability type*

*4. Sharing Quitline retention data*

*-would be interested in knowing how many people with disabilities follow through beyond the initial call*

*-can look at follow up survey data for specific populations and can work with ODH on sharing that*

*The group felt that this reflected the main points. In terms of what they want to do the most , there following action steps were highlighted:*

*1. getting funding for more collaboration with the CILs to use the LIFT program*

*--mentioned upcoming interview with Kay Grier interview and happy for Adriane to remind her of this priority; she was involved in the first grant application*

1. Training people to do cessation work with specific populations fits within strategic plan at ODH
  - this may be able to be funded
  - already covering training for tobacco cessation specialists
  - National Jewish may be able to work in full continuing education training modules for coaches on people with disabilities
  - ODH external evaluator is in process of looking at experience of people with mental health issues who use the quitline; this could possibly expanded to sub populations if those are defined; interesting findings that can be shared with the community of practice that may help make the quitline experience better for people with disabilities
  - connect the local resources for training of coaches at National Jewish Health, a face-to-face training with the UCEDD in CO; Susan and Adriane can follow up with Cindy on connecting.
  - will bring up opportunity to do training at internal staff meeting

*Sharing of data can happen now*

*-quitline retention data for people with disabilities*

*---have data for mental health*

*---Yiping/Nisonger can review intake form items and think more specifically about the information they would want from the existing data navigation, just looking at the current questions – not adding any new intake items; include Mandy in follow up conversation with Cindy*

*Continue to look at the data together*

*---Mandy would like to have another conversation on how to look at the data as the evaluation is expanded so that the group does not interpret the data in different ways*

*---look at more than just the quitline retention data, like what kinds of things worked for them or*

why those who don't follow up do not continue ; there is an opportunity to gather additional information to make the smoking cessation efforts for an extended definition of disability

*What else do you need to learn to accomplish these action steps?*

*1. More focus on disability data*

*2. Supporting referral to smoking cessation services*

*3. May need to make modifications of offerings to be a good fit for the different diverse populations and include other needs beyond just cessation services themselves*

-- like their transportation needs – how do they get there, what other kinds of supports do they need beyond what has been traditionally thought of for cessation; it's not just the cessation services themselves; it includes what is going to keep them engaged and what follow up may be needed

*4. More information on who is using the quitline and who is not using the quitline*

--This will help inform the training that we can do with the quitline staff; there may be things that the counselors could be doing differently

*Who else needs to be involved?*

1. Need to think of the reach to get them into the program; ask CILs about the reach for these programs and what we can do to increase

2. Include representatives of providers of direct service – medical, counseling, treatment

3. Need to have someone who is knowledgeable about the communications of how to promote referral services to providers; e.g. campaign for people with disabilities based on focus groups with people with disabilities; Need to think about how to create messages for each disability sub population and health care providers/physicians;

4. Need to know more about who with a disability smokes

-look at SC study data

-DOH may be able to add questions to the BRFSS; 2016 data are expected to have more identifiers; Adult Tobacco Survey is done annually in Ohio

Look at CDC data release coming out this week

**Next Community of Practice: Thursday, August 27, 11:30amET 866-951-1151, code 7307522**

### Session 3:



Ohio Community of Practice  
Focus=Smoking Cessation for People with a Disability

#### **8/27/15 Agenda** *(60 minute discussion)*

Introductions– 5 mins (all)

Reflect on 2<sup>nd</sup> Community of Practice meeting and surveys– 5 mins (AG)

Review prospective information creation together-45 mins (all)

Recommendations for other states(*in advance*)

Action plan to support working together

Learning agenda to support action plan

Wrap up and next steps– 5 mins (AG)

***Review findings of Community of Practice meeting and surveys– 5 mins (AG)***

**Community of Practice Update**

7 participants in live phone meeting (7/8)

Reviewed recommendations for other states and possible action steps to take together as a group: “Steps for People with a Disability to be Included in Public Health Programs”

Developed draft action plan and supporting learning agenda

***Action Plan:***

1. Funding for more collaboration with the CILs to use the LIFT program
2. Training for Quitline Coaches
3. Sharing data and looking at it together

***Learning Agenda:***

1. Focus on disability data, including who with a disability smokes
2. Support referral to smoking cessation services (talk with CILs, direct service providers)
3. Communications to promote referral services

3

***Review findings of Community of Practice meeting and surveys– 5 mins (AG)***

**Survey Update**

5 participated (5/7)

More report incorporating information learned into job and efforts with partners

Most goals being met

Most were able to contribute and share information during the last phone meeting

4

***Review Recommendations 5 minutes (all)***

“Steps for People with a Disability to be Included in Public Health Programs”

---See Word document

Target audience: other State Disability and Health Grantees/Disability experts

Version for State Public Health Programs – another target audience

---See Word document

6

***8/27/15 Agenda (60 minute discussion)***

✓ Introductions – 5 mins (all)

✓ Review findings of initial Community of Practice meeting and surveys – 5 mins (AG)

**Review prospective information creation together-45 mins (all)**

✓ Recommendations for other states (*please review in advance*)

Action plan to support working together

Learning agenda to support action plan

Wrap up and next steps – 5 mins (AG)

7

***Action plan to support working together***

1. Funding for more collaboration with the CILs to use the LIFT program
2. Training for Quitline Coaches
3. Sharing data and looking at it together

***Learning agenda to support action plan***

1. Focus on disability data, including who with a disability smokes
2. Support referral to smoking cessation services (talk with CILs, direct service providers)
3. Communications to promote referral services

*How do the action plan steps and learning agenda steps match up?*

8

***Action plan to support working together***

1. Funding for more collaboration with the CILs to use the LIFT program

***Learning agenda to support action plan***

1. Focus on disability data, including who with a disability smokes
2. Support referral to smoking cessation services (talk with CILs, direct service providers)
3. Communications to promote referral services

*Any other more specific learning needed to support action?*

9



*Action plan to support working together*

2. Training for Quitline Coaches

*Learning agenda to support action plan*

1. Focus on disability data, including who with a disability smokes
2. Support referral to smoking cessation services (talk with CILs, direct service providers)
3. Communications to promote referral services
4. Disability awareness, by functional type of disability

*Any other more specific learning needed to support action?*

***Action plan to support working together***

3. Sharing data and looking at it together

***Learning agenda to support action plan***

1. Focus on disability data, including who with a disability smokes
2. Support sharing of smoking cessation retention data
3. Know which Staff interested/available

*Any other more specific learning needed to support action?*

11

***Learning agenda to support action plan***

1. Focus on disability data, including who with a disability smokes
2. Support referral to smoking cessation services (talk with CILs, direct service providers)
3. Communications to promote referral services
4. Disability awareness, by functional type of disability
5. Know which Staff interested/available

*Any other more specific learning needed to support action?*

12

***Action plan & Learning agenda: check in – 5 mins (all)***

*Is this summary true for you?*

*What else do you need to know to get there?*

*What steps do you need to take? What steps can you take now? What will take more time?*

*Who else needs to be involved?*

13

***Learning agenda and check in – 2 mins (all)***

*Possible Opportunities...*

More guidance/training for your ongoing Community of Practice Facilitator...

Keep asking (for each action plan item...)

Who are your Champions?

Who are your Sponsors?

Who are your peripheral supporters?



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*Wrap up and next steps – 5 mins (AG)*

- Follow up survey:  
<https://www.surveymonkey.com/s/PY2SFCY>
- Send me any additional resources that this conversation brought to mind for you



13

*Wrap up and next steps – 5 mins (AG)*

**Questions?**

*Adriane Griffen*  
Work 240-821-9374  
Cell 202-210-1546  
[aqriff27@uic.edu](mailto:aqriff27@uic.edu)

***Thank you!!!!!!!***

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**Steps for People with a Disability to be Included in Public Health Programs**

Prepared by: Adriane K. Griffen, MPH, MCHES, 2012 Cohort DrPH Candidate, [agriff27@uic.edu](mailto:agriff27@uic.edu)  
Based on findings from Ohio's Community of Practice on Smoking Cessation and People with a Disability

- 1. Use of data from a state-level needs assessment with disability identifiers is critical.** *The more you can show that data that are from surveys that have broad based support, the better able you will be to talk articulately about this data, while acknowledging any limitations. If you do not have disability identifiers in your state-level data, encourage your state public health partners to include questions on the six functional types of disability, as based on the American Community Survey (ACS). These include hearing, vision (even when wearing glasses), cognitive (concentrating, remembering, or making decisions), or ambulatory (walking or climbing stairs); or any limitation with the following: self-care (dressing or bathing) or independent living (e.g., running errands or visiting a doctor's office).*
- 2. Know what your goal or "ask" is. Craft your message for your "ask" in a way that would speak to the public health program.** *Use your message to convey the vision that public health programs should be addressing people with disabilities and making sure that their work is accessible to everyone.*
- 3. Take time to create and practice a compelling presentation to get partner attention to these messages.** *Infographics in addition to a needs assessment convey the background data in a meaningful way.*
- 4. Do your homework-create a list of potential partners.** *Think about which relationships are critical. You will want to focus your efforts on the potential leads that you think will be most fruitful. Look for areas where you may already have buy-in. We all have limited time and resources, so focus and make your efforts count.*
- 5. Request a meeting with a specific public health program.** *Initially meet face-to-face. Use email to follow up on the meeting, express thanks, and highlight the take-aways and action steps. You are looking for partners that share your vision that public health programs should be addressing people with disabilities and making sure that their work is accessible to everyone.*
- 6. Stay in touch your public health colleagues.** *Your colleagues in public health are interested, even if they do not respond right away. Remember - It is a lot of work to establish the relationship.*
- 7. Dedicate a staff member to facilitate and connect disability experts and public health programs to provide encouragement to establish the relationship.** *It is important to make sure that there is a shared understanding so that partners have appropriate expectations. It is critical to have staff person thinking about this all the time to set up check in meetings to plan and review.*
- 8. Pick one project to do together.** *Be specific about the project parameters so that you can define what early success looks like. Establish and utilize a planning group comprised of disability community leaders from*

*around the state to get input on the project. This is an essential part of making sure that public health is for everyone.*

**9. Once the relationship is established and strong, then staff at the public health program will feel connected with disability and health,** *know the people and the players, and bring them to the meetings and the coalitions going on in the state.*

**10. Keep going! Encourage your public health partners to make an investment of their time and resources to learn more about how to include people with disabilities across programs.** *For example, you might ask for disability to be included in the health equity definitions when speaking about disparity. Start with something that you can achieve in your state and build on your success.*



## **State Public Health Program Version**

### ***Steps for People with a Disability to be Included in Public Health Programs***

Prepared by: Adriane K. Griffen, MPH, MCHES, 2012 Cohort DrPH Candidate, [agriff27@uic.edu](mailto:agriff27@uic.edu)

Based on findings from Ohio's Community of Practice on Smoking Cessation and People with a Disability

- 1. Nationally, 1 in 5 American adults has a disability. Use of data from a state-level needs assessment with disability identifiers is critical.** *The more you can show that data that are from surveys that have broad based support, the better able you will be to talk articulately about this data, while acknowledging any limitations. If you do not have disability identifiers in your state-level data, encourage your BRSFF coordinator to include questions on the six functional types of disability, as based on the American Community Survey (ACS). These include hearing, vision (even when wearing glasses), cognitive (concentrating, remembering, or making decisions), or ambulatory (walking or climbing stairs); or any limitation with the following: self-care (dressing or bathing) or independent living (e.g., running errands or visiting a doctor's office).*
- 2. Know what your goal or "ask" is. Craft the message for your "ask" in a way that would speak to the partners who have expertise in disability, such as Centers for Independent Living, University Centers for Excellence in Disabilities, or LEND interdisciplinary leadership training programs. Use your message to convey the vision that public health programs should address people with disabilities and be accessible to everyone, including people with disabilities.**
- 3. Take time to create and practice a compelling presentation to get partner attention to these messages.** *Infographics in addition to a needs assessment convey the background data in a meaningful way.*
- 4. Do your homework-create a list of potential partners.** *Think about which relationships are critical. You will want to focus your efforts on the potential leads that you think will be most fruitful. Look for areas where you may already have buy-in. We all have limited time and resources, so focus and make your efforts count.*
- 5. Request a meeting with a specific disability partner.** *Initially meet face-to-face. Use email to follow up on the meeting, express thanks, and highlight the take-aways and action steps. You are looking for partners that share your vision that public health programs should address people with disabilities and be accessible to everyone, including people with disabilities.*
- 6 It is important to stay in touch your disability and health colleagues.** *Your colleagues in disability and health are interested. It is a lot of work to establish the relationship.*
- 7. Dedicate a staff member to facilitate and connect disability experts and public health programs to provide encouragement to establish the relationship.** *It is important to make sure that there is a shared understanding so that partners have appropriate expectations. It is critical to have a staff person thinking about this all the time to set up check in meetings to plan and review.*
- 8. Pick one project to do together.** *Be specific about the project parameters so that you can define what early success looks like. Establish and utilize a planning group comprised of disability community leaders from*

*around the state to get input on the project. This is an essential part of making sure that public health is for everyone.*

**9. Once the relationship is established and strong, then your disability and health colleagues will feel connected with your public health programs, know the people and the players, and bring them to the meetings and the coalitions going on in the state.**

**10. Keep going! Encourage your partners who have expertise in disability to make an investment of their time and resources to provide guidance on how to include people with disabilities across programs. Start with something that you can achieve in your state and build on your success.**





## **Ohio Community of Practice Meeting 2: 8.27.15 NOTES**

***Focus=Smoking Cessation for People with a Disability***

***Attendees:*** ✓ Ohio Community of Practice Members

Guest and facilitator: ✓Adriane K. Griffen, MPH, MCHES, 2012 Cohort DrPH Candidate: [agriff27@uic.edu](mailto:agriff27@uic.edu)

***Reflect on 2<sup>nd</sup> Community of Practice meeting and surveys***

***Findings of the interviews and surveys so far:***

### *Community of Practice Update*

7 participants in live phone meeting (7/8)

Reviewed recommendations for other states and possible action steps to take together as a group:  
“Steps for People with a Disability to be Included in Public Health Programs”

Developed draft action plan and supporting learning agenda

### *Action Plan:*

1. Funding for more collaboration with the CILs to use the LIFT program
2. Training for Quitline Coaches
3. Sharing data and looking at it together

### *Learning Agenda:*

1. Focus on disability data, including who with a disability smokes
2. Support referral to smoking cessation services (talk with CILs, direct service providers)
3. Communications to promote referral services

### *Survey Update*

5 participated (5/7)

More report incorporating information learned into job and efforts with partners

Most goals being met

Most were able to contribute and share information during the last phone meeting

***Review prospective information creation together***

***Recommendations for other states***

Reviewed recommendations for reaching people with disabilities and including them in public health efforts like smoking cessation

Reviewed draft *Steps for People with a Disability to be Included in Public Health Programs*

*The group felt that this summary was accurate. The following suggestions and thoughts were shared:*

Be explicit with potential partners on #4 in the version for state public health partners

The “ask” needs to be specific. It’s important for it to be concrete and small to move the partnership and collaboration along. It takes time to think about what to focus on and what to do together, but you can get some experience under your belt on what to do together while you are getting to know each other.

Some of the partner steps in #4 may be combined with step #8

It is important to note that these are broad recommendations and states need to keep in mind their own unique situations; there is no cookie cutter approach

There needs to be an introduction for these recommendations on making the case for why these partners should engage with each other and why it is important

***Action plan to support working together and Learning agenda to support action plan***

Action Plan 1. Funding for more collaboration with the CILs to use the LIFT program

Learning Agenda 1:

1. Focus on disability data, including who with a disability smokes
2. Support referral to smoking cessation services (talk with CILs, direct service providers)
3. Communications to promote referral services

As a follow up to the last meeting, Adriane requested information from SC on their analysis on their state data on the different types of characteristics of people with disabilities who smoke; she’ll share any details

She also shared that she will follow up with the Ohio Disability and Health Program and the Quitline group in Denver to connect with the Denver-based University Center on Disabilities to possibly do some disability awareness training

Adriane shared that during the OH CIL interview, Kay Grier expressed interest in pursuing funding for use of the LIFT program. Kay shared that the CILs need to better understand what you get by calling the quitline.

Many mentioned that the Ohio Department of Health has a brochure on the quitline and the process, including what to expect. Eligibility criteria are not shared as during campaigns the eligibility varies. Sharing some of that information and/or seeing what Cindy may have would be a possible next step. This could also help inform provider education seminars and how to promote cessation to providers to make sure they are getting people with disabilities.

### Action Plan 2. Training for Quitline Coaches

#### Learning Agenda:

1. Focus on disability data, including who with a disability smokes
2. Support referral to smoking cessation services (talk with CILs, direct service providers)
3. Communications to promote referral services
4. Disability awareness, by functional type of disability

Need more information on how TTS training addresses information for mobility limitation or other disability conditions and how they might impact someone; Strategies to get people to quit may need to be adapted to the different disability conditions; There may need to be some general disability awareness and sensitivity skills

Disability awareness depends on what the specific disability is. For example, hearing issues are very different than mental health issues.

Perhaps the training could be an all in one training or on a specific disability; Need to know which disabilities are most represented on the phone line; some coaches may need familiarity with adaptations such as a phone relay service or behavioral health training

### Action Plan 3. Sharing data and looking at it together

#### Learning Agenda:

1. Focus on disability data, including who with a disability smokes
2. Support sharing of smoking cessation retention data
3. Know which staff interested/available

Data sets to share include:

- Quitline use and follow up; need snap shot of who is using the Quitline; Maureen may be able to work with Amy and Cindy to get more specific data on disability; mindful of adding time to the intake data
- BRFSS – start here with the battery of disability questions from the Census (hearing acuity will likely be added for next administration); would still have lag time
- Other validated questionnaires, eg. Nat'l Survey of Drug Use and Health, Medicaid claims data as a potential data set (Adriane can share updates from the current Medicaid analysis project as they become available)

***Wrap up and next steps***

-Susan asked about the availability of funding from ODH for demonstration projects; Mandy shared that she hopes to have an announcement out by the end of September; the award for be for a 1-2 year demonstration project

*-Reviewed Focus of this Community of Practice=Smoking Cessation for People with a Disability*

For each action plan item, keep asking who are your champions, your sponsors and supporters on the periphery

-Yiping will serve as ongoing group facilitator as you move forward with these action plans

Adriane will be doing an additional training session with him next week

-Adriane will be conducting the wrap up interviews next week and will share updates on her dissertation progress

Many thanks for all your help!

## Appendix M: Steps for People with a Disability to be Included in Public Health Programs- State Public Health Program Version



### **Steps for People with a Disability to be Included in Public Health Programs**

Prepared by: Adriane K. Griffen, MPH, MCHES, 2012 Cohort DrPH Candidate, [agriff27@uic.edu](mailto:agriff27@uic.edu)  
Based on findings from Ohio's Community of Practice on Smoking Cessation and People with a Disability

- 1. Nationally, 1 in 5 American adults has a disability. Use of data from a state-level needs assessment with disability identifiers is critical.** *The more you can show that data that are from surveys that have broad based support, the better able you will be to talk articulately about this data, while acknowledging any limitations. If you do not have disability identifiers in your state-level data, encourage your BRSFF coordinator to include questions on the six functional types of disability, as based on the American Community Survey (ACS). These include hearing, vision (even when wearing glasses), cognitive (concentrating, remembering, or making decisions), or ambulatory (walking or climbing stairs); or any limitation with the following: self-care (dressing or bathing) or independent living (e.g., running errands or visiting a doctor's office).*
- 2. Know what your goal or "ask" is. Craft the message for your "ask" in a way that would speak to the partners who have expertise in disability,** *such as Centers for Independent Living, University Centers for Excellence in Disabilities, or LEND interdisciplinary leadership training programs. Use your message to convey the vision that public health programs should address people with disabilities and be accessible to everyone, including people with disabilities.*
- 3. Take time to create and practice a compelling presentation to get partner and leader attention to these messages.** *Infographics in addition to a needs assessment convey the background data in a meaningful way. Use your data to educate your agency leaders and decision makers about the importance of addressing people with disabilities as part of the population.*
- 4. Do your homework-create a list of potential partners.** *Think about which relationships are critical. You will want to focus your efforts on the potential leads that you think will be most fruitful. Look for areas where you may already have buy-in. We all have limited time and resources, so focus and make your efforts count.*
- 5. Request a meeting with a specific disability partner.** *Initially meet face-to-face. Use email to follow up on the meeting, express thanks, and highlight the take-aways and action steps. You are looking for partners that share your vision that public health programs should address people with disabilities and be accessible to everyone, including people with disabilities.*
- 6 It is important to stay in touch your disability and health colleagues.** *Your colleagues in disability and health are interested. It is a lot of work to establish the relationship.*
- 7. Dedicate a staff member to facilitate and connect disability experts and public health programs to provide encouragement to establish the relationship.** *It is important to make sure that there is a shared understanding so that partners have appropriate expectations. It is critical to have a staff person thinking about this all the time to set up check in meetings to plan and review.*
- 8. Pick one project to do together.** *Be specific about the project parameters so that you can define what*

*early success looks like. Establish and utilize a planning group comprised of disability community leaders from around the state to get input on the project. This is an essential part of making sure that public health is for everyone.*

**9. Once the relationship is established and strong, then your disability and health colleagues will feel connected with your public health programs, know the people and the players, and bring them to the meetings and the coalitions going on in the state.**

**10. Keep going! Encourage your partners who have expertise in disability to make an investment of their time and resources to provide guidance on how to include people with disabilities across programs. Start with something that you can achieve in your state and build on your success.**

## Appendix N: Steps for People with a Disability to be Included in Public Health Programs- State Disability and Health Program Version



### **Steps for People with a Disability to be Included in Public Health Programs**

Prepared by: Adriane K. Griffen, MPH, MCHES, 2012 Cohort DrPH Candidate, [agriff27@uic.edu](mailto:agriff27@uic.edu)  
Based on findings from Ohio's Community of Practice on Smoking Cessation and People with a Disability

- 1. Use of data from a state-level needs assessment with disability identifiers is critical.** *The more you can show that data that are from surveys that have broad based support, the better able you will be to talk articulately about this data, while acknowledging any limitations. If you do not have disability identifiers in your state-level data, encourage your state public health partners to include questions on the six functional types of disability, as based on the American Community Survey (ACS). These include hearing, vision (even when wearing glasses), cognitive (concentrating, remembering, or making decisions), or ambulatory (walking or climbing stairs); or any limitation with the following: self-care (dressing or bathing) or independent living (e.g., running errands or visiting a doctor's office).*
- 2. Know what your goal or "ask" is. Craft your message for your "ask" in a way that would speak to the public health program.** *Use your message to convey the vision that public health programs should be addressing people with disabilities and making sure that their work is accessible to everyone.*
- 3. Take time to create and practice a compelling presentation to get partner attention to these messages.** *Infographics in addition to a needs assessment convey the background data in a meaningful way. Use your data to educate your agency leaders and decision makers about the importance of addressing people with disabilities as part of the population.*
- 4. Do your homework-create a list of potential partners.** *Think about which relationships are critical. You will want to focus your efforts on the potential leads that you think will be most fruitful. Look for areas where you may already have buy-in. We all have limited time and resources, so focus and make your efforts count.*
- 5. Request a meeting with a specific public health program.** *Initially meet face-to-face. Use email to follow up on the meeting, express thanks, and highlight the take-aways and action steps. You are looking for partners that share your vision that public health programs should be addressing people with disabilities and making sure that their work is accessible to everyone.*
- 6. Stay in touch your public health colleagues.** *Your colleagues in public health are interested, even if they do not respond right away. Remember - It is a lot of work to establish the relationship.*
- 7. Dedicate a staff member to facilitate and connect disability experts and public health programs to provide encouragement to establish the relationship.** *It is important to make sure that there is a shared understanding so that partners have appropriate expectations. It is critical to have staff person thinking about this all the time to set up check in meetings to plan and review.*

**8. Pick one project to do together.** *Be specific about the project parameters so that you can define what early success looks like. Establish and utilize a planning group comprised of disability community leaders from around the state to get input on the project. This is an essential part of making sure that public health is for everyone.*

**9. Once the relationship is established and strong, then staff at the public health program will feel connected with disability and health,** *know the people and the players, and bring them to the meetings and the coalitions going on in the state.*

**10. Keep going! Encourage your public health partners to make an investment of their time and resources to learn more about how to include people with disabilities across programs.** *For example, you might ask for disability to be included in the health equity definitions when speaking about disparity. Start with something that you can achieve in your state and build on your success.*



## Appendix O: Document Review Findings and Content Summary

Document	Content Summary	Readiness, Capacity Building, and Capacity Factors
Work plan	<ul style="list-style-type: none"> <li>-ODHP team included the Nisonger Center University Centers of Excellence on Developmental Disabilities (UCEDD) and the Cincinnati Children's Hospital UCEDD</li> <li>-Activities with partners emphasized the importance of including people with disabilities as a priority or a component of a strategy</li> </ul>	<p><u>Capacity Building Factor: Engagement in a network</u> Measure: Being part of a team or planning group</p> <p><u>Capacity Building Factor: Practical experience</u> Measure 1: Including people with disabilities in a work plan for public health efforts</p>
ODHP APHA Poster	<ul style="list-style-type: none"> <li>-Disability identifiers used by the OH quitline</li> <li>-Demonstrates the partnership of the Ohio Department of Health (OH DOH) and the quitline in the effort to identify people with disabilities who use the smoking cessation services</li> </ul>	<p><u>Readiness Factor: Understanding the work of other organizations in this area</u> Measure: Collaboration with partners in a program, including knowledge, value, interest</p>
Needs Assessment	<ul style="list-style-type: none"> <li>- Conducted by ODHP identified health disparities among Ohioans living with a disability</li> <li>-Disability organizations involved in conducting this assessment</li> <li>-Needs assessment is the foundation for the ongoing efforts of the OH Disability and Health Program</li> </ul>	<p><u>Readiness Factor: Understanding the work of other organizations in this area</u> Measure: Collaboration with partners in a program, including knowledge, value, interest</p> <p><u>Capacity Building Factor: Practical experience</u> Measure 1: Including people with disabilities in a work plan for public health efforts</p>
Collaboration proposal	<ul style="list-style-type: none"> <li>-Between ODHP and the OH Department of Health Tobacco Program</li> <li>-Revealed a priority of partners being involved in activities that serve the needs of people with disabilities, such as smoking cessation</li> <li>-Needs assessment data served as a basis for the collaboration proposal</li> </ul>	<p><u>Readiness Factor: Positive perception of other organizations</u> Measure: Quality interactions with partners</p>
Vision and Mission Statements	<ul style="list-style-type: none"> <li>-Vision and Mission statements of ODHP, the OH DOH, and the OH quitline vendor, National Jewish Health, were reviewed</li> <li>- All showed an emphasis on health and a value of knowledge</li> </ul>	<p><u>Capacity Building Factor: Practical experience</u> Measure 1: Including people with disabilities in a work plan for public health efforts</p>

	<p>-ODHP and the OH DOH statements showed a value of including partners in activities.</p> <p>-Involvement of disability organizations and the concept of including people with disabilities in programs was emphasized in the ODHP statement</p>	<p><u>Capacity Factor: Leadership support and vision</u> Measure: Vision, mission, strategic plan</p> <p><u>Capacity Factor: Technical skills and knowledge</u> Measure: Disability knowledge as a critical technical skill</p>
RFA for CDC Disability and Health Grant	<p>-Received by ODHP</p> <p>-Indicates that involvement of disability organizations and including people living with a disability in programs are essential public health activities</p> <p>-Needs assessment and a work plan were required for this funding</p>	<p><u>Capacity Building Factor: Practical experience</u> Measure 1: Including people with disabilities in a work plan for public health efforts</p> <p><u>Capacity Building Factor: Practical experience</u> Measure 2: Disability identifier to describe people with a disability as a demographic</p>
OH Quitline Promotional Materials (n=3)	<p>-ODHP and DOH collaboration with the OH quitline, included development of promotional materials (two marketing posters and brochure)</p> <p>-Posters encourage people with a mobility disability to call the quitline for smoking cessation assistance.</p> <p>-Brochure has information for people with disabilities and their caregivers.</p> <p>-Imagery depicts people with a mobility disability with a photo of a wheelchair on the cover.</p> <p>-Knowledge on smoking cessation, involvement of partners and disability organizations are emphasized</p>	<p><u>Capacity Factor: Technical skills and knowledge</u> Measure: Disability knowledge as a critical technical skill</p> <p><u>Capacity Building Factor: Practical experience</u> Measure 3: Collaboration with partners</p>
Policy briefs (n=2)	<p>-Developed by ODHP</p> <p>-Described people with disabilities as a critical portion of the population which requires smoking cessation services</p> <p>-Need to tailor programs to the needs of people with disabilities as based on the needs assessment findings was emphasized</p>	<p><u>Capacity Building Factor: Practical experience</u> Measure 2: Disability identifier to describe people with a disability as a demographic</p> <p><u>Capacity Factor: Technical skills and knowledge</u> Measure: Disability knowledge as a critical technical skill</p>
Note: The original study protocol included trainings developed by OH partners in the document review. No trainings were reviewed as a smoking cessation program used in another state is currently being adapted for use in		

Ohio. No original trainings developed in Ohio were shared by the CoP participants.

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Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. Atlanta, 2014.

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## **Vita**

Adriane K. Griffen, MPH, MCHES  
Association of University Centers on Disability (AUCD)  
1100 Wayne Ave., Suite 1000  
Silver Spring, MD 20910  
Phone (301) 588-8252 □ Email: agriffen@aucd.org

## **Employment**

2009-present Association of University Centers on Disabilities (AUCD), Silver Spring, MD

- Director of Public Health (2014 – present)
- Project Director, CDC Cooperative Agreement (2009-2014)

2000-2009 Spina Bifida Association, Washington, DC

- Director of Health Promotion and Partnerships (2006-2009)
- Director, Public Health Programs (2002-2006)
- Prevention Program Manager (2000-2002)

1998-2000 Marketing and Outreach Manager, Social & Health Services, Ltd., Rockville, MD  
Contractor for the Office of Disease Prevention and Health Promotion Communication Support Center (OCSC) and the National Health Information Center (NHIC), services of the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services (HHS), including healthfinder® and Healthy People

1998 Intramural Research Training Award Fellow, National Institutes of Health, National Institutes of Child Health and Human Development, Prevention Research Branch - Division of Epidemiology, Statistics and Prevention Research, Bethesda, MD

1996 Information Center Intern, National Mental Health Association, Alexandria, VA

1994-1995 Dental Assistant, Dr. J. Pukatch, DDS, Private Practice, Washington, DC

## **Education and Certifications**

Present Doctor of Public Health - Program in Leadership  
University of Illinois at Chicago (UIC), School of Public Health  
Chicago, IL

April 2011 Master Certified Health Education Specialist (#6839): October 1998 (CHES),  
(MCHES), National Commission for Health Education Credentialing, Inc.

August 1998 Master of Public Health - Health Promotion and Disease Prevention

The George Washington University, School of Public Health and Health Services,  
Washington, DC

May 1996      Bachelor of Science, Biology  
May 1996      Bachelor of Arts, Psychology  
The George Washington University, Washington, DC

## **Leadership Skills and Work Experience**

Director, Association of University Centers on Disabilities (AUCD):

- Facilitate leadership and member exchange for national coalitions
- Connect health and disability practitioners with general public health practitioners
- Engage multiple stakeholders in translational science program and collaborate on community change agent pilot program
- Manage multiple teams concurrently and serve as liaison to senior leaders internally at AUCD and externally to partners

Director, Spina Bifida Association:

- Developed and led health program portfolio to include overall management, coordination, and evaluation of prevention efforts for both primary and secondary prevention
- Initiated development of publication series based on participatory audience research
- Led and implemented social marketing and outreach strategies for first national spina bifida recurrence prevention program
- Led and designed public health trainings for national chapters

Marketing and Outreach Manager, Social and Health Services:

- Gained national level communications strategy skills on issues communication in a timely manner and media outreach.

Intramural Research Training Award Fellow, NIH, NICHD:

- Cultivated ability to speak with general public on basic public health research questions

Information Center Intern, National Mental Health Association:

- Initiated development of fact sheet series

Dental Assistant, Dr J. Pukatch:

- Gained experience in direct service team environment, patient communications, and coordination of laboratory support

## **Other Experience and Professional Leadership**

2013-2017

Appointed Member, Disability and Health Workgroup, National Association of County

and City Health Officials (NACCHO): Review policy guidelines on disability and health

2012-present

Chair, Executive Committee, Friends of NCBDDD (National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention (CDC): Oversee and lead coalition and developed shared communication strategies across coalition

2012-present

American Public Health Association, Disability Section, Awards Chair - Section Councilor: Led communications coordination effort with national APHA communications team; Facilitated information exchange between APHA sections

2011-2012

Membership and Communications Chair, Executive Committee, Friends of NCBDDD: Facilitated leadership and member exchange; Developed and administered coalition managing guidelines

2011-present

Abstract Reviewer, 139th American Public Health Association Annual Meeting, Public Health Education and Health Promotion program

2011-2012

Act Early Systems Grant Reviewer, Association of Maternal and Child Health Programs (AMCHP): Served as liaison for Act Early projects at CDC, AUCD, MCHB/HSRA, and AMCHP

2008-2011

Membership Chair, Executive Committee, Friends of NCBDDD (National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention (CDC)

2005-2008

Chair, National Council on Folic Acid

- Initiated national media outreach for coalition with paid and non-paid outlets
- Serve as national spokesperson on national radio media tours
- Chair-Elect (2004-2005)
- Steering Committee Member (2001-Present)

2002-2004

Member at Large, Executive Committee External Partners of the National Center on Birth Defects and Developmental Disabilities (NCBDDD), Centers for Disease Control and Prevention (CDC)

2001-Present

Member, National Birth Defects Prevention Network

1998-Present Member, Society for Social Marketing

## **Publications**

2016 Griffen, A.; “Early Childhood Screening and Services For All” – presenter; “State planning workshop” – facilitator; Nevada Act Early Summit and Workshop

2015 Marks, K; Griffen, A.; Herrera, P.; Macias, M.; Rice, C.; and Robinson, C. “System-wide Solutions to Improve Early Intervention for Developmental-Behavioral Concerns,” *Journal of Pediatrics*. *Pediatrics Perspectives*, December issue

2015 Griffen, A. "Healthy Living for All: How Sixby'15 Campaign Works to Include People with Disabilities in Public Health," American Public Health Association

2015 Griffen, A. and Armour, B. "Disability and Health Value: A Multistate Medicaid Data Analysis Collaboration" American Public Health Association

2015 Alberico, Abigail; Griffen, Adriane K; “Public Health is for Everyone,” American Marketing Association Non Profit Conference, Washington, DC.

2014 “Communication Skills in the Context of Health and Wellness,” Online tutorial of The Arc HealthMeet initiative, Westchester Institute for Human Development, and Association of University Centers on Disabilities: <http://www.iddhealthtraining.org>, Developed by Edwards, K. and Yankou, C. Review and Input by Griffen, A.

2013 Griffen, Adriane K; “Act Early Network and Action Learning,” Association of University Centers on Disabilities, Annual Conference Training Workshop, Washington, DC.

2013 “Understanding Health and Health Promotion for People with Intellectual Disabilities,” Online tutorial of The Arc HealthMeet initiative, Westchester Institute for Human Development, and Association of University Centers on Disabilities: <http://www.iddhealthtraining.org>, Developed by Edwards, K.; Havercamp, S.; Cohen, L.; O’Hara, D.; with Review and Input by Perry, J; Griffen, A.; and Jesien, G.

2013 Griffen, Adriane K; “Act Early Ambassadors: Pilot to Program,” Association of Maternal and Child Health Programs, Washington, DC.

2012 "Innovative Public Health Strategies to Address Disparities in Early Identification of Young Children with Autism and other Developmental Disabilities," Proceedings of 2012 Science of Eliminating Health Disparities Summit, National Harbor, MD

2012 "Public Health Workforce Competencies: A collaborative effort to address health disparities for people with disabilities through workforce capacity building," Proceedings of



American Public Health Association 140th Annual Meeting, San Francisco, CA

2012 "Public Health is for Everyone: Inclusive Planning Toolkit for Public Health,"  
Proceedings of American Public Health Association 140th Annual Meeting, San Francisco, CA

2012 "Public-Private Partnerships to Improve the Health Status of People with Intellectual  
Disabilities, A Model From the United States," International Association for the Scientific Study  
of Intellectual Disabilities World Congress, Halifax, Nova Scotia

2012 "Public Health is for Everyone: An inclusive planning toolkit for public health  
professionals," Proceedings of the National Health Promotion Summit, Washington, DC

2011 Griffen, Adriane K; Webber, Danielle; and Jesien, George; "Combating Autism  
Reauthorization Act Signed into Law—Many Benefit," Exceptional Parent Magazine, November  
2011.

2011 "Collaborations to implement effective surveillance: Improving the health status of  
people with intellectual disabilities;" "The Act Early Initiative: A Public Health Approach to  
Early Awareness and Identification of Autism and other Developmental Disabilities"  
Proceedings of the American Public Health Association 139th Annual Meeting & Exposition

2011 "Association of University Centers on Disabilities: Partnership and Collaboration to  
Move Public Health Forward," National Association of County & City Health Officials

2009 "Folic Acid Outreach: Reaching Hispanic Populations," HRSA, MCHB/ DHSPS  
MCHCOM.COM webcast

2007 "Assessing and Improving Health Risks for Women of Reproductive Age," Proceedings  
of the National Prevention and Health Promotion Summit.

2006 "ABCs of Folic Acid Counseling," Spina Bifida Association tutorial, lead author  
<http://sba-resource.org/sbaacd/>

2002 "Recurrence Prevention Program: A Social Marketing Approach," Proceedings of the  
American Public Health Association 130th Annual Meeting & Exposition

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