The **Arkansas** Profile:

Aligning with Best Practices

Use of Evidence-based Guidelines in State Tobacco Control Programs

Prepared by
The Center for Tobacco Policy Research at
Washington University in St. Louis

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We would like to extend our sincere appreciation and gratitude to the Arkansas tobacco control partners who participated in this evaluation.

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Executive Summary

Introduction

There has been a significant amount of research done on what works to curb tobacco use. Many agree that the evidence-base for tobacco control is one of the most developed in the field of public health. However, the advancement in the knowledge base is only effective if that information reaches those who work to reduce tobacco consumption. Evidence-based guidelines, such as the Centers for Disease Control and Prevention's *Best Practices Guidelines for Comprehensive Tobacco Control Programs* (*Best Practices*), are a key source of this information. However, how these guidelines are utilized can significantly vary across states.

This profile presents findings from an evaluation conducted by the Center for Tobacco Policy Research at Washington University in St. Louis that aimed to understand how evidence-based guidelines were disseminated, adopted, and used within state tobacco control programs. Arkansas served as the sixth case study in this evaluation. The project goals were two-fold:

- Understand how Arkansas used evidence-based guidelines to inform their programs, policies, and practices; and,
- Produce and disseminate findings and lessons from Arkansas and other states so that readers can apply the information to their work in tobacco control.

Findings from Arkansas

The following are highlights from Arkansas' profile. Please refer to the complete report for more detail on the topics presented below.

- Partners looked to the Tobacco Prevention and Cessation Program (TPCP) at the Arkansas Department of Health for program direction and information on evidence-based strategies.
- Every Arkansas partner was aware of the CDC's *Best Practices* and partners used the guideline to inform program development and funding allocation.
- Despite their acknowledged importance, some challenges were identified with using evidence-based guidelines, such as:
    - Partners perceived the translation of new research into evidence-based materials to be a lengthy process.
    - Partners believed evidence-based guidelines did not adequately address how to work with populations with tobacco-related disparities.
- Partners stressed the need for additional technical assistance and support from the CDC.

Introduction

Project overview

States often struggle with limited financial and staffing resources to combat the burden of disease from tobacco use. Therefore, it is imperative that efforts that produce the greatest return on investment are implemented. There has been little research on how evidence-based interventions are disseminated and utilized by state tobacco control programs. To begin to answer this question, the Center for Tobacco Policy Research at Washington University in St. Louis conducted a multi-year evaluation in partnership with the CDC Office on Smoking and Health (CDC OSH). The aim of this project was to examine how states used the CDC's *Best Practices for Comprehensive Tobacco Control Programs* (*Best Practices*) and other evidence-based guidelines for their tobacco control efforts and to identify opportunities that encouraged guideline use.

Qualitative and quantitative data from key partners in eight states were collected during the project period. States were selected based on several criteria, including funding level, lead agency structure, geographic location, and reported use of evidence-based guidelines. Information about each state's tobacco control program was obtained in several ways, including: 1) a survey completed by the state program's lead agency; and 2) key informant interviews with approximately 20 tobacco control partners in each state.

State profiles

This profile is part of a series of profiles that aims to provide readers with a picture of how states accessed and utilized evidence-based guidelines. This profile presents data collected in July 2010 from Arkansas partners. The profile is organized into the following sections:

- **Program Overview –** provides background information on Arkansas' tobacco control program.
- **Evidence-based Guidelines –** presents the guidelines we asked about and a framework for assessing guideline use.
- **Dissemination –** discusses how Arkansas partners learned of new guidelines and their awareness of specific tobacco control guidelines.
- **Adoption Factors –** presents factors that influenced Arkansas partners' decisions about their tobacco control efforts, including use of guidelines.
- **Implementation –** provides information on the critical guidelines for Arkansas partners and the resources they utilized for addressing tobacco-related disparities and in communication with policymakers.
- **Conclusions –** summarizes the key factors that influenced use of guidelines based on themes presented in the profile and current research.

Quotes from participants (offset in green) were chosen to be representative examples of broader findings and provide the reader with additional detail. To protect participants' confidentiality, all identifying phrases or remarks have been removed.

Program Overview

Arkansas' tobacco control program

In November 2000, Arkansas voters approved a ballot initiative that allocated 100% of the state's Master Settlement Agreement (MSA) funds to health-related programs, including 31.6% to the Tobacco Prevention and Cessation Program (TPCP) at the Arkansas Department of Health. The initiative also established the Arkansas Tobacco Settlement Commission (ATSC), an external contractor that oversaw and evaluated all MSA funded programs. TPCP provided ATSC with quarterly reports on current program activities and progress, the program's short- and long-term goals, and program finances.

TPCP worked to reduce the burden of tobacco use through the development of a comprehensive tobacco prevention, education, and cessation program aligned with the five components of a comprehensive program as outlined in the CDC's *Best Practices* guideline. These components were integrated into TPCP's program goals to be met by 2014: 1) Reduce youth tobacco use to 17.5%; 2) Reduce adult tobacco use to 17.5%; 3) Reduce tobacco use by pregnant women to 12.5%; 4) Reduce employee exposure to secondhand smoke in workplaces to 2%; and, 5) Pass statewide comprehensive smokefree legislation.

At the time of this evaluation, Arkansas was funded at $16.4 million, meeting 45% of the CDC's recommended annual funding level for a comprehensive tobacco control program in Arkansas. Like most states, TPCP had experienced significant budget cuts. However, TPCP had made great strides towards reaching its goals. In 2005, Arkansas' legislature passed Act 134, making all hospital grounds tobacco free and in 2006, Arkansas became the first state to implement a law protecting children from secondhand smoke in cars. Additionally, with the passage of a 56¢ cigarette tax increase in 2009, Arkansas' cigarette tax had reached $1.15 per pack. In March 2010, Free & Clear was contracted to design and develop a statewide training program to assist Arkansas' healthcare providers and organizations with their cessation interventions. Although no statewide comprehensive smokefree policy existed, the Arkansas Clean Air on Campus Act of 2009 went into effect in August 2010 in an effort to reduce secondhand smoke exposure on all state-funded campuses.

Arkansas' tobacco control partners

Arkansas' tobacco control efforts involved a variety of partners. Partners included voluntaries and advocacy groups, coalition members, marketing agencies, and other state government departments. Some partners also had secondary roles as members of the ATSC. Sixteen individuals from 14 organizations were identified as a sample of key members of Arkansas' tobacco control program. On average, partners had been involved in Arkansas' tobacco control efforts for more than seven years, with a range of two to thirteen years. Table 1 presents the list of partners who participated in the interviews.

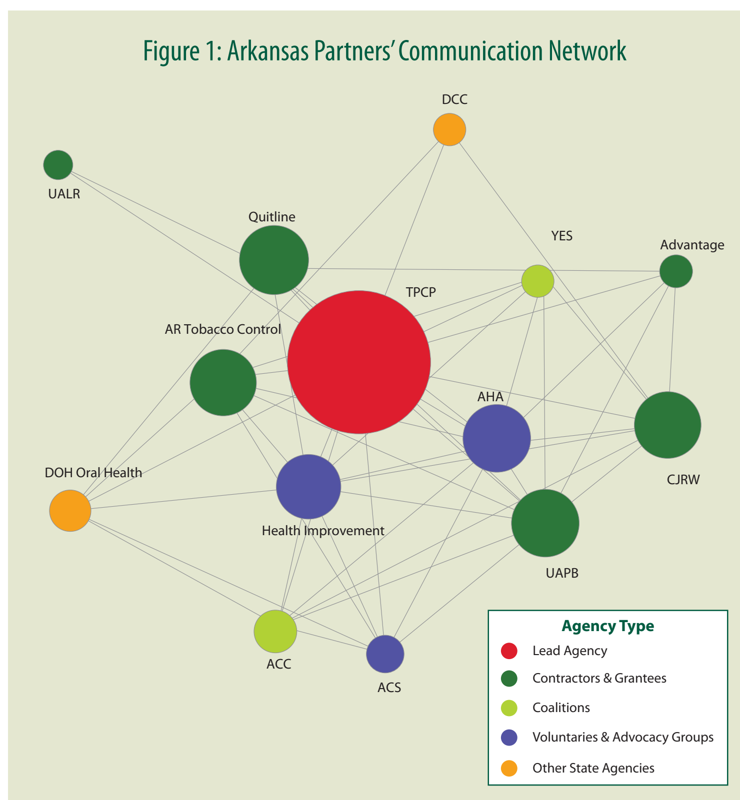
Table 1: Arkansas Tobacco Control Partners

Agency	Abbreviation	Agency Type
Tobacco Prevention and Cessation Program	TPCP	Lead Agency
Advantage Communications, Inc.	Advantage	Contractors & Grantees
Arkansas Tobacco Control	AR Tobacco Control	Contractors & Grantees
Cranford Johnson Robinson Woods	CJRW	Contractors & Grantees
Free & Clear	Quitline	Contractors & Grantees
University of Arkansas, Little Rock	UALR	Contractors & Grantees
University of Arkansas, Pine Bluff	UAPB	Contractors & Grantees
Arkansas Cancer Coalition	ACC	Coalitions
YES Team	YES	Coalitions
American Cancer Society	ACS	Voluntaries & Advocacy Groups
American Heart Association	AHA	Voluntaries & Advocacy Groups
Arkansas Center for Health Improvement	Health Improvement	Voluntaries & Advocacy Groups
Arkansas Department of Health, Office of Oral Health	DOH Oral Health	Other State Agencies
Department of Community Corrections	DCC	Other State Agencies

Communication between Arkansas partners

To gain a better understanding of partner relationships within Arkansas' tobacco control network, partners were asked about their interaction with other tobacco control organizations within the state. Partners were asked how often they had direct contact (such as meetings, phone calls, or e-mails) with other partners within the network in the past year. In the figure to the right, a line connects two partners if they had contact with each other on more than a quarterly basis. The size of the node (dot representing each agency) indicates the amount of influence a partner had over contact in the network. An example of having more influence, or a larger node, was seen between DOH Oral Health, TPCP, and DCC. DOH Oral Health did not have direct contact with DCC, but both had contact with TPCP. As a result, TPCP

Figure 1: Arkansas Partners' Communication Network



acted as a bridge between the two and had more influence within the network. Communication within Arkansas indicated a relatively decentralized structure among partners in which members of the network had contact with many others agencies throughout the state.

Collaboration between Arkansas partners

Partners were asked to indicate their working relationship with each partner with whom they communicated. Relationships could range from not working together at all to working together as a formal team on multiple projects. A link between two partners signifies that they at least worked together informally to achieve common goals. Partners were not linked if they did not work together or only shared information. The node size is based on the amount of influence a partner had over collaboration in the network. A partner was considered influential if he or she connected partners who did not work directly with each other. For example, UALR and ACS did not work directly with each other, but both worked with TPCP. TPCP acted as a "broker" between the two agencies, resulting in its larger node size. Collaboration within Arkansas indicated a fairly centralized network. Although members collaborated with multiple agencies throughout the state, TPCP played a more central role connecting partners.

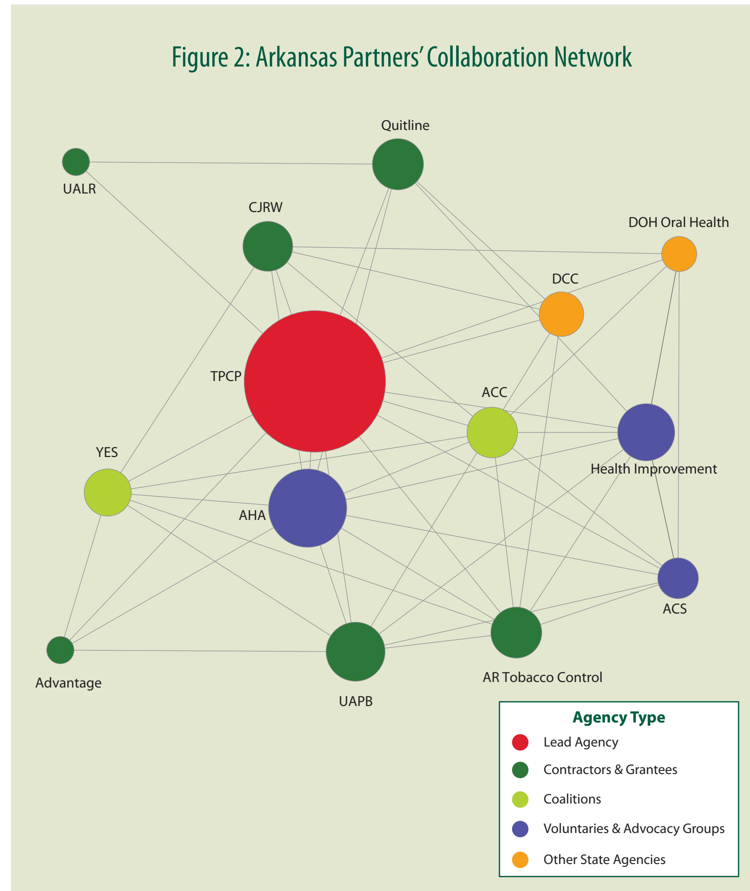


Figure 2: Arkansas Partners' Collaboration Network

Evidence-based Guidelines

There are a number of evidence-based guidelines for tobacco control, ranging from broad frameworks to those focusing on specific strategies. Below in Figure 3 are the set of guidelines partners were asked about during their interviews. Partners also had the opportunity to identify additional guidelines or information they used to guide their work. Other resources identified by Arkansas partners included:

- The World Health Organization's International Agency for Research on Cancer (IARC), *IARC Monographs on the Evaluation of Carcinogenic Risks to Humans, Tobacco Smoke and Involuntary Smoking*;
- Cochrane Reviews;
- Rand Corporation's *Evaluation of the Arkansas Tobacco Settlement Program*;
- The Association of State and Territorial Dental Directors' (ASTDD) 14 Best Practice reports;
- American Cancer Society's *How Do You Measure Up?: A Progress Report on State Legislative Activity to Reduce Cancer Incidence and Mortality*; and,
- The CDC's *Guidance for Comprehensive Cancer Control Planning*.

Figure 3: Evidence-based Guidelines for Tobacco Control

Research has shown that the use of evidence-based practices, such as those identified in these guidelines, results in reductions in tobacco use and subsequent improvements in population health. Whether an individual or organization implemented evidence-based practices depended on a number of factors, including capacity, support, and available information. The remainder of this report will look at how evidence-based guidelines fit into this equation for Arkansas. The framework below will guide the discussion, specifically looking at which guidelines Arkansas partners were aware of, which ones were critical to partners' efforts, and how guidelines were used in their work.

Figure 4: Framework for Use of Evidence-based Guidelines

Dissemination

How did partners define "evidence-based guidelines"?

Arkansas partners defined evidence-based guidelines as practices that had been scientifically proven to be effective. Additionally, partners frequently associated evidence-based guidelines with the CDC due to the organization's strong presence in the field of tobacco control.

> [Evidence-based guidelines are] proven model programs or activities or standards that have been vetted and proven and have shown and demonstrated success.

> [An evidence-based guideline is] a tool or a process that has been studied and found to be effective.

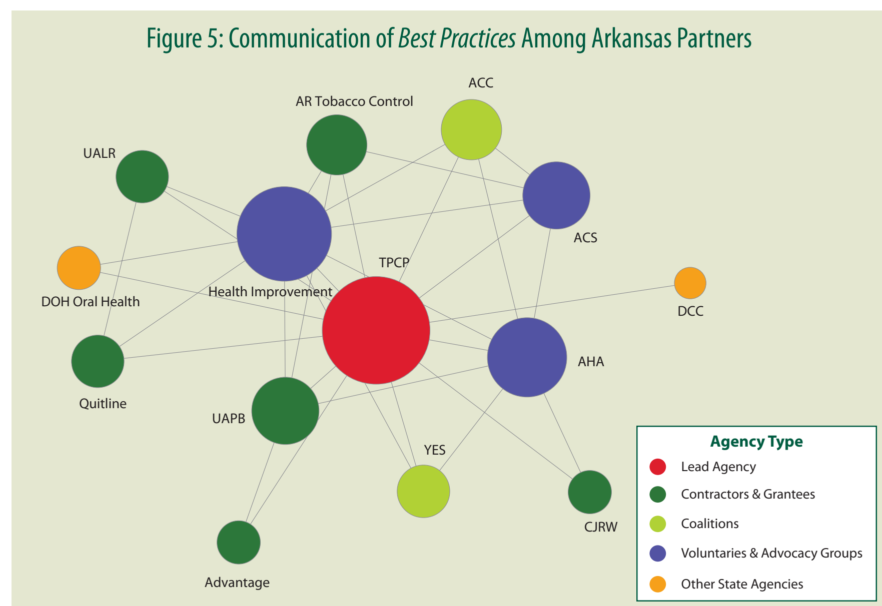
How did partners learn of evidence-based guidelines?

Leadership within partners' organizations was most often identified as a source for learning about new evidence-based guidelines. Within TPCP, this included the Program Director and the Section Chief for State and Community Interventions. Partners also noted learning of new guidelines during in-state meetings, specifically those hosted by TPCP. Additionally, some partners were informed of new guidelines through the CDC, including CDC conferences during which guidelines were referenced. Partners then shared information about new evidence-based guidelines internally through e-mail and regular staff meetings.

> If it's something that [staff] need to act upon then we send e-mails and we do conference calls.

To get a better sense of the dissemination of *Best Practices* within the state, Arkansas partners were asked who they talked to about the guideline. In Figure 5, a line connecting two agencies indicates they talked about *Best Practices* with each other. The size of the node indicates the number of agencies each partner talked to about the guideline. For example, TPCP talked with the most partners about *Best Practices*, resulting in the largest node size. Arkansas' network represents a fairly centralized network.

Figure 5: Communication of *Best Practices* Among Arkansas Partners



What tobacco control guidelines were partners aware of?

The *Best Practices* was the most well-known guideline in Arkansas. All partners interviewed recalled at least hearing of *Best Practices*. Partners referred to *Best Practices* on a daily to annual basis and were made aware of the guideline primarily through the CDC and TPCP. There was a drop in awareness for most of the remaining guidelines, with only 50% or fewer partners aware of the majority of the remaining guidelines.

Table 2: Number of Partners Aware of Tobacco Control Guidelines

Guideline	# of Partners
Best Practices for Comprehensive Tobacco Control Programs	16/16
Best Practices User Guide Series	11/16
Designing and Implementing an Effective Tobacco Counter-Marketing Campaign	10/16
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	9/16
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	8/16
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	8/16
Introduction to Process Evaluation in Tobacco Use Prevention and Control	8/16
Key Outcome Indicators for Evaluating Tobacco Control Programs	7/16
The Guide to Community Preventive Services: Tobacco	7/16
Tobacco Control Monograph Series	6/16
Ending the Tobacco Problem: A Blueprint for the Nation	5/16
NACCHO 2010 Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs	4/16

Adoption Factors

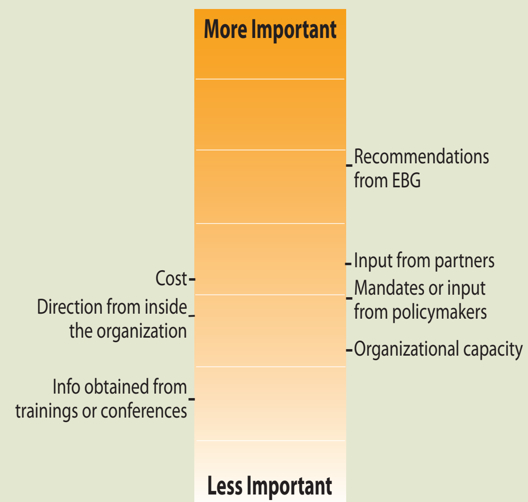
What did partners take into consideration when making decisions about their tobacco control efforts?

Arkansas partners took several key factors into consideration when making decisions about their tobacco control efforts. These factors included the political climate, areas with the greatest tobacco use burden, and input from partners. Partners particularly valued input from the Department of Health, clients, and funders.

> [We] gauge the appetite of the state legislature to readdress current issues. We have to look at the political landscape.

> [The Department of Health is] typically our primary source. And they usually drive our tobacco control agenda. One, because we receive money from them, two, because they've been a very vested partner for the last several years.

Figure 6: Ranking of Decision-making Factors



When asked to rank specific factors in their overall importance when making decisions to design or adopt programs or policies for tobacco control, partners most often ranked recommendations from evidence-based guidelines as most important, with 87.5% of partners ranking it in their top three. Partners stated that evidence-based guidelines not only provided a general framework for their efforts, but also promoted effective strategies. Partners reported that leadership within their organization as well as at the Department of Health required programs to be supported by evidence.

> [Evidence-based guidelines] provide us with a structure for what we are going to look like and then we try to design our programs around those kinds of things.

> Recommendations from evidence-based guidelines are always number one, because it's our agency culture and a requirement from all leadership that you can come in with a great idea, but if you really want it to be considered, then it has to be based on something substantive and fact-based.

Input from partners was also highly valued and was consequently ranked as the second most important decision-making factor. Input from partners, in addition to direction from inside partners' organizations, was used to guide programmatic decision-making.

> I think what [partners] have to say has a big influence on what we put into our programs, our plan of work for the year.

Additionally, cost and input from policymakers, which were perceived as closely linked, played a role in decision-making for Arkansas partners. Cost ultimately determined what programs could be implemented and partners relied on policymakers for the necessary funding. In order to maintain adequate funding and justify spending, partners considered programs supported by the state legislature when determining what interventions to implement. Cost was also viewed as important because funding influenced organizational capacity, specifically the staffing and resources needed to implement tobacco control efforts.

> If we are going to implement something we usually start out with how much it's going to cost.

> We do go before the legislature so often and we don't want to lose our funding; therefore, we do take into consideration what they say and what they would like to see before we implement things.

How did organizational characteristics influence partners' decisions about their tobacco control efforts?

Partners stated that their dedication to research and knowledge of current scientific evidence enhanced their tobacco control efforts. These organizational characteristics ensured that partners were aware of new research and the release of new guidelines.

> We have a very robust clinical team who continually monitor scientific evidence related to treating tobacco use and dependence, so we're very well connected in the treatment and research community.

> We have a culture with our organization of fact-based decision-making. So when we're brainstorming ideas, it has to be supported by something that is fact-based, that is research-based.

"The fact that state organizations do have red tape, they do answer to legislators, is a process that sometimes is lengthy."

Additionally, support from leadership within the Department of Health facilitated partners' tobacco control efforts. Partners particularly valued the experience of TPCP's program director and viewed her input as critical to program and policy development.

> Having [TPCP's program director] on board and her vast knowledge of tobacco control helps us a lot in moving things forward.

Conversely, the policies and red tape inherent to bureaucratic organizations, such as the lengthy legislative review process, often hindered Arkansas partners' efforts. Additionally, Arkansas' political climate was not particularly receptive to tobacco control efforts, which limited what partners could do.

> One of the things that we have to do annually [is] report to the legislature. And of course it's an opportunity, but sometimes it serves as a barrier because policymakers don't always relate to the overall goal of the program.

What facilitated or hindered use of evidence-based guidelines?

Arkansas partners often looked to evidence-based guidelines to inform their efforts and guide program direction. Since the guidelines were thought to promote effective and proven strategies, Arkansas partners felt confident using them to support their efforts and justify spending, especially when communicating with policymakers. Evidence-based guidelines provided a sense of authority and something substantial upon which to base their work.

> [Evidence-based guidelines] help me support what we're doing. So if we get challenged on something, I have a reference point that I can go to and say, "Based on this…"

> The guidelines are a very useful way of grounding people to help them understand what is proven to work.

While evidence-based guidelines provided a solid foundation for Arkansas' tobacco control efforts, partners also faced several challenges with using the guidelines. Partners noted that the translation of research into evidence-based practice was a slow process. Therefore, at times, partners felt that adhering to evidence-based guidelines limited creativity.

> Recognition of what is evidence-based is a little slower than what we'd like.

> Sometimes when you're being creative, it can't be based on science. Sometimes you've got to let us work outside the box…it can hinder us in delivering the right, appropriate message that's going to resonate with our audience.

The slow release of new guidelines was particularly problematic when catering to the needs of populations with tobacco-related disparities. Partners felt that the guidelines did not promote the most effective or timely approaches for working with specific populations, therefore making the guidelines inapplicable to the populations with whom they worked.

> Some of what [evidence-based guidelines] recommend may not fit very well with the population that we work with.

"[Evidence-based guidelines] give you almost a sense of authority…so it's not speculation, it's not opinion, it's pretty hard core black and white proof."

Implementation

Which guidelines were critical for Arkansas' tobacco control partners?

Arkansas partners had a relatively low level of awareness of evidence-based guidelines. However, several guidelines were identified as critical resources when partners were asked to group guidelines into one of three categories: 1) *Critical* for their tobacco control efforts; 2) *Not critical, but useful* for their tobacco control efforts; and 3) *Not useful* for their tobacco control efforts. The following are the guidelines identified most frequently as critical resources for Arkansas partners.

Clinical Practice Guidelines: Treating Tobacco Use and Dependence

Although only half of the partners were aware of the *Clinical Practice Guidelines*, 75% of those partners ranked the guideline as a critical resource. The guide was primarily used by healthcare providers as a reference to guide their cessation treatment plans.

> We turn to [the *Clinical Practice Guidelines*] to see what else we can do differently in terms of groups, in terms of individual sessions, sometimes of tobacco therapies, and then of course in developing treatment plans. So we use this as an everyday reference.

Best Practices for Comprehensive Tobacco Control Programs

Every Arkansas partner was aware of *Best Practices*, and 73% ranked it as a critical resource for their tobacco control efforts. The guideline was primarily used as a general reference to inform program development and funding allocation. Partners aligned their efforts with the five categories outlined in *Best Practices*.

> We base our entire program around *Best Practices* and what it says that we should do. We realigned our whole program to match along...not just what they say we should do, but how they say we should do it.

Table 3: Percentage of Partners Who Identified Guideline as a Critical Resource

Guideline	% of Partners*
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	75%
Best Practices for Comprehensive Tobacco Control Programs	73%
Key Outcome Indicators for Evaluating Tobacco Control Programs	71%
Ending the Tobacco Problem: A Blueprint for the Nation	60%
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	50%
Best Practices User Guide Series	46%
The Guide to Community Preventive Services: Tobacco	43%
Introduction to Process Evaluation in Tobacco Use Prevention and Control	38%
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	33%
Designing and Implementing an Effective Counter-Marketing Campaign	30%
NACCHO 2010 Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs	25%
Tobacco Control Monograph Series	17%

* Based on partners who were aware of the guideline

Revisions to the CDC *Best Practices*

In 2007, *Best Practices* was revised. To find out how changes to the guideline were perceived, Arkansas partners were asked additional questions about *Best Practices*. Most partners were either not aware of the changes or were not familiar enough with the specific changes to comment. The few partners aware of the revisions mentioned that they did not perceive a significant difference in the content from the original 1999 *Best Practices* to the 2007 update.

> You open up the [1999 *Best Practices*] and [the components] are all there, and then you open up the [2007 *Best Practices*], and you think, "Well where's the difference?" So you combined it together, you changed the words, but I mean, what changed here?

> [The revisions were] sort of refreshing the brand, sort of an update because [the same components] were still immersed in there. . .so it was just a refreshment of the *Best Practices*.

Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs

The *Key Outcome Indicators* guide was identified as a critical resource for 71% of the partners familiar with the guideline. The guide was used to inform program objectives and determine appropriate outcome measures to evaluate progress towards those objectives.

> We use [the *Key Outcome Indicators*] to determine the objectives and goals that we select every single year.

> We have to be concerned about the outcomes. This is a part of the evaluation process. In other words, if you have a program and you don't know what the outcomes are, how are you going to get there?

What resources were used to address tobacco-related disparities?

Arkansas legislation stipulated that 15% of the funds designated to tobacco control be allocated to activities aimed at reducing tobacco consumption in minority populations. This funding was allocated in the form of community grants by the University of Arkansas at Pine Bluff (UAPB) Minority Initiative Sub-Recipient Grant Office. UAPB provided administrative oversight and direction to guide these grant-funded programs targeting minority populations in Arkansas.

> There is a Minority Initiative Sub-Recipient Grant Office which provides grants to minority communities in order to do CDC's *Best Practices*. . .So our 15% funding is allocated in order to do that outreach to the minority communities.

Partners who worked with populations with tobacco-related disparities determined which populations to focus on by utilizing data from the Adult Tobacco Survey, the Youth Tobacco Survey, and the Behavioral Risk Factor Surveillance System. Partners did not use *Best Practices* as a resource for working with populations with tobacco-related disparities due to the guide's lack of specificity regarding ways to address tobacco control for those populations.

> There's very little that's targeted in [*Best Practices*]. [Disparities is] a concept that's out there, but as far as best practices of what's working, there's very little.

What resources were used to communicate with policymakers?

Partners stressed the importance of sharing the results of their evidence-based activities with policymakers. Partners communicated directly with the legislative body and the governor's office. TPCP was evaluated every two years by an outside contractor regarding the progress of their funded programs. The results from these evaluations were shared during annual legislative reviews in the form of brief executive summaries. Partners also illustrated their program's effectiveness by sharing surveillance data from Quitline reports.

> We [communicate with our legislators] through a series of one-page update articles. They just want us to come in and update them during legislative session.

> Because we serve at the will of the governor, anything that we do policy related is approved basically through him.

Partners found it important to communicate information directly tied to the policymaker's constituency. Therefore, tobacco control advocates used specific Quitline data and personal stories from constituents within policymakers' districts to demonstrate the need for tobacco control funding.

> We did a special report that showed all of the participants over a one-year period by what House and Senate district they were from, so each one of the Representatives could see the direct involvement of their constituents with the Quitline.

> A lot of times [we share] dollars spent within our communities so that [policymakers] understand what's being done in their communities.

"[We are] always using *Best Practices* and evidence-based information in any of the things that we discuss [with policymakers]. As a public health agency, it's first and foremost that we present that information, that it is evidence-based."

What other resources were needed?

Partners outside of the lead agency expressed a need for more technical assistance and interaction with CDC staff. Furthermore, they stated that it would be particularly useful to have a CDC point of contact available to them at any time.

> I think the CDC might be more helpful if they could give us more resources on the ground, more people to help us in the state.

> [We] need two or three CDC fellows down here. [We] could really use them. Just get an army of people in here and just really charge this place up. That would be the single most [important] thing.

Arkansas partners also wanted information available on other states' initiatives and their outcomes. Partners stated that they could learn from other state program's challenges and successes just as other state programs could learn from them. Partners felt that exchange of this information located in an easily accessible venue would enhance their efforts.

"What's happening with the states right around us?" [Knowing] that is a big help when you're looking to draw up policy, and that's always the question, "What's going on around us?" I'd really like to see a little bit more on that.

Maintain a database or something on the outreach efforts of different tobacco programs. It's hard every year to think of something new, and maybe another state is doing that, or maybe we've got some proven programs here that reaches the youth with a prevention message that another state might want. Because we've got a couple of programs here that we've had huge success with that I'm more than willing to share with other states.

Conclusions

The use of evidence-based guidelines was perceived as an important part of the Arkansas tobacco control program and provided a foundation for partners' tobacco control efforts. Guidelines were used for program development, outcome tracking and communication with policymakers. Other factors that contributed to the adoption of evidence-based guidelines in Arkansas included:

- Partners felt that guidelines provided justification for their efforts when communicating with policymakers.
- Partners found *Best Practices*' five categories useful and aligned their program components with them.
- TPCP played a central role in Arkansas' tobacco control efforts by connecting partners who looked to them for direction and guidance. TPCP used evidence-based guidelines and partners followed their lead by implementing them in their work as well.

Despite the importance of guidelines for partners, several challenges identified with guideline use included:

- Guidelines lacked information on how to address populations with tobacco-related disparities.
- The lag time between research and new guideline development was too long.
- Strict adherence to evidence-based guidelines was thought to hamper creativity and flexibility in programming.

An abundance of information is available to inform the work of those involved in tobacco control. In Arkansas, recommendations from evidence-based guidelines, organizational direction and capacity, and input from partners played an important role in guiding tobacco control efforts. The degree to which particular evidence-based guidelines were incorporated into partners' work was dependent upon factors tied to three main phases of information diffusion highlighted throughout this report: dissemination, adoption, and implementation. Such factors included avenues of guideline dissemination to stakeholders, presence or absence of support by other individuals or policies, and the feasibility of applying that information into one's work. Arkansas partners found the release of new evidence-based guidelines to be a lengthy process, making it difficult to adhere to them as they were not the timeliest and most applicable approaches to certain populations. Partners suggested that information on other states' initiatives and their outcomes be located in a easily accessible and continually updated venue. Taking these factors into consideration when developing and releasing a new guideline will help to optimize use of the guideline by intended stakeholders.

The Colorado Profile:

Prioritizing funding and integration

Use of Evidence-based Guidelines in State Tobacco Control Programs

Prepared by
The Center for Tobacco Policy Research at
Washington University in St. Louis

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Introduction

There has been a significant amount of research done on what works to curb tobacco use. Many agree that the evidence base for tobacco control is one of the most developed in the field of public health. However, the advancement in the knowledge base is only effective if that information reaches those who work to reduce tobacco consumption. Evidence-based guidelines, such as the Centers for Disease Control and Prevention's *Best Practices Guidelines for Comprehensive Tobacco Control Programs* (*Best Practices*), are a key source of this information. However, how these guidelines are utilized can significantly vary across states.

This profile presents findings from an evaluation conducted by the Center for Tobacco Policy Research at Washington University in St. Louis that aimed to understand how evidence-based guidelines were disseminated, adopted, and used within state tobacco control programs. Colorado served as the fifth case study in this evaluation. The project goals were two-fold:

- Understand how Colorado partners used evidence-based guidelines to inform their programs, policies, and practices;
- Produce and disseminate findings and lessons from Colorado and other states so that readers can apply the information to their work in tobacco control.

Findings from Colorado

The following are highlights from Colorado's profile. Please refer to the complete report for more detail on the topics presented below.

- Evidence-based guidelines were generally thought to provide the foundation for the program and were used as an advocacy tool.
- The Colorado Department of Public Health and Environment (CDPHE) served as a primary source for guideline dissemination.
- The integration of Colorado's tobacco grant program and staff with other chronic disease efforts enhanced partners' decision-making by providing new perspectives from individuals outside of tobacco control.
- Every Colorado partner was aware of the CDC's *Best Practices* and primarily used the guideline to advocate for funding from policymakers and develop strategic plans.
- Despite the acknowledged importance of evidence-based guidelines, some challenges were identified with utilizing them.
  - Due to significant budget cuts, CDPHE could not fund all of *Best Practices*' recommended categories.
  - Evidence-based guidelines lacked sufficient information on how to effectively address populations with tobacco-related disparities.
- Colorado partners emphasized the need for further direction and guidance from the CDC, such as:
  - Guidance on how to strengthen the organizational aspects of the process of integrating the tobacco grant program with other chronic disease initiatives; and,
  - Guidance on community-based initiatives, specifically additional data and strategies for more local level efforts.

Introduction

Project overview

States often struggle with limited financial and staffing resources to combat the burden of disease from tobacco use. Therefore, it is imperative that efforts that produce the greatest return on investment are implemented. There has been little research on how evidence-based interventions are disseminated and utilized by state tobacco control programs. To begin to answer this question, the Center for Tobacco Policy Research at Washington University in St. Louis conducted a multi-year evaluation in partnership with the CDC Office on Smoking and Health (CDC OSH). The aim of this project was to examine how states used the CDC's *Best Practices for Comprehensive Tobacco Control Programs* (*Best Practices*) and other evidence-based guidelines for their tobacco control efforts and to identify opportunities that encouraged guideline use.

Qualitative and quantitative data from key partners in eight states were collected during the project period. States were selected based on several criteria, including funding level, lead agency structure, geographic location, and reported use of evidence-based guidelines. Information about each state's tobacco control program was obtained in several ways, including: 1) a survey completed by the state program's lead agency; and 2) key informant interviews with approximately 20 tobacco control partners in each state.

State profiles

This profile is part of a series of profiles that aims to provide readers with a picture of how states accessed and utilized evidence-based guidelines. This profile presents data collected in June 2010 from Colorado partners. The profile is organized into the following sections:

- **Program Overview –** provides background information on Colorado's tobacco control program.
- **Evidence-based Guidelines –** presents the guidelines we asked about and a framework for assessing guideline use.
- **Dissemination –** discusses how Colorado partners learned of new guidelines and their awareness of specific tobacco control guidelines.
- **Adoption Factors –** presents factors that influenced Colorado partners' decisions about their tobacco control efforts, including use of guidelines.
- **Implementation –** provides information on the critical guidelines for Colorado partners and the resources they utilized for addressing tobacco-related disparities and in communication with policymakers.
- **Conclusions –** summarizes the key factors that influenced use of guidelines based on themes presented in the profile and current research.

Quotes from participants (offset in green) were chosen to be representative examples of broader findings and provide the reader with additional detail. To protect participants' confidentiality, all identifying phrases or remarks have been removed.

Program Overview

Colorado's tobacco control program

Colorado's tobacco grant program, the Colorado Department of Public Health and Environment (CDPHE), functioned as the lead agency for Colorado's tobacco control efforts. Formerly known as the State Tobacco Education and Prevention Partnership (STEPP), the program was supported by funds from Amendment 35, a tobacco excise tax increase passed by a statewide ballot initiative in 2004. Sixteen percent of the tobacco tax revenue was allocated to tobacco control efforts. The 2004 ballot initiative also established the Tobacco Education, Prevention and Cessation Grant Program Review Committee (Review Committee) to oversee the program, ensure compliance with state legislation, and formulate grant funding recommendations.

Colorado was one of four chronic disease integration pilot projects funded by the CDC. CDPHE was chosen to be a part of the CDC pilot in 2008, although they had already begun the integration process on their own in 2006. The process included consolidating staff and creating the Center for Healthy Living and Chronic Disease Prevention. The Center for Healthy Living and Chronic Disease Prevention had developed an integrated work plan and was undergoing reorganization efforts, which included integrating the tobacco grant program and staff with other chronic disease efforts. Lead agency staff noted that the most important outcomes thus far from integration were centralizing functional aspects, such as policy expertise, and developing cross-cutting programs (e.g., environmental change, physical activity, nutrition). These changes were implemented in order to improve overall health outcomes by providing a more comprehensive approach to serving populations with the greatest burden of chronic disease, including tobacco-related illness.

Colorado's program incurred significant funding cuts in FY2010. In response to economic crises, the state legislature passed a bill that decreased CDPHE's budget by $8 million and Governor Ritter passed an executive order that reduced the budget by another $7 million. Consequently, the program's budget dropped from $27.5 million in FY2009 to $12.4 million in FY2010, meeting only 22.8% of the amount recommended by the CDC for a comprehensive tobacco control program in Colorado. CDPHE, which had been seen as a leader in the tobacco control movement, was thus forced to discontinue or cut back on many of the prevention and cessation projects it funded.

Colorado's tobacco control partners

Colorado's tobacco control efforts involved a variety of partners. Partners included health voluntaries, evaluators, other state agencies, a marketing agency, and national organizations. Some partners also had secondary roles as members of the Review Committee. Twenty individuals from 15 organizations were identified as a sample of key members of Colorado's tobacco control network. The majority of Colorado partners had extensive experience in tobacco control, averaging nine years of involvement. Many partners worked under the broader auspices of chronic disease and tobacco control was one of several areas they addressed. Table 1 presents the list of partners who participated in the interviews.

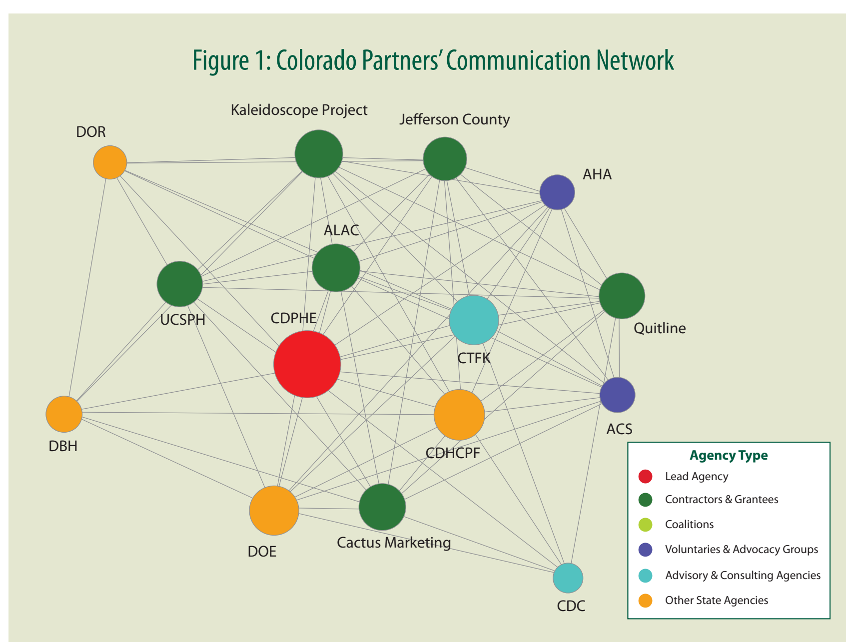
Table 1: Colorado Tobacco Control Partners

Agency	Abbreviation	Agency Type
Colorado Department of Public Health & Environment	CDPHE	Lead Agency
Cactus Marketing Communication	Cactus Marketing	Contractors & Grantees
National Jewish Health	Quitline	Contractors & Grantees
University of Colorado School of Public Health, Surveillance & Evaluation	UCSPH	Contractors & Grantees
American Lung Association of Colorado	ALAC	Contractors & Grantees
Jefferson County Public Health Department	Jefferson County	Contractors & Grantees
The Kaleidoscope Project	Kaleidoscope	Contractors & Grantees
American Heart Association	AHA	Voluntaries & Advocacy Groups
American Cancer Society, Great West Division	ACS	Voluntaries & Advocacy Groups
Colorado Department of Human Services, Division of Behavioral Health	DBH	Other State Agencies
Department of Revenue	DOR	Other State Agencies
Department of Education, Coordinated School Health	DOE	Other State Agencies
Colorado Department of Health Care Policy & Financing	CDHCPF	Other State Agencies
Campaign for Tobacco Free Kids	CTFK	Advisory & Consulting Agencies
Centers for Disease Control & Prevention	CDC	Advisory & Consulting Agencies

Communication between Colorado partners

To gain a better sense of partners' relationships in Colorado, partners were asked about their interaction with other tobacco control organizations. Partners were asked how often they had direct contact (e.g., meetings, phone calls, or e-mails) with other partners within their network in the past year. In the figure to the right, a line connects two partners if they had contact with each other on more than a quarterly basis. The size of the node (dot representing each agency) indicates the amount of influence a partner had over contact in the network. An

Figure 1: Colorado Partners' Communication Network

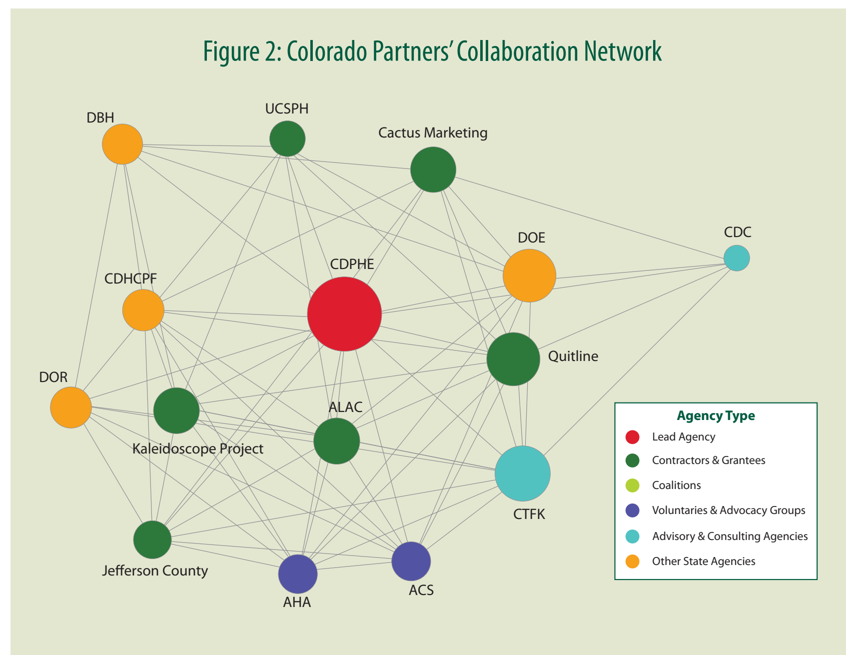


example of having more influence, or a larger node, was seen between Kaleidoscope Project, CDPHE, and Cactus Marketing. Kaleidoscope Project did not have direct contact with Cactus Marketing, but both had contact with CDPHE. As a result, CDPHE acted as a bridge between the two and thus, had more influence within the network. Communication within Colorado displayed a relatively decentralized structure among partners in which network members had contact with many agencies and did not rely on one main agency to facilitate communication.

Collaboration between Colorado partners

Partners were also asked to indicate their working relationship with each partner with whom they communicated. Relationships could range from not working together at all to working together as a formal team on multiple projects. A link between two partners indicates that they at least worked together informally to achieve common goals. Partners were not linked if they did not work together or only shared information. Node size is based on the amount of influence a partner had over collaboration in the network. A partner was considered influential if he or she connected partners who did not work directly with each other. For example, ACS and UCSPH did not work directly with one other, but both worked with Quitline. Quitline acted as a "broker" between the two agencies, and, as a result, is represented by a larger node. CDPHE had the most influence over collaboration among partners as demonstrated by its larger node size. This confirms its role as the lead agency for Colorado's tobacco control efforts and indicates it had working relationships with many partners in the state.

Figure 2: Colorado Partners' Collaboration Network



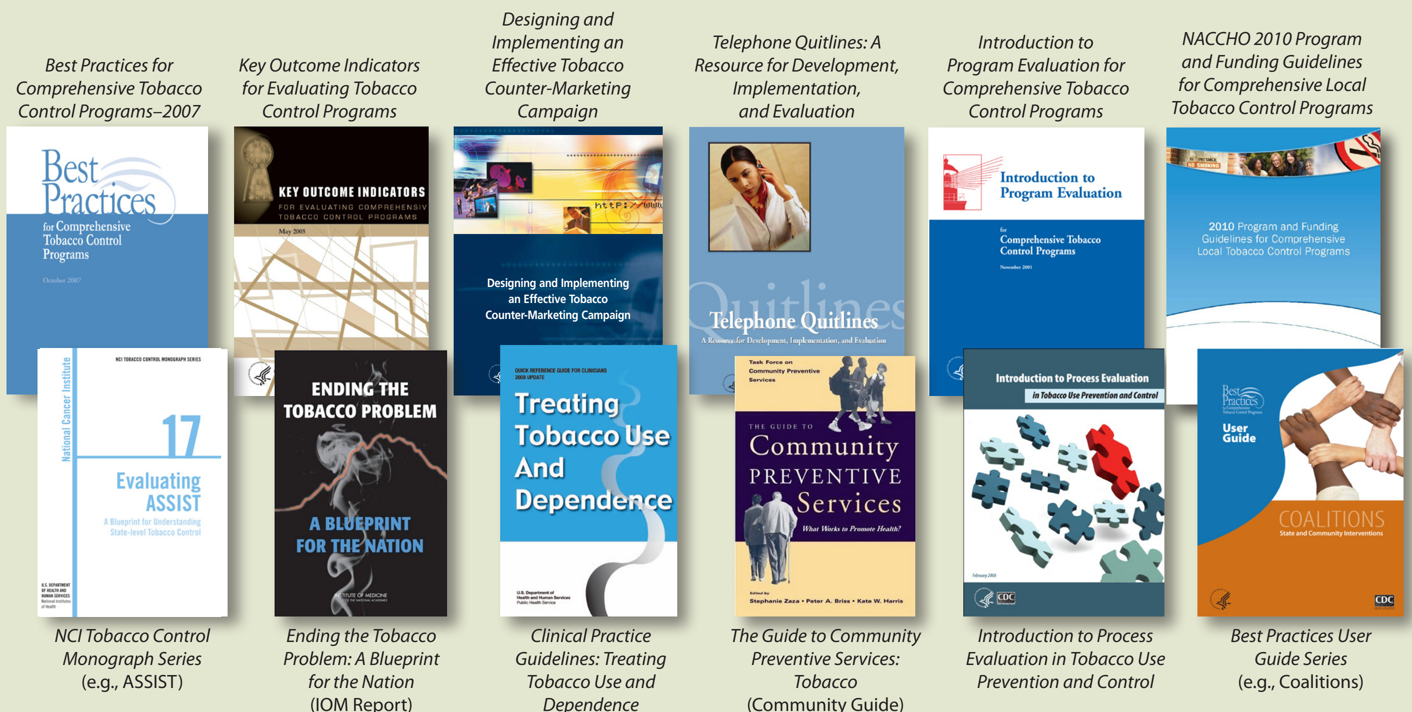
Evidence-based Guidelines

There are a number of evidence-based guidelines for tobacco control, ranging from specific strategies to broad frameworks. Below in Figure 3 are the set of specific guidelines partners were asked about during their interviews.

Partners also had the opportunity to identify additional guidelines or information they used to guide their work. Other resources identified by Colorado partners included:

- Surgeon General's reports;
- Guidelines produced by the Joint Commission on the Accreditation of Healthcare Organizations;
- Curriculum recommendations from the U.S. Department of Education's Office of Safe and Drug-Free Schools;
- National Cancer Institute State of the Science reports;
- Information from the Substance Abuse and Mental Health Services Administration; and,
- Resources developed by Colorado State University.

Figure 3: Evidence-based Guidelines for Tobacco Control



Research has shown that the use of evidence-based practices, such as those identified in these guidelines, results in reductions in tobacco use and subsequent improvements in population health. Whether an individual or organization implemented evidence-based practices depended on a number of factors, including capacity, support, and available information. The remainder of this report will look at how evidence-based guidelines fit into this equation for Colorado. The framework below will guide the discussion, specifically looking at which guidelines Colorado partners were aware of, which ones were critical to partners' efforts, and how guidelines were used in their work.

Figure 4: Framework for Use of Evidence-based Guidelines

Dissemination

How did partners define "evidence-based guidelines"?

Colorado partners were asked to describe what came to mind when they heard the term "evidence-based guidelines." Many partners listed titles of specific guidelines, most often those produced by the CDC. Additionally, partners defined evidence-based guidelines as practices or interventions that had been proven to work based on research and evaluation by credible organizations.

> [Evidence-based guidelines] are things that have been tested in the field that again, we know make a difference, and so those are the things that I tend to prioritize and support more.

> [Evidence-based guidelines] are recommendations from expert groups who have reviewed all of the available evidence that relates to the specific topic being guided.

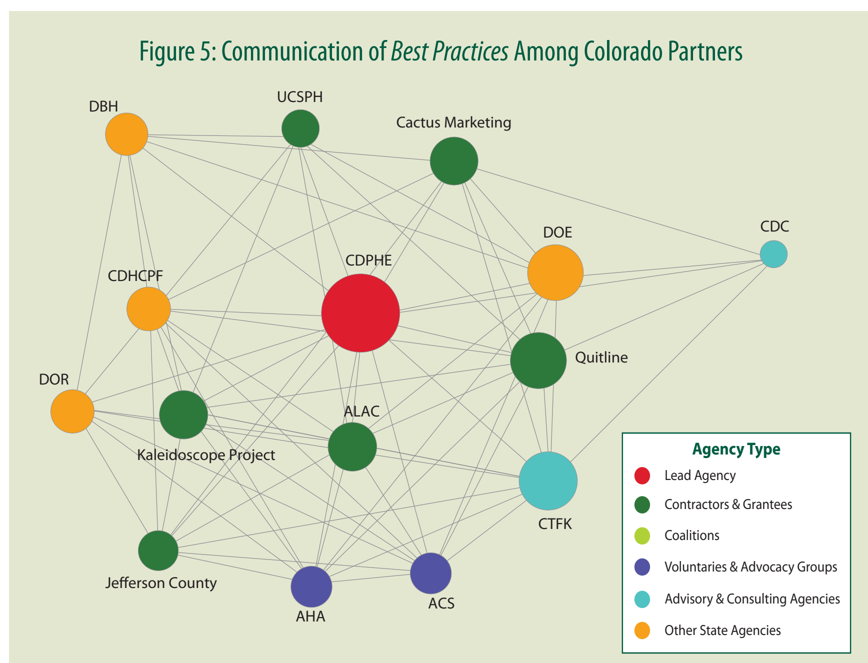
How did partners learn of evidence-based guidelines?

Partners were made aware of new guidelines through meetings, trainings, and conferences at both the state and national level. Within the state, CDPHE was most often cited as an important source for dissemination of evidence-based guidelines. Information was most frequently distributed via electronic communication and internal staff meetings. National contacts, particularly at the CDC, were mentioned as additional resources for evidence-based guideline dissemination.

> We get the announcements from CDC and others that [evidence-based guidelines] are coming out. CDC tends to keep us in the loop as far as what is coming.

To gain a better understanding of communication about evidence-based guidelines, Colorado partners were asked whom they talked to about CDC's *Best Practices*. In Figure 5, a line connecting two partners indicates they talked about *Best Practices* with one another. The size of the node reflects the number of agencies each partner communicated with about the guideline. For example, CDPHE most often talked with other agencies about *Best Practices*, resulting in the largest node size. This falls in line with CDPHE frequently being identified by partners as a source for guideline dissemination.

Figure 5: Communication of *Best Practices* Among Colorado Partners



What tobacco control guidelines were partners aware of?

Best Practices was the most well-known guideline in Colorado. All of the partners interviewed recalled at least hearing of *Best Practices*. Most partners referenced *Best Practices* frequently and all partners had referenced the guide within the past year. At least half of the partners were aware of the remaining guidelines, with the exception of *Introduction to Process Evaluation in Tobacco Use Prevention and Control*.

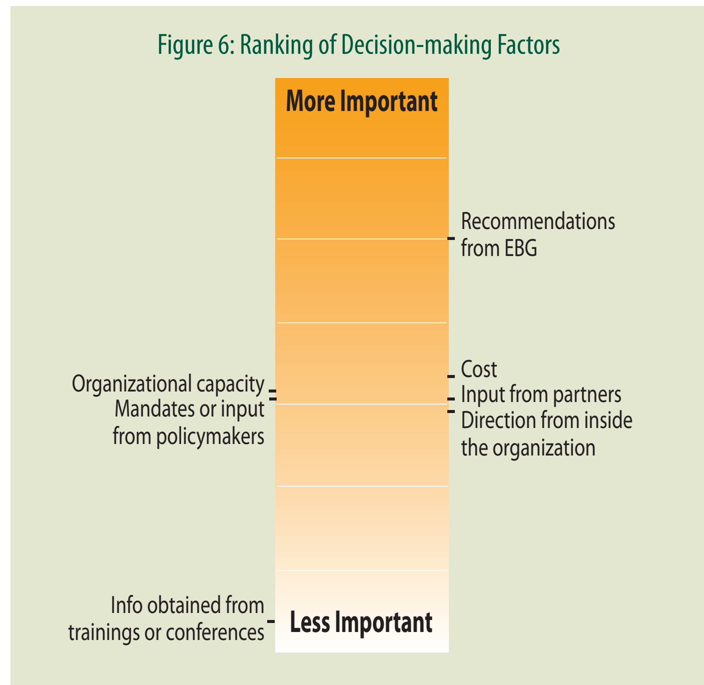
Table 2: Number of Partners Aware of Tobacco Control Guidelines

Guideline	# of Partners
Best Practices for Comprehensive Tobacco Control Programs	20/20
Tobacco Control Monograph Series	16/20
The Guide to Community Preventive Services: Tobacco	15/20
Designing and Implementing an Effective Tobacco Counter-Marketing Campaign	15/20
NACCHO 2010 Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs	15/20
Ending the Tobacco Problem: A Blueprint for the Nation	14/20
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	14/20
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	13/20
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	13/20
Best Practices User Guide Series	11/20
Key Outcome Indicators for Evaluating Tobacco Control Programs	10/20
Introduction to Process Evaluation in Tobacco Use Prevention and Control	9/20

Adoption Factors

What did partners take into consideration when making decisions about their tobacco control efforts?

Many factors were taken into consideration by Colorado partners when making decisions about their tobacco control efforts. When asked to rank several factors in their importance for making decisions about their tobacco control efforts, 60% of partners ranked recommendations from evidence-based guidelines as the most important factor; 85% ranked it in their top three. Guidelines, particularly *Best Practices*, provided a foundation and justification for partners' specific interventions.



> Where we start is *Best Practices* and the things that are handed down by CDC.

> [Evidence-based guidelines] give you a foundation from which to begin to have the conversations about what you should be doing and really focusing on what works.

Cost and organizational capacity, perceived to be inextricably linked, also played an important role in partners' decision-making. In order to effectively implement programs, partners needed sufficient funding as well as appropriate staff capacity. Partners also noted that due to the recent budget constraints, cost had become increasingly more important in their decision-making process.

> Cost and organizational capacity [are important] because you have to have capacity and a certain amount of funding in order to make progress.

> The truth is, right now cost is probably number one because we entered this fiscal crisis. But three years ago when we were planning the program according to how it was originally created to be funded, cost was something we were aware of, but it probably was not number one.

Additionally, partners valued input from their partners and relied on them as resources when making decisions. Partners stated that in order to accomplish their goals, it was important to engage partners and establish consensus.

> If you don't really know where your partners are coming from, then it's really hard to get anywhere...if you're not on the same page, it's not going to happen.

> [Partners] are going to have to help us implement the program, or the guidelines, or the policy, and so they must be engaged.

How did organizational characteristics influence partners' decisions about their tobacco control efforts?

Colorado partners felt that their leadership was supportive, innovative, and knowledgeable. These leadership characteristics helped to facilitate partners' decision-making efforts.

> We have an excellent mix of leadership in our organization of folks that are really well read and confident of what works out there, and who are willing to take some risks.

> The Department of Public Health has really supported me over the past two years...they really supported me and encouraged me to just do what I said I was going to do, and they've never stopped supporting me in my work.

"I think the integration [of the tobacco grant program with chronic disease] is a big driver in terms of innovation and creativity."

Partners also found that a creative culture facilitated their decision-making. In order to accomplish their goals, partners oftentimes had to come up with innovative ideas for their implementation efforts. Partners pointed out that the tobacco program's integration with chronic disease enhanced innovation by providing new perspectives from individuals outside of tobacco control.

> The beauty of integration [is] having the different disciplines working together in a unit...it allows people to think outside of their stovepipes a lot more, and I think simply because of that, it increases the possibility of new ideas, or the possibility of the permutations of new ideas than when you're just sort of thinking how you usually think.

Some lead agency staff mentioned having dual roles by acting as sitting members on the Review Committee, in addition to their CDPHE position. These partners ultimately had to review themselves, therefore challenging the ability of members to be open and honest. Partners found that a culture built on trust and open communication facilitated their decision-making. When this was inhibited, it was difficult for partners to move forward with their tobacco control efforts.

> We have a novel, probably unusual structure in our review committee in that the program staff members actually sit as members of the review committee as well. So in effect, they are asked to review themselves, and that's been awkward. It took several years of heavy lifting to reach a point where we were satisfied that we had worked through the issues and could trust each other and could rely on each other to act as independent thinking members rather than one side against the other.

What facilitated or hindered use of evidence-based guidelines?

Most partners found value in evidence-based guidelines because they promoted proven practices and provided a foundation to support their efforts. Additionally, partners noted that evidence-based guidelines provided strong parameters that helped prioritize their efforts.

> You have a reference point, or you have a foundation to build from, and you can set limits on what you fund and what you don't fund.

Furthermore, partners found evidence-based guidelines to be a useful tool in facilitating communication with policymakers. Partners stated that because evidence-based guidelines described approaches that were proven to work, they could confidently rely on them to defend their efforts.

> I think [evidence-based guidelines] give us a very useful tool in which to guide not only advocacy efforts, but then inform legislators in a very believable way.

> [Evidence-based guidelines] give you something tangible, that have been proven to work, [and] we can actually model and get results from [them]. So there's no doubt; there's no wavering. [They are] a strong foundation for you to promote what it is that you're doing.

Although the guidelines, particularly Best Practices, did provide direction on what areas to fund, CDPHE noted that they could not fund all of the recommended components due to budget cuts. Grantees and community partners expected their programs to remain funded in order to maintain Best Practices' recommendations for a comprehensive program even when the state experienced significant funding cuts. It was very difficult to prioritize where funding should be allocated, when Colorado did not have CDC's recommended level of funding.

> "The biggest challenges are that we can't do everything [*Best Practices*] tells us to do because we don't have the budget to do it, so we really have to pick and choose wisely. We have to prioritize."

> I think the challenges are how these documents are interpreted by others, and I would say *Best Practices* is the one that has been the most challenging, because given our limited resources, the expectations from grantees and community partners are, "Well, you should have a comprehensive tobacco control program, so you should still be funding all of these pieces, because it says so in the *Best Practices*, and that's what comprehensive tobacco control programming is."

Additionally, partners felt that evidence-based guidelines did not provide sufficient information on effective strategies for working with populations with tobacco-related disparities. The lack of specific direction created difficulties in determining how to apply the guidelines to populations with tobacco-related disparities.

> I think the challenge is not knowing for sure if that evidence-based practice really works in segments of the community.

> [Evidence-based guidelines] aren't as proven within disparate populations and you want a companion piece to go with it to show what the effective strategies are to address tobacco in those populations.

Implementation

Which guidelines were critical for Colorado's tobacco control partners?

Colorado partners were aware of a number of evidence-based guidelines and reports. However, several guidelines were identified as critical resources when partners were asked to group guidelines into one of three categories: 1) *Critical* for their tobacco control efforts; 2) *Not critical, but useful* for their tobacco control efforts; and 3) *Not useful* for their tobacco control efforts. The following are the guidelines identified most frequently as critical resources for Colorado partners.

Best Practices for Comprehensive Tobacco Control Programs

All Colorado partners were aware of the CDC's *Best Practices*, and 80% identified it as a critical resource for their tobacco control efforts. Partners most often used *Best Practices'* funding recommendations to advocate for more funding. Some partners also referred to *Best Practices* for strategic planning.

When we're looking at putting together work plans and looking at how we should be moving forward [we refer to *Best Practices*].

I would say [*Best Practices*] is very helpful for advocacy purposes too. So anytime we're updating what the program is doing, and also with budget reductions, we can refer to *Best Practices* and say, "Colorado receives this much money, but for us to have a comprehensive tobacco control program with the greatest impact, we would need $54 million."

Table 3: Percentage of Partners Who Identified Guideline as a Critical Resource

Guideline	% of Partners*
Best Practices for Comprehensive Tobacco Control Programs	80%
The Guide to Community Preventive Services: Tobacco	80%
Key Outcome Indicators for Evaluating Tobacco Control Programs	73%
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	69%
Ending the Tobacco Problem: A Blueprint for the Nation	57%
NACCHO 2010 Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs	44%
Designing and Implementing an Effective Counter-Marketing Campaign	40%
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	36%
Best Practices User Guide Series	36%
Introduction to Process Evaluation in Tobacco Use Prevention and Control	33%
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	31%
Tobacco Control Monograph Series	27%

* Based on partners who were aware of the guideline

Revisions to the CDC *Best Practices*

In 2007, *Best Practices* was revised. To find out how these changes were perceived, Colorado partners were asked additional questions about *Best Practices*. Most partners were aware of the 1999 version and the specific changes that were made. Partners found that the revised *Best Practices* provided a clearer description of a fully funded program. Partners noted that by taking into account state demographics, the updated funding recommendations were more state-specific. In addition, many felt the consolidation of categories in the 2007 version increased comprehension, particularly how communities fit into the overall statewide efforts.

> I appreciated that they combined the state and community interventions together. I think in the past we've done our work based on sectors and segmented out communities, and I thought it helped to pull communities back together.

> I think [the 2007 *Best Practices*] did a better job of defining what a fully funded program looks like…I think before it was more of a generic formula. This time they really took into consideration the specifics of the demographic and the amounts they were recommending for each state in order to be fully funded.

The Guide to Community Preventive Services: Tobacco

Of those partners aware of *The Guide to Community Preventive Services*, or the "*Community Guide*", 80% identified it as a critical resource. The *Community Guide* served as an important resource for partners when prioritizing services, particularly during budget shortfalls. Partners also felt the *Community Guide* was critical due to its provision of evidence-based interventions not only for tobacco, but also other public health areas. As such, the guideline aligned well with Colorado's focus on integrating with chronic disease.

> When we got funding cut and we had to prioritize what we called core services, the *Community Guide* was…probably the main ranking criteria. So if it was in here as a best practice, then we designated it as a core service.

> This is the core evidence base of work we should be doing. And now we're not only doing it in tobacco, but we're doing it in physical activity and nutrition, and all of our other programming too. It's really a key source for us.

Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs

Of those aware of the *Key Outcome Indicators*, 73% rated it as critical to their work. Partners used this guideline for evaluation work, particularly when developing logic models, designing surveys, and preparing work plans.

> In order to build a program, I went [to the *Key Outcome Indicators*] for the logic model for secondhand smoke programs and youth programs and made sure that we're designing our programs so that we're getting the short-term changes and the long-term impact.

Clinical Practice Guidelines: Treating Tobacco Use and Dependence

Sixty-nine percent of Colorado partners aware of the *Clinical Practice Guidelines* cited it as a critical resource. The guideline was used to direct partners' cessation efforts. Specifically, it served as justification for requiring insurance companies to cover cessation treatments and for determining Quitline cessation counseling methods.

> We just passed legislation that's requiring coverage for preventive benefits. . . So when [the *Clinical Practice Guidelines*] get updated, then the insurance companies have to comply with the updates. So they're a great foundation for doing the policy work.

> [We have used the *Clinical Practice Guidelines* when] working and contracting with our Quitline provider and what kinds of things are in there determined what we should be doing.

Ending the Tobacco Problem: A Blueprint for the Nation

Of the partners aware of the Institute of Medicine's *Ending the Tobacco Problem: A Blueprint for the Nation* (*IOM Report*), 57% ranked it as a critical resource for their tobacco control efforts. Partners utilized this guideline for funding allocation recommendations, writing grant proposals, and working with coalitions and policymakers.

> [The *IOM Report* is helpful when] informing legislators and committees. When we're testifying we make reference a lot, or I do, to the *IOM Report*, making sure legislators are familiar with it, they know the research behind it and the messages that are in it. So I use this a lot with legislators.

"I've used [CDPHE], and not just documents, but people at [CDPHE] for resources, particularly in areas that were very, very gray areas for me. I've had lots of support from the program manager that's working in health disparities."

What resources were used to address tobacco-related disparities?

Colorado partners primarily used statewide surveillance data, such as the Tobacco Attitudes and Behavior Survey (TABS) and the Behavioral Risk Factor Surveillance System (BRFSS), to identify populations with tobacco-related disparities.

> [We look] at the information we have from surveys, BRFSS data, of who the smokers are in the state and how do we focus on them.

Partners looked to their colleagues, individuals in the community, and experts on populations with tobacco-related disparities to provide knowledge and direction for addressing disparities. CDPHE and the Tobacco Disparities Advisory Committee (TDAC) served as resources for partners by providing information on ways to address tobacco-related disparities.

> We have a couple of staff members who are very, very knowledgeable in who the resources are in terms of people across the state, what resources are online and in books, so I'd say they'd be my first stop if I wanted to know something.

> I've gone to several [TDAC] meetings where our grantees are all working on disparities efforts so there's a grantee who is working with the LGBT community, one who's working to look at strategies for low SES and so on and so forth, so TDAC serves as a forum for connecting with those grantees.

Some partners had referenced guidelines, such as *Best Practices*, in their work with populations with tobacco-related disparities. Partners typically used *Best Practices* for general guidance, but felt that it lacked specific strategies for sub-populations. Partners noted that they were aware of the populations with tobacco-related disparities in Colorado, but had not been successful in changing their tobacco-related behaviors. Therefore, partners suggested using focus groups to obtain more in-depth information on those populations that had not been affected by traditional interventions.

> It's a wish…it really is a wish that we get further study, or evidence-based practices, just to see how effective they are in some of these sub-populations.

> I think the best way for us to approach [disparities] is having individuals [from] those populations [participate in] focus groups, larger study areas that look at those groups, and providing information right here in the state.

What resources were used to communicate with policymakers?

CDPHE staff did not have direct communication with policymakers. Instead, they communicated information through legislative liaisons. However, two legislators sat on the Review Committee, which gave some CDPHE staff the opportunity to work directly with policymakers. Partners wanted to illustrate their program's effectiveness, particularly when budgets were limited. Evidence-based guidelines and data, such as information from *Best Practices* and surveillance data, were shared with the legislators on the Review Committee.

> We have the senate majority leader on our Review Committee. Now the department has a policy that we can't talk directly with legislators, or legislative officials unless it goes through the department, but since he's on the Review Committee, we can have direct access to him, so it's a unique situation, and it's good to have him in that role.

> "So [because of] the budget reductions, we got a lot of calls from the budget office, and we tried to focus on the impact and the effectiveness of the program. *Best Practices* and a lot of surveillance evaluation data [were used as references]."

Colorado's coalitions and advocacy groups were able to have direct communication with policymakers and often shared specific data from their community. TABS and the Youth Risk Behavior Survey (YRBS) provided much of this data. Partners found that translating data on a local level (e.g., the impact of tobacco taxes for legislators' communities) was most relevant to policymakers. Partners also shared predictions for Colorado based on comparisons to other states to illustrate the possible ramifications of cutting CDPHE's budget. Emphasis was placed on national rankings, program funding, use rates, and expected cost to the policymakers' constituencies.

> We talk about money to their counties, the vote of Amendment 35 Tobacco Tax, youth rates, what exactly is happening in their community.

> We do a lot of national ranking just to share with legislators how far they've dropped, and if they consider another budget cut, how much further they would drop, and what they could anticipate in terms of increased rates with youth and adults as a result of those cuts.

What other resources were needed?

Colorado partners expressed the need for additional data and strategies for working at the local level. Partners also wanted information available regarding other states' initiatives and their outcomes. Partners felt that having this information continually updated and located in an easily accessible and user-friendly venue would benefit their efforts.

> Help with getting lower level data, like sub-county data on tobacco utilization...help with letting us get to drill down because we realize we need to do more community-based efforts as opposed to statewide efforts to really get to the problem.

> A much more dynamic way for states to share insights, content, campaigns, information, that's more user-friendly, more dynamic, more coordinated.

Additionally, Colorado partners expressed their concern that local public health agencies were not as valued by legislators as in previous years. There was a fear that grantees' funding would be cut due to budget cuts to CDPHE. Partners felt that they should receive continued support from the state because of their record in achieving significant positive impacts in tobacco control.

> You may hear some people with some confusion and frustration about the value of local public health… And so it's been kind of the sense that we're not as valued as many of us feel we should be in terms of the inroads we've made in tobacco control work. So it's been a little bit of a trying time I think for a lot of us in local health and in tobacco control…largely due to the economic duress that our state is in.

Partners recognized that due to budget cuts, an increased emphasis needed to be placed on efficiency, most notably through strengthening integration of the tobacco grant program with other chronic disease initiatives. However, partners felt that frequent CDC project officer turnover hindered their ability to smoothly implement this process. Partners felt that more communication with CDC would clarify how to integrate tobacco control with chronic disease.

> [We need] to integrate with other efforts, particularly in resource challenged times. If we're really looking at utilization of our resources, [then] multiple efforts working together rather than singularly [makes the most sense].

> There has been a lot of changing of the guards within CDC. I don't have direct contact, but with the whole integration effort of being one of four states that's on this journey to integrate…I feel like there's not absolute clarity about how tobacco control fits in with chronic disease.

Conclusions

Evidence-based guidelines played an important role in Colorado's tobacco control efforts. Colorado partners were aware of a number of guidelines and primarily looked to their recommendations when making decisions about their tobacco control efforts. Because partners perceived evidence-based guidelines' recommendations as proven to work, they relied on them to develop their work plans and defend their efforts. Additional factors that contributed to the adoption of evidence-based guidelines included:

- CDPHE served as a primary resource for evidence-based guideline dissemination.
- Evidence-based guidelines came from reputable sources, which provided credibility to efforts and helped partners justify their work to policymakers.
- *Best Practices* provided a framework for a comprehensive program and was used by partners to advocate for funding from policymakers and develop strategic plans.
- The *Community Guide* provided partners with examples of proven community health interventions for tobacco control and other public health areas, which helped guide their integration efforts.

Although evidence-based guidelines were mainly perceived as beneficial, partners noted some hindrances to guideline use:

- As the state was experiencing significant budget cuts, partners found it difficult to have a truly comprehensive program as defined by *Best Practices* and, therefore, struggled with determining how to prioritize funding allocation.
- Evidence-based guidelines lacked strategies on how to address specific populations with tobacco-related disparities.

An abundance of information is available to inform the work of those involved in tobacco control. Colorado partners utilized evidence-based guidelines and other resources such as the CDC, the Tobacco Review Committee, and internal and national data to aid in their tobacco control efforts. The degree to which particular evidence-based guidelines were incorporated into partners' work was dependent upon factors tied to three main phases of information diffusion highlighted throughout this report: dissemination, adoption, and implementation. Such factors included avenues of guideline dissemination to stakeholders, presence or absence of support by other individuals or policies, and the feasibility of applying that information to one's work. Colorado partners expressed a need for reliable direction and guidance to help overcome the continual challenges faced by tobacco control programs, such as prioritizing funding allocation during budget shortfalls and integration of tobacco control with other initiatives. Taking these factors into consideration when developing and releasing a new guideline will help to optimize use of the guideline by intended stakeholders.

The **Florida** Profile:

Mandating the Best Practices

Use of Evidence-based Guidelines in State Tobacco Control Programs

Prepared by
The Center for Tobacco Policy Research at
Washington University in St. Louis

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Executive Summary

Introduction

There has been a significant amount of research done on what works to curb tobacco use. Many agree that the evidence-base for tobacco control is one of the most developed in the field of public health. However, the advancement in the knowledge base is only effective if that information reaches those who work to reduce tobacco consumption. Evidence-based guidelines, such as the Centers for Disease Control and Prevention's *Best Practices Guidelines for Comprehensive Tobacco Control Programs* (*Best Practices*), are a key source of this information. However, how these guidelines are utilized can vary significantly across states.

This profile presents findings from an evaluation conducted by the Center for Tobacco Policy Research at Washington University in St. Louis that aims to understand how evidence-based guidelines are disseminated, adopted, and used within state tobacco control programs. Florida served as the third case study in this evaluation. The project goals were two-fold:

- Understand how Florida used evidence-based guidelines to inform their programs, policies, and practices;
- Produce and disseminate findings and lessons from Florida so that readers can apply the information to their work in tobacco control.

Findings from Florida

The following are highlights from Florida's profile. Please refer to the complete report for more detail on the topics presented below.

- Florida partners were aware of many evidence-based guidelines and used them often in their work, most commonly for program planning and as a reference when advocating for funding.
- Florida's Department of Health and the Tobacco Education and Use Prevention Advisory Council, charged with providing direction and oversight to the state program, were seen as key sources for guideline dissemination.
- The state tobacco control program was mandated by the state legislature to abide by *Best Practices*. Therefore, *Best Practices* was the most commonly cited guideline, and Florida partners deemed it central to their program.
- Partners noted both pros and cons to mandating adherence to *Best Practices*:
    - Florida partners thought that abiding by evidence-based guidelines, such as *Best Practices*, provided legitimacy to their efforts and insured that they were implementing effective programs.
    - Partners found the mandate to be restrictive and thought that it stifled innovation in program planning.
- While partners were generally supportive of evidence-based guidelines, they cited several areas in which more guidance was needed:
    - Partners wanted to see more information on how to use guidelines with specific demographic subgroups, especially those with tobacco-related disparities.
    - Partners also thought that information about practical applications of the guidelines would be helpful.

Introduction

Project overview

States often struggle with limited financial and staffing resources to combat the burden of disease from tobacco use. Therefore, it is imperative that efforts that produce the greatest return on investment are implemented. There has been little research on how evidence-based interventions are disseminated and utilized by state tobacco control programs. To begin to answer this question, the Center for Tobacco Policy Research at Washington University in St. Louis conducted a multi-year evaluation in partnership with the CDC Office on Smoking and Health (CDC OSH). The aim of this project was to examine how states were using the CDC's *Best Practices for Comprehensive Tobacco Control Programs* (*Best Practices*) and other evidence-based guidelines for their tobacco control efforts and to identify opportunities that encouraged guideline use.

Qualitative and quantitative data from key partners in eight states were collected during the project period. States were selected based on several criteria, including funding level, lead agency structure, geographic location, and reported use of evidence-based guidelines. Information about each state's tobacco control program was obtained in several ways, including: 1) a survey completed by the state program's lead agency; and 2) key informant interviews with approximately 20 tobacco control partners in each state.

State profiles

This profile is part of a series of profiles that aims provide readers with a picture of how states accessed and utilized evidence-based guidelines. This profile presents data collected in March and April 2010 from Florida partners. The profile is organized into the following sections:

- **Program Overview**- provides background information on Florida's tobacco control program.
- **Evidence-based Guidelines**- presents the guidelines we asked about and a framework for assessing guideline use.
- **Dissemination**- discusses how Florida partners learned of new guidelines and their awareness of specific tobacco control guidelines.
- **Adoption Factors**- presents factors that influenced Florida partners' decisions about their tobacco control efforts, including use of guidelines.
- **Implementation**- provides information on the critical guidelines for Florida partners and the resources they utilized for addressing tobacco-related disparities and in communication with policymakers.
- **Conclusions**- summarizes the key factors that influenced use of guidelines based on themes presented in the profile and current research.

Quotes from participants (offset in green) were chosen to be representative examples of broader findings and provide the reader with additional detail. To protect participants' confidentiality, all identifying phrases or remarks have been removed.

Program Overview

Florida's tobacco control program

Florida has been actively involved in tobacco prevention efforts since 1989. Florida's tobacco control efforts were led by the Bureau of Tobacco Prevention Program at the Department of Health. With funds from its tobacco settlement agreement, Florida was able to significantly reduce youth smoking rates during the 1990s and was seen as a leader in the tobacco control movement. Despite its successes, tobacco prevention in Florida incurred significant funding cuts in 1999-2000 and again in 2003, which greatly impacted the program's effectiveness. In reaction to these cuts, a 2006 ballot initiative passed an amendment that required the state to spend 15 percent of tobacco trust fund interest payments on tobacco prevention and education programs. This amendment also established the Tobacco Education and Use Prevention Advisory Council (TAC), which provided oversight and guidance to the state program.

Total spending on tobacco prevention and cessation in Florida for FY2010 was $67.7 million, which represented 32.1% of the CDC-recommended funding amount. The program was mandated by state statute to follow CDC's *Best Practices*, and funds were allocated in a competitive process based on the five categories from the guideline.

Florida's tobacco control partners

Florida's tobacco control efforts involved a variety of partners. Partners included health voluntaries, a marketing agency and other departments in the state government. Several partners also had dual roles as part of TAC. Twenty individuals from 14 organizations were identified as a sample of key members of Florida's tobacco control program. The majority of Florida partners had extensive experience in tobacco control, averaging 7 years of involvement. Below is the list of partners that participated in the interviews.

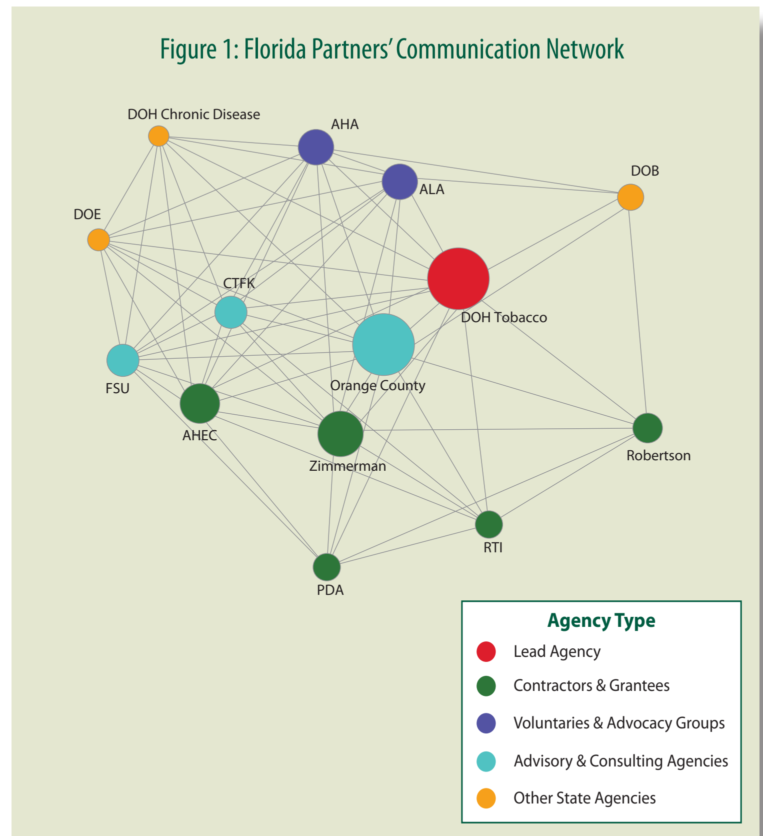
Table 1: Florida Tobacco Control Partners

Agency	Abbreviation	Agency Type
Department of Health-Bureau of Tobacco Prevention Program	DOH Tobacco	Lead Agency
Area Health Education Center	AHEC	Contractors & Grantees
Zimmerman Agency	Zimmerman	Contractors & Grantees
Professional Data Analyst, Inc.	PDA	Contractors & Grantees
Research Triangle Institute	RTI	Contractors & Grantees
Robertson Consulting	Robertson	Contractors & Grantees
American Lung Association	ALA	Voluntaries & Advocacy Groups
American Heart Association	AHA	Voluntaries & Advocacy Groups
Department of Business and Professional Regulation	DOB	Other State Agencies
Department of Education	DOE	Other State Agencies
Department of Health-Chronic Disease Prevention & Health Promotion	DOH Chronic Disease	Other State Agencies
Oragne County Health Department	Orange County	Advisory & Consulting Agencies
Florida State University College of Medicine	FSU	Advisory & Consulting Agencies
Campaign for Tobacco Free Kids	CTFK	Advisory & Consulting Agencies

Communication between Florida partners

Partners were asked how often they had direct contact (such as meetings, phone calls, or e-mails) with other partners within their network in the past year. In the figure to the right, a line connects two partners if they had contact with each other on more than a quarterly basis. The size of the node (dot representing each agency) indicates the amount of influence a partner had over contact in the network. An example of having more influence, or a larger node, was seen between Orange County, ALA, and Robertson. ALA did not have direct contact with Robertson, but both had contact with Orange County. As a result, Orange County acted as a bridge between the two and had more influence within the network. Communication within Florida displayed a relatively decentralized structure among partners in which network members had contact with many agencies.

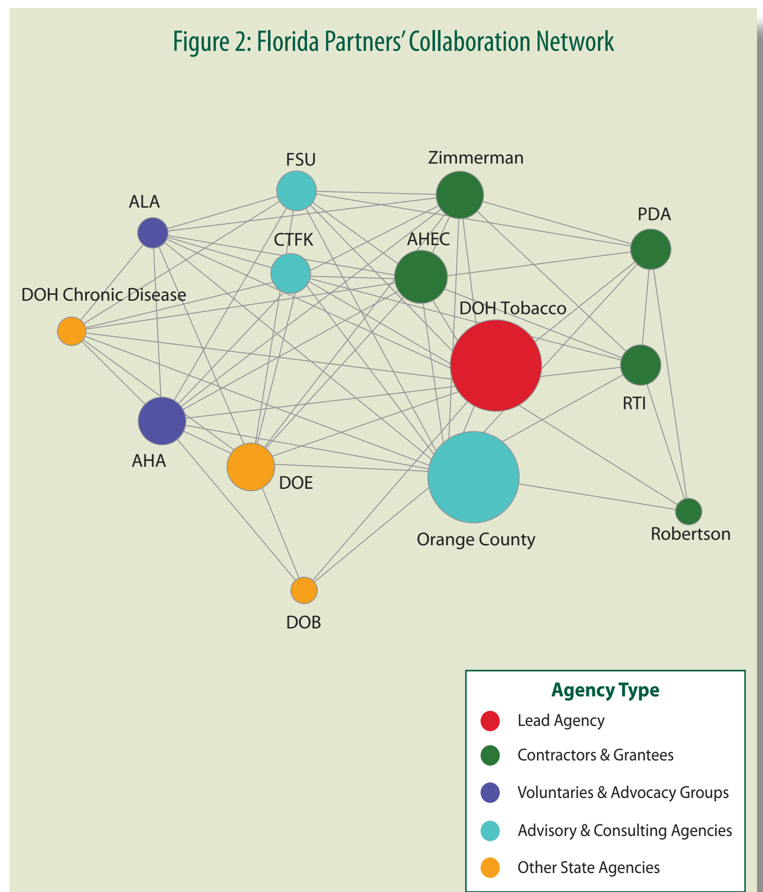
Figure 1: Florida Partners' Communication Network



Collaboration between Florida partners

Partners were asked to indicate their working relationship with each partner with whom they communicated. Relationships could range from not working together at all to working together on multiple projects. A link between two partners means that they at least worked together informally to achieve common goals. Partners were not linked if they did not work together or only shared information. The node size is based on the amount of influence a partner had over collaboration in the network. A partner was considered influential if he or she connected partners who did not work together directly with each other. For example, RTI and AHA did not work directly with each other, but both worked with DOH Tobacco. DOH Tobacco acted as a "broker" between the two agencies, and, as a result, has a larger node size. DOH Tobacco and Orange County had the most influence over collaboration among partners as demonstrated by their larger node sizes. This indicates that they had working relationships with many partners in the state.

Figure 2: Florida Partners' Collaboration Network



Evidence-based Guidelines

There are a number of evidence-based guidelines for tobacco control, ranging from broad frameworks to those focusing on specific strategies. Below in Figure 3 are the set of guidelines partners were asked about during their interviews. Partners also had the opportunity to identify additional guidelines or information they used to guide their work. Other resources identified by Florida partners included:

- North American Quitline Consortium (NAQC) resources
- Cochrane Reviews
- Information from the American Medical Association and the American Academy of Family Physicians
- Florida Area Health Education Centers Network (AHEC) resources
- President's Cancer Panel reports
- Global Dialogue for Effective Stop-Smoking Campaigns resources

Figure 3: Evidence-based Guidelines for Tobacco Control

Research has shown that the use of evidence-based practices, such as those identified in these guidelines, results in reductions in tobacco use and subsequent improvements in population health. Whether an individual or organization implemented evidence-based practices depended on a number of factors, including capacity, support, and available information. The remainder of this report will look at how evidence-based guidelines fit into this equation for Florida. The framework below will guide the discussion, specifically looking at which guidelines Florida partners were aware of, which ones were critical to partners' efforts, and how guidelines were used in their work.

Figure 4: Framework for Use of Evidence-based Guidelines

Dissemination

How did partners define "evidence-based guidelines"?

Florida partners were asked to describe what came to mind for them when they heard the term "evidence-based guidelines." Most partners thought of evidence-based guidelines as providing information on practices that had been scientifically tested to yield a positive result.

> [Evidence-based means] it's tried, true, and tested. That there's fidelity in the program.

> [Evidence-based guidelines are] guidelines that have some evidence, some actual research behind them that they're based on. You know that they're not just somebody's idea. There's actually some research that says, 'Yes this works.' Or, 'This doesn't work.'

Partners noted that one successful study was not enough to produce an evidence-base. They further defined an evidence-base as practices backed up by numerous peer-reviewed studies.

> To me, evidence-based is not a practice or a program that has been proven in one study, but it has been proven in multiple studies over time for which you've got good results, report, design and structure of your evaluation.

How did partners learn of evidence-based guidelines?

Partners were made aware of new guidelines through meetings, conferences, and contacts at both the national (e.g., CDC OSH) and state level. Staff members at the Florida Department of Health's Bureau of Tobacco Prevention Program, especially the Bureau Chief and the Community Grantee Manager, were a major resource for partners. Additionally, TAC, comprised of key state tobacco stakeholders, held monthly conference calls during which they often discussed guidelines. A statewide tobacco listserve was also cited as a key source for guideline dissemination.

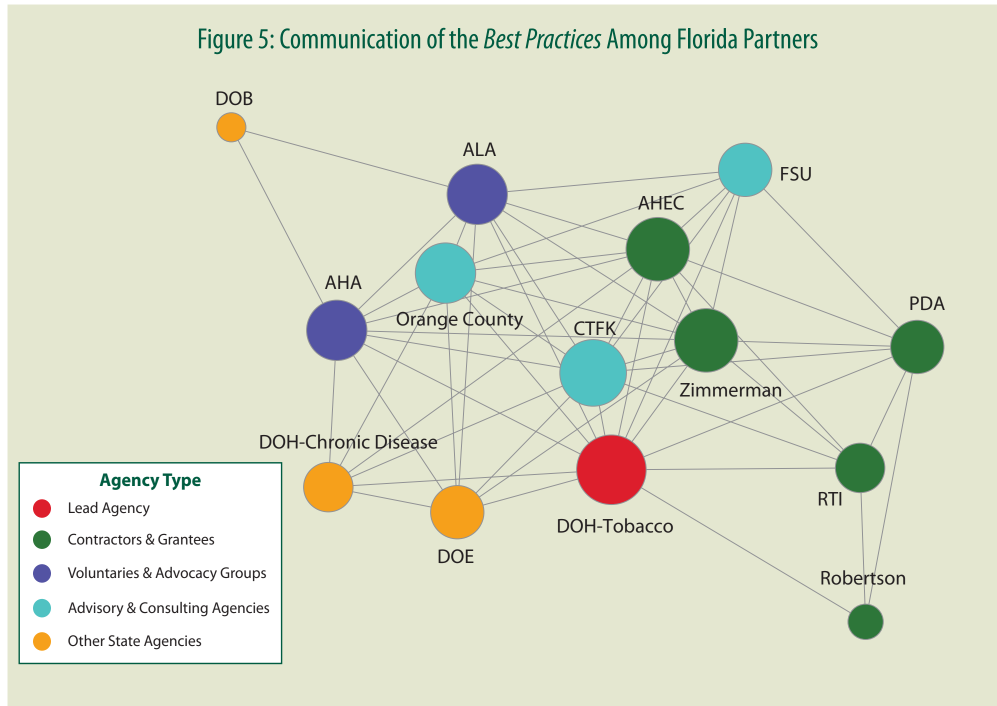
> We have [TAC] that is comprised of key tobacco staff around the state. They meet via monthly conference calls. And then we have a tobacco listserve which is another e-mail listserve that is all of the tobacco staff around the state, and so things are shared pretty quickly via those listserves.

Internally, partners shared information about new guidelines through e-mail and discussed the relevant research during regular staff meetings. Within the Department of Health, guidelines were also frequently referenced during annual strategic planning meetings.

> We have morning meetings with the entire tobacco team… and we talk about and discuss some of the new findings and research.

To gain a better understanding of communication specifically about *Best Practices*, Florida partners were asked who they talked to about the guideline. In the figure below, a line connects two partners who indicated they talked about *Best Practices* with each other. The size of the node reflects the number of agencies each partner talked to about the guideline. For example, DOH-Tobacco and CTFK talked with the most partners about *Best Practices*, resulting in their larger node sizes. Many other agencies also played a prominent role in the diffusion of *Best Practices*, resulting in a relatively decentralized network.

Figure 5: Communication of the *Best Practices* Among Florida Partners



What tobacco control guidelines were partners aware of?

Best Practices was the most well-known guideline in Florida. Ninety percent of partners interviewed recalled at least hearing of *Best Practices*. Many partners referred to the guideline frequently, with others using it on at least an annual basis. At least half of the partners were aware of the other guidelines, with the exception of *Ending the Tobacco Problem: A Blueprint for the Nation*, which only had 35% awareness.

Table 2: Number of Partners Aware of Tobacco Control Guidelines

Guideline	# of Partners
Best Practices for Comprehensive Tobacco Control Programs	18/20
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	16/20
Key Outcome Indicators for Evaluating Tobacco Control Programs	15/20
Guide to Community Preventive Services- Tobacco	14/20
Designing and Implementing an Effective Tobacco Counter-Marketing Campaign	13/20
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	12/20
Tobacco Control Monograph Series	12/20
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	12/20
Introduction to Process Evaluation in Tobacco Use Prevention and Control	11/20
Best Practices User Guides- Coalitions	10/20
Ending the Tobacco Problem: A Blueprint for the Nation	7/20

Adoption Factors

What did partners take into consideration when making decisions about their tobacco control efforts?

Most Florida partners identified research from evidence-based guidelines (specifically *Best Practices*) and the state statutes as key influences on their decisions about tobacco control efforts. Consequently, when asked to rank several factors in their importance in making decisions, recommendations from evidence-based guidelines was most often ranked as the most important factor, with 80% of partners placing it in their top three. Partners emphasized their dedication to implementing programs or strategies that were proven to be effective and efficient.

> Well we really try to be evidence-based. We don't want to waste our resources or anybody else's pursuing things that we don't have a pretty good sense will work, and I think that's really the driver of everything we do.

> We're very dedicated to looking at the research and making sure that any program that we embark on is evidence-based and has been evaluated.

Following closely behind recommendations from evidence-based guidelines, partners ranked mandates or input from policymakers as the second most important decision-making factor. The state mandate to adhere to *Best Practices* was particularly influential in partners' decision-making.

> We are required to utilize the CDC guidelines . . . the CDC *Best Practices*. That was actually written into the statute in Florida to utilize the CDC *Best Practices*, which is more global on how dollars should be spent and in what ways dollars should be spent.

> By statute, we have to follow the . . . *Best Practices* guidelines. So we make sure that everything that we're doing is in line with that.

Partners also noted that mandates or input from policymakers were closely linked to other key decision-making factors, such as cost and direction from inside the organization. Because of the state statute, policymakers influenced the funding levels of Florida's tobacco control program as well as what could be done within the Department of Health.

"We take into consideration what is going on in our organization, any partner inputs, mandates from the legislature, what the *Best Practices* say from CDC, can we afford it, and do we have enough people who can handle whatever we are trying to do?"

Input from partners was also ranked as valuable in guiding decision-making. Partners' input helped to coordinate and enhance efforts. A collaborative environment was seen as an important characteristic of Florida's tobacco control network.

> We do have a lot of collaborative partners that we work with, and it's important for everybody to be on the same page if you're working together.

How did organizational characteristics influence partners' decisions about their tobacco control efforts?

Florida partners felt that collaboration between partners at the national, state, and local levels facilitated decisions about their tobacco control efforts. This collaborative environment made partners feel included and supported, and also cultivated partners' willingness to offer new ideas.

> It's more of a collaborative effort. It's not like a top-down management; it's more of a partnership between the counties and the county health departments and the Department of Health headquarters in Tallahassee. So I think that helps as well. That's an important structure that facilitates the efforts of the tobacco program.

> We are very inclusive of our staff and our volunteers and really seek input so that we're . . . always trying to stay on the cutting edge.

The foremost barriers to partners' tobacco control efforts were the state mandate, procurement processes, and funding levels. The mandate to adhere to *Best Practices* was seen as useful in guiding tobacco control efforts and promoting effective strategies, but it also made it difficult for partners to implement any new or promising strategies, therefore limiting creativity and flexibility. While not denying the importance or merit of *Best Practices*, partners frequently noted that the mandate was overly restrictive.

> I think sometimes maybe [the mandate] feels like it's so prescribed. We have a lot of innovative grantees and a lot of innovative staff members, and so I think it's . . . you can feel like you're kind of restricted in that way.

> I think that one thing that may be an issue with us, it took CDC ten years to update the *Best Practice* from 1998 . . . I guess eight years from the *Best Practice* of 1998 or 1999. And if it's going to take another ten years . . . eight or nine years to do that, then that can be problematic for us, because the policies are getting to the point right now where . . . what else is left for us to do?

> I think sometimes [the mandate] does hamper flexibility. . . Some slight hampering, but not enough to justify not using [*Best Practices*].

The state statute also required the Department of Health to follow certain procurement processes that partners perceived as burdensome. The program was required to award funding to grantees and vendors through a lengthy competitive bidding process.

> The other thing is that because of that [state statute], we're looked at really closely. So we have a procurement process that takes a long time. We have to make sure that we bid out everything that we do.

> One of the biggest issues we tend to have is . . . all of our funding [has] to be competitively bid, so everything has to go out to contractors to be carried out, and the competitive processes are taking months and months.

In addition to the challenges faced in adhering to the state statute, partners were limited by funding levels. Partners felt that their efforts were constrained since FY2010 funding was only 31.2% of the CDC-recommended amount for a comprehensive tobacco control program in Florida, as outlined in *Best Practices*.

> Our challenge right now, and not just ours, but others in tobacco control advocacy, is funding. The infrastructure for doing tobacco control in this country has diminished drastically over the last several years.

What facilitated or hindered use of evidence-based guidelines?

Most partners felt that evidence-based guidelines, particularly the CDC's *Best Practices*, provided legitimacy to their efforts. As a result, programs were more likely to be taken seriously when they had the backing of a credible agency like the CDC.

> Well it's the legitimacy…you've got a national, well-respected organization like the CDC saying, "This is the best way to do this. These are the best practices. These are the guidelines to have an effective program."

> "[Evidence-based guidelines] make our work defensible so that our recommendations have grounding and are taken more seriously."

Adherence to evidence-based guidelines also increased the likelihood that partners' efforts would be successful. The guidelines provided structure to efforts while simultaneously preventing resources from being wasted on unproven programs or policies.

> Most [evidence-based guidelines] have been evaluated to a certain extent, and you aren't recreating the wheel. You've got guidance on what to do and how to do it… not assurance of success, but a better chance of having a successful outcome.

Synergy was mentioned as another benefit to using evidence-based guidelines. Partners noted that the impact of tobacco control efforts was compounded when everyone, from the national to the local level, was focusing on the same effective strategies.

> We're going to have the best impact on outcomes if we follow what already is known as efficacious intervention, and what we're talking about I think, is reinforcement from one community to another…a synergy across the U.S. for the best evidence guidelines.

On the other hand, some partners mentioned that evidence-based guidelines brought push-back from various groups such as retailers, political members, and the community in general, as well as some of their own partners. Strategies outlined in guidelines were not always universally accepted, often because they conflicted with people's preconceptions about what the best strategies were. For example, some partners and other stakeholders had grown accustomed to certain practices, such as conducting health fairs, that were not evidence-based.

> I've seen the evidence-base being challenged. So you kind of have to convince your partners, and partners… oftentimes want to do their own thing.

Implementation

Which guidelines were critical for Florida's tobacco control partners?

Florida partners were aware of a number of evidence-based guidelines and reports. However, a smaller number of those guidelines were identified as critical resources when partners were asked to group guidelines into one of three categories: 1) *Critical* for their tobacco control efforts; 2) *Not critical, but useful* for their tobacco control efforts; and 3) *Not useful* for their tobacco control efforts. Three of the top four guidelines identified by partners covered more than one strategy and provided guidance that could be applied to a comprehensive tobacco control effort. The following are the guidelines identified most frequently as critical resources by Florida partners.

Table 3: Percentage of Partners Who Identified Guideline as a Critical Resource

Guideline	% of Partners*
Best Practices for Comprehensive Tobacco Control Programs	88%
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	67%
Guide to Community Preventive Services: Tobacco	62%
Key Outcome Indicators for Evaluating Tobacco Control Programs	57%
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	46%
Ending the Tobacco Problem: A Blueprint for the Nation	33%
Tobacco Control Monograph Series	27%
Designing and Implementing an Effective Tobacco Counter-Marketing Campaign	25%
Best Practices User Guides: Coalitions	22%
Introduction to Process Evaluation in Tobacco Use Prevention and Control	22%
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	9%

* Based on partners who were aware of the guideline

Best Practices for Comprehensive Tobacco Control Programs

Eighty-eight percent of Florida partners aware of the CDC's *Best Practices* identified this guideline as a critical resource. Partners cited the guideline as a central document for Florida's tobacco control program and stressed the importance of *Best Practices* due to its inclusion in Florida's statute. Partners noted that it was also useful as a resource or point of reference, such as when advocating for funding.

> Any conversation we have with anyone we reference the CDC *Best Practices*, because basically that's our bible so to speak, on how we actually function. It's also in our statute … that the work, or the program must be consistent with CDC *Best Practices*.

> It's a centerpiece of our advocacy efforts for funding tobacco control prevention and cessation programs…I rely completely on *Best Practices*.

Revisions to the CDC *Best Practices*

In 2007, *Best Practices* was revised. To find out how these changes were perceived, Florida partners were asked additional questions about *Best Practices*. A number of partners within Florida were either unfamiliar with the previous version (released in 1999), or were unsure of the changes. However, the majority of partners who were aware of the *Best Practices* update responded positively, especially to the consolidation of the categories and the guideline's comprehensive approach.

> [The 1999 version] had nine categories that nobody really understood, or were difficult to explain, and then boiled them down into really three intervention categories; community programs, media campaigns, and cessation. So it's a lot easier to describe these programs according to *Best Practices* than it used to be.

Those partners who responded negatively to the update most often commented on the funding recommendations. While partners recognized the importance of setting the bar high, they did not view the recommended funding amount as a practical expectation given the economic climate. Additionally, partners found it difficult to base their efforts on recommendations that were designed for a fully-funded program.

> I understand [the funding recommendations], and I think that we always have to have the "perfect" to reach for, but it's very hard as an advocate to try to convince a legislator that we need to be spending 217 [million] when we have a huge budget crisis.

Clinical Practice Guidelines: Treating Tobacco Use and Dependence

Of those partners aware of the *Clinical Practice Guidelines*, 67% identified the guide as a critical resource for their cessation efforts. This guide was identified as helpful for work with healthcare professionals. Partners specifically cited this document when developing promotional information for healthcare providers.

> The program uses it as part of our community-based work plan. We are having our community-based partners work with local physicians to make sure that they are using the *Clinical Practice Guidelines*.

Additionally, partners used this guide as a reference, specifically to look at how program outcomes corresponded to the publication's recommendations.

> During reporting, especially if there's a finding that we don't understand, or if something crops up that we didn't anticipate, then we refer to the [*Clinical Practice Guidelines*] to help make sense of our findings.

Furthermore, partners utilized the *Clinical Practice Guidelines* to advocate for funding, particularly in regards to comprehensive coverage for smoking cessation.

> We use [the *Clinical Practice Guidelines*] in a number of advocacy efforts…certainly in advocating for coverage of smoking cessation interventions, but also funding…from the stimulus dollars, to state appropriations, to federal appropriations, we use it.

Guide to Community Preventive Services: Tobacco

Of those aware of the *Guide to Community Preventive Services*, or the "*Community Guide,*" 62% listed it as a critical resource to their tobacco control efforts. Since the *Community Guide* was based on programs that had previously been shown to be effective, many used it as a point of reference when advocating for funding.

> When things make it into the *Community Guide* with a sufficient level of evidence, then it's kind of shorthand to say, …someone has looked into this systematically and shown that it's effective, so you don't have to make a case for it yourself.

Key Outcome Indicators for Evaluating Tobacco Control Programs

More than half of the partners in Florida aware of the *Key Outcome Indicators* listed it as a critical resource to their tobacco control efforts. This guide was used to identify appropriate program outcome measures and in the development of work plans.

> What we're looking to say, 'Are we going in the right direction? What should we be looking for as far as what outcome indicators are available to us to make sure that our programs are on track?'

What resources were used to eliminate tobacco-related disparities?

Partners in Florida had most often utilized surveillance data (e.g. the Behavioral Risk Factor Surveillance System) to identify populations with tobacco-related disparities. However, there was a lack of consensus on who the disparate populations were in Florida and how to define a disparate population.

> That's [disparities] one area that we really haven't done a lot in. And that's something that CDC hasn't given us much direction on.

> We've all said we really need to better define who our disparity populations are.

As a result, partners looked to various local coalitions and partnerships to provide direction and examples on how to best approach populations with tobacco-related disparities.

> We're talking about those natural coalitions that already exist. It's not just what the guidelines tell us of which groups we need to include. We have to look at our local community and figure out who's here and how can they be networked into this.

Few partners used the 2007 *Best Practices* for their work with populations with tobacco-related disparities. Many believed that the guideline provided general tobacco prevention recommendations, but not state-specific recommendations or directives for disparate populations. Partners felt that a guide devoted to working with populations with tobacco-related disparities would be most helpful to their efforts.

> I wouldn't say that the *Best Practices* guidelines have helped as much with disparate populations as with overall tobacco prevention messaging.

> Some things are culturally sensitive, and some things are not, and so maybe we need a little more of that nuance of guidance of what has worked best, where the best practices are, some example communities, and people we can talk to.

"How about using [*User Guides*] for disparate populations and how they should be addressed? What should we focus on? How do you determine that? We're just not sure."

What resources were used to communicate with policymakers?

Many partners within the state of Florida did not have direct communication with policymakers at the state level. Therefore, the "Tri-Agency" partners (i.e., American Heart Association, American Lung Association, American Cancer Society) and TAC were seen as the voice of the Department of Health and other partners through their advocacy efforts.

> [TAC] is also very instrumental in policy change and policy direction suggestions. They have the ability to work and interact directly with the legislators, the legislators individually that we don't have that authority to do.

Due to the inclusion of *Best Practices* in the Florida statute, policymakers were aware of the state's utilization of evidence-based practices for their tobacco control efforts. Therefore, partners provided outcomes, as opposed to research details, when making their case to policymakers. Surveillance data and programmatic updates were also shared with policymakers in order to provide evidence when building a case for tobacco prevention policy and the state's tobacco control program.

> Well they have all been educated on what we do, that's why we adopted the CDC *Best Practices* into our statute... So we do talk to them, and they know about evidence-based guidelines. They know that we follow those, and they know that legislature appropriates our funding based on those categories in the *Best Practices*.

> Any type of resources that we get in a national organization or in our local data, or any data from any of our evaluations that's helpful to support what we're doing and help them to build a better case for tobacco prevention policy issues, we give them that.

What other resources were needed?

When asked what the CDC could do to continue to support Florida's tobacco control efforts, partners suggested providing new guidelines and assessment tools as well as utilizing webinars and trainings as arenas for dissemination of new information. More specific data and guidelines for the community level were also desired. Partners expressed an interest in information on ways in which other states were implementing *Best Practices*. They wanted to learn more about practical applications of the guideline.

Partners also cited the need for greater acknowledgement of state-specific issues, such as varying funding levels.

> A recognition of what we deal with every day and the fact that the state governments are hurting financially. We have to figure out ways to make the money go further.

In addition to guidance on prioritization of efforts due to limited funding, partners wanted more information on identifying ways to operate most effectively, such as integration with chronic disease.

> We have quite a few practices, proven work that can be implemented in the community, but you've got to have a vehicle that's in tip-top shape... What does that look like? And, furthermore, how can you integrate with chronic disease programs to enhance what we're doing with tobacco prevention?

"I think that the CDC needs to, through these corollary guides or whatever, step up and offer more concrete, real-world advice about the community-based component of *Best Practices*. And I think that would help our work immeasurably."

Conclusions

Many Florida partners were aware of and reported referring to evidence-based guidelines when making decisions about their tobacco control efforts. Partners saw evidence-based guidelines as an important part of advocacy efforts and as useful in program planning and evaluation. Additional factors that contributed to the adoption of evidence-based guidelines included:

- Guidelines were backed by reputable organizations, such as the CDC, and therefore seen as promoting effective strategies and providing legitimacy to efforts; and
- Key agencies in the state (e.g., Florida Department of Health and the Tobacco Education and Use Prevention Advisory Council) frequently cited and disseminated information from guidelines.

Florida's state mandate to allocate funding based on *Best Practices* categories played a major role in partners' decision-making process. As a result, partners identified *Best Practices* as a central framework to help guide the state's tobacco control program. This mandate provided structure and consistency to the program; however also posed a number of challenges. For example, Florida's funding for tobacco control did not currently meet the CDC's recommended amount. Thus, partners found it difficult to achieve a comprehensive program with significantly reduced funding.

Partners cited additional challenges associated with guideline use overall, including restricting innovation, the length of time to release new guidelines, and the need for detailed information to help implement guideline recommendations. Guidance on prioritizing funding allocation, integrating efforts with other chronic disease areas, and the implementation of evidence-based practices for eliminating tobacco-related disparities were identified as needed resources by Florida partners.

Tobacco control partners possess an abundance of information at their disposal to inform their decision-making process. Previous experiences, information obtained from trainings, input from partners, and policies or mandates all play a role in decision-making about tobacco control efforts. The degree to which particular evidence-based guidelines stand out among various informational resources is largely dependent upon factors tied to three main phases of information diffusion highlighted throughout this report: dissemination, adoption, and implementation. Such factors include avenues of guideline dissemination to stakeholders, presence or absence of support by other individuals or policies, and the incorporation of that information into one's work. The input provided by Florida's partners can be used to inform future training opportunities on implementation of evidence-based guidelines. Additionally, taking these factors into consideration when developing and releasing a new guideline will help to optimize use of the guideline by intended stakeholders.

The **Indiana** Profile:

Prioritizing policy change

Use of Evidence-based Guidelines in State Tobacco Control Programs

Prepared by
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Executive Summary

Introduction

There has been a significant amount of research done on what works to curb tobacco use. Many agree that the evidence-base for tobacco control is one of the most developed in the field of public health. However, the advancement in the knowledge base is only effective if that information reaches those who work to reduce tobacco consumption. Evidence-based guidelines, such as the Centers for Disease Control and Prevention's *Best Practices Guidelines for Comprehensive Tobacco Control Programs* (*Best Practices*), are a key source of this information. However, how these guidelines are utilized can significantly vary across states.

This profile presents findings from an evaluation conducted by the Center for Tobacco Policy Research at Washington University in St. Louis that aimed to understand how evidence-based guidelines were disseminated, adopted, and used within state tobacco control programs. Indiana served as the fourth case study in this evaluation. The project goals were two-fold:

- Understand how Indiana partners used evidence-based guidelines to inform their programs, policies, and practices;
- Produce and disseminate findings and lessons from Indiana so that readers can apply the information to their work in tobacco control.

Findings from Indiana

The following are highlights from Indiana's profile. Please refer to the complete report for more detail on the topics presented below.

- The Indiana Tobacco Prevention and Cessation (ITPC) agency served as the main source for the dissemination of evidence-based guidelines in Indiana, particularly *Best Practices*.
    - ITPC referenced *Best Practices* in new coordinator trainings. Statewide trainings hosted by ITPC served as an arena for *Best Practices* dissemination and implementation planning.
- Evidence-based guidelines were seen as providing credibility to the work of Indiana partners and brought consistency to their efforts.
- Despite these benefits, partners identified challenges with the implementation and understanding of evidence-based guidelines, such as:
    - Resistance from some partners who thought that the guidelines did not apply to a specific community or population.
    - The challenge of sifting through an overwhelming amount of information to find the appropriate information for an individual's efforts.
- Due to the separation of ITPC from the Department of Health, Indiana partners directly communicated with policymakers.
    - This allowed for more frequent communication with policymakers, making policy change a central aspect of Indiana partners' efforts.
    - Evidence-based guidelines, data, personal testimonies, and health and economic benefits were identified as common sources used in communication with policymakers.

Introduction

Project overview

States often struggle with limited financial and staffing resources to combat the burden of disease from tobacco use. Therefore, it is imperative that efforts that produce the greatest return on investment are implemented. There has been little research on how evidence-based interventions are disseminated and utilized by state tobacco control programs. To begin to answer this question, the Center for Tobacco Policy Research at Washington University in St. Louis conducted a multi-year evaluation in partnership with the CDC Office on Smoking and Health (CDC OSH). The aim of this project was to examine how states were using the CDC's *Best Practices for Comprehensive Tobacco Control Programs* (*Best Practices*) and other evidence-based guidelines for their tobacco control efforts and to identify opportunities that encouraged guideline use.

Qualitative and quantitative data from key partners in eight states were collected during the project period. States were selected based on several criteria, including funding level, lead agency structure, geographic location, and reported use of evidence-based guidelines. Information about each state's tobacco control program was obtained in several ways, including: 1) a survey completed by the state program's lead agency; and 2) key informant interviews with approximately 20 tobacco control partners in each state.

State profiles

This profile is part of a series of profiles that aims to provide readers with a picture of how states accessed and utilized evidence-based guidelines. This profile presents data collected in April and May 2010 from Indiana partners. The profile is organized into the following sections:

- **Program Overview –** provides background information on Indiana's tobacco control program.
- **Evidence-based Guidelines –** presents the guidelines we asked about and a framework for assessing guideline use.
- **Dissemination –** discusses how Indiana partners learned of new guidelines and their awareness of specific tobacco control guidelines.
- **Adoption Factors –** presents factors that influenced Indiana partners' decisions about their tobacco control efforts, including use of guidelines.
- **Implementation –** provides information on the critical guidelines for Indiana partners and the resources they utilized for addressing tobacco-related disparities and in communication with policymakers.
- **Conclusions –** summarizes the key factors that influenced use of guidelines based on themes presented in the profile and current research.

Quotes from participants (offset in green) were chosen to be representative examples of broader findings and provide the reader with additional detail. To protect participants' confidentiality, all identifying phrases or remarks have been removed.

Program Overview

Indiana's tobacco control program

In 2001, the Indiana Tobacco Prevention and Cessation (ITPC) agency was created by the Indiana General Assembly. For many states, tobacco control programs are housed in state health departments. However, Indiana provided a unique example in that ITPC was established as a separate state agency. ITPC was responsible for providing direction to Indiana's tobacco control program, overseeing operations, and providing technical assistance to partners. Serving as a separate state agency also allowed for more direct communication with policymakers.

ITPC received a majority of its financial support from Master Settlement Agreement (MSA) funding. Due to significant budget cuts in recent years, funding fell from $35 million in FY 2000 to $10.2 million for FY 2010, representing 15% of the CDC's recommended funding level for a comprehensive tobacco control program in Indiana. In order to lower costs, state lawmakers proposed that ITPC be absorbed into the Indiana Department of Health. However, strong support helped maintain the current organizational structure of Indiana's tobacco control program.

Although a number of communities throughout Indiana had passed smokefree policies, no statewide law existed at the time of our evaluation. As such, many Indiana residents remained unprotected from secondhand smoke. Although ITPC supplied a great deal of leadership and direction focused on policy change, there had been resistance from both residents and legislators to enact a statewide comprehensive smokefree air ordinance. Thus, this remained a priority for Indiana partners.

Indiana's tobacco control partners

Indiana's tobacco control efforts involved a variety of key partners. Partners included health voluntaries, program evaluators, community and statewide organizations, and a marketing agency. Additionally, ITPC funded and worked with regional coalition coordinators throughout the state who focused on preventing youth initiation and promoting cessation services. Twenty-nine individuals from 24 organizations were identified as a sample of key members of Indiana's tobacco control program. On average, Indiana partners had been involved in tobacco control for eight years; 40% of partners interviewed had been involved in tobacco control for more than ten years. Table 1 presents the list of partners who participated in the interviews.

Table 1: Indiana Tobacco Control Partners

Agency	Abbreviation	Agency Type
Indiana Tobacco Prevention and Control	ITPC	Lead Agency
Promotus Advertising	Promotus	Contractors & Grantees
RTI International	RTI	Contractors & Grantees
Free & Clear	Quitline	Contractors & Grantees
Indiana Dental Hygienists Association	IDHA	Contractors & Grantees
Indiana Latino Institute	IN Latino	Contractors & Grantees
King's Daughters' Hospital	King's Daughters'	Contractors & Grantees
Hancock Regional	Hancock Regional	Contractors & Grantees
Madison Health Partners	Madison	Contractors & Grantees
Tobacco Free Wabash County	Wabash	Contractors & Grantees
Tobacco Free Tippecanoe County	Tippecanoe	Contractors & Grantees
CHANCES for Indiana Youth	CHANCES	Contractors & Grantees
Johnson Memorial Hospital	Johnson Memorial	Contractors & Grantees
Indiana Campaign for Smokefree Air	ICSA	Coalitions
Indiana Cancer Consortium	IN Cancer	Coalitions
Coalition to Promote Smokefree Pregnancies	Smokefree Pregnancies	Coalitions
American Lung Association	ALA	Voluntaries & Advocacy Groups
American Heart Association	AHA	Voluntaries & Advocacy Groups
Indiana State Department of Education	DOE	Other State Agencies
Indiana State DOH/Diabetes Prevention and Control	DOH Chronic Disease	Other State Agencies
Office of Medicaid Policy and Planning	Medicaid	Other State Agencies
Partnership for Prevention	Partnership	Advisory & Consulting Agencies
Tobacco Technical Assistance Consortium	TTAC	Advisory & Consulting Agencies
Campaign for Tobacco Free Kids	CTFK	Advisory & Consulting Agencies
Americans for Nonsmokers' Rights	ANR	Advisory & Consulting Agencies

Communication between Indiana partners

Partners were asked how often they had direct contact (such as meetings, phone calls, or e-mails) with other partners within their network in the past year. In the figure to the right, a line connects two partners if they had contact with each other on more than a quarterly basis. The size of the node (dot representing each agency) indicates the amount of influence a partner had over contact in the network. An example of having more influence, or a larger node, was seen between CTFK, ALA, and RTI. ALA did not have direct contact with RTI, but both had contact with CTFK. As a result, CTFK acted as a bridge between the two and had more influence within the network. Overall, Indiana partners frequently engaged with one another, resulting in a fairly even distribution of communication among partners.

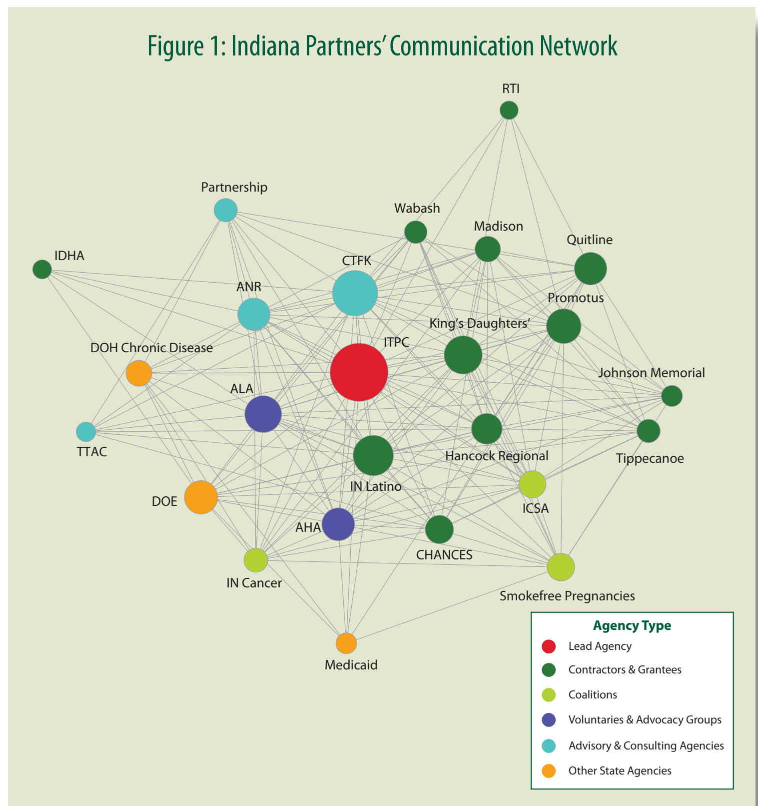


Figure 1: Indiana Partners' Communication Network

Collaboration between Indiana partners

Partners were asked to indicate their working relationship with each partner with whom they communicated. Relationships could range from not working together at all to working together on multiple projects. A link between two partners indicates that they at least worked together informally to achieve common goals. Partners were not linked if they did not work together or only shared information. Node size is based on the amount of influence a partner had over collaboration in the network. A partner was considered influential if he or she connected partners who did not work directly with each other. For example, ANR and Wabash did not work directly with one other, but both worked with ITPC. ITPC acted as a "broker" between the two agencies, and as a result, is characterized by a larger node size. ITPC and IN Latino had the most influence over collaboration among partners as demonstrated by their large node sizes. This indicates that they were central to the network and had working relationships with many partners in the state.

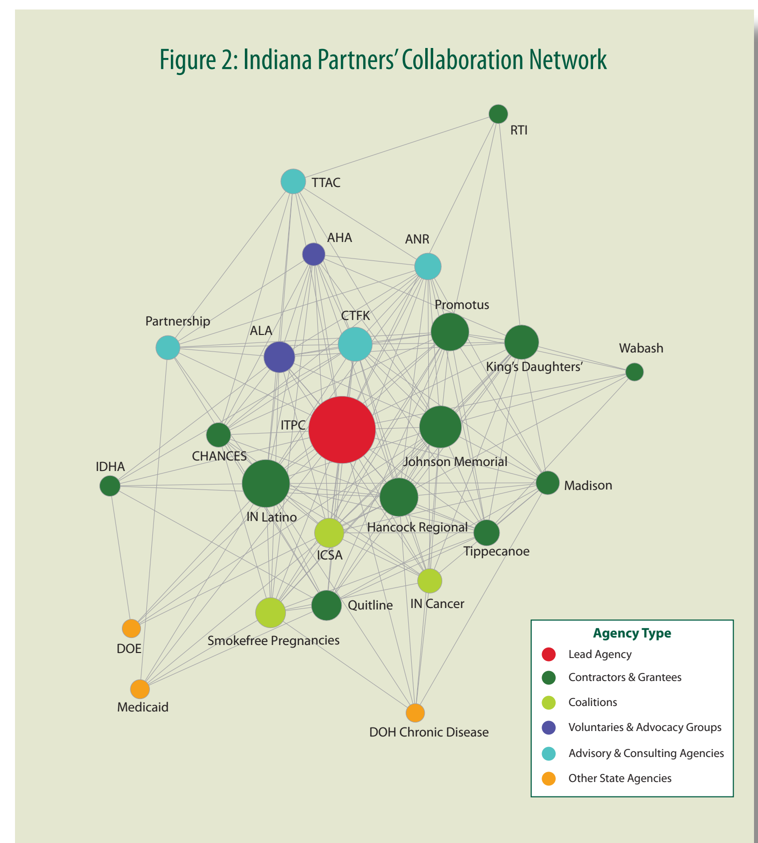


Figure 2: Indiana Partners' Collaboration Network

Evidence-based Guidelines

There are a number of evidence-based guidelines for tobacco control, ranging from broad frameworks to those focusing on specific strategies. Below in Figure 3 are the set of guidelines partners were asked about during their interviews. Partners also had the opportunity to identify additional guidelines or information they used to guide their work. Indiana partners identified the following resources:

- Surgeon General's Reports;
- Americans for Nonsmokers' Rights *Model Ordinance Prohibiting Smoking in All Workplaces and Public Places*;
- Published materials from the Partnership for Prevention; and
- Indiana's *Fundamentals of Smokefree Air Policy Development for Hoosier Communities.*

Figure 3: Evidence-based Guidelines for Tobacco Control

Research has shown that the use of evidence-based practices, such as those identified in these guidelines, results in reductions in tobacco use and subsequent improvements in population health. Whether an individual or organization implemented evidence-based practices depended on a number of factors, including capacity, support, and available information. The remainder of this report will look at how evidence-based guidelines fit into this equation for Indiana. The framework below will guide the discussion, specifically looking at which guidelines Indiana partners were aware of, which ones were critical to partners' efforts, and how guidelines were used in their work.

Figure 4: Framework for Use of Evidence-based Guidelines

Dissemination

How did partners define "evidence-based guidelines"?

When asked to define the term "evidence-based guidelines," the majority of Indiana partners described them as proven and effective practices. Partners further defined "evidence-based guidelines" as documents that described practices that had been tested, published, and transformed into practical, results-oriented recommendations.

> When I hear [evidence-based guidelines] I think of something that has been developed scientifically and peer reviewed and is seen as a best practice, something that's been proven to hold value and merit and accomplish the goals, and it's recognized in the professional or scientific world as something that's got value and credible and can be used as a model program because it has been shown to work.

How did partners learn of evidence-based guidelines?

Partners were often made aware of relevant guidelines when they started their current position or when they first started working in tobacco control. The CDC's *Best Practices* was a common guideline for partners to receive as part of their orientation. For example, ITPC included *Best Practices* in its new coordinator trainings.

> [*Best Practices* is] incorporated into our training, because it is the foundation [of our program]…It's definitely a part of our new coordinator training.

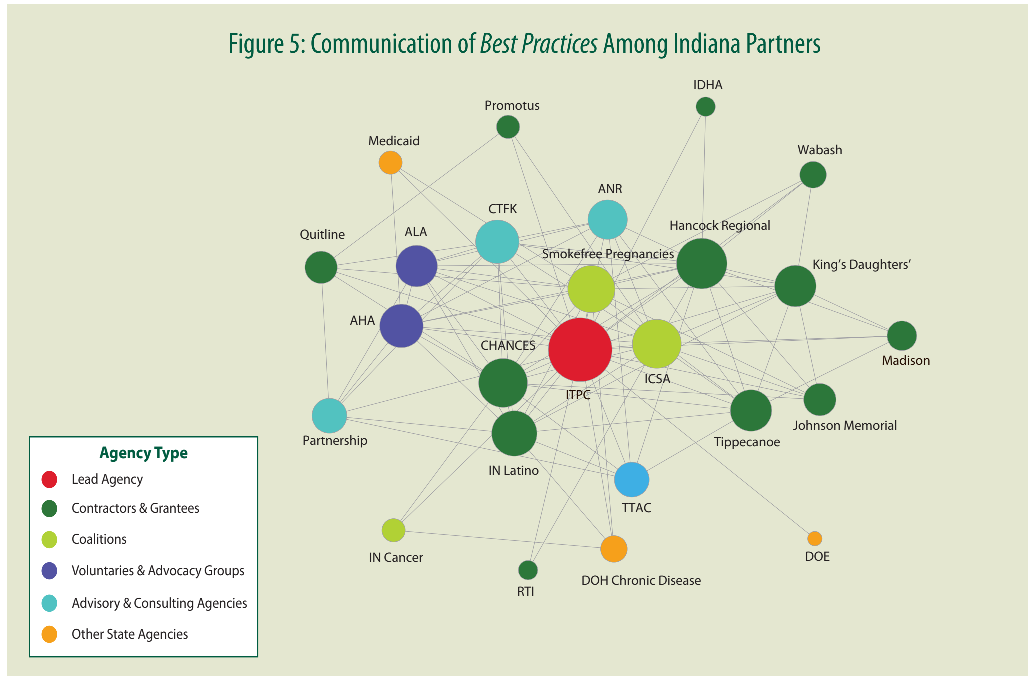
ITPC, particularly the agency's program manager, served as the main source for guideline dissemination to Indiana partners. ITPC informed partners of new guidelines through presentations, meetings, and e-mails. Additionally, partners frequently attended ITPC-sponsored statewide trainings on evidence-based guidelines during which *Best Practices* was the most frequently referenced guideline.

> I think every training that we've had from the ITPC as far as writing the new work plan or evaluating the work plan or orientation for new coordinators, they always refer to *Best Practices*. I think that's something that has been a key component and a cornerstone.

> I would say that most of [the evidence-based guidelines], I've learned through ITPC…I feel like they're the direct contact to receive that information.

To gain a better understanding of the *Best Practices* guideline diffusion, Indiana partners were asked whom they talked to about the guideline. In Figure 5, a line connecting two agencies indicated they talked about *Best Practices* with one another. The size of the node reflects the number of agencies each partner communicated with about the guideline. For example, ITPC talked most often to other agencies about *Best Practices*, resulting in the largest node size. This falls in line with ITPC frequently being identified by partners as a major source for guideline dissemination. However, ITPC did not act as the sole resource for information regarding *Best Practices*, as other partners spoke with one another about the guideline as well.

Figure 5: Communication of *Best Practices* Among Indiana Partners



What tobacco control guidelines were partners aware of?

All Indiana partners interviewed recalled at least hearing of the *Best Practices* guideline. Partners' frequency for referencing *Best Practices* ranged from a weekly to annual basis, with those at ITPC referring to it most often. At least half of Indiana partners were aware of the remaining guidelines. Additional resources, such as internally-developed guidelines, were also used in partners' tobacco control efforts.

Table 2: Number of Partners Aware of Tobacco Control Guidelines

Guideline	# of Partners
Best Practices for Comprehensive Tobacco Control Programs	28/28
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	23/28
Designing and Implementing an Effective Tobacco Counter-Marketing Campaign	21/28
Best Practices User Guide Series (e.g., Coalitions)	18/28
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	18/28
Ending the Tobacco Problem: A Blueprint for the Nation	18/28
The Guide to Community Preventive Services: Tobacco	17/28
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	17/28
Introduction to Process Evaluation in Tobacco Use Prevention and Control	17/28
Key Outcome Indicators for Evaluating Tobacco Control Programs	14/28
Tobacco Control Monograph Series	14/28

Adoption Factors

What did partners take into consideration when making decisions about their tobacco control efforts?

Numerous factors were taken into consideration by Indiana partners when making decisions about their tobacco control efforts. When asked to rank several decision-making factors by their importance, 43% of partners ranked recommendations from evidence-based guidelines as the most important factor, with 79% ranking it in their top three. On average, partners listed direction from inside their organization as the second most important factor. Partners further emphasized the significance they placed on ITPC as a leader in Indiana's tobacco control efforts.

Figure 6: Ranking of Decision-making Factors

> With ITPC we look at the CDC *Best Practices* and recommendations and long-term policy interventions to reduce tobacco control. And how to not only understand them, but the tools to actually implement them.

> We look back to ITPC for guidance. They have pretty much stayed with the same four goals which I believe are best practices as far as reducing tobacco use.

Additionally, organizational capacity and input from partners were ranked as important decision-making factors for Indiana partners. Input from other partners, including out of state guidance, aided in program implementation.

> A lot of what we do when we're trying to figure out our planning is also looking at, what is our capacity in the state? What are our relationships with other groups? How can we . . . make sure that we partner with the right groups of people to get these projects implemented?

> We do work closely with a number of organizations so we get input from them, but, we look inside [our organization] first and then go outside.

How did organizational characteristics influence partners' decisions about their tobacco control efforts?

Indiana partners noted that extensive experience in tobacco, as well as diversity in partners' backgrounds, enhanced their tobacco control efforts.

> We've been doing [tobacco control] well, and we continue to be a resource for so many people in a lot of different ways. . . that I think it gives us a certain amount of street credit when we're working with coalitions, and it really does help get buy-in and support from the local groups.

> There are a diverse group of people that present from prevention; from medical doctors, to researchers in prevention, to state health commissioners with knowledge of this entity, to hospital administration, we bring diverse backgrounds to the [ITPC] board.

Furthermore, partners described a positive relationship with ITPC as a facilitating factor to their efforts. Partners felt that ITPC was approachable and open to new ideas. This type of relationship fostered creativity, communication, and trust amongst partners when making decisions for their tobacco control efforts.

"[ITPC is] always really open to new ideas and recognizing things that could improve the program."

> What helps us implement new ideas and expedite changes or bring on new techniques is the fact that I have a long-standing personal relationship with [ITPC]. . . over the years we've built trust. We certainly built our knowledge base on the industry, and [the program manager] recognizes that. . . So what we're able to do is really just go straight to the top and lay out what we see and what we believe is the best route to take.

Conversely, partners identified limited funding and state agency processes as primary barriers to their efforts. The budget cuts made it more difficult to implement programs for Indiana partners. Additionally, the state review process was perceived as lengthy, which hindered partners from moving forward as quickly as possible.

> [The government] cuts our budgets every year, so it is harder to accomplish more when you don't have as many resources.

> We're a state agency, and all of the obstacles that I think slow us down have a lot to do with the state agency processes. . . I would be crazy not to mention that we've had challenges just with the administration in the past few months, and so we've had to battle just for the life of the program, and getting support from this current administration in the program.

What facilitated or hindered use of evidence-based guidelines?

Evidence-based guidelines were beneficial to Indiana partners and provided a solid foundation on which to base their efforts. Partners felt that the guidelines were reliable, scientifically proven, effective strategies that provided credibility when defending their efforts.

> [Evidence-based guidelines] are proven…it's not like you're going in blind and not knowing what the results will be. I know that they are effective, and so I know that it's an effective use of my time, so that's why I feel like using the evidence-based guidelines is important, so I'm not recreating the wheel myself.

> As a field, you're constantly under scrutiny from the opposition about what it is that you do. People are skeptical, and being able to go back to the science for all of the interventions that you're doing is critical. Everything you do is based on science.

The utilization of evidence-based guidelines also ensured consistency among partners' efforts. Partners felt that having unified goals both locally and nationally compounded the impact of their efforts.

> "[Evidence-based guidelines] give you a foundation. They give you something to anchor your reasons on."

> We have to be consistent in this movement. The tobacco industry would love to see us divided and going in different directions, so we are fortunate that there has been an investment in science and it's policy research related to what we do, and so it's up to the leaders in the movement to consistently package it, and train it, and use it, and discuss it, and keep it current, and push for more, and that's why we do it.

> I think that [utilizing evidence-based guidelines is] a way to standardize all the different vendors and people that are doing the same thing across the nation if you have one central source for recommendations.

Despite the advantages to using evidence-based guidelines, partners encountered resistance from some stakeholders and communities to certain evidence-based practices. They often continued to rely on ineffective programs rather than evidence-based practices because of a belief that the guidelines were not applicable to their unique community.

> I think there's a set of our partners who just don't think [evidence-based guidelines] work for their community for any particular reason.

> Oh the general, "That works in California and New York, but we're Indiana, and everything is different here." That's probably the biggest [challenge]; people don't like outsiders telling them what to do.

Finally, partners felt that some evidence-based guidelines contained an overwhelming amount of information that was difficult to grasp. A lack of understanding further increased the challenge of implementing the guidelines for partners.

> I think sometimes pulling out the information that you need can be difficult. Even in an executive summary, if it's 75 pages long, I'm not really interested in reading it. So I think that that could be a barrier. If you're not well-versed in the terms that are used in the books, it's going to be a little difficult to be able to translate how it's going to work in real life.

Implementation

Which guidelines were critical for Indiana's tobacco control partners?

Indiana partners were aware of a number of evidence-based guidelines and reports. However, a smaller number of those guidelines were identified as critical resources when partners were asked to group guidelines into one of three categories: 1) *Critical* for their tobacco control efforts; 2) *Not critical, but useful* for their tobacco control efforts; and 3) *Not useful* for their tobacco control efforts. Two of the top guidelines identified by partners covered more than one strategy and provided guidance that could be applied to a comprehensive tobacco control effort. The following are the guidelines identified most frequently as critical resources by Indiana partners.

Best Practices for Comprehensive Tobacco Control Programs

All Indiana partners were aware of *Best Practices,* and 82% identified it as a critical resource to their tobacco control efforts. Most often used as a reference for program and strategic planning, *Best Practices* provided the framework for Indiana's tobacco control program. Most partners received this resource, usually from ITPC, when they started their work in tobacco control as an orientation to the basics of a comprehensive program. Partners also found *Best Practices* to be a useful resource when communicating with policymakers. They referenced the guide to support their program and funding needs.

Table 3: Percentage of Partners Who Identified Guideline as a Critical Resource

Guideline	% of Partners*
Best Practices for Comprehensive Tobacco Control Programs	82%
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	74%
Ending the Tobacco Problem: A Blueprint for the Nation	67%
The Guide to Community Preventive Services: Tobacco	47%
Best Practices User Guides Series (e.g., Coalitions)	42%
Tobacco Control Monograph Series	29%
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	29%
Key Outcome Indicators for Evaluating Tobacco Control Programs	21%
Introduction to Process Evaluation in Tobacco Use Prevention and Control	18%
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	16%
Designing and Implementing an Effective Counter-Marketing Campaign	10%

* Based on partners who were aware of the guideline

[*Best Practices*] provides an infrastructure for describing an ideal tobacco control program.

When we talk about funding with a senator or representative, I refer to the book [*Best Practices*], or I refer partners to the book.

Revisions to the CDC *Best Practices*

In 2007, the *Best Practices* guideline was revised. To find out how these changes were perceived, Indiana partners were asked additional questions about *Best Practices.* Most partners were not aware of the 1999 version or were not familiar with the specific changes made since the previous version. Those who remembered the changes noted that collapsing the categories from nine to five made it easier to explain the key components of the guideline to stakeholders. Several partners stated that they had collapsed the categories for their own purposes before the 2007 version was released, so they appreciated that CDC had also restructured the categories.

> I really like the way that the model was reconfigured into five components…In fact, we had taken the old *Best Practices* and made our own model up that had five components, for different reasons…so I think that they did an excellent job in reconfiguring that.

Additionally, partners supported simplifying the funding recommendation to a specific dollar amount as opposed to a range. However, many commented that the funding recommendations were unrealistically high in terms of financial and political feasibility.

> The overall funding level number is just…such sticker shock.

Clinical Practice Guidelines: Treating Tobacco Use and Dependence

Seventy-four percent of Indiana partners aware of the *Clinical Practice Guidelines* ranked it as a critical resource and referenced it frequently. Partners utilized the *Clinical Practice Guidelines* for training and education purposes, especially when collaborating with healthcare providers.

> I primarily use [the *Clinical Practice Guidelines*] to educate other healthcare providers on what we know works. And I tell them that that is their bible.

> Because we have some statewide grants that are specifically reaching out to healthcare providers, clinicians who would use [the *Clinical Practice Guidelines*], we talk about it all the time.

Ending the Tobacco Problem: A Blueprint for the Nation

Of those partners who were aware of the Institute of Medicine's *Ending the Tobacco Problem: A Blueprint for the Nation* (*IOM Report*), 67% identified it as critical. This guideline was primarily used for strategic plan development, as well as educating partners and policymakers on the key recommendations.

> [We pull] out specific pieces and recommendations from [the *IOM Report*] for that purpose, for our strategic plan. Also communicating what's in it at a higher level and educating our board members.

> As we do our work in educating state and local partners or policymakers, you're always able to go back to say, "And this intervention is supported by the IOM [Institute of Medicine] as well."

Other Resources

Additional resources cited as critical by Indiana partners included *The Guide to Community Preventive Services* (*Community Guide*) and the *Best Practices User Guide Series*, both useful for local level efforts. The *Community Guide* was used as a reference for programming and designing interventions at the local level, while the *Best Practices User Guide Series* was used for building coalitions.

> We use the *Community Guide* especially with the local partners to reinforce why we do certain interventions.

> We refer to [*Best Practices User Guide Series*] quite a bit and use that as a resource for building our coalition, for trying to identify and help in recruiting areas that may not be represented in our coalition, to look on how to empower members to see their strengths.

Surgeon General's reports and Indiana's *Fundamentals of Smokefree Air Policy Development for Hoosier Communities* guideline were also noted as important resources. These resources were used to educate policymakers on the hazards of secondhand smoke and the benefits of smokefree policies.

> [*Fundamentals of Smokefree Indoor Air Policy* provides] both guiding principles for policy and also for process…a way to insure policy discipline around the country and around a state.

"[The Surgeon General's Report] uses very clear language stating that there's no safe level of exposure to secondhand smoke."

What resources were used to eliminate tobacco-related disparities?

Indiana partners identified disparate populations based on input or mandates from ITPC as well as the available data (e.g., the Behavioral Risk Factor Surveillance System). Partners in Indiana most frequently noted working with pregnant women, individuals of low socioeconomic status, and the mental health community.

> The ITPC [has included] pregnant woman [as] a mandate all along, and then the other areas, they made suggestions on other populations that you can work with. And so we basically chose from there what the greatest needs were in our community or the realistic type of outreach that we have.

Partners found minority organizations and community-based coalitions (e.g., Indiana Rural Health Association) to be important resources in their work with disparate populations. Information from the CDC-supported National Networks for Tobacco Control and Prevention also proved useful. Specifically, input from the Indiana Latino Institute, a partner organization of the National Latino Tobacco Control Network, was helpful to partners' tobacco efforts.

> We really look at working with our minority health partners that already exist in the state.

While some partners had referenced evidence-based guidelines in their work with populations with tobacco-related disparities, the majority did not. Specifically, most partners did not find *Best Practices* particularly useful. They noted that *Best Practices* lacked specificity and did not provide sufficient focus on practical applications of the guideline to disparate populations.

> So while I know about CDC *Best Practices* and use it, to some degree it's just not that critical because it doesn't speak directly to that population and get down to the very specific level that I need.

Consequently, partners commented on the need for additional resources to fill this gap. They suggested providing additional information or trainings on cultural competency, as well as guidance on working with specific communities and how to apply the evidence base to those populations.

> There's probably another piece that needs to be a little bit more in-depth as far as interventions that are really able to address some of those populations. More practical things with that disparities lens on it.

> Real world ideas. I need to know when I'm talking to these people what helps them to relate better to me.

What resources were used to communicate with policymakers?

The majority of partners in Indiana regularly communicated with policymakers, specifically citing contact with the governor's office, state legislators, mayors, and city and county council members. Much of the communication with policymakers revolved around defending ITPC's efforts to support funding as well as emphasizing the importance of smokefree policies.

To support funding for tobacco control efforts, partners frequently referenced evidence-based guidelines, particularly *Best Practices*, the *Community Guide*, the *IOM Report*, the *Clinical Practice Guidelines* and Surgeon General's reports. These guidelines were especially helpful in advocating for funding for the program and supporting ITPC's activities.

> We're using the *Best Practices* document to defend funding [for tobacco control] and to keep our funding in place.

> [Evidence-based guidelines are] generally the basis for having a conversation to defend what we want to do, or need to do, or need [policymakers] to do.

Partners provided personal testimony and information from other states when educating policymakers about the need to implement smokefree policies. To support their case, partners also referred to evidence-based guidelines in conjunction with available data, such as smoking rates.

> [Policymakers] may know *Best Practices*, or evidence-based guidelines as a concept, but I try to explain to them how it translates into activities that we're doing, and why we need for them to pass a smokefree air law.

What other resources were needed?

When asked what the CDC could do to continue to support Indiana's tobacco control efforts, partners expressed an interest in guidance on effective communication with policymakers. Additionally, partners thought that direct communication between the CDC and Indiana policymakers, such as writing letters or testifying to the state legislature, would have a strong influence on policymakers and would provide powerful reinforcement to their tobacco control efforts.

> [CDC] could work more closely with the National Council on State Legislators and the National Governor's Association to change opinions of our legislators.

> It would be great if [the CDC] could come and testify to the effectiveness of the ITPC program in front of the legislature.

Indiana partners also wanted to see more materials produced by the CDC. Specifically, partners noted a need for resources tailored to demographic subgroups as well as research on effective strategies for working with disparate populations.

> More information about promising practices in the specific communities.

> Things that would help us relate better to the different demographics that we need to work with, giving us some real world ideas on what we can do.

Finally, partners noted several ways to improve the communication and dissemination of new resources. Suggestions included:

- Centralizing and improving access to CDC OSH resources through a more user-friendly website; and
- Combining trainings, webinars, and/or technical assistance with the release of new resources or information.

> Well I'm beginning to be a fan of webinars and distance learning. So it would be a combination of friendly access on a website with tools and all the essential resources, and some distance learning so that individuals most interested can get the basics.

> Somehow if [the CDC] could be a little bit more user-friendly, and if they could send out some sort of updates on their resources [that would help my efforts].

Several individuals mentioned that due to the important role ITPC played for partners in the state, continuing to channel new information through the lead agency would be helpful to their efforts.

> I think to deliver [a new resource] through our state agency and have them disseminate to all their local partners [would be helpful].

Conclusions

Indiana tobacco control partners demonstrated a high level of awareness of evidence-based guidelines, particularly *Best Practices*, and used them frequently in their work. Partners primarily used the guidelines to educate stakeholders, in program planning, and to advocate for funding from policymakers. The *Best Practices* guideline was seen as providing the structure and foundation for a comprehensive tobacco control program. Additional factors that contributed to the adoption of *Best Practices* and other evidence-based guidelines included:

- ITPC served as the main resource for guideline dissemination and many received the *Best Practices* guideline from ITPC when they started their work in tobacco control.
- Partners saw guidelines as a way to provide credibility to their work because of their promotion of effective and proven practices.
- Partners thought that utilizing evidence-based guidelines compounded the impact of their work by providing consistency to both local and national tobacco control efforts.
- Indiana partners used evidence-based guidelines during frequent communication with policymakers. ITPC's separation from the Department of Health facilitated communication with policymakers, allowing policy change to take a central role in Indiana partners' efforts.

Despite the importance of evidence-based guidelines to Indiana's tobacco control efforts, partners noted several challenges to using the guidelines:

- Application of the guidelines occasionally met resistance from the community and some partners.
- Some of the guidelines were seen as too dense and technical to be easily translated into partners' work.
- Partners found the guidelines to be minimally useful in their work with disparate populations and they found it difficult to apply the guidelines to specific populations or communities. Therefore, partners suggested developing guidelines targeted at specific disparate populations.

A variety of different resources were employed to inform the work of those involved in tobacco control. In Indiana, recommendations from evidence-based guidelines, organizational direction and capacity, and input from partners played an important role in guiding tobacco control efforts. The degree to which particular evidence-based guidelines were incorporated into partners' work was dependent upon factors tied to three main phases of information diffusion highlighted throughout this report: dissemination, adoption, and implementation. Such factors included avenues of guideline dissemination to stakeholders, presence or absence of support by other individuals or policies, and the feasibility of applying that information to one's work. Indiana partners suggested disseminating evidence-based guidelines through ITPC and combining webinars and trainings to enhance the utilization of guidelines. Taking these factors into consideration when developing and releasing a new guideline will optimize use of the guideline by intended stakeholders.

The **Oregon** Profile:

Advancing the Best Practices

Use of Evidence-based Guidelines in
State Tobacco Control Programs

Prepared by
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Executive Summary

Introduction

There has been much research done on what works to curb tobacco use. Many agree that the evidence base for tobacco control is one of the most developed in the field of public health. However, the advancement in the knowledge base is only effective if that information reaches those who work to reduce tobacco consumption. Evidence-based guidelines, such as the Centers for Disease Control and Prevention's *Best Practices Guidelines for Comprehensive Tobacco Control Programs* (*Best Practices*), are a key source of this information. However, how these guidelines are utilized can significantly vary across states.

This profile presents findings from an evaluation conducted by the Center for Tobacco Policy Research at Washington University in St. Louis that aimed to understand how evidence-based guidelines were disseminated, adopted, and used within state tobacco control programs. Oregon served as the first case study in this evaluation. The project goals were two-fold:

- Understand how Oregon partners used evidence-based guidelines to inform their programs, policies, and practices;
- Produce and disseminate findings and lessons from Oregon so that readers can apply the information to their work in tobacco control.

Findings from Oregon

The following are highlights from Oregon's profile. Please refer to the complete report for more detail on the topics presented below.

- *Best Practices* was heavily cited by almost all of the Oregon partners and provided the basis for the state's tobacco control program direction. The guideline was a core document for Oregon partners, which was reflected by the comprehensive approach pursued by the Oregon program.
- Recommendations from evidence-based guidelines were cited as being the most important decision-making factor when designing programs or adopting policies for tobacco control. Support from leaders within partners' organizations was important for facilitating guideline use.
- Evidence-based guidelines were generally thought as being beneficial; still, challenges were identified with evidence-based guidelines, such as:
  - Lag time between new science and guideline release;
  - Resistance to change among partners;
  - Identifying evidence-based approaches for what is politically supported; and,
  - Applying interventions into practice.
- *Best Practices* was the primary guide for Oregon due to the following factors:
  - The document's framework provided a comprehensive approach that had been proven to work;
  - The guideline was disseminated through multiple communication channels and was formally incorporated into strategic plans and new staff orientations; and,
  - It was produced by the CDC, which was considered a reputable organization.

Introduction

Project overview

States often struggle with limited financial and staffing resources to combat the burden of disease from tobacco use. Therefore, it is imperative that effective efforts that produce the greatest return on investment are implemented. There has been little research on how evidence-based interventions are disseminated and utilized among state tobacco control programs. To begin to answer this question, the Center for Tobacco Policy Research at Washington University in St. Louis conducted a multi-year evaluation in partnership with the CDC Office on Smoking and Health. The aim of this project was to examine how states were using the CDC's *Best Practices for Comprehensive Tobacco Control Programs* (*Best Practices*) and other evidence-based guidelines for their tobacco control efforts and to identify opportunities that encouraged guideline use.

Qualitative and quantitative data from key partners in eight states were collected during the project period. States were selected based on several criteria, including funding level, lead agency structure, geographic location, and reported use of evidence-based guidelines. Information about each state's tobacco control program was obtained in several ways, including: 1) a survey completed by the state program's lead agency; and 2) key informant interviews with approximately 20 tobacco control partners in each state.

State profiles

This profile is part of a series of profiles that aims to provide readers with a picture of how states accessed and utilized evidence-based guidelines. This profile presents data collected in August 2009 from Oregon partners. The profile is organized into the following sections:

- **Program Overview –** provides background information on Oregon's tobacco control program.
- **Evidence-based Guidelines –** presents the guidelines we asked about and a framework for assessing guideline use.
- **Dissemination –** discusses how Oregon partners learned of new guidelines and their awareness of specific tobacco control guidelines.
- **Adoption Factors –** presents factors that influenced Oregon partners' decisions about their tobacco control efforts, including use of guidelines.
- **Implementation –** provides information on the critical guidelines for Oregon partners and the resources they utilized for addressing tobacco-related disparities and in communication with policymakers.
- **Conclusions –** summarizes the key factors that influenced use of guidelines based on themes presented in the profile and current research.

Quotes from participants (offset in green) were chosen to be representative examples of broader findings and provide the reader with additional detail. To protect participants' confidentiality, all identifying phrases or remarks have been removed.

Program Overview

Oregon's tobacco control program

In November 1996, voters in Oregon passed Measure 44. This measure increased excise taxes on tobacco and dedicated a percentage of the revenue to tobacco prevention. With funding from the tax increase, the Oregon Department of Human Services launched the Tobacco Prevention and Education Program (TPEP). TPEP served as the lead tobacco control agency in the state. Since its inception, TPEP had implemented a comprehensive tobacco control program, including: community programs, Quitline services, media campaigns, and state-level administration and surveillance support.

Since the 1998 Master Settlement Agreement, no settlement money had been spent on tobacco prevention in Oregon. Therefore, TPEP relied primarily on tobacco excise taxes from Measure 44. This led to fluctuations in TPEP's budget as revenue from the tobacco tax was diverted to other state programs. In FY2008, the program experienced its first significant funding increase since a drastic reduction in FY2004. In FY2010, TPEP received $7.7M; meeting 17.7% of the CDC's recommended funding level for a comprehensive tobacco control program in Oregon.

Oregon's tobacco control partners

Oregon's tobacco control efforts involved a variety of partners. Partners included coalitions, marketing agencies, health voluntaries, foundations, and other community and statewide organizations. One partner who was particularly unique to Oregon was a member of CDC's *Community Guide* staff. This partner worked in the same building as TPEP and participated in their team meetings. Twenty-one individuals from 15 organizations were identified by the lead agency as a sample of key partners in Oregon's tobacco control program. On average, partners had been involved in tobacco control for seven years. Below is the list of partners who participated in the interviews.

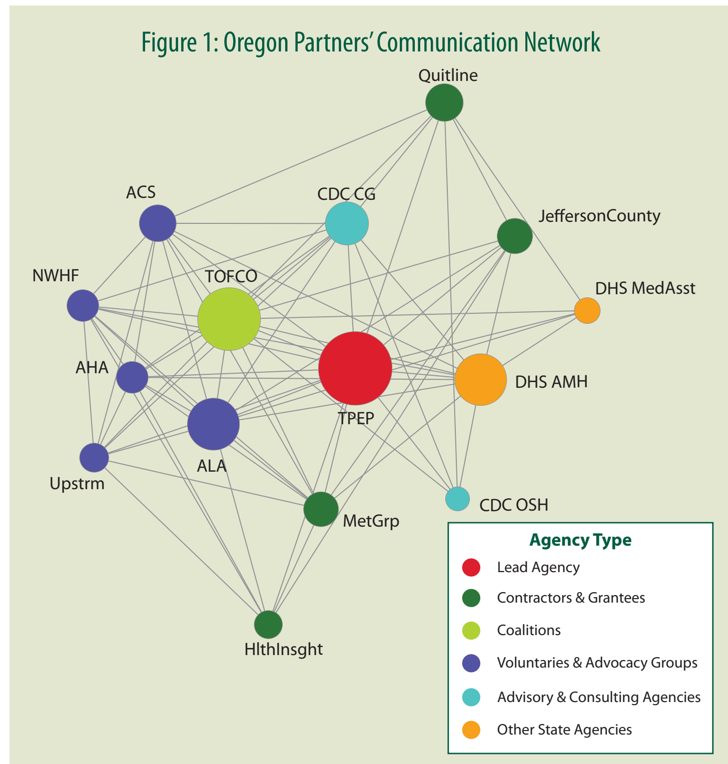
Table 1: Oregon Tobacco Control Partners

Agency	Abbreviation	Agency Type
Department of Human Services, Tobacco Prevention & Education Program	TPEP	Lead Agency
Metropolitan Group	MetGrp	Contractors & Grantees
Free & Clear	Quitline	Contractors & Grantees
Health Insight	HlthInsight	Contractors & Grantees
Jefferson County Health Department	JeffersonCounty	Contractors & Grantees
Tobacco Free Coalition of Oregon	TOFCO	Coalitions
American Heart Association/American Stroke Association	AHA	Voluntaries & Advocacy Groups
American Lung Association of Oregon	ALA	Voluntaries & Advocacy Groups
Upstream Public Health	Upstrm	Voluntaries & Advocacy Groups
American Cancer Society	ACS	Voluntaries & Advocacy Groups
Northwest Health Foundation	NWHF	Voluntaries & Advocacy Groups
Department of Human Services, Addictions and Mental Health Division	DHS AMH	Other State Agencies
Department of Human Services, Division of Medical Assistance Programs	DHS MedAsst	Other State Agencies
CDC, Office on Smoking and Health	CDC OSH	Advisory & Consulting Agencies
CDC, Community Guide	CDC CG	Advisory & Consulting Agencies

Communication between Oregon partners

Partners were asked how often they had contact (such as meetings, phone calls, or e-mails) with other partners within their network in the past year. In the figure to the right, a line connects two partners if they had contact with each other on more than a quarterly basis. The size of the node (dot representing each agency) indicates the amount of influence a partner had over contact in the network. An example of having more influence, or a larger node, was seen between TPEP, ALA, and CDC OSH. ALA did not have a direct connection with CDC OSH, but both had contact with TPEP. As a result, TPEP acted as a bridge between the two and had more influence within the network, and consequently, a larger node size. Oregon partners were tightly connected and frequently engaged with each other.

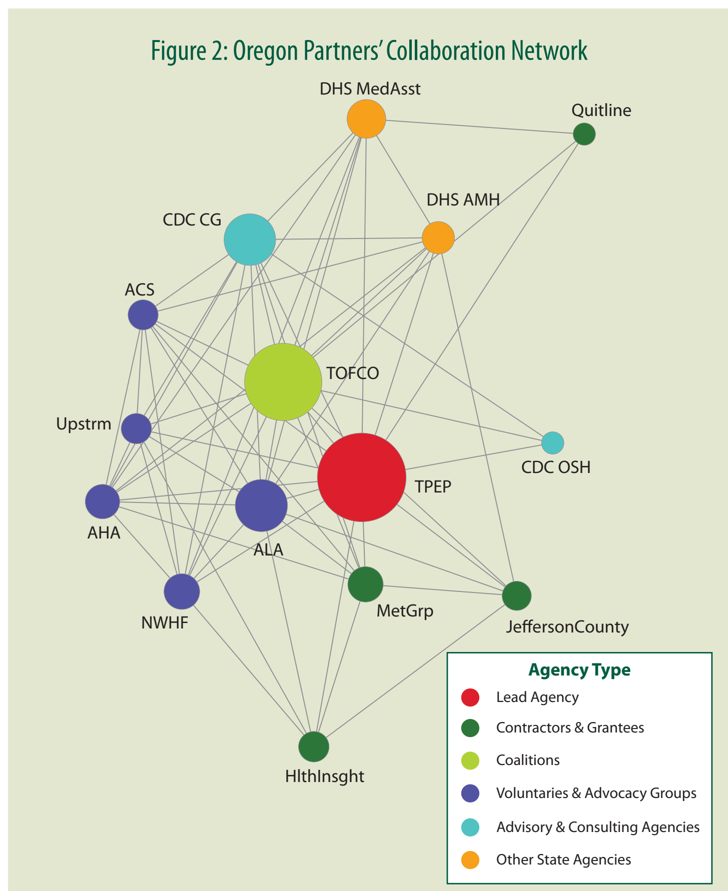
Figure 1: Oregon Partners' Communication Network



Collaboration between Oregon partners

Partners were asked to indicate their working relationship with each partner with whom they communicated. Relationships could range from not working together at all to working together as a formal team on multiple projects. A link between two partners indicates that they at least worked together informally to achieve common goals. Partners were not linked if they did not work together or only shared information. The node size (dot representing each agency) is based on the amount of influence a partner had over collaboration in the network. A partner was considered influential if he or she connected partners who did not work directly with each other. For example, Jefferson County and CDC OSH did not work directly with each other, but both worked with TPEP. TPEP acted as the "broker" between the two agencies and, as a result, has a larger node size. TPEP and TOFCO had the most influence over collaboration among partners as demonstrated by their larger node sizes. This indicates they were central to the network and had working relationships with many partners in the state.

Figure 2: Oregon Partners' Collaboration Network



Evidence-based Guidelines

There are a number of evidence-based guidelines for tobacco control, ranging from broad frameworks to documents focusing on specific strategies. Below are the guidelines partners were asked about during their interviews.

Partners also had the opportunity to identify additional guidelines or reports they used in their work. Other resources identified by Oregon partners included:

- Oregon's strategic plan, *Taking Action for a Tobacco-free Oregon*;
- Surveillance and evaluation reports from TPEP;
- American Lung Association's *Making Your Campus Tobacco-Free*, American Cancer Society's *How Do You Measure Up*, and other policy-related manuals and updates;
- Journal articles; and,
- Surgeon General reports.

Figure 3: Evidence-based Guidelines for Tobacco Control

Research has shown that the use of evidence-based practices, such as those identified in these guidelines, results in reductions in tobacco use and subsequent improvements in population health. Whether an individual or organization implemented evidence-based practices depended on a number of factors, including capacity, support, and available information. The remainder of this report will look at how evidence-based guidelines fit into this equation for Oregon. The framework below will guide the discussion, specifically looking at which guidelines Oregon partners were aware of, which ones were critical to partners' efforts, and how guidelines were used in their work.

Figure 4: Framework for Use of Evidence-based Guidelines

Dissemination

How did partners define "evidence-based guidelines"?

There was strong consensus among Oregon partners on what the term evidence-based guidelines meant. Partners viewed evidence-based guidelines as a compilation of published evidence, reports, and additional data that identified effective practices for addressing tobacco use (i.e., what works). Evidence-based guidelines provided credibility and justification for their efforts and helped to avoid "reinventing the wheel."

> When I am talking to people about why we are so focused on evidence-based guidelines, I say, tobacco control is a very old movement. . . we've narrowed down to a good understanding of what we feel works the best. The role of public health is to implement [what works best]. . . We follow those things that have been proven to have an effect on tobacco use and therefore tobacco morbidity and mortality.

How did partners learn of evidence-based guidelines?

Partners often heard about new guidelines from meetings, conferences, and contacts at the national level. Meetings sponsored by CDC OSH and the National Conference on Tobacco or Health were common events identified as venues for learning of new guidelines. Contacts at CDC OSH, Campaign for Tobacco Free Kids, and voluntaries at the national level (e.g., American Heart Association) were also identified as common sources for learning about guidelines. This was particularly the case for TPEP staff who regularly attended national meetings and had communication with CDC OSH through their program officer.

> Infrastructure at OSH does a great job at keeping in the loop on things coming out.

Within the state, listserves (i.e., TPEP and TOFCO), regional meetings, and TPEP's annual statewide meeting were mentioned as sources for hearing about new guidelines. Once they heard of a new guideline, partners often shared the information with their colleagues through e-mail or during staff meetings.

> When somebody goes to a conference and brings back something like the [*Best Practices*] *User Guides*, we'll debrief or we'll set aside time in a meeting to go over and share what we learned.

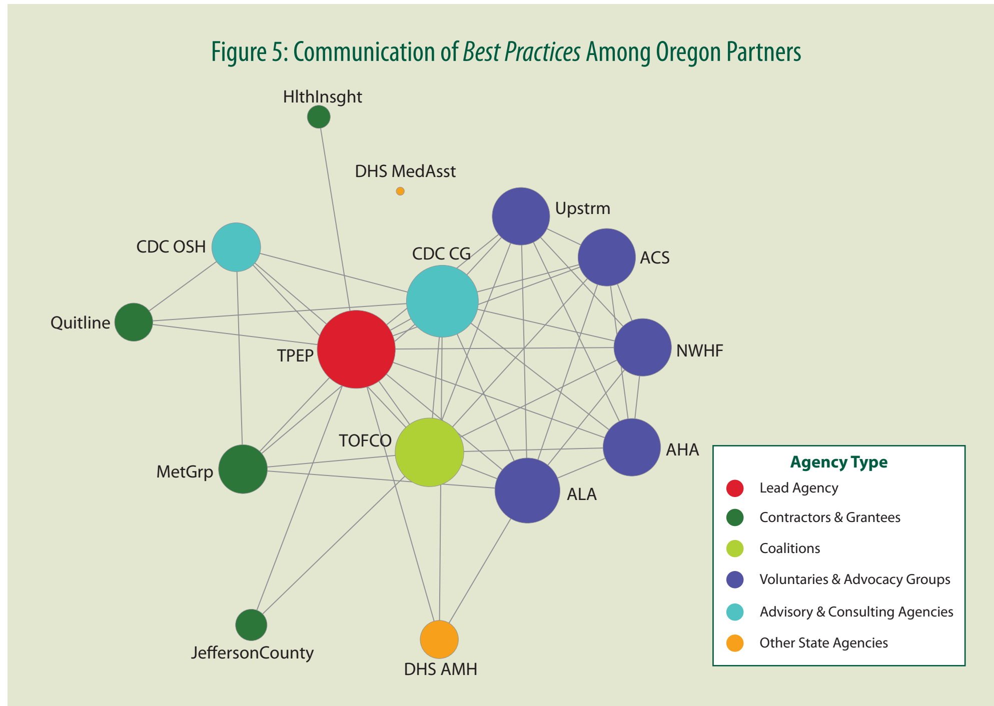
Once a guideline had been available for a while, they were not typically the focus of discussions or meetings. Guidelines were primarily brought up in new staff orientations or as a reference during planning meetings. For Oregon partners, *Best Practices* was frequently mentioned as a guideline that was referenced in discussions.

> Once a year at our annual meeting, we have what we call Tobacco 101 training, which is a specific half-day orientation where we present the concept of best practice work and environmental policy systems change.

> I go to a lot of organizational coalition meetings where we will talk about *Best Practices*...we utilize that a lot as guide. All throughout the session I think we were using *Best Practices*.

To get a better sense of who talked to whom about *Best Practices*, Oregon partners were asked who they talked to about the guideline. In the figure below, a line connects two partners who indicated they talked about the *Best Practices* guideline with each other. The size of the node indicates the number of agencies each partner talked to about the guideline. TPEP talked with the most partners about *Best Practices*. Advisory partners, the statewide coalition, and advocacy groups also talked with a number of other partners about the guideline. This falls in line with *Best Practices* frequently being identified by partners as a reference for planning and advocacy activities.

Figure 5: Communication of *Best Practices* Among Oregon Partners



Which tobacco control guidelines were partners aware of?

The *Best Practices* guideline was the most well-known in Oregon. Twenty out of 21 partners interviewed recalled at least hearing of *Best Practices*. In 2007, the revised version of *Best Practices* was a highly anticipated document for Oregon partners. Partnering organizations were made aware of the guideline through TPEP or from attending national conferences where the guideline was distributed.

The majority of partners were aware of the other guidelines listed as well. Awareness of guidelines was particularly strong for those partners who focused the majority of their time on tobacco control, since the topic of the guideline was most relevant to their work.

Table 2: Number of Partners Aware of Tobacco Control Guidelines

Guideline	# of Partners
Best Practices for Comprehensive Tobacco Control Programs	20/21
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	17/21
The Guide to Community Preventive Services: Tobacco	16/21
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	16/21
Ending the Tobacco Problem: A Blueprint for the Nation	15/21
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	15/21
Best Practices User Guide Series (e.g., Coalitions)	14/21
Designing and Implementing an Effective Tobacco Counter-Marketing Campaign	14/21
Key Outcome Indicators for Evaluating Tobacco Control Programs	14/21
Tobacco Control Monograph Series	14/21
Introduction to Process Evaluation in Tobacco Use Prevention and Control	12/21

Adoption Factors

What did partners take into consideration when making decisions about their tobacco control efforts?

Oregon partners overwhelmingly identified evidence-based guidelines, published literature, and surveillance data as information sources they took into consideration when making decisions about their tobacco control efforts. When asked to rank several factors in their importance for making decisions, 60% of partners ranked recommendations from evidence-based guidelines as the most important factor; 90% of partners ranked it in their top three. *Best Practices* was cited as being the predominant resource in Oregon. The guideline served as a framework for all of the activities supported by TPEP.

> All of our decisions about programs, projects, policies, etc. are based on *Best Practices*.

> It is really important to be able to continually justify our programmatic decisions. As the tobacco program, we're the most visible target for people who want to argue about funding. So we have to make sure that anything that we do, we can defend.

Guidance from TPEP often played a role in decision-making for partners. Requests For Applications (RFAs) included a menu of options for contractors from which to select. There were opportunities to identify strategies outside of the "menu," but they needed to be justified by evidence.

> We get a menu of choices in terms of what objectives we can move toward and that menu is based on the CDC *Best Practices*.

A major focus in the menu of options was policy change. TPEP and their partners focused on building local capacity for policy change and ensuring it was a priority on a statewide level.

> We try to get the biggest bang for the buck by changing broad policies [to affect] population level health.

Cost and organizational capacity were often tightly linked in decision-making for partners. Availability of resources influenced where money was allocated and what strategies were emphasized. In one way, cost and capacity were viewed as restricting what partners could do. In another way, partners viewed limited resources as a justification for focusing on evidence-based practices.

> When formulating policy, I think in terms of what we can actually do. How many policies can we actually advance? Looking at my budget, my human resources, if we have a lobbyist. . . If you don't have a sense of what you are actually able to accomplish, you're going to be overwhelmed.

Mandates or input from policymakers were also taken into consideration when making decisions about tobacco control efforts. Oregon partners often equated the term "policymakers" with their funder, whether it was the legislature, TPEP, or another agency with oversight of funding allocation. Since mandates often come first in decision-making, TPEP worked to make sure legislative decisions regarding tobacco control were based on evidence-based practices.

> If you've got mandates from policymakers, you need to do that. We work really, really hard for any statutory mandates to be based on *Best Practices*.

How did organizational characteristics influence partners' decisions about their tobacco control efforts?

Support for tobacco control within or outside a partner's organization was by far the most important factor that facilitated decisions about tobacco control efforts. Oregon partners described having a high level of support from leadership within their organization, the partners with whom they worked, and others in the state. This support facilitated the use of evidence-based guidelines. For example, senior leadership within the Department of Human Services, where TPEP was housed, acknowledged the importance of evidence-based guidelines. With limited resources for tobacco control, evidence-based practices were emphasized to ensure Oregon partners received the most return on their investment.

> "We do not have enough resources in public health to go try some stuff. There's no reason to if we know what works."

> If we can prove that this is effective or shows promise of being effective and this is what CDC recommends, then we have an easier time adopting it than maybe some states do.

The primary barriers identified by partners were funding and other resource constraints (e.g., staffing). Not having enough funding, restrictions on how it could be used, and instability from year to year were all identified as challenges for partners' tobacco control efforts. Stability of funding was of particular importance to Oregon's tobacco control program. In 2003, the program lost its funding due to state budget constraints. Local programs could no longer be funded and some staff were lost. The program's funding had since been reinstated, but the significant cut to the program emphasized the importance of maintaining funding to ensure programs continued at the community level.

> Overwhelmingly, all the partners felt the best thing to do with the money is to keep intact the programs at the county and local levels. We don't [want to] let these programs desist, because we know how difficult it is to resurrect a program once it's gone.

What facilitated or hindered use of evidence-based guidelines?

Oregon partners felt evidence-based guidelines provided legitimacy to their programs, helped justify their decisions to policymakers, and provided a way for partners to be on the same page about the best approaches. Guidelines identified effective strategies for addressing tobacco use and could be easily shared with partners and other stakeholders.

> When you are committed to doing the things that are known to get results, you get results…We have stuck by our guns and gotten results and then a legislator, not being prompted, said "TPEP works." That's as good of validation as we are ever going to get.

> [Guidelines] help us to do effective work. We want to do things that are going to move the needle in consumption and prevalence, so it doesn't make sense to not do something that has some sort of basis in evidence…It really helps us justify our existence because if your program isn't effective then you're not going to stick around in this climate.

Partners thought that evidence-based guidelines did not always include the most current evidence and were not "cutting edge." It takes time to translate research into evidence-based guidelines. Partners felt that finding a balance between implementing evidence-based interventions and promising practices that lacked a substantial evidence base was challenging. This was particularly the case for keeping up with the fast-paced tobacco market and its release of new products.

> The most common problem is that [guidelines] can't be cutting edge, the guidelines are always based on evidence…So OSH can't provide guidance on whether we should be jumping into internet-based cessation because there is not a body of evidence yet…OSH needs to be listening to what programs are doing and still allow some freedom and listen to what other programs are finding effective. By and large, they've done that.

> There might be some practices that aren't yet proven; promising practices…sometimes you need to step out on a limb and try.

Strategies identified in evidence-based guidelines were not always popular. Partners discussed how implementing evidence-based practices may go against what had been done in the past. At times, it was a challenge to stay on point about the importance of following evidence-based guidelines and convincing others to avoid doing something they had always done, even though it was not evidence-based.

> "It is not so much a challenge to use evidence-based practices, but it's a little bit of a challenge to convince people to not use non-evidence-based practices."

> Not all the counties are cohesive around policy and systems change and supportive of evidence-based practices. Some are very uncomfortable with the policy and environmental approach.

Other challenges for using evidence-based guidelines included:

- Determining how to apply guidelines in practice;
- Implementing guidelines with varying levels of resources; and,
- Explaining the importance of a comprehensive approach to policymakers.

> When people say, "What do you do for cessation?", we try to say, "We pass smokefree policies, we raise the price of tobacco, we have a Quitline." We do all of these things that lead people to want to quit and then stay quit. We try to talk about that comprehensive nature all of the time, but it can be hard.

Implementation

Which guidelines were critical for Oregon's tobacco control partners?

Oregon partners were aware of a number of evidence-based guidelines and reports. However, a smaller number of these guidelines were identified as critical resources when partners were asked to group guidelines into one of three categories: 1) *Critical* for their tobacco control efforts; 2) *Not critical, but useful* for their tobacco control efforts; and 3) *Not useful* for their tobacco control efforts. Three of the top four critical guidelines identified by partners covered more than one strategy and provided guidance that could be applied to a comprehensive tobacco control effort. The following are the guidelines identified most frequently as critical resources by Oregon partners.

Best Practices for Comprehensive Tobacco Control Programs

Ninety percent of Oregon partners aware of the CDC's *Best Practices* identified it as a critical resource. Partners cited the guideline as the central document for Oregon's tobacco control program and stressed the importance of its comprehensive approach. The guideline was primarily referred to for strategic planning and as an advocacy tool with policymakers. The guideline was also incorporated into TPEP's Requests For Proposals (RFPs) to ensure work plans were grounded in *Best Practices* from the time they were approved.

> [*Best Practices*] really provides a good summary and good direction for why each component is important and why it's important to have them all working together.

> [Partners] have taken *Best Practices* to legislative meetings and said, "This is how much we should be spending and the way that we should be spending it."

Table 3: Percentage of Partners Who Identified Guideline as a Critical Resource

Guideline	% of Partners*
Best Practices for Comprehensive Tobacco Control Programs	90%
The Guide to Community Preventive Services: Tobacco	63%
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	53%
Key Outcome Indicators for Evaluating Tobacco Control Programs	50%
Ending the Tobacco Problem: A Blueprint for the Nation	43%
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	31%
Best Practices User Guides Series (e.g., Coalitions)	23%
Tobacco Control Monograph Series	14%
Designing and Implementing an Effective Tobacco Counter-Marketing Campaign	7%
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	6%
Introduction to Process Evaluation in Tobacco Use Prevention and Control	0%

* Based on partners who were aware of the guideline

Revisions to the CDC *Best Practices*

In 2007, *Best Practices* was revised. To find out how these changes were perceived, Oregon partners were asked additional questions about *Best Practices*. Overall, partners felt the changes from the original version, released in 1999, were appropriate. The revised guidelines provided additional evidence for strategies and explained some concepts that were unclear in the first version. Most partners were positive about the

changes to the recommended funding levels for states. Although the removal of lower and upper estimates resulted in a higher recommended annual investment for Oregon, the explanation of how CDC determined the funding amount was helpful.

> The only thing that really seemed to change dramatically was the funding amount. There seemed to be a lot of evidence and a lot of good training around that…It was really helpful to have that specific number, the amount that we really need and to learn the evidence behind it, so I think the changes were very positive.

Oregon partners frequently cited using information presented at national meetings on how to maintain a comprehensive program with varying funding levels. This information was seen as a good accompaniment to *Best Practices.* Partners expressed an interest in seeing this information released by CDC in document form so they could share it with partners and utilize it in strategic planning.

> This was an excellent way to put things forward because we don't have very much money…we didn't know what to pick. It's a critical piece of information in determining how much money to allocate to the communities.

"The message [in *Best Practices*] that was really critical was the message that we know what works in tobacco control and what we need now is the political support to do the things that work."

The Guide to Community Preventive Services: Tobacco

The *Community Guide* was identified as critical by 63% of the partners familiar with the resource. The guide was primarily used to identify which interventions were evidence-based and should be pursued. Partners felt the *Community Guide* provided validity for the implementation of particular interventions, as well as justification for the funding of those interventions. Another benefit of the *Community Guide* was the fact that it also identified strategies that lacked sufficient evidence.

> The *Community Guide* has been helpful for us I would say in seeing the kinds of components, elements that need to be built into our comprehensive tobacco control program.

> The list of things that are recommended and things that are not recommended [in the *Community Guide*], that's really valuable for states.

Clinical Practice Guidelines: Treating Tobacco Use and Dependence

The *Clinical Practice Guidelines* was cited as critical by 53% of Oregon partners aware of the guideline. The guide served as a reference for developing outcome measures for cessation and informing partners' work with healthcare systems.

> [*Clinical Practice Guidelines*] provides the evidence-basis for all of the interactions between a provider and his or her patient regarding smoking, and it provides guidance on system changes that could be done and how you would do that.

Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs

Key Outcome Indicators was identified as a critical resource by 50% of Oregon partners who were aware of the guide. The guide was referred to for planning and developing logic models and evaluation plans. It was also a valuable resource for setting goals for programs and interventions.

> [*Key Outcome Indicators*] identifies indicators so that as you're writing your activities and objectives...your short-term and long-term and intermediate-term objectives . . . these things demonstrate the effect [of your efforts].

Other Resources

Additional resources cited as critical by Oregon partners included Surgeon General reports, CDC's *Introduction to Program Evaluation for Comprehensive Tobacco Control Programs*, and the Institute of Medicine's *Ending the Tobacco Problem: A Blueprint for the Nation*. Surgeon General reports were not included in the list of resources for partners to rank as critical, but they were identified as a valuable resource for orienting individuals to tobacco control and cited as a reference in communications with policymakers.

> Even though it's much longer, someone successfully making their way through the Surgeon General's Report would know essentially all of the issues relevant to modern tobacco control.

The Institute of Medicine's report was cited as a reference in fact sheets for policymakers and journalists. The *Introduction to Program Evaluation* provided a good framework for developing evaluations. Evaluation findings were also identified as important by some partners because they provided additional information regarding what worked and did not work in the field of tobacco control.

> The most critical resource for me is the data from the state. I can look in Oregon at the evaluations of the programs that have happened here before I started doing this work. I tend to look very strongly at what I'm hearing from the field about what the challenges are and what's working and what's not working.

What resources were used to address tobacco-related disparities?

Partners utilized surveillance and Quitline data to identify populations with tobacco-related disparities. Partners primarily looked to TPEP to provide this information. TPEP utilized its strategic plan and the Tobacco Disparities Advisory Council to provide guidance on the populations of focus. In addition, the program funded five in-state networks to provide technical assistance and outreach within their communities.

> The state determines which populations to focus on and they select grantees that serve those populations. The population networks are relied on to do specific outreach within their communities and are provided the media support and messaging support to help them do that.

Partners looked to individuals in their communities, the CDC, and other states to provide direction and examples of the best strategies for eliminating tobacco-related disparities. Partners rarely looked to *Best Practices* for addressing tobacco-related disparities. Several partners did emphasize how addressing tobacco-related disparities was an important component of a comprehensive approach. However, partners felt a better summary of the evidence base and how to apply it to tobacco-related disparities (e.g., policy changes) was needed.

> CDC was able to direct us to other states that were trying to answer the same questions about what to do around disparities. [Oregon] borrowed heavily from California and the way they structured funds to community-based agencies to support policy work and coordination among communities around the state to address disparities.

> [*Best Practices*] is moderately useful. It provides big picture stuff, but the actual drilldown into communities with tobacco-related disparities is not sufficient.

What resources were used to communicate with policymakers?

Oregon partners often tried to tailor their information to the specific interests of policymakers. State and county specific data, as well as constituents' stories, were shared to highlight the economic and health costs of tobacco use in Oregon. This information was often developed into one-page fact sheets or used in testimonies to the state legislature.

> Personal stories from constituents to state legislators on the health consequences of tobacco are influential to the state of Oregon's tobacco control program.

Evidence-based guidelines served as references for what worked to reduce the burden of tobacco use in Oregon. Partners often referenced the funding levels recommended in the CDC's *Best Practices* and evidence-based strategies from the *Community Guide*.

> *Best Practices* provides the recommended funding levels, what areas to focus on in tobacco control, and the need for a comprehensive approach to reduce the burden of tobacco.

What other resources did partners need?

Partners knew what worked to reduce tobacco consumption and initiation in Oregon. Partners indicated they had strong support within the state and had made great strides in reducing tobacco use in the state over the past several years. In order to continue to achieve their goals, partners needed consistent funding and continued support from leadership within their organizations and from policymakers.

When asked what the CDC could do to continue to help partners in their work, partners identified communication as one area of focus. This included facilitating communication with individuals and groups on a national level, continuing to bring together states to hear from one another, and expanding communication beyond the state's lead agency.

> Broader communication or engagement with people beyond program people, they are really focused on the state, but I'm not sure that they expand their communication further than that.

Partners also thought that identifying or supporting training and technical assistance would be helpful. Suggested topics for trainings included policy advocacy, application of *Best Practices* to the local level, and how to scale their program based on varying funding levels.

"Having a more formal way to take all of our lessons learned and create something which would build on all of our work and make it that much better would be a good role for the CDC to support."

Finally, partners emphasized the importance of the CDC in continuing to provide evidence-based practice information to states, as well as identifying what does not work. This included providing funding or other support for evaluation and research at the local, state, and national levels, and ensuring that information about the most current evidence, tools, and reports was delivered to states and communities as quickly as possible.

> Stay on course. Stay focused on *Best Practices.*

Conclusions

Many Oregon partners were aware of evidence-based guidelines and used them when making decisions about their tobacco control efforts. In Oregon, *Best Practices* was the central document for the state's comprehensive tobacco control efforts. Several factors contributed to the adoption of *Best Practices* in Oregon, including:

- The guideline was produced by the CDC, which was viewed as a reputable health organization.
- The importance of the guideline was communicated through multiple channels, including e-mail, trainings, planning meetings, and advocacy activities.
- The guideline was formally incorporated into applications for funding, strategic plans, new partner orientations, and policies.
- *Best Practices* provided a useful framework for a comprehensive approach to tobacco control and recommendations that could be referenced when making the case for program funding.
- Partners perceived that the approach described in *Best Practices* had worked in the past and would continue to help in their work to reduce the burden of tobacco use in the future.

Despite the heavy use of certain guidelines, other guidelines asked about were less known or less commonly listed as critical. There were several reasons why, including:

- Some of the guidelines were perceived as out of date and no longer thought of as providing the latest science;
- They were not emphasized as guidelines partners should use;
- They were not comprehensive and were only used by those partners interested in the specific topic they covered; and,
- Use of the guidelines was not tied to certain incentives (e.g., funding, leadership support).

Tobacco control partners possess an abundance of information at their disposal to inform their decision-making process. Previous experiences, information obtained from trainings, input from partners, and policies or mandates all play a role in decision-making about tobacco control efforts. Whether particular evidence-based guidelines stood out in this vast amount of information was largely dependent on factors tied to three main phases of information diffusion highlighted in this report: Dissemination, Adoption, and Implementation. Influential factors included how the guideline was disseminated to stakeholders, if its use was supported by other individuals or policies, and whether it could be incorporated into one's work. Taking these factors into consideration when developing and releasing a new guideline will help to optimize by intended stakeholders.

The **Texas** Profile:

Merging best practices from two sides

Use of Evidence-Based Guidelines in State Tobacco Control Programs

Prepared by
The Center for Tobacco Policy Research at
Washington University in St. Louis

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Executive Summary

Introduction

There has been a significant amount of research done on what works to curb tobacco use. Many agree that the evidence-base for tobacco control is one of the most developed in the field of public health. However, the advancement in the knowledge base is only effective if that information reaches those who work to reduce tobacco consumption. Evidence-based guidelines, such as the Centers for Disease Control and Prevention's *Best Practices Guidelines for Comprehensive Tobacco Control Programs* (*Best Practices*), are a key source for this information. However, how these guidelines are utilized can vary significantly across states.

This profile presents findings from an evaluation conducted by the Center for Tobacco Policy Research at Washington University in St. Louis that aimed to understand how evidence-based guidelines were disseminated, adopted, and used within state tobacco control programs. Texas served as the second case study in this evaluation. The project goals were two-fold:

- Understand how Texas partners used evidence-based guidelines to inform their programs, policies, and practices;
- Produce and disseminate findings and lessons from Texas so that readers can apply the information to their work in tobacco control.

Findings from Texas

The following are highlights from Texas' profile. Please refer to the complete report for more detail on the topics presented below.

- Texas' Tobacco Prevention and Control Program (TPCP) is located in the Mental Health and Substance Abuse Division within the Department of State Health Services. This is different from many state tobacco control programs, which are often housed within chronic disease divisions.
- Due to the lead agency's placement in substance abuse, Texas tobacco control partners relied heavily on the Substance Abuse and Mental Health Services Administration's guidelines and other resources (e.g., *Strategic Prevention Framework)*. This was in addition to the use of the CDC's *Best Practices* to guide their tobacco control efforts.
    - Partners felt overall, guidelines from both agencies complemented each other. For example, the *Best Practices* was described as the guideline that outlined what interventions to pursue and SAMHSA's *Strategic Framework* outlined the steps that needed to take place for the intervention to be successful.
- Texas partners thought that evidence-based guidelines provided proven strategies to reduce tobacco use and provided justification for their work. Still challenges were identified with using evidence-based guidelines:
    - Legislation mandated that a comprehensive evidence-based tobacco control program based on *Best Practices* was to be implemented in Texas. However, limited funding and staff turnover with many partners' agencies made implementing a comprehensive program a significant challenge.
    - Guidelines often presented many components or strategies making it difficult for partners to know where to focus their efforts. There was a need for more training or information on how to implement guidelines and prioritize efforts in real world settings.

Introduction

Project overview

States often struggle with limited financial and staffing resources to combat the burden of disease from tobacco use. Therefore, it is imperative that effective efforts that produce the greatest return on investment are implemented. There has been little research on how evidence-based interventions are disseminated and utilized among state tobacco control programs. To begin to answer this question, the Center for Tobacco Policy Research at Washington University in St. Louis conducted a multi-year evaluation in partnership with the Centers for Disease Control and Prevention Office on Smoking and Health (CDC OSH). The aim of this project was to examine how states were using the *CDC Best Practices for Comprehensive Tobacco Control Programs* (*Best Practices*) and other evidence-based guidelines for their tobacco control efforts and to identify opportunities that encouraged guideline use.

Qualitative and quantitative data from key partners in eight states were collected during the project period. States were selected based on several criteria, including funding level, lead agency structure, geographic location, and reported use of evidence-based guidelines. Information about each state's tobacco control program was obtained in several ways, including: 1) a survey completed by the state program's lead agency; and 2) key informant interviews with an average of 22 tobacco control partners in each state.

State profiles

This profile is part of a series of profiles that aims to provide readers with a picture of how states accessed and utilized evidence-based guidelines. This profile presents data collected in October 2009 from Texas partners. The profile is organized into the following sections:

- **Program Overview-** provides background information on Texas' tobacco control program.
- **Evidence-based Guidelines-** presents the guidelines we asked about and a framework for assessing guideline use.
- **Dissemination-** discusses how Texas partners learn of new guidelines and their awareness of specific tobacco control guidelines.
- **Adoption Factors-** presents factors that influence Texas partners' decisions about their tobacco control efforts, including use of guidelines.
- **Implementation-** provides information on the critical guidelines for Texas partners and the resources they utilize for addressing tobacco-related disparities and communication with policy makers.
- **Conclusions-** summarizes the key factors that influence use of guidelines based on themes presented in the profile and current research.

Quotes from participants (offset in green) were chosen to be representative examples of broader findings and provide the reader with additional detail. To protect participants' confidentiality, all identifying phrases or remarks have been removed.

Program Overview

Texas' tobacco control program

After the Texas tobacco settlement of 1998, Texas implemented a pilot study to evaluate tobacco control interventions at various levels in 18 Texas counties. The results showed that there was a significant impact in reducing tobacco use in counties that implemented a comprehensive program. As a result of these findings, the 80th Texas Legislature mandated that a comprehensive program be applied statewide. However, funding was not increased sufficiently to support a comprehensive statewide program in all of Texas' 254 counties.

At the time of the evaluation, Texas' state tobacco prevention and control program was housed in the Texas Department of State Health Services (DSHS). In 2006, the tobacco program moved from the chronic disease section of the agency to the Mental Health and Substance Abuse Division in an effort to increase efficiency. Due to a legislative mandate, the Tobacco Prevention and Control Program (TPCP) was created to fund community coalitions through a competitive grant process. In 2009, there were six regional coalitions that were funded throughout the state. In FY 2010, the TPCP received $11.8 million in funds, which was only 5% of *CDC's Best Practices* recommended spending level for a comprehensive tobacco control program.

Texas' tobacco control partners

Texas' tobacco control efforts involve a variety of partners. Partners include marketing agencies, health voluntaries, community coalitions, and other community and statewide organizations. Twenty-three individuals from 20 organizations were identified as a sample of key members of Texas' tobacco control program. Texas partners' tobacco control experience ranged from one year to over 10 years of involvement. Below is the list of partners that participated in the interviews.

Table 1: Texas Tobacco Control Partners

Agency	Abbreviation	Agency Type
Department of State Health Services - Tobacco Prevention & Control	DSHS Tobacco	Lead Agency
University of Texas at Austin	UT Austin	Contractors & Grantees
EnviroMedia Social Marketing	EnviroMedia	Contractors & Grantees
Texas State Univ. at San Marcos-Center for Safe Communities & Schools*	TX State	Contractors & Grantees
University of Houston	UofH	Contractors & Grantees
American Cancer Society National Cancer Information Center/Quitline	ACS	Contractors & Grantees
San Antonio Metropolitan Health District	San Antonio	Coalitions
Austin-Travis County Health & Human Services	Austin	Coalitions
East Texas Council on Alcohol & Drug Abuse	East Texas	Coalitions
Fort Bend County Health & Human Services	Fort Bend	Coalitions
Permian Basin Regional Council on Alcohol and Drug Abuse	Permian Basin	Coalitions
Abilene Regional Council on Alcohol & Drug Abuse	Abilene	Coalitions

*Now known as Texas School Safety Center

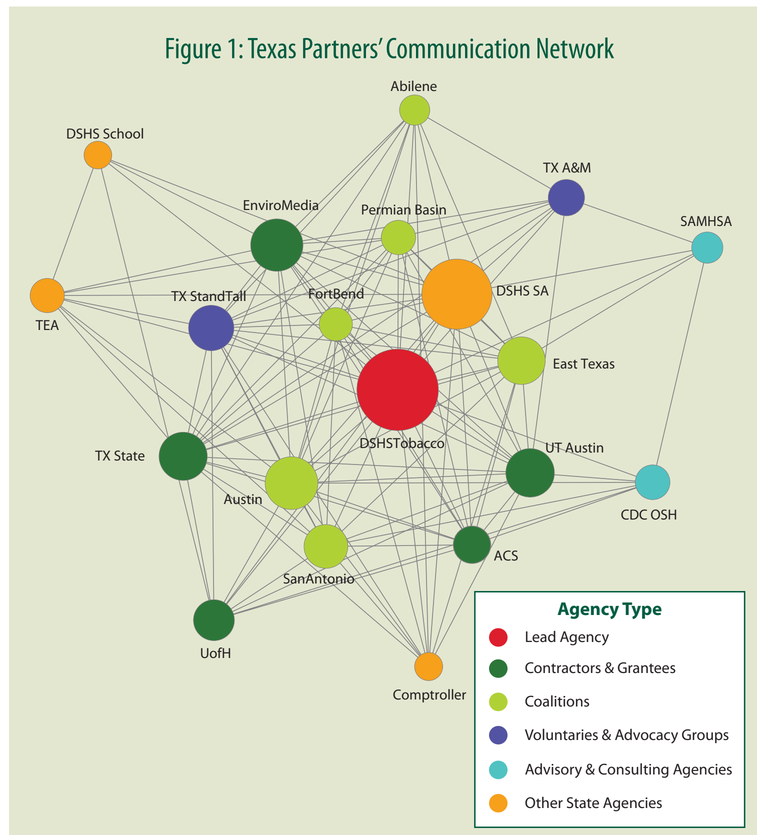
Table 1: Texas Tobacco Control Partners (continued)

Agency	Abbreviation	Agency Type
Texas A&M University/PRC 10	TX A&M	Voluntaries & Advocacy Groups
Texans Standing Tall	TX StandTall	Voluntaries & Advocacy Groups
State Comptroller of Public Accounts	Comptroller	Other State Agencies
Department of State Health Services-School Health Program	DSHS School	Other State Agencies
Department of State Health Services - Substance Abuse Prevention	DSHS SA	Other State Agencies
Texas Education Agency	TEA	Other State Agencies
CDC-Office on Smoking and Health	CDC OSH	Advisory & Consulting Agencies
SAMHSA-National Synar Program	SAMHSA	Advisory & Consulting Agencies

Communication between Texas partners

To gain a better sense of Texas partners' relationships, we asked about their interaction with other tobacco control organizations in the state program. Partners were asked how often they had contact (such as meetings, phone calls, or e-mails) with other partners within their network in the past year. In the figure to the right, a line connects two partners if they had contact with each other on more than a quarterly basis. The size of the node (dot representing each agency) indicates the amount of influence a partner had over contact in the network. An example of having more influence, or a larger node, was seen between DSHS Tobacco, CDC OSH, and TX A&M. CDC OSH did not have a direct connection with TX A&M, but both had contact with DSHS Tobacco (the lead agency). As a result, DSHS Tobacco acted as the bridge between the two and had more influence within the network, and is therefore represented by a larger node. Communication within Texas indicated a relatively decentralized structure among partners where members of the network had contact with many agencies.

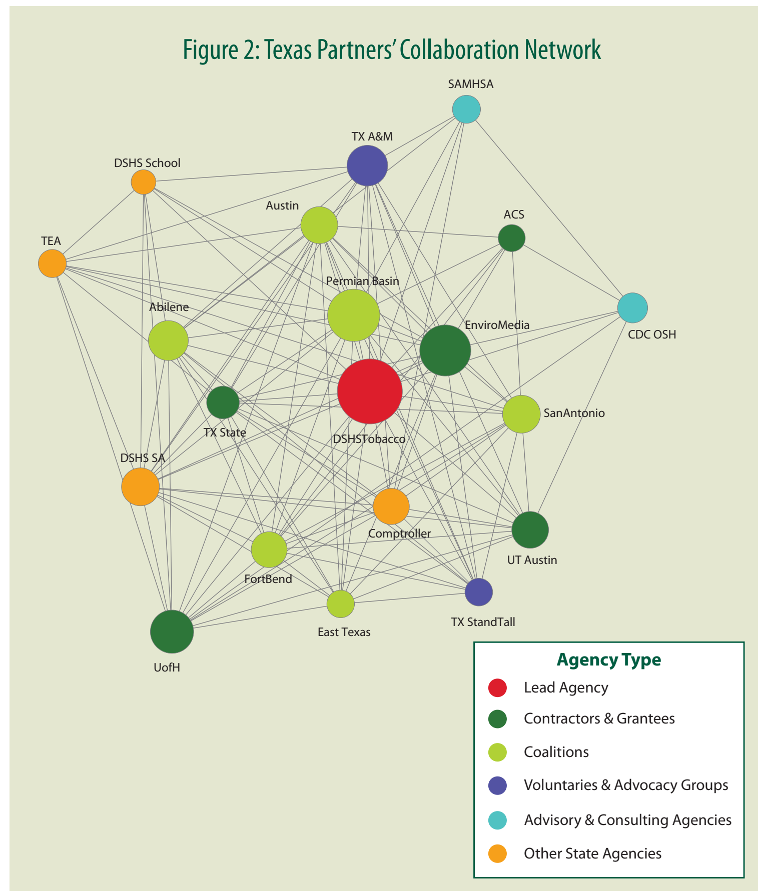
Figure 1: Texas Partners' Communication Network



Collaboration between Texas partners

Partners were asked to indicate their working relationship with each partner they communicated with. Relationships could range from not working together at all to working together on multiple projects. A link between two partners means that they at least worked together informally to achieve common goals. Partners were not linked if they did not work together or only shared information. The node size is based on the amount of influence a partner had over collaboration in the network. A partner was considered influential if he or she connected partners who did not work directly with each other. For example, ACS and UT Austin did not work directly with each other, but both worked with DSHS Tobacco. DSHS Tobacco acted as the "broker" between the two agencies and, as a result, has a larger node size. DSHS Tobacco, Permian Basin, and EnviroMedia had the most influence over collaboration among partners as demonstrated by their larger node sizes. This indicates they were central to the network and had working relationships with many partners in the state.

Figure 2: Texas Partners' Collaboration Network



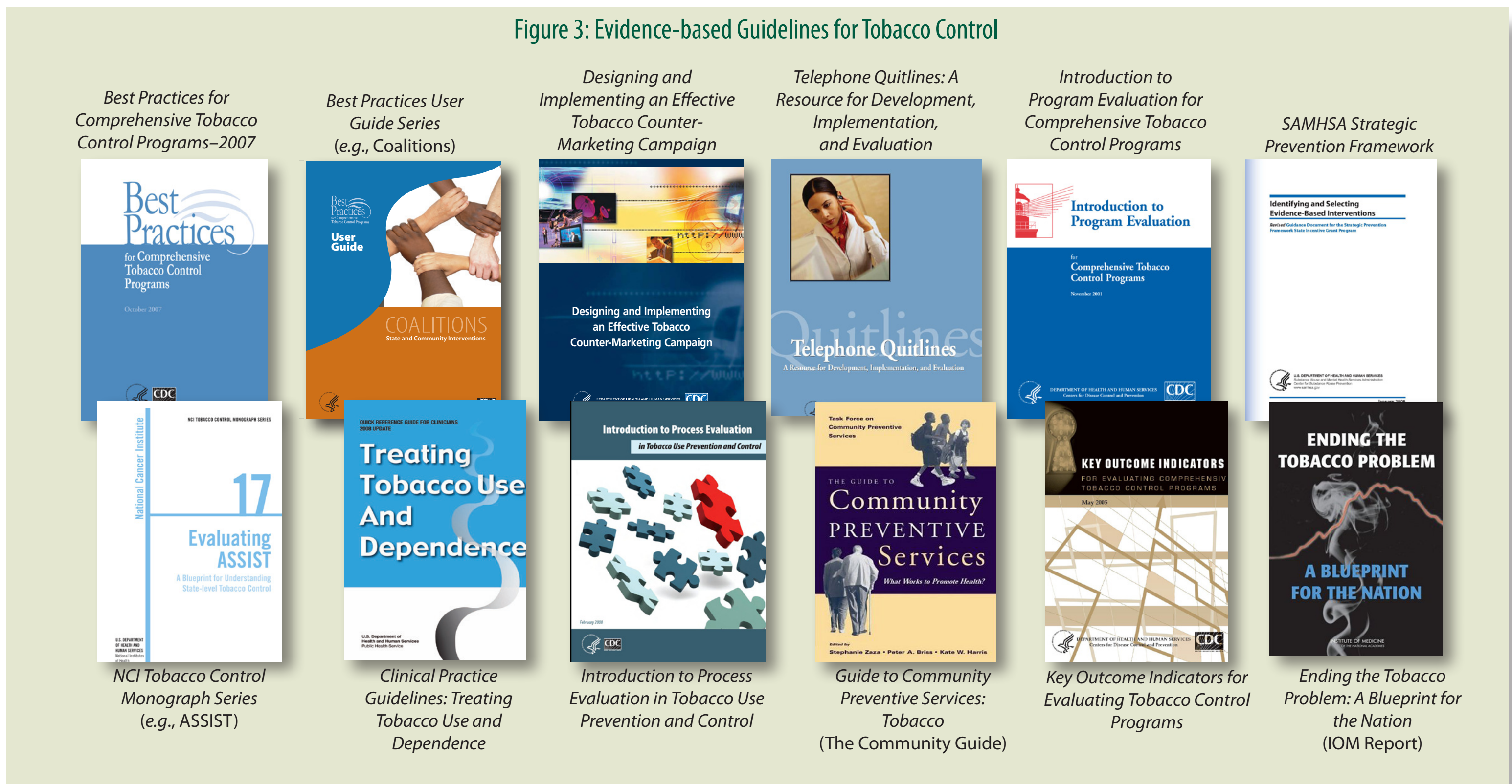
Evidence-based Guidelines

There are a number of evidence-based guidelines for tobacco control, ranging from broad frameworks to those focusing on specific strategies. Below in Figure 3 are the set of guidelines partners were asked about during their interviews.

Partners also had the opportunity to identify additional guidelines or reports they used in their work. Other resources identified by Texas partners included:

- Substance Abuse and Mental Health Services Administration (SAMHSA) *Administrative Directive of Promising Practice*;
- Surgeon General reports;
- Community-based guidelines or tools:
  - Texas DSHS *Community Tobacco Prevention and Control Toolkit*;
  - University of Kansas *Community Toolbox*;
- RAND technical reports on process evaluation;
- SAMHSA *National Registry of Evidence-based Programs and Practices*;

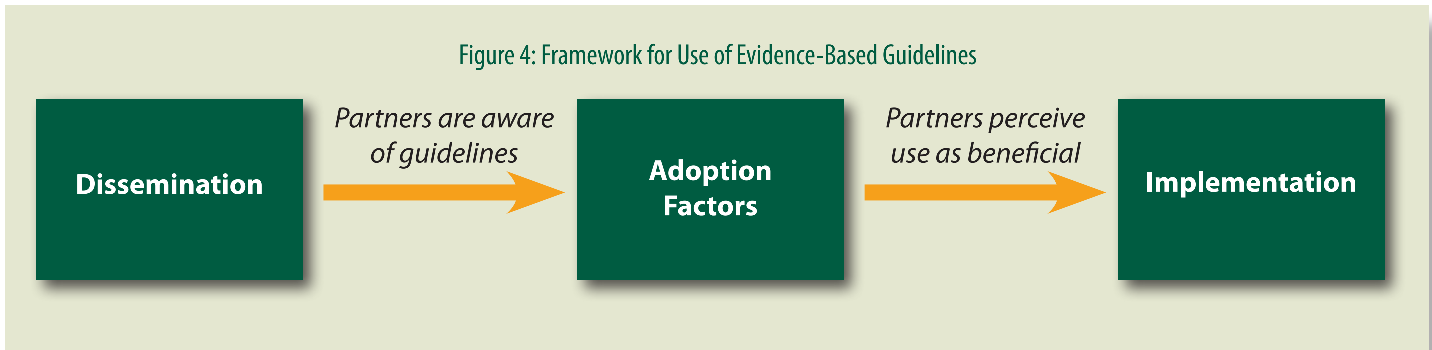
Figure 3: Evidence-based Guidelines for Tobacco Control



- US DHHS *Healthy People 2010: The Cornerstone for Prevention*;
- CDC *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*; and
- CDC *School Health Education Profile Tobacco Module*.

Research has shown that the use of evidence-based practices, such as those identified in these guidelines, results in reductions in tobacco use and subsequently improvements in population health. Whether an individual or organization implemented evidence-based practices depends on a number of factors, including capacity, support, and available information. The remainder of this report will look at how evidence-based guidelines fit into this equation for Texas. The framework below will guide the discussion, specifically looking at which guidelines Texas partners were aware of, which ones were critical to partners' efforts, and how guidelines were used in their work.

Figure 4: Framework for Use of Evidence-Based Guidelines



Dissemination

How did partners define "evidence-based guidelines"?

Texas partners overwhelmingly defined the term evidence-based guidelines as a compilation of research that had been tested by a reputable source. Interventions listed in guidelines were thought of as proven practices that were developed from the literature and previous evaluation efforts.

> Evidence-based practices are practices that should be guaranteed to work every time if they're implemented and held with fidelity, they should yield the results.

How did partners learn of evidence-based guidelines?

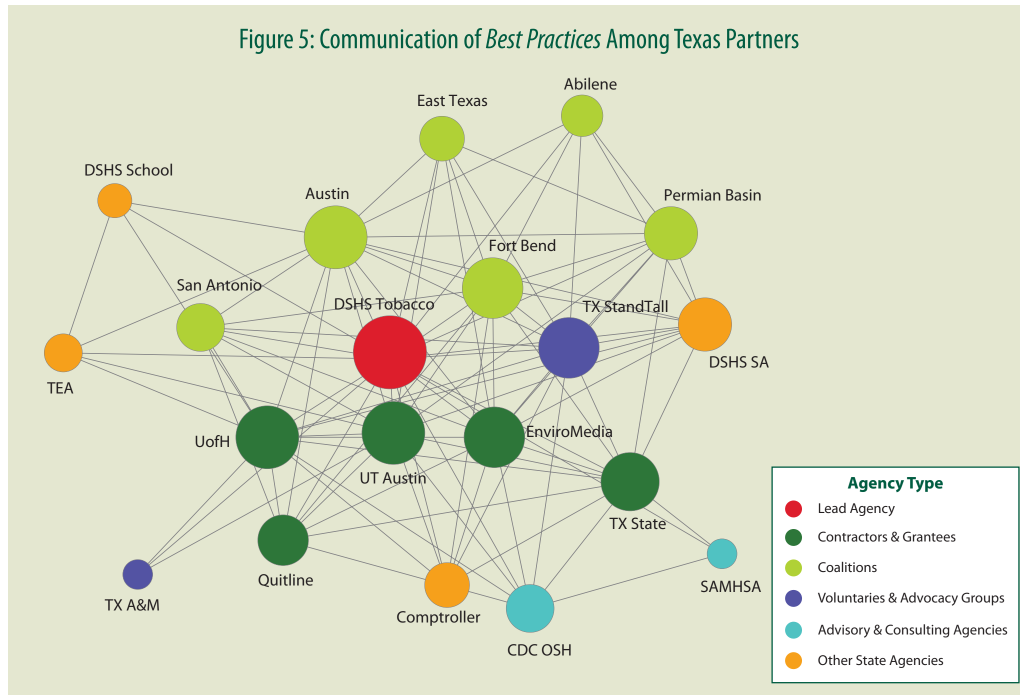
Those whose work was predominantly focused on tobacco were commonly identified as the first to know of guidelines within an organization. Additionally, individuals in leadership positions within their organization, or those in charge of partners' tobacco control programs, such as program managers, tended to be the first to hear of new guidelines. The majority of materials were distributed to partners through emails or listservs within the state. Regular internal meetings and the Prevention Resource Center provided additional opportunities for partners to receive and distribute evidence-based guideline information.

> We get a lot of communication from the state from the grant program directors…And they have a listserv that's for coordinators and evaluators. Then we also hear about things through our direct services contractor, because they get a lot through the substance abuse side of things as well…Our Prevention Resource Center here in the area is pretty strong too, so they push out a lot of information.

The National Conference on Tobacco and Health, CDC meetings, and conferences held within the state were all well attended by members of Texas' tobacco control program. Although guidelines were made available at these meetings they did not act as the main venue for guideline diffusion. Some partners identified the need for assistance in applying evidence-based guidelines to their community. There was a lot of information on evidence-based tobacco control activities available, however sorting through the many guidelines and finding the ones pertinent to their work and applying them was challenging. Conferences and meetings had the potential to serve as one source for addressing this challenge in the future.

> The state tells us to use them…evidence-based guidelines, but they've never done a training on exactly how to pick them.

Those who attended conferences and other meetings recalled CDC's *Best Practices* as the guideline most frequently referenced. To gain a better sense of communication regarding *Best Practices*, Texas partners were asked who they talked to about the guideline. In the figure on the following page a line connects two partners who indicated that they talked about *Best Practices* with each other. The size of the node indicates the number of agencies each partner talked to about the guideline. For example, DSHS Tobacco talked with the most partners about *Best Practices*, resulting in the largest node size. Contractors and coalitions also talked with a number of partners about *Best Practices*. This falls in line with *Best Practices* being used as a resource for partners in their planning and advocacy efforts.



Which tobacco control guidelines were partners aware of?

The CDC's *Best Practices* was the most well-known guideline in Texas. Twenty-two out of 23 partners interviewed recalled at least hearing of *Best Practices*. The next most well-known guideline was SAMHSA's *Strategic Prevention Framework*. Partners within Texas viewed the SAMHSA guideline, along with the *Best Practices*, as the foundation for their state's tobacco control program.

Over half of the partners were aware of the other guidelines. Other forms of information, such as internally developed toolkits or guidelines, were also used for their work in tobacco control.

Table 2: Number of Partners Aware of Tobacco Control Guidelines

Guideline	# of Partners
Best Practices for Comprehensive Tobacco Control Programs	22/23
SAMHSA Strategic Prevention Framework	21/23
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	18/23
Ending the Tobacco Problem: A Blue Print for the Nation	18/23
Introduction to Process Evaluation in Tobacco Use Prevention and Control	18/23
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	17/23
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	15/23
Designing and Implementing an Effective Tobacco Counter-Marketing Campaign	15/23
Key Outcome Indicators for Evaluating Tobacco Control Programs	15/23
Guide to Community Preventive Services- Tobacco	15/23
Best Practices User Guides- Coalitions	12/23
Tobacco Control Monograph Series	11/23

Adoption Factors

What do partners take into consideration when making decisions about their tobacco control efforts?

When partners were asked what they took into consideration when making decisions about their tobacco control efforts, they most frequently identified information from research and evidence-based guidelines. However, when asked to rank specific factors in their importance when making decisions, mandates or input from policy makers was identified by the highest number of partners as the most important factor they took into consideration when making tobacco control decisions.

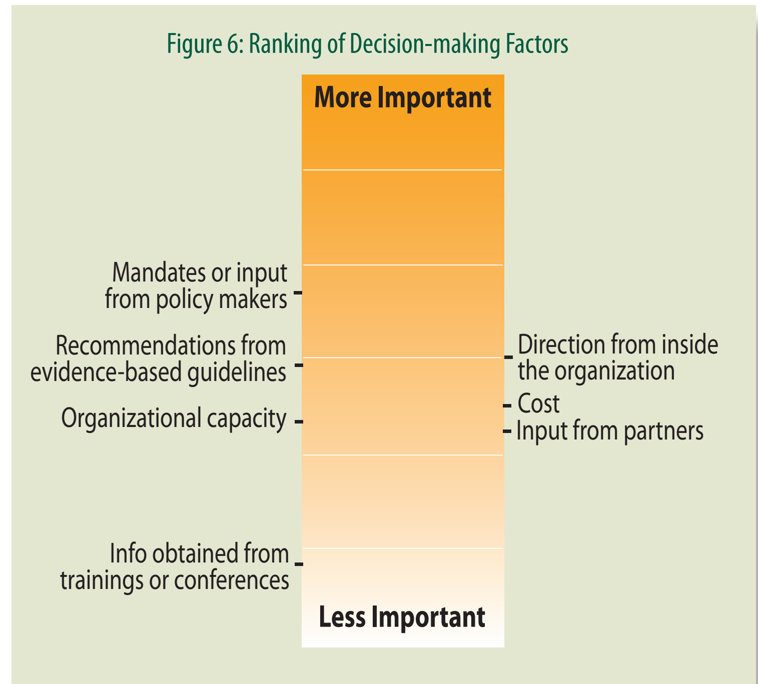


Figure 6: Ranking of Decision-making Factors

> Obviously, mandates from policymakers, unfortunately, have to take precedent because they're the ones who are paying the bills. So I guess I have to rank that the most important because, frankly, if they don't want to do it in Texas, especially since we're not an MSA state, there's a lot of freedom for the legislature here to do whatever they want to do.

Recommendations from evidence-based guidelines and direction from inside the organization were the second most frequent decision-making factor cited by partners during the ranking exercise.

> One would be evidence-based guidelines…from the beginning, that's just my whole frame of reference. If it's been researched and shown to be effective, why not do that? We're trying to get the outcomes and we don't have the money that we need, so the first thing that you can do is really start with doing what had already been proven effective, so that's very important to us.

Cost and organizational capacity played an important role in decision-making for Texas partners. Due to Texas' large population, tobacco control funding could not cover the entire state; thus, partners focused on the areas with the greatest need.

> Texas is so big, and our geography is so big, there are 254 counties. We have to take into consideration how we can best affect the state, because we do not have the money to affect the whole state. So we look at high risk areas as far as smoking and lung cancer and that kind of thing.

What facilitated or hindered use of evidence-based guidelines?

There were many benefits to using evidence-based guidelines. For Texas partners, guidelines provided proven strategies for reducing the burden of tobacco use. They also provided justification for the strategies partners implemented and informed their evaluations.

> [Evidence-based guidelines facilitate]. . . you're not using money for strategies or programs that people think work because they sound good, for instance, or they make people feel good.

> We have to utilize our resources in a manner that we know is effective, because if not, we're just throwing money out. We're not good stewards of the state or federal funds if we know what we're doing is not making an impact. There are only a limited number of resources, and we have to use that to the best of our ability to make an impact, [evidence-based guidelines help with this].

Mandates from policymakers and others who had influence over funding represented one of the main influences that facilitated the adoption of guidelines. Texas law stated that tobacco control efforts were to be evidence-based, which emphasized the importance of using evidence-based guidelines for many partners.

> I think because [using *Best Practices*] is a mandate, there's a lot of support there. It's required of the state, and so I think everyone knows the impact it will have.

Integration of the state tobacco control program with the mental health and substance abuse was also seen as advantageous to the adoption of guidelines. Using information from multiple sources allowed for partners to take approaches that could use the best information from both the CDC and SAMHSA.

> Having moved from a chronic disease based tobacco program to a substance abuse mental health based tobacco program. . . we're much more open to try to work on merging best practices from both sides, the things that CDC puts out, the things that SAMHSA puts out, and subsequently we don't have blinders on saying, "This is the only way to do it," and I think that helps us out.

There were some challenges to the adoption and use of evidence-based guidelines. For example, though state mandates emphasized following an evidence-based approach as outlined in the *Best Practices*, limited funding and staff turnover inhibited partners being able to carry this out. Partners stated that more money went to combating alcohol than tobacco use which made it difficult to sustain a comprehensive tobacco control program. Also, many organizations reported high staff turnover, resulting in partners with less than a year of experience in tobacco control. This made it difficult to maintain staff that were familiar with evidence-based strategies and were able to effectively implement programs.

> We devote less time to tobacco because we have less dedicated money. We have more dedicated money to alcohol than we do for tobacco.

Partners identified implementation of guidelines as another challenge. Specifically, partners felt that trainings and information on how to put the research into practice was needed. There were multiple components within many guidelines leading to partners not knowing where to focus their efforts. For some, this led to referring back to what they were comfortable with, whether it was evidence-based or not.

> "There's not enough training of how to really implement [information from evidence-based guidelines] into our daily work."

Implementation

Which guidelines are critical for Texas' tobacco control partners?

Texas partners were aware of a number of evidence-based guidelines and reports. However, a smaller number of these guidelines were identified as critical resources. Partners were asked to group guidelines into one of three categories: 1) Critical for their tobacco control efforts; 2) Not critical, but useful for their tobacco control efforts; and 3) Not useful for their tobacco control efforts. The top two guidelines that were identified as being most critical were produced by the CDC and SAMHSA and served as frameworks for the program. The following are the guidelines identified most frequently as critical resources by Texas partners.

Best Practices for Comprehensive Tobacco Control Programs

Eighty-one percent of Texas partners identified *Best Practices* as a critical resource to their work. The guideline was primarily used in program planning, for funding recommendations, and as an educational tool for tobacco control professionals.

> Our state contract with DSHS references our involvement with the *Best Practices* and our statement of work adheres to that. We use *Best Practices* in planning our youth efforts as much as we can, because we're part of the state and community intervention piece.

Table 3: Percentage of Partners Who Identified Guideline as a Critical Resource

Guideline	% of Partners*
Best Practices for Comprehensive Tobacco Control Programs	81%
Key Outcome Indicators for Evaluating Tobacco Control Programs	79%
SAMHSA Strategic Prevention Framework	75%
Guide to Community Preventive Services: Tobacco	64%
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	53%
Best Practices User Guides- Coalitions	50%
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	47%
Ending the Tobacco Problem: A Blueprint for the Nation	41%
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	29%
Designing and Implementing an Effective Tobacco Counter-Marketing Campaign	27%
Introduction to Process Evaluation in Tobacco Use Prevention and Control	18%
Tobacco Control Monograph Series	17%

* Based on partners who were aware of the guideline

Revisions to CDC *Best Practices*

In 2007, *Best Practices* was revised. To find out how changes to the guideline were perceived, Texas partners were asked additional questions about *Best Practices*. Several partners were not aware of the original version or did not know enough about the changes to comment. Those aware of the changes noted that the funding levels were a significant change. While the methods for the changes were viewed as sound, partners questioned whether the funding level was realistic.

> The funding levels went up. I applaud them doing that, and I appreciate the methodology and the reasoning behind it. However, I'm not totally sold that it was realistic to put those higher dollars out there, simply because if your legislature is not going to fund you at $3 per capita, what makes you expect they're going to do $11 per capita just because it's in a book from somebody in Atlanta? It doesn't address the realities of lesser funding.

> It's kind of depressing to see that you're never at the minimal funding level. But on the flip side, I think you need to know that there's a basic per capita level that you need to hit in order for you to see any comprehensive and effective change.

Partners felt that *Best Practices* acted as a framework and showed the broad categories that needed to be addressed. Many partners stated that there needed to be more detailed steps on how to achieve those categories. In particular, direction was needed on how *Best Practices* categories should be funded when funding was not at the recommended level.

> [For example] How much money should be going into evaluation? There's still some lack of clarity around just what is considered acceptable from a research and evaluation component at the community level.

Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs

Just a little over half of Texas partners were aware of the *Key Outcome Indicators*. However, 79% of those aware considered the guideline critical to their work. Partners cited that it was used to develop logic models as well as short and long term outcomes for programs.

> I pull it [*Key Outcome Indicators*] out when working with coalitions. . . how to pick a baseline data point, and how to pick strategies, and how to be able to measure for outcomes, we sit down and walk them through some of the aspects of the *Key Outcome Indicators.*

Strategic Prevention Framework

Out of the partners aware of SAMHSA's *Strategic Framework*, 75% identified the guideline as critical. The *Strategic Framework* was built on a approach that focused on community-based risk and prevention factors. It contained a series of guiding principles that could be utilized at the federal, state, and community levels. The *Strategic Framework* required states and communities to systematically:

1. Assess their prevention needs based on epidemiological data;
2. Build their prevention capacity;
3. Develop a strategic plan;
4. Implement effective community prevention programs, policies and practices; and
5. Evaluate their efforts for outcomes.

> "*Best Practices* serves as a framework. SAMHSA provides the how."

> The *Strategic Prevention Framework* [presents] more of a process. It has more on assessing, planning, evaluating, and implementing. What you are doing is an ongoing process.

> [*Strategic Prevention Framework*] is kind of like a foundation too with the other one [*Best Practices*]. So when you mix it and CDC's *Best Practices* together, you have a pretty good guideline then.

Texas partners worked to integrate *Best Practices* with the *Strategic Framework*. Partners expressed that the two documents could be used together quite well. The *Strategic Framework* provided the operational steps and *Best Practices* supplied the evidence-base.

The Guide to Community Preventive Services

Out of the fourteen partners aware of the *Community Guide*, 64% cited it as critical. The *Community Guide* was used to determine which interventions were supported by the evidence-base.

> If people are trying to figure out if there's strategy that's evidence-based, I tell them to go to it and see if they can find it on the *Community Guide*. If they're trying to figure out how to implement something and they don't know how, I send them to it. So I use it a lot around strategy selection and implementation; I send them to the guide.

What resources were used to eliminate tobacco-related disparities?

Addressing populations with tobacco-related disparities had been a challenging task for Texas partners. Partners realized that working with populations with tobacco-related disparities was important, but there were not enough resources to guide them. The state had begun coalition trainings around addressing disparity-related issues, but they were abandoned due to perceived ineffectiveness.

Many cited that there was not enough evidence or specific strategies in *Best Practices* on how to deal with populations with tobacco-related disparities. Some partners had begun collecting data to assess what populations and issues needed to be addressed. However, no specific plans or current interventions were identified.

> We've kind of struggled here because of the limited amount of money. We realize that the disparities are there, and we realize that it's important to include that in everything that we do, but we haven't been able to, say develop media only for the African American population or that kind of thing. We can't spend money down to that level where we're targeting specific populations. So it's probably one of the areas where we need help.

What resources were used to communicate with policymakers?

The majority of Texas partners did not have any direct communication with policymakers. Bureaucracy played a significant role in inhibiting communication. With so many communication channels, it was hard to get information directly to a policymaker. Information moved up and down a chain in the state government and that was how information was relayed from tobacco control professionals to offices of the state legislators. Messages had the possibility to be altered or misinterpreted with this form of communication.

> The way it comes down is generally it will go from legislators, to government relations, over to an associate commissioner who's downtown, and then they will then through channels, question it back to us. And then we respond back up that way. It's really kind of frustrating a bit.

> I don't know if it's a specific rule, like a written rule or an unwritten rule, but I know that I have been forbidden to go down to city council.

Members of TPCP were restricted from communicating directly with legislators. However, bill analysis was performed by TPCP, and the anticipated impact of a bill communicated to legislators. Of the few partners who did communicate with policymakers, prevalence data and Synar reports were most commonly shared. Evidence-based guidelines played a limited role in communication with policymakers.

What other resources did partners need?

Texas partners communicated a need for clear direction from the federal agencies that worked in tobacco control. For example, SAMHSA and CDC had different approaches for reducing tobacco use in communities. The mixed messages could be confusing for those who had contact with both organizations, particularly related to reducing youth initiation. For example, partners stated that the SAMHSA guidelines tended to emphasize strategies restricting youth access to tobacco much more than CDC.

> There is a perceived feeling from many states that they're hearing different information from SAMHSA, and from CDC. CDC, I think is pushing less of a focus on youth access type strategies, where SAMHSA, because they're enforcing the regulation on access strategies, youth access is what they're talking about. And I think the issue comes down to sort of focus on how things are talked about.

State partners would also benefit from education surrounding tobacco issues stemming from the new Food and Drug Administration (FDA) regulations. There was confusion surrounding what powers the FDA would have and in what ways Texas' program would be impacted. Education on new guidelines was also cited as being beneficial. Partners emphasized wanting guidance in the form of trainings or webinars to accompany the release of new information. Finally, education of the state legislature and leadership in general was thought to be an important role for the CDC to play in Texas. Partners stated that advocacy from a respected health agency would result in more attention to the need for tobacco control.

Conclusions

The structure of Texas' Tobacco Prevention and Control Program was different from many of its counterparts across the nation. Often state tobacco control programs were associated with chronic disease divisions within departments of health, however several years ago Texas' program moved from the Health Promotion and Chronic Disease Section to the Mental Health and Substance Abuse Section. The move from chronic disease to substance abuse brought a new national-level perspective to the tobacco control program from the Substance Abuse and Mental Health Services Administration (SAMHSA). This change led to many Texas partners using information and guidance from both the CDC Office on Smoking and Health and SAMHSA.

Overall, partners felt using information from both agencies was beneficial to the program:

- For example, the SAMHSA *Strategic Prevention Framework* organized an intervention by outlining the steps needed to be taken to achieve significant results.
- CDC's *Best Practices* provided the information that addressed areas in which to focus partners' efforts.
- Partners felt that using information from CDC and SAMHSA provided a comprehensive approach to tobacco control.

Though partners reported benefits of receiving guidance from both federal agencies, there were some challenges related to this. For example, partners stated that there was a great deal of information available from CDC, SAMHSA, and other federal agencies on what tobacco control activities to pursue. Having so much information available made it difficult for partners at times to prioritize which strategies should be adopted and implemented in their communities. This was particularly the case when guidelines differed on what strategies they emphasized as important for reducing tobacco use.

The degree to which particular evidence-based guidelines were incorporated into partners' work was dependent upon factors tied to three main phases of information diffusion highlighted throughout this report: 1) Dissemination; 2) Adoption; and 3) Implementation. For any stakeholders involved in the dissemination of evidence-based guidelines, taking these factors into consideration when developing and releasing a new guideline will optimize use of the guideline by intended users.

In the case of Texas, partners reported that there was a large amount of evidence-based information available and there were individuals and organizations in the state that aided with dissemination of new guidelines. Though guidelines were readily available, there were challenges to adopting and implementing guidelines. These challenges included limited funding, staff turnover, conflicting information from funding and advisory agencies, and being able to prioritize which strategies were most important to address partners' goals. Trainings associated with the release of new guidelines could improve the uptake and use of the information. Also collaboration between federal agencies to help states, such as Texas, prioritize their strategies would be beneficial.

The

Washington, D.C. Profile:

Focusing on sustainability

Use of Evidence-based Guidelines in State Tobacco Control Programs

Prepared by
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Executive Summary

Introduction

There has been a significant amount of research done on what works to curb tobacco use. Many agree that the evidence base for tobacco control is one of the most developed in the field of public health. However, the advancement in the knowledge base is only effective if that information reaches those who work to reduce tobacco consumption. Evidence-based guidelines, such as the Centers for Disease Control and Prevention's *Best Practices Guidelines for Comprehensive Tobacco Control Programs* (*Best Practices*), are a key source of this information. However, how these guidelines are utilized can significantly vary across states.

This profile presents findings from an evaluation conducted by the Center for Tobacco Policy Research at Washington University in St. Louis that aimed to understand how evidence-based guidelines were disseminated, adopted, and used within state tobacco control programs. Washington, D.C. served as the eighth case study in this evaluation. The project goals were two-fold:

- Understand how Washington, D.C. partners used evidence-based guidelines to inform their programs, policies, and practices;
- Produce and disseminate findings and lessons from Washington, D.C. so that readers can apply the information to their work in tobacco control.

Findings from Washington, D.C.

The following are highlights from Washington, D.C.'s profile. Please refer to the complete report for more detail on the topics presented below.

- CDC conferences were frequently cited as an arena for guideline dissemination and partners in leadership positions were usually the first in their organization to learn of new evidence-based guidelines.
- Both the specific target population and the public health impact of any activity were considered when partners made programmatic or policy-related decisions for their tobacco control efforts.
- Due to budget constraints, partners focused on cost-effective and sustainable approaches to their tobacco control efforts, as promoted in evidence-based guidelines.
- Washington, D.C. partners noted several challenges to using evidence-based guidelines, such as:
  - Partners found that guidelines had been adapted for broad state demographics and were not appropriate for their city's specific population needs.
  - Due to a decrease in both fiscal and staff-related resources, partners' ability to implement evidence-based practices was hindered.
- Washington, D.C. partners expressed a need for assistance from the CDC, including:
  - Additional resources, such as technical assistance; and
  - Continued awareness about the release of new evidence-based guidelines or relevant data.

Introduction

Project overview

States often struggle with limited financial and staffing resources to combat the burden of disease from tobacco use. Therefore, it is imperative that efforts that produce the greatest return on investment are implemented. There has been little research on how evidence-based interventions are disseminated and utilized by state tobacco control programs. To begin to answer this question, the Center for Tobacco Policy Research at Washington University in St. Louis conducted a multi-year evaluation in partnership with the CDC Office on Smoking and Health (CDC OSH). The aim of this project was to examine how states were using the CDC's *Best Practices for Comprehensive Tobacco Control Programs* (*Best Practices*) and other evidence-based guidelines for their tobacco control efforts and to identify opportunities that encouraged guideline use.

Qualitative and quantitative data from key partners in eight states were collected during the project period. States were selected based on several criteria, including funding level, lead agency structure, geographic location, and reported use of evidence-based guidelines. Information about each state's tobacco control program was obtained in several ways, including: 1) a survey completed by the state program's lead agency; and 2) key informant interviews with approximately 20 tobacco control partners in each state.

State profiles

This profile is part of a series of profiles that aims to provide readers with a picture of how states accessed and utilized evidence-based guidelines. This profile presents data collected in September 2010 from Washington, D.C. partners. The profile is organized into the following sections:

- **Program Overview –** provides background information on Washington, D.C.'s tobacco control program.
- **Evidence-based Guidelines –** presents the guidelines we asked about and a framework for assessing guideline use.
- **Dissemination –** discusses how Washington, D.C. partners learned of new guidelines and their awareness of specific tobacco control guidelines.
- **Adoption Factors –** presents factors that influenced Washington, D.C. partners' decisions about their tobacco control efforts, including use of guidelines.
- **Implementation –** provides information on the critical guidelines for Washington, D.C. partners and the resources they utilized for addressing tobacco-related disparities and in communication with policymakers.
- **Conclusions –** summarizes the key factors that influenced use of guidelines based on themes presented in the profile and current research.

Quotes from participants (offset in green) were chosen to be representative examples of broader findings and provide the reader with additional detail. To protect participants' confidentiality, all identifying phrases or remarks have been removed.

Program Overview

Washington, D.C.'s tobacco control program

Since its inception in 1993, the Washington, D.C. Tobacco Control Program, housed in the Department of Health (DOH), had functioned as the lead agency for the District's tobacco control efforts. DOH's over-arching vision and mission were to reduce tobacco-related morbidity and mortality by providing cessation, prevention, and education services. DOH followed the four goals established by the CDC in order to achieve this mission: 1) prevent youth from smoking; 2) promote cessation to adults and youth; 3) eliminate secondhand smoke; and 4) identify and eliminate tobacco-related disparities in specific populations.

At the time of this evaluation, Washington, D.C. was funded at 5.4% of the CDC's recommended $10.5 million needed to effectively implement a comprehensive tobacco prevention and cessation program in the District. In addition to the $569,000 allocated for tobacco prevention and cessation for FY2011 by the D.C. City Council, DOH received $5.9 million in federal funds. Despite low funding levels, partners had success in passing policies for tobacco control. A comprehensive smokefree policy for the District went into effect in January 2001 and, in 2009, Washington, D.C. increased its tobacco tax to $2.50.

Washington, D.C.'s tobacco control partners

Washington, D.C.'s tobacco control efforts involved a variety of key partners. Partners included voluntaries and advocacy groups, a program evaluator, and community and national organizations. Some partners also had secondary roles as members of the D.C. Tobacco Free Coalition (DCTFC). DCTFC played an active role in educating the D.C. community about the effects and the harm of tobacco and secondhand smoke as part of the D.C. Tobacco Free Families campaign. Twenty-three individuals from 16 organizations were identified as a sample of key members of D.C.'s tobacco control network. On average, D.C. partners had been involved in tobacco control for five years, ranging from less than one year to twenty years of involvement within the District. Table 1 presents the list of partners who participated in the interviews.

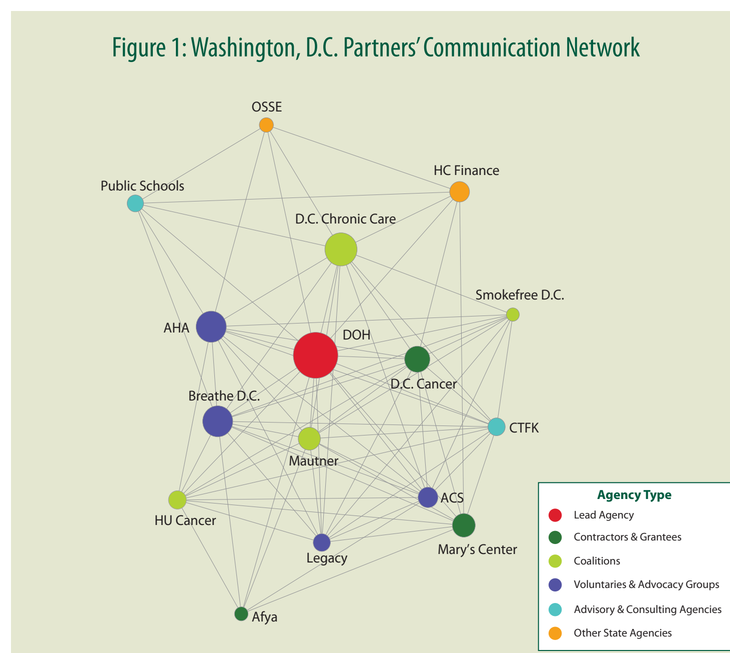
Table 1: Washington, D.C. Tobacco Control Partners

Agency	Abbreviation	Agency Type
Department of Health Tobacco Control Program	DOH	Lead Agency
Afya, Inc.	Afya	Contractors & Grantees
Mary's Center for Maternal and Child Care	Mary's Center	Contractors & Grantees
Howard University Cancer Center	HU Cancer	Coalitions
D.C. Cancer Consortium	D.C. Cancer	Coalitions
Smoke Free D.C.	Smoke Free D.C.	Coalitions
D.C. Chronic Care Coalition	D.C. Chronic Care	Coalitions
Mautner Project	Mautner	Coalitions
Breathe D.C.	Breathe D.C.	Voluntaries & Advocacy Groups
American Heart Association	AHA	Voluntaries & Advocacy Groups
American Legacy Foundation	Legacy	Voluntaries & Advocacy Groups
American Cancer Society	ACS	Voluntaries & Advocacy Groups
Office of the State Superintendent of Education	OSSE	Other State Agencies
Office of Preventive & Acute Care, D.C. Department of Health Care Finance	HC Finance	Other State Agencies
Campaign for Tobacco Free Kids	CTFK	Advisory & Consulting Agencies
Office of Youth Engagement, D.C. Public Schools	Public Schools	Advisory & Consulting Agencies

Communication between Washington, D.C. partners

To gain a better understanding of partner relationships within Washington, D.C.'s tobacco control network, partners were asked about their interaction with other tobacco control organizations within the District. Partners were asked how often they had direct contact (such as meetings, phone calls, or e-mails) with other partners within their network in the past year. In the figure to the right, a line connects two partners if they had contact with each other on more than a quarterly basis. The size of the node (dot representing each agency) indicates the amount of influence a

Figure 1: Washington, D.C. Partners' Communication Network

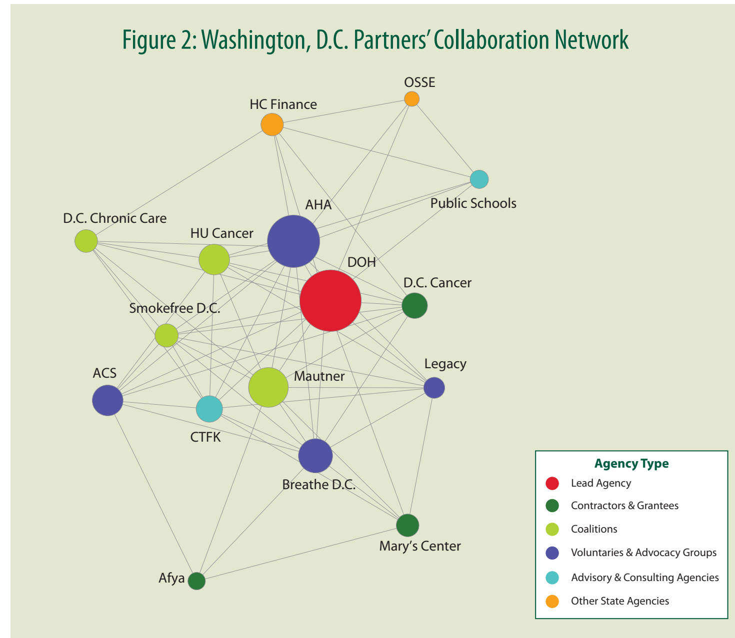


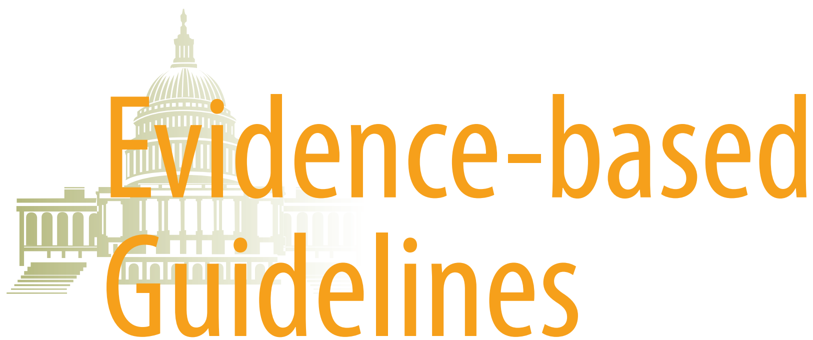
partner had over contact in the network. An example of having more influence, or a larger node, was seen between DOH, Public Schools, and Afya. Public Schools did not have direct contact with Afya, but both had contact with DOH. As a result, DOH acted as a bridge between the two and had more influence over communication within the network. Communication within D.C. displayed a relatively decentralized structure among partners in which network members had contact with many agencies.

Collaboration between Washington, D.C. partners

Partners were asked to indicate their working relationship with each partner with whom they communicated. Relationships could range from not working together at all to working together on multiple projects. A link between two partners indicates that they at least worked together informally to achieve common goals. Partners were not linked if they did not work together or only shared information. Node size is based on the amount of influence a partner had over collaboration in the network. A partner was considered influential if he or she connected partners who did not work directly with each other. For example, OSSE and D.C. Chronic Care did not work directly with one other, but both worked with DOH. DOH acted as a "broker" between the two agencies, and, as a result, is represented by a larger node. Collaboration within Washington, D.C. displayed a relatively decentralized structure among partners in which network members indicated working relationships with many agencies.

Figure 2: Washington, D.C. Partners' Collaboration Network





Evidence-based Guidelines

There are a number of evidence-based guidelines for tobacco control, ranging from broad frameworks to those focusing on specific strategies. Below in Figure 3 are the set of guidelines partners were asked about during their interviews. Partners also had the opportunity to identify additional guidelines or information they used to guide their work. Other resources identified by Washington, D.C. partners included:

- The National Cancer Institute's *Research-Tested Intervention Programs* database
- The Tobacco Cessation Leadership Network's *Bringing Everyone Along* resource guide
- The American Lung Association's *Freedom from Smoking* program

Figure 3: Evidence-based Guidelines for Tobacco Control

Research has shown that the use of evidence-based practices, such as those identified in these guidelines, results in reductions in tobacco use and subsequent improvements in population health. Whether an individual or organization implemented evidence-based practices depended on a number of factors, including capacity, support, and available information. The remainder of this report will look at how evidence-based guidelines fit into this equation for Washington, D.C. The framework below will guide the discussion, specifically looking at which guidelines Washington, D.C. partners were aware of, which ones were critical to partners' efforts, and how guidelines were used in their work.

Figure 4: Framework for Use of Evidence-based Guidelines

Dissemination

How did partners define "evidence-based guidelines"?

Washington, D.C. partners defined evidence-based guidelines as activities or interventions that had been researched or tested over time and proven to be effective. Partners associated the implementation of evidence-based practices with successful outcomes and frequently linked evidence-based guidelines with the CDC.

> [An evidence-based guideline is] something that has been shown to be effective and it's been tested in a way that we could have a high level of confidence that it will be effective.

> I understand evidence-based to mean that there is published evidence…showing that a particular model or approach to a public health problem has shown to be effective in achieving the outcomes that you're trying to achieve.

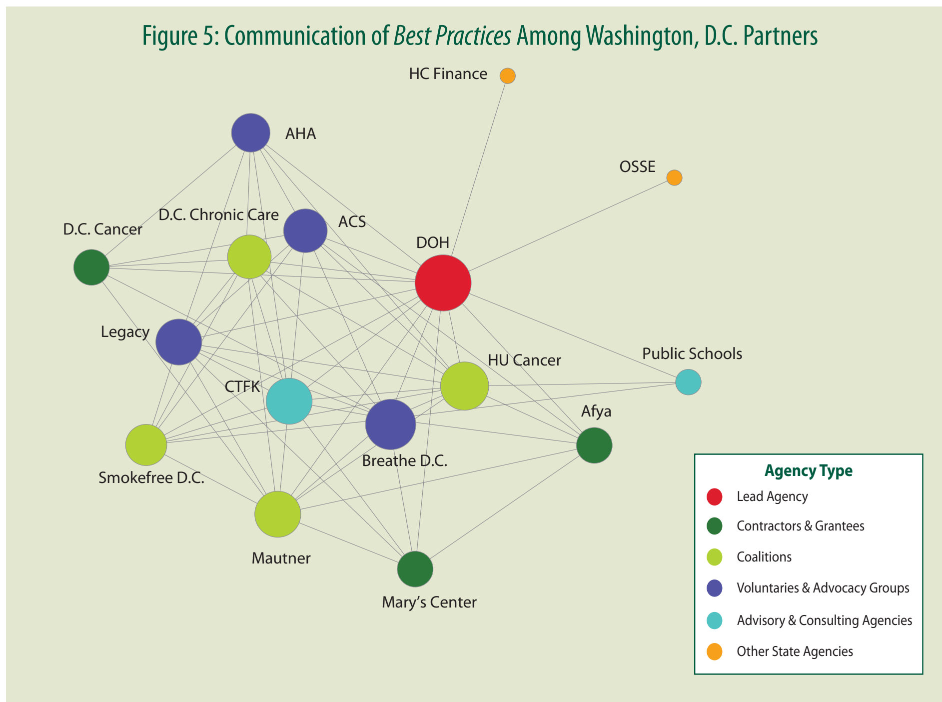
"[Evidence-based means] there is established evidence showing that this particular method will work if implemented appropriately."

How did partners learn of evidence-based guidelines?

Partners were made aware of new guidelines through meetings, conferences, and contacts at both the national and local level. CDC conferences were frequently cited as an arena for guideline dissemination. Partners in leadership positions were usually the first in their organization to learn of evidence-based guidelines. Within the Department of Health, the Tobacco Control Program Manager was an important resource for guideline dissemination. Internally, partners shared information about new guidelines through e-mail and discussion at regular staff meetings.

> When I receive mailings, the first thing I do is I refer them to the program manager and give him the time and opportunity to review the guidelines and let him disseminate them to his staff.

To gain a better understanding of communication specifically about *Best Practices*, D.C. partners were asked who they talked to about the guideline. In Figure 5, a line connecting two agencies indicated they talked about *Best Practices* with one another. The size of the node reflects the number of agencies each partner communicated with about the guideline. For example, DOH talked with the most partners about *Best Practices*, resulting in the largest node size. However, DOH did not act as the sole resource for information regarding *Best Practices*, as other partners spoke with one another about the guideline as well.



What tobacco control guidelines were partners aware of?

The *Best Practices* guideline was the most well-known guideline in Washington, D.C. Twenty out of 23 partners interviewed recalled at least hearing of *Best Practices*. Partners referenced *Best Practices* frequently, ranging from a daily to quarterly basis. At least half of D.C. partners were aware of the remaining guidelines, with the exception of the *Tobacco Control Monograph Series* and the NACCHO *2010 Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs*.

Table 2: Number of Partners Aware of Tobacco Control Guidelines

Guideline	# of Partners
Best Practices for Comprehensive Tobacco Control Programs	20/23
Designing and Implementing an Effective Tobacco Counter-Marketing Campaign	18/23
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	17/23
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	16/23
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	15/23
Introduction to Process Evaluation in Tobacco Use Prevention and Control	14/23
Ending the Tobacco Problem: A Blueprint for the Nation	14/23
Key Outcome Indicators for Evaluating Tobacco Control Programs	12/23
The Guide to Community Preventive Services: Tobacco	12/23
Best Practices User Guide Series	12/23
NACCHO 2010 Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs	10/23
Tobacco Control Monograph Series	10/23

Adoption Factors

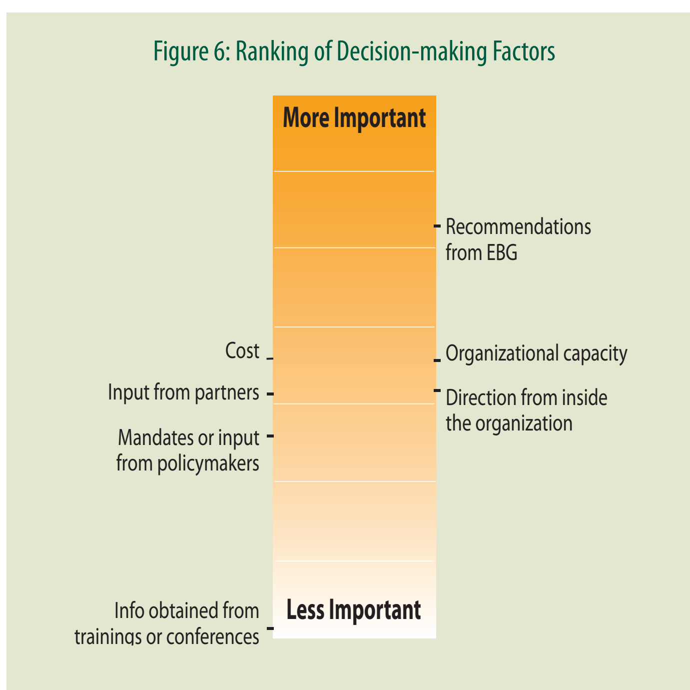
What did partners take into consideration when making decisions about their tobacco control efforts?

When partners were asked what they took into consideration when making decisions about their tobacco control efforts, they most often cited looking to evidence-based strategies and input from partners. It was also important for partners to take into consideration their target population and the public health impact of any activity. Additionally, partners had to work within the constraints of their funding, which made sustainability an important concern.

> One thing that we do in our decision-making process is bring everyone to the table so that our community partners are actively involved in our planning.

> Our general organizational philosophy is to be involved in policy efforts that will ultimately lead to reductions of tobacco use. We're looking for high impact things to be involved in.

> We want to consider what our community footprint is going to be with each of our decisions. We want to make sure that everything that we do is to the betterment of our residents.



Consequently, when asked to rank several factors in their overall importance when making decisions to design or adopt programs or policies for tobacco control, partners most often ranked recommendations from evidence-based guidelines as the most important factor, with 72.7% of partners ranking it in their top three factors. Partners found that following recommendations from evidence-based guidelines, particularly those produced by the CDC, provided credibility to their efforts. Many partners, especially those funded by CDC, were required by contract to follow evidence-based guidelines, making the guidelines a priority for partners' decision-making.

> I have recommendations from evidence-based guidelines as number one, because everything we do centers around CDC's evidence-based guidelines. So since it's their money, we have to do what works.

Organizational capacity and cost also played an important role in partners' decision-making since partners had to operate within the constraints of their resources. Many organizations had incurred budget cuts, forcing partners to maximize the use of their funds and focus on sustainability. Many partners looked to high-impact, evidence-based practices in order to ensure efficient use of resources.

> Along with cost would be making sure that whatever is implemented is cost-effective, but also sustainable.

> The recommendations [from evidence-based guidelines] would really be the driver, but once we look at the recommendations, we have to look at if we can get funding to act.

Partners also found it important to have cooperation from within their organization as well as input from external partners. Engaging partners and establishing consensus was crucial to the success of partners' efforts.

> When you are establishing programs, including policy goals, we want to make sure everybody is on the same page, because it's going to be difficult to move forward and achieve success unless you have the partners' buy-in.

"As many organizations face the issue of losing funding, we've become more creative on how to address these costs."

While not ranked as highly as the previous factors, partners did take into consideration input from policymakers as well. Since the D.C. City Council was considered progressive and receptive to tobacco control efforts, partners did not face as many obstacles to policy change as members of other state tobacco control programs. However, it was still important for partners to develop positive relationships with policymakers to facilitate policy advancement. As such, partners focused on establishing relationships with those council members who they identified as champions for tobacco control efforts.

> I think it's really important, obviously, if we want to move forward a policy [to look] for sponsors or strong relationships with those who can push policy forward.

How did organizational characteristics influence partners' decisions about their tobacco control efforts?

Washington, D.C. partners valued an organizational structure that was flexible, innovative and progressive. These characteristics facilitated the adoption of new ideas and allowed partners to adapt to the changing environment surrounding tobacco control. Partners in smaller organizations noted that having a small staff facilitated open exchange of ideas.

> We as an organization pride ourselves on being nimble, proactive, strategic, and creative. We're constantly on the lookout for something new and cutting edge to do, if it makes sense strategically.

> [Our organization] tends to be a fairly lean and mean non-profit, and we're often credited with being fairly nimble and innovative, and in a position where we can take bold positions that others might not be able to do.

Partners also noted the importance of an organization's dedication to being research-based. Access to resources and expertise in tobacco control were essential to informing partners' efforts.

> We have an extensive, robust research department, and we also have a research institute that focuses on tobacco control and policy studies. Both of these departments are very, very active and engaged in helping us.

> I have tremendous resources as far as policy experts at our national level that help with translating anything that might be giving me heartburn, and they do a great job.

Conversely, partners identified bureaucratic constraints as the foremost barrier to their tobacco control efforts. These constraints included procurement processes, slow approval processes, and the restrictions associated with using Master Settlement Agreement (MSA) funds. DOH also found the legal barriers preventing policy advocacy to be particularly problematic. These factors hindered partners from moving forward quickly with program or policy development and implementation.

> The governmental process as a whole sometimes can be a challenge. There can be red tape in terms of procurement items that take place. Government's bureaucracy would be our largest challenge or hindrance.

> Because of our funding coming from [MSA], we can't do necessarily direct advocacy and really get involved in specific legislation. So that's one hindrance certainly.

Organizational capacity also had a significant influence on partners' decisions. Staffing and time commitment constrained what partners could do. This was especially challenging for some of the coalitions, which did not have a full-time staff.

> "[Our tobacco control efforts are] really driven by staffing and the time level that we have to address things."

> Because [our coalition] doesn't work on [tobacco control efforts] eight hours a day and we don't have an infrastructure, and we don't really have a budget. Obviously, we could be doing more if we were devoting all our time to it.

What facilitated or hindered use of evidence-based guidelines?

Partners perceived evidence-based guidelines as beneficial to their work because they promoted proven practices with successful results. Relying on evidence-based guidelines ensured efficient use of time and money.

> It's good to know that you have proven interventions that you can come to and rely on and use.

> You are saving time, you're saving money, and most importantly you're not recreating or spending money on programs that don't work.

Additionally, because evidence-based practices were proven successful and seen as a good investment of resources, partners felt that they provided credibility to their efforts. Using evidence-based guidelines made partners' work defensible to policymakers and facilitated securing funding.

> I think policymakers want to know that you are advocating for something that is scientifically proven to work…it seems to be you can't advocate for public policy without evidence-based data.

> I think that now funding is driven by use of evidence-based practices, so you have to make your case that you're using the strongest evidence possible.

While evidence-based guidelines were an important part of partners' efforts, there were still some challenges to using the guidelines. The foremost hindrance to guideline implementation was applicability to certain communities and populations. Partners believed the guidelines promoted a broad approach, which presented a challenge since D.C.'s tobacco control efforts were solely implemented in an inner-city environment. However, some partners found the coalitions to be useful resources for guidance on tailoring interventions to certain populations.

> Because we're just a city really impacts the demographics of our population regionally, ethnically, and socioeconomically. What will work is different here than other places… Looking at the evidence base we really have to factor in how we're different and how something might break differently here.

"It makes it easier to get funding and approval for a project if we can prove that what we're doing is evidence-based."

> You have to have knowledge and a foundation of the area that you work in, in order to know what could work better than something else…which is why we have a coalition that we can bounce ideas off of…and determine what's going to be best for our residents.

Implementation

Which guidelines were critical for Washington, D.C.'s tobacco control partners?

Washington, D.C. partners were aware of a number of evidence-based guidelines and reports. However, a smaller number of those guidelines were identified as critical resources when partners were asked to group guidelines into one of three categories: 1) *Critical* for their tobacco control efforts; 2) *Not critical, but useful* for their tobacco control efforts; and 3) *Not useful* for their tobacco control efforts. The following are the guidelines identified most frequently as critical resources by D.C. partners.

Best Practices for Comprehensive Tobacco Control Programs

Seventy-five percent of D.C. partners aware of *Best Practices* identified this guideline as a critical resource. Partners found the document useful for comprehensive program planning and generating new ideas for prioritizing and implementing policies and programs.

> [We have used *Best Practices*] for our action plan, making sure that we are in accordance with the best practices for tobacco control.

> I use [*Best Practices*] mainly to get ideas for policy priorities. You need to be in alignment with what CDC is saying and [you] don't want to be reinventing the wheel…[you need to] make sure that whatever you put on the table is going to work.

Table 3: Percentage of Partners Who Identified Guideline as a Critical Resource

Guideline	% of Partners*
Best Practices for Comprehensive Tobacco Control Programs	75%
Key Outcome Indicators for Evaluating Tobacco Control Programs	75%
Tobacco Control Monograph Series	70%
Best Practices User Guide Series	67%
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	60%
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	53%
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	50%
Ending the Tobacco Problem: A Blueprint for the Nation	50%
The Guide to Community Preventive Services: Tobacco	50%
Designing and Implementing an Effective Counter-Marketing Campaign	44%
NACCHO 2010 Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs	40%
Introduction to Process Evaluation in Tobacco Use Prevention and Control	21%

* Based on partners who were aware of the guideline

Revisions to the CDC *Best Practices*

In 2007, *Best Practices* was revised. To find out how changes to the guideline were perceived, D.C. partners were asked additional questions about *Best Practices*. Most partners were either not aware of the changes or were not familiar enough with the specific changes to comment. The few partners aware of the revisions mentioned that collapsing the categories increased reader comprehension.

> I thought [the 2007 update] was easier to follow. [CDC] simplified [the *Best Practices'*] framework and I thought that was useful.

Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs

Key Outcome Indicators was identified as a critical resource by 75% of partners familiar with the resource. The guide was used to inform evaluation and program planning. Partners found the guide particularly useful for measuring the progress of their program objectives.

> Our objectives still come from [the *Key Outcome Indicators*]. What's wonderful about [the guide] is it gives you ideas on how to measure [your objectives].

Tobacco Control Monograph Series

Of the partners aware of the National Cancer Institute's *Tobacco Control Monograph Series*, 70% ranked it as a critical resource for their tobacco control efforts. Specifically, partners found *Monograph 17: Evaluating ASSIST–A Blueprint for Understanding State-level Tobacco Control* (*ASSIST*) particularly helpful for evaluating the American Stop Smoking Intervention Study.

> "I think by and large [the changes to *Best Practices* have] been great, particularly the collapsing of the elements."

> So a lot of times when you just need in-depth knowledge on a specific topic, or empirical basis for a specific topic, that's where you look . . . the *ASSIST* is really, really useful.

Best Practices User Guide Series

Of the partners aware of the *Best Practices User Guide Series*, 67% identified it as critical. Specifically, the *Best Practices User Guide: Coalitions-State and Community Interventions* (*Coalitions Guide*) provided helpful information for partners working with coalitions. The *Coalitions Guide* was useful for developing and directing coalition efforts.

> I've used [the *Coalitions Guide*] a lot in terms of how I continue working with the coalition or suggestions they have. The resources that they give at the end of [the guide] are also very useful.

> I think [the *Coalitions Guide* is] very helpful. It helped to mold and develop our coalition as a whole.

Clinical Practice Guidelines: Treating Tobacco Use and Dependence

More than half of D.C. partners were aware of the *Clinical Practice Guidelines*, and 60% of those partners ranked it as a critical resource. Partners utilized the guideline for training healthcare providers and Quitline counselors.

> I use [the *Clinical Practice Guidelines*] for training our physicians and our medical students [around cessation].

> [I use the *Clinical Practice Guidelines*] to confirm any treatment that we utilize, because I oversee several counselors who are treating tobacco dependence. I make sure they are following the guideline.

Telephone Quitlines: A Resource for Development, Implementation, and Evaluation

Fifty-three percent of D.C. partners aware of *Telephone Quitlines* identified this guideline as a critical resource. The guideline provided useful information during the construction and establishment of Quitline services in D.C.

> *Telephone Quitlines* [was important when] we were doing the implementation to get the Quitline here, and figuring out who we were going to partner with to get it going, and what the requirements are…

> In some of the round table discussions that we had prior to even having a Quitline in place we used [*Telephone Quitlines*] to help us formulate what we wanted, or what we called the Cadillac model of Quitlines, and what would be the ideal that we would want to see.

What resources were used to eliminate tobacco-related disparities?

Washington, D.C. partners primarily used data (e.g., Behavioral Risk Factor Surveillance System, Quitline data) to identify populations with tobacco-related disparities. These data provided information on where to focus efforts to reach the populations with the highest tobacco use.

> The data that we have from our Quitline shows us who our greatest [tobacco users] are.

Additionally, partners relied on advocacy groups such as D.C. Tobacco Free Families and Breathe D.C. for information on their work with populations with tobacco-related disparities. D.C. Tobacco Free Families, in collaboration with the Department of Health, worked to secure funding for reducing disparities among youth, African American, Latino, and LGBTQ populations. Breathe D.C. provided partners with prevalence data, analyses, and direction on where to direct their efforts. Partners also relied on the Mautner Project for guidance on working with LGBTQ populations.

> The D.C. Tobacco Free Families Program was very good at ensuring that [grant] money went to [populations with tobacco-related disparities] here in D.C.

The majority of partners used *Best Practices* in their work with populations with tobacco-related disparities. Most partners found the guideline helpful for emphasizing the importance of engaging the community, planning interventions, and as a general reference.

> [*Best Practices* has been] very helpful. Its emphasis on community involvement and organization is key to [working with populations with tobacco-related disparities].

What resources were used to communicate with policymakers?

The majority of partners communicated directly with D.C. City Council members. Some partners communicated specifically with the Chair of the Health Committee as the Department of Health fell under the Health Committee's oversight.

> The D.C. Council are the primary policymakers. We can say all we want, but at the end of the day, you need to have their ear. You need to go and make sure that those in power know that this is what you are thinking would be a good policy to implement.

Partners typically shared community-specific tobacco use prevalence data with policymakers from sources such as the Quitline and the Youth Risk Behavior Survey (YRBS). Partners also highlighted the impact of implementing comprehensive tobacco control policies when communicating with policymakers. Additionally, information from evidence-based guidelines, specifically *Best Practices*, was shared with policymakers. Policymakers typically responded favorably to evidence-based guidelines due to the guidelines' support for maintaining a comprehensive program and because they were produced by credible sources such as the CDC.

> [We share] data on where the District is, what the picture is right now, with the snapshot of the tobacco burden in the city, and how we can improve that through changing our policies via legislation . . . Prevalence data helps me make the argument for changing the policy.

> We would give specific numbers and look at the impact of these guidelines that have been utilized in D.C., and how the numbers have shifted as a result of this comprehensive program being placed here.

What other resources were needed?

Washington, D.C. partners expressed the need for continued resources from the CDC, such as technical assistance regarding program implementation. Partners also stated the need for an efficient and timely approach to the dissemination of new information. Partners wanted a more direct line of communication with the CDC, and suggested adding those outside of the lead agency to the CDC's listserve.

> "[What I need is] for [the CDC] to continue with the educational and technical assistance that they provide."

> [I need the CDC] to put out data in a timely fashion. And I think very importantly, where feasible, to give organizations like ours a heads up on when that data is going to be released so that we can prepare our partners for it and get what we're going to say about it ready and so on.

> We could get more timely information, or maybe just kept in the loop altogether as part of a listserve. I think that would really start in helping us to have a better understanding of what's going on and who is doing what and who we can also tap into to make sure that there's no duplication of effort.

Conclusions

Washington, D.C. partners were aware of a number of evidence-based guidelines in tobacco control and referred to them as a general reference and for program planning. Additionally, partners felt that evidence-based guidelines, particularly *Best Practices*, helped encourage the development of new ideas related to tobacco control policy and program implementation. Additional factors contributing to the adoption of *Best Practices* and other evidence-based guidelines included:

- Many partners found that their organizations supported the use of research-based materials, including evidence-based guidelines.
- Due to budget constraints, partners focused on cost-effective and sustainable approaches to their tobacco control efforts, as promoted in evidence-based guidelines.
- Evidence-based guidelines provided credibility to partners' efforts because they were produced by reputable organizations such as the CDC.

Despite the importance of evidence-based guidelines to D.C.'s tobacco control efforts, partners noted several challenges to using the guidelines:

- Partners found that guidelines had been adapted for broad state demographics and were therefore inapplicable to their city's specific population needs.
- Budget cuts and limited staff capacity hindered partners' ability to implement certain evidence-based practices.
- Production and dissemination of new guidelines was perceived to be an inefficient and lengthy process.

An abundance of information is available to inform the work of those involved in tobacco control. For D.C. partners, recommendations from evidence-based guidelines, organizational capacity, and input from partners played an important role in guiding tobacco control efforts. Additionally, a focus on cost-effective, sustainable approaches allowed partners to continue tobacco control efforts despite restricted funding. The degree to which particular evidence-based guidelines were incorporated into partners' work was dependent upon factors tied to three main phases of information diffusion highlighted throughout this report: dissemination, adoption, and implementation. A culture that valued research and provided easily accessible resources made the adoption and implementation of evidence-based guidelines possible for Washington, D.C. partners. Taking these factors into consideration when developing and releasing a new guideline will optimize use of the guideline by intended stakeholders.

The **Wyoming** Profile:

Focusing on local efforts

Use of Evidence-based Guidelines in State Tobacco Control Programs

Prepared by
The Center for Tobacco Policy Research at
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Executive Summary

Introduction

There has been a significant amount of research done on what works to curb tobacco use. Many agree that the evidence-base for tobacco control is one of the most developed in the field of public health. However, the advancement in the knowledge base is only effective if that information reaches those who work to reduce tobacco consumption. Evidence-based guidelines, such as the Centers for Disease Control and Prevention's *Best Practices Guidelines for Comprehensive Tobacco Control Programs* (*Best Practices*), are a key source of this information. However, how these guidelines are utilized can significantly vary across states.

This profile presents findings from an evaluation conducted by the Center for Tobacco Policy Research at Washington University in St. Louis that aims to understand how evidence-based guidelines were disseminated, adopted, and used within state tobacco control programs. Wyoming served as the seventh case study in this evaluation. The project goals were two-fold:

- Understand how Wyoming used evidence-based guidelines to inform their programs, policies, and practices;
- Produce and disseminate findings and lessons from Wyoming and other states so that readers can apply the information to their work in tobacco control.

Findings from Wyoming

The following are highlights from Wyoming's profile. Please refer to the complete report for more detail on the topics presented below.

- Wyoming's tobacco control efforts were primarily focused on developing comprehensive programs at the local level. Therefore, the program managers of the Tobacco Free Wyoming Communities (TFWC) initiative were seen as an important part of Wyoming's tobacco control network.
- Overall, awareness of evidence-based guidelines among Wyoming partners was low, with the exception of *Best Practices*, the *Best Practices User Guide Series*, and SAMHSA's *Strategic Prevention Framework*.
- Despite a low level of awareness of evidence-based guidelines, Wyoming partners still considered recommendations from evidence-based guidelines to be an important part of their decision-making process. Evidence-based guidelines were seen as describing strategies that were proven, effective, and a good investment of resources.
- Wyoming partners noted several challenges to using evidence-based guidelines, such as:
    - Partners found it difficult to implement evidence-based practices in the small, rural communities of Wyoming.
    - Partners did not find evidence-based guidelines useful when working with populations with tobacco-related disparities.
    - Partners faced resistance from the community when trying to implement some evidence-based practices, especially smokefree ordinances.
- Wyoming partners expressed a need for further resources, including:
    - Trainings or guidelines for working with populations with tobacco-related disparities; and,
    - Information and further guidance on passing smokefree ordinances, particularly in rural areas.

Introduction

Project overview

States often struggle with limited financial and staffing resources to combat the burden of disease from tobacco use. Therefore, it is imperative that efforts that produce the greatest return on investment are implemented. There has been little research on how evidence-based interventions are disseminated and utilized by state tobacco control programs. To begin to answer this question, the Center for Tobacco Policy Research at Washington University in St. Louis conducted a multi-year evaluation in partnership with the CDC Office on Smoking and Health (CDC OSH). The aim of this project was to examine how states were using the CDC's *Best Practices for Comprehensive Tobacco Control Programs* (*Best Practices*) and other evidence-based guidelines for their tobacco control efforts and to identify opportunities that encouraged guideline use.

Qualitative and quantitative data from key partners in eight states were collected during the project period. States were selected based on several criteria, including funding level, lead agency structure, geographic location, and reported use of evidence-based guidelines. Information about each state's tobacco control program was obtained in several ways, including: 1) a survey completed by the state program's lead agency; and 2) key informant interviews with approximately 20 tobacco control partners in each state.

State profiles

This profile is part of a series of profiles that will be distributed to stakeholders to provide readers with a picture of how states accessed and utilized evidence-based guidelines. This profile presents data collected in August 2010 from Wyoming partners. The profile is organized into the following sections:

- **Program Overview –** provides background information on Wyoming's tobacco control program.
- **Evidence-based Guidelines –** presents the guidelines we asked about and a framework for assessing guideline use.
- **Dissemination –** discusses how Wyoming partners learned of new guidelines and their awareness of specific tobacco control guidelines.
- **Adoption Factors –** presents factors that influenced Wyoming partners' decisions about their tobacco control efforts, including use of guidelines.
- **Implementation –** provides information on the critical guidelines for Wyoming partners and the resources they utilized for addressing tobacco-related disparities and in communication with policymakers.
- **Conclusions –** summarizes the key factors that influenced use of guidelines based on themes presented in the profile and current research.

Quotes from participants (offset in green) were chosen to be representative examples of broader findings and provide the reader with additional detail. To protect participants' confidentiality, all identifying phrases or remarks have been removed.

Program Overview

Wyoming's tobacco control program

Wyoming's tobacco control efforts were led by the Tobacco Prevention and Control Program, housed in the Mental Health and Substance Abuse Services Division at the Department of Health (DOH). In 2000, Wyoming's legislature allocated all Master Settlement Agreement (MSA) funds into a Settlement Trust Fund to support tobacco prevention and control efforts. However, in 2002 the Wyoming legislature enacted the Substance Abuse Control Plan which redistributed these funds amongst three agencies: the Department of Health, the Department of Family Services, and the Department of Corrections. According to legislative stipulations, the three agencies worked together to develop comprehensive strategies focused on prevention, early intervention, and treatment of tobacco, alcohol, and drug abuse. Wyoming's funding placed the state sixth in the nation in FY2010 for tobacco control spending as a percentage of the CDC's recommended funding level. At the time of this evaluation, the program was funded at $5.8 million; meeting 64% of the CDC recommended funding level for a comprehensive tobacco control program in Wyoming.

Cessation efforts were the main focus of DOH's tobacco program staff. DOH also funded the Tobacco Free Wyoming Communities (TFWC) initiative, which provided funding to each county to implement comprehensive local tobacco control programs. As part of the TFWC initiative, several local communities, including the state capital, had been able to pass smokefree ordinances in recent years.

Although Wyoming had made great strides, it also faced challenges due to its unique political and cultural environment. Wyoming's tobacco tax, ranked fortieth in the nation, had not increased since 2003, which some partners attributed to Wyoming's tradition of anti-tax sentiment. Wyoming also had the highest rate of smokeless tobacco use in the nation. Furthermore, although advocates proposed a statewide smokefree bill to the floor in 2009, it met great resistance and was ultimately defeated. Wyoming's libertarian culture was thus frequently perceived as hindering progress in tobacco control.

Wyoming's tobacco control partners

Wyoming's tobacco control efforts involved a variety of partners. Partners included health voluntaries, marketing agencies, coalition members, and other departments in the state government. Twenty-three individuals from twenty organizations were identified as a sample of key members of Wyoming's tobacco control program. On average, partners had been involved in Wyoming's tobacco control efforts for five years, although experience ranged from three months to twenty years. Table 1 lists the partners who participated in the interviews.

Table 1: Wyoming's Tobacco Control Partners

Agency	Abbreviation	Agency Type
Wyoming Department of Health - Tobacco Prevention & Control Program	DOH Tobacco	Lead Agency
Wyoming Survey & Analysis Center	WYSAC	Contractors & Grantees
Wyoming Prevention Technical Assistance Consortium	WYPTAC	Contractors & Grantees
Sukle Advertising & Design	Sukle	Contractors & Grantees
Albany County Tobacco Prevention	Albany County	Contractors & Grantees
Uinta County Tobacco Prevention	Uinta County	Contractors & Grantees
Fremont County Tobacco Prevention	Fremont County	Contractors & Grantees
Hot Springs County Tobacco Prevention	Hot Springs County	Contractors & Grantees
Johnson County Tobacco Prevention	Johnson County	Contractors & Grantees
Healthways, Inc.	Quitline	Contractors & Grantees
Wyoming Through with Tobacco	WY Through w/ Tobacco	Contractors & Grantees
Wyoming Association of Sheriffs & Chiefs of Police	WY Sheriffs	Contractors & Grantees
Wyoming Comprehensive Cancer Control Consortium	WYCCCC	Coalitions
American Cancer Society	ACS	Voluntaries & Advocacy Groups
Wyoming Department of Education	DOE	Other State Agencies
Attorney General's Office	Atty Gen Office	Other State Agencies
Wyoming Department of Health - Preventive Health & Safety (Chronic Disease & Epidemiology Department)	DOH Prev Health	Other State Agencies
Wyoming Department of Health - Community & Public Health	DOH Comm Health	Other State Agencies
Wyoming Department of Health - Rural & Frontier Health	DOH Rural Health	Other State Agencies
Americans for Non-smokers' Rights	ANR	Advisory & Consulting Groups

Communication between Wyoming partners

To gain a better understanding of relationships within Wyoming's tobacco control network, partners were asked how often they had direct contact (such as meetings, phone calls, or e-mails) with other partners within the network in the past year. In the figure to the right, a line connects two partners if they had contact with each other on more than a quarterly basis. The size of the node (dot representing each agency) indicates the amount of influence a partner had over contact in the network. An example of having more influence, or a larger node, was seen between DOH Tobacco, Atty Gen Office, and WYPTAC. The Atty Gen Office did not have direct contact with WYPTAC, but both had contact with DOH Tobacco. As a result, DOH Tobacco acted as a bridge between the two and had more influence within the network. Overall, communication within Wyoming indicated a decentralized structure among partners in which members of the network had contact with many agencies.

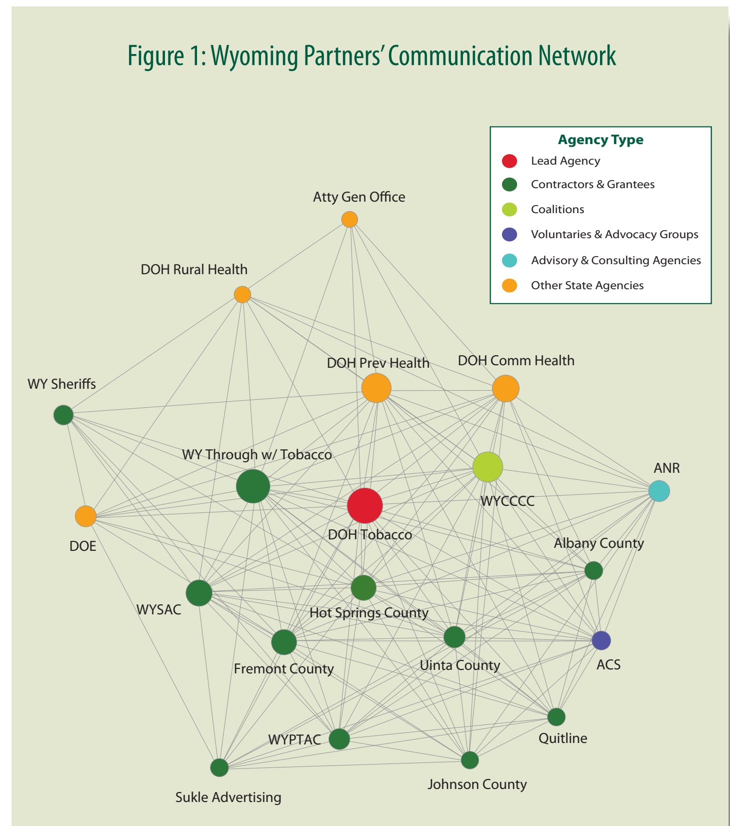


Figure 1: Wyoming Partners' Communication Network

Collaboration between Wyoming partners

Partners were asked to indicate their working relationship with each partner with whom they communicated. Relationships could range from not working together at all to working together as a formal team on multiple projects. A link between two partners signifies that they at least worked together informally to achieve common goals. Partners were not linked if they did not work together or only shared information. The node size is based on the amount of influence a partner had over collaboration in the network. A partner was considered influential if he or she connected partners who did not work directly with each other. For example, Atty Gen Office and DOE did not work directly with each other, but both worked with WYSAC. WYSAC acted as a "broker" between the two agencies, and, as a result, has a larger node size. Wyoming's collaboration network was relatively decentralized, with many partners exhibiting working relationships with other partners throughout the state.

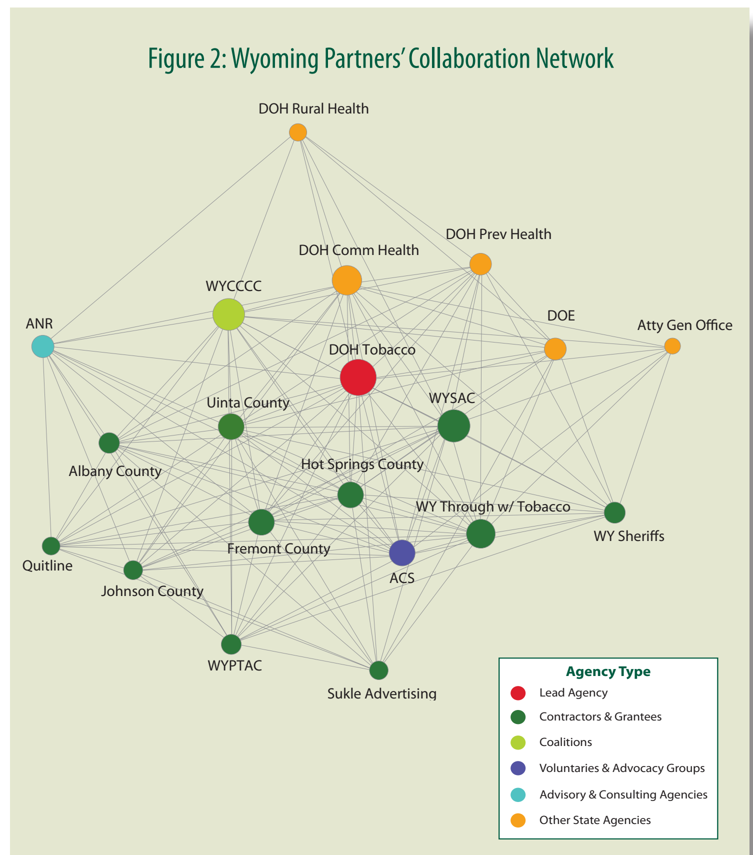


Figure 2: Wyoming Partners' Collaboration Network

Evidence-based Guidelines

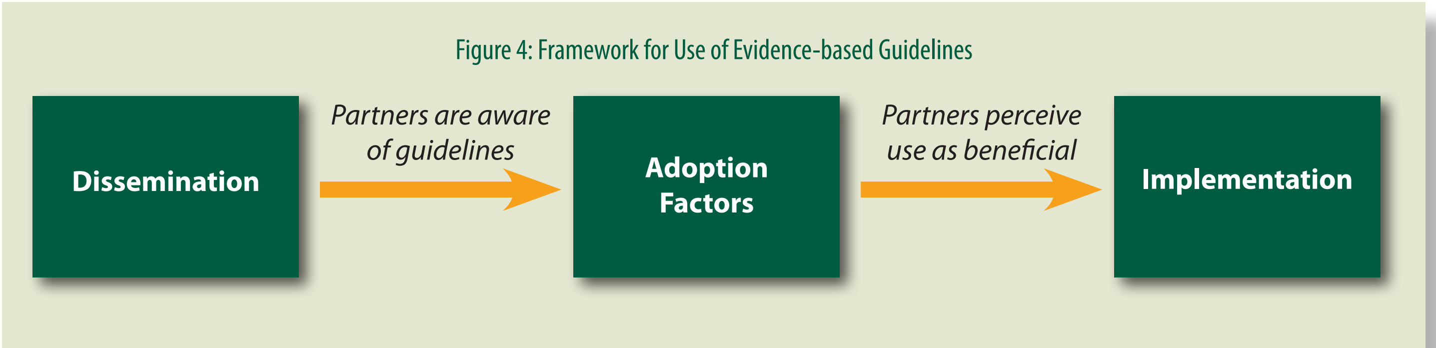
There are a number of evidence-based guidelines for tobacco control, ranging from broad frameworks to those focusing on specific strategies. Below in Figure 3 are the set of guidelines partners were asked about during their interviews. Partners also had the opportunity to identify additional guidelines or information they used to guide their work. Other resources identified by Wyoming partners included:

- Information provided by the Wyoming Prevention Technical Assistance Consortium (WYPTAC);
- Surgeon General reports;
- SAMHSA's *Reducing Tobacco Use Among Youth: Community-Based Approaches*;
- Publications from the North American Quitline Consortium;
- Guidelines produced by the Office of Juvenile Justice and Delinquency Prevention and the Pacific Institute for Research and Evaluation; and,
- Join Together's *How Do We Know if We Are Making a Difference?: A Community Alcohol, Tobacco and Drug Indicator Handbook*.

Figure 3: Evidence-based Guidelines for Tobacco Control

Research has shown that the use of evidence-based practices, such as those identified in these guidelines, results in reductions in tobacco use and subsequent improvements in population health. Whether an individual or organization implemented evidence-based practices depended on a number of factors, including capacity, support, and available information. The remainder of this report will look at how evidence-based guidelines fit into this equation for Wyoming. The framework below will guide the discussion, specifically looking at which guidelines Wyoming partners were aware of, which ones were critical to partners' efforts, and how guidelines were used in their work.

Figure 4: Framework for Use of Evidence-based Guidelines



Dissemination

How did partners define "evidence-based guidelines"?

Wyoming partners defined evidence-based guidelines as promoting practices that had been researched and proven effective. Therefore, pursuing evidence-based practices was seen as a useful investment of resources. Partners also frequently associated evidence-based guidelines with the CDC.

> [Evidence-based guidelines are] activities that have been shown through research, evaluation, and data collection to achieve the outcomes they set.

> Just in general, I find maybe that [evidence-based guidelines] would be supported by CDC or some other national organization. Something that's been scientifically proven.

"[Evidence-based practices] are a good bang for your buck. You know they're going to work."

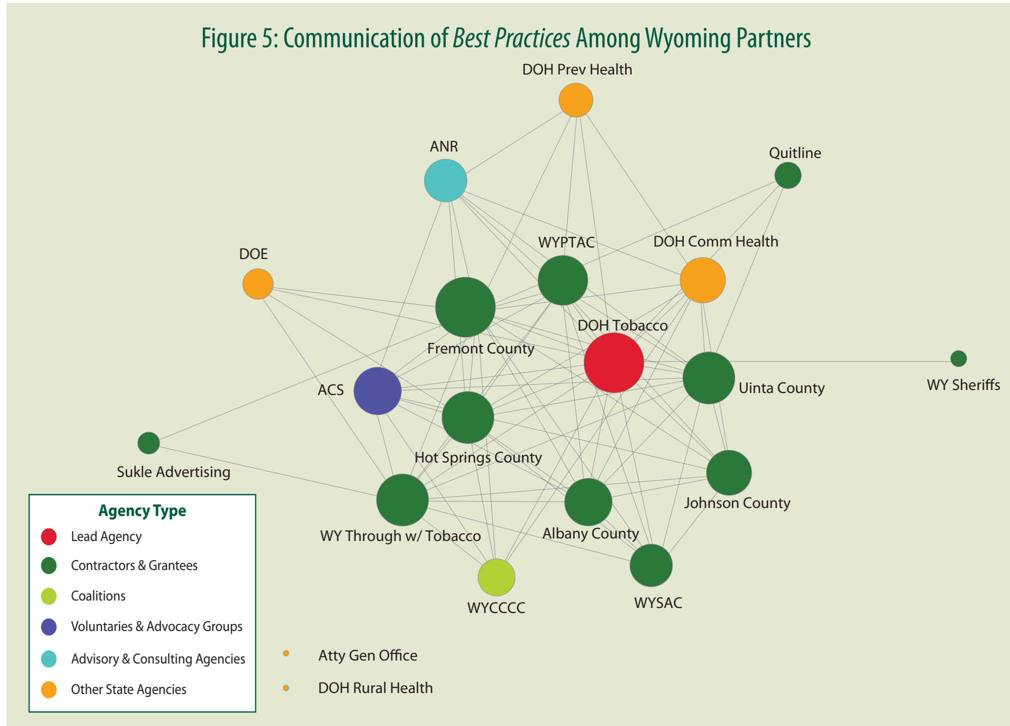
How did partners learn of evidence-based guidelines?

Partners in leadership positions were usually the first in their organization to learn of new evidence-based guidelines. Within the Wyoming Department of Health, the tobacco program manager was cited as being a primary source for guideline diffusion. Additionally, partners often learned of new guidelines at local and national conferences and meetings. In particular, many partners learned of the CDC *Best Practices* at statewide strategic planning meetings. After learning of new guidelines, partners shared the information with colleagues through e-mail and internal staff meetings.

> The state tobacco program is currently writing their strategic plan to the CDC and certainly talks about *Best Practices* as part of that.

> We [discuss evidence-based guidelines at] monthly and quarterly meetings, or if the [DOH tobacco program manager] gets them electronically, he forwards them in e-mails.

To get a better understanding of communication specifically about *Best Practices*, Wyoming partners were asked whom they talked to about the guideline. In Figure 5, a line connects two partners who indicated they talked about *Best Practices* with each other. The size of the node reflects the number of agencies each partner talked to about the guideline. For example, DOH Tobacco and Fremont County talked with many partners about *Best Practices*, resulting in their larger node sizes. The Tobacco Free Wyoming Communities' program managers who participated in the evaluation (Albany, Uinta, Fremont, Hot Springs, and Johnson Counties) talked with a number of other partners about the guideline, indicating they were a source of guideline diffusion in the state.



What tobacco control guidelines were partners aware of?

Best Practices was the most well-known guideline in Wyoming. Twenty-one out of 23 partners interviewed recalled at least hearing of *Best Practices*. Most partners referred to *Best Practices* frequently, ranging from weekly to annually. The CDC *Best Practices User Guide Series* and SAMHSA's *Strategic Prevention Framework* were also well-known by Wyoming partners. However, fewer than half of partners were aware of the majority of tobacco control guidelines listed.

Table 2: Number of Partners Aware of Tobacco Control Guidelines

Guideline	# of Partners
Best Practices for Comprehensive Tobacco Control Programs	21/23
Best Practices User Guides Series	18/23
SAMHSA Strategic Prevention Framework	16/23
Designing and Implementing an Effective Tobacco Counter-Marketing Campaign	13/23
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	13/23
Introduction to Process Evaluation in Tobacco Use Prevention and Control	11/23
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	10/23
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	10/23
Ending the Tobacco Problem: A Blueprint for the Nation	9/23
Key Outcome Indicators for Evaluating Tobacco Control Programs	9/23
NACCHO 2010 Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs	8/23
The Guide to Community Preventive Services: Tobacco	6/23
Tobacco Control Monograph Series	4/23

Adoption Factors

What did partners take into consideration when making decisions about their tobacco control efforts?

When partners were asked what they took into consideration when making decisions about their tobacco control efforts, they most often noted looking to *Best Practices* and other evidence-based guidelines to determine which activities would have the most impact. Input from partners, especially at the Department of Health, and direction from clients were also key influences on partners' decision-making.

> The primary factor is evidence-based strategies. And even with that, it's divided into what will have the biggest impact of the evidence-based strategies.

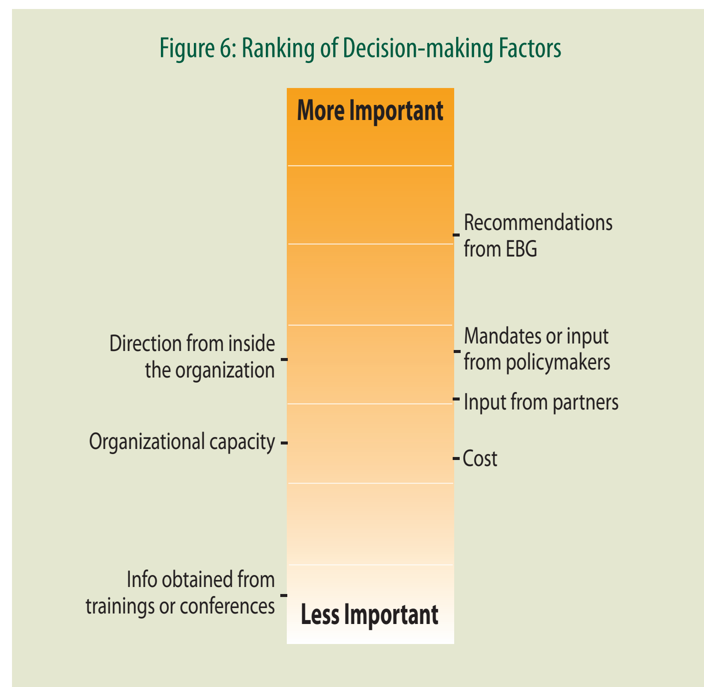
> Probably the biggest thing is making sure that we're aligning with the Tobacco Prevention and Control Program direction, and support those efforts.

Consequently, when asked to rank several factors in their overall importance when making decisions to design or adopt programs or policies for tobacco control, partners most often ranked recommendations from evidence-based guidelines as the most important factor, with 91% of partners ranking it in their top three. *Best Practices* and other evidence-based information acted as a foundation for planning and program direction. Following recommendations from evidence-based guidelines ensured efficient use of limited time and money by focusing on practices that had been proven to work.

> We are totally dedicated and ruled by if you can't prove it works, we're not going to do it.

> With the limited amount of funding that we have, I think we have to be really careful about what we're doing. So the most important thing is not to waste money, so whatever we're working on, we want to make sure that we're working on something that we know will work in the long run.

Figure 6: Ranking of Decision-making Factors



Mandates or input from policymakers was ranked as the second most important factor in the decision-making process. Since Wyoming partners were working to pass local smokefree ordinances, they recognized the important influence that policymakers had on the success of their tobacco control efforts. Policymakers' input was also important because partners relied on policymakers for program funding.

> We want to keep [policymakers] happy because…we don't want them cutting funds. So they do have a slight influence.

Additionally, Wyoming partners looked for buy-in and direction from inside their organization, as well as from outside partners. Consideration of partners' input helped inform the decision-making process.

> I think that [input from partners] is a selling point to making good, informed decisions by getting input from other people that have a different perspective to the issue.

> We want to make sure that we're doing things that [our partners are] wanting us to do.

Like many other states, the tobacco control program in Wyoming faced reduced staffing and limited funding. Therefore, before designing and implementing new programs, partners considered the impact of organizational capacity and the cost of the program. Funding and staff ultimately determined what programs partners could implement.

> We need to have the capacity within the organization to implement the decisions and adopt the programs or policies that we're looking at.

> Cost…does obviously factor into if you can even implement something or not.

"The things that are important right now are what policymakers can actually influence, which is taxes and smokefree ordinances. So [input from policymakers] always seems to be a big part of making decisions."

How did organizational characteristics influence partners' decisions about their tobacco control efforts?

Partners stated that quality leadership facilitated their tobacco control efforts. Partners particularly valued leadership that fostered innovation and emphasized end results.

> We have a leadership that is very open to doing things that will produce results, and so they are happy to change things…if you can make a good case to them that this will improve the results.

> I think that my program, one of the big things that we do is come up with innovative ways to affect tobacco use.

Conversely, partners found bureaucratic constraints to be the foremost barrier to their tobacco control efforts. Specifically, not being able to lobby and the slow legislative process were seen as challenges. These factors made it especially difficult to advance a statewide smokefree law.

> Well just the usual red tape in government that it just takes so long to get anything done. It seems like when you're trying to move forward something that is as important to healthy lifestyle as not using tobacco, it just seems like it takes forever to get anywhere in the governmental system.

> We know that smokefree ordinances and raising taxes are the best way to reduce your rates, which we, a) don't have any control over, and b) can't lobby in any way, shape or form. So we always have to be careful that we're only educating.

These bureaucratic constraints were compounded by the influence of Wyoming's culture. Aversion to change and an emphasis on individual rights made it difficult to enact policy change for tobacco control. Additionally, the small population size and geographic isolation of communities made it difficult for partners to establish a statewide movement.

> We live in Wyoming and we like our rights, so just kind of having people who aren't really on board and have a set way of thinking that's very difficult to change.

> Wyoming offers some unique barriers that we've had to look into, just because we're a very large state with a fairly small population and so you get geographic isolation.

What facilitated or hindered use of evidence-based guidelines?

Wyoming partners often utilized evidence-based guidelines as a framework for their tobacco control efforts. Partners felt that they would be successful in achieving their desired outcomes because evidence-based practices were proven to work. Following these proven practices also saved partners both time and money.

> You know that what you're using and what you're doing has shown success in other communities, and if you're doing it right then you're more likely to have success with the programs that you're doing, and you're not wasting your time.

Despite the perceived importance of evidence-based guidelines, partners still encountered some challenges to using them. The biggest challenge was implementing evidence-based practices to fidelity since some partners did not feel that the guidelines were as applicable to Wyoming. Specifically, partners found it difficult to apply the guidelines to the small, rural communities throughout the state.

> "If I know that I'm using evidence-based practices, then I know I'm doing what's right."

> The one size fits all, or the lack thereof [is a challenge]. We'll have a strategy that was developed in New Orleans for 100 kids in a classroom and I'm supposed to take it to Hudson, Wyoming, with all three kids in the classroom and it's supposed to work out the same? I don't think so.

> In the state of Wyoming the biggest challenge is that several of [the evidence-based guidelines] are not for extreme rural locations. There are some very good things out there that are for urban locations, and that would not be us.

Partners also found communities' resistance to change to be a challenge for implementing evidence-based practices. Some partners were more comfortable implementing activities with which they were more familiar and which were perceived as less controversial. In some cases, these activities, such as health fairs, were not evidence-based.

> [Some tobacco control professionals] have ideas about things that they want to do, and it might not be an evidence-based guideline or practice…it's just more comfortable to go with something that you know as opposed to something that's been proven.

> People like to do the stuff that makes them feel good, you know…health fairs.

Implementation

Which guidelines were critical for Wyoming's tobacco control partners?

Overall guideline awareness among Wyoming partners was low, and an even smaller number of those guidelines were identified as critical resources when partners were asked to group guidelines into one of three categories: 1) *Critical* for their tobacco control efforts; 2) *Not critical, but useful* for their tobacco control efforts; and 3) *Not useful* for their tobacco control efforts. The following are the guidelines identified most frequently as critical resources by Wyoming partners.

Best Practices for Comprehensive Tobacco Control Programs

Ninety-one percent of Wyoming partners were aware of *Best Practices*, and 76% identified it as a critical resource to their tobacco control efforts. Most often cited as a general reference for strategic planning, *Best Practices* provided overall guidance to ensure a comprehensive approach to partners' tobacco control efforts. Most partners received this resource at the start of their current position as an introduction to tobacco control.

> [*Best Practices* was used to] make sure that [the Wyoming DOH Tobacco Prevention and Control Program] had all of the components in place for a truly comprehensive tobacco control program.

Revisions to the CDC *Best Practices*

In 2007, the *Best Practices* guideline was revised. To find out how these changes were perceived, Wyoming partners were asked additional questions about *Best Practices*. Most partners were not aware of the 1999 version or were not familiar with the specific changes made. However, one partner stated that the collapsing of the categories provided focus, which was particularly helpful when using the guide at the community level.

> The condensing of [the categories] and being more focused I think is really good for communities.

Table 3: Percentage of Partners Who Identified Guideline as a Critical Resource

Guideline	% of Partners*
Best Practices for Comprehensive Tobacco Control Programs	76%
Key Outcome Indicators for Evaluating Tobacco Control Programs	67%
Tobacco Control Monograph Series	50%
SAMHSA Strategic Prevention Framework	44%
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	40%
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	40%
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	33%
Ending the Tobacco Problem: A Blueprint for the Nation	33%
Best Practice User Guide Series	28%
NACCHO 2010 Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs	25%
The Guide to Community Preventive Services: Tobacco	17%
Designing and Implementing an Effective Tobacco Counter-Marketing Campaign	15%
Introduction to Process Evaluation in Tobacco Use Prevention and Control	0%

* Based on partners who were aware of the guideline

Key Outcome Indicators for Evaluating Tobacco Control Programs

Awareness of the *Key Outcome Indicators* was low among Wyoming partners. However, of those aware of the guideline, 67% identified it as a critical resource. Partners first learned of this guide at the start of their current position and utilized it as a resource in their evaluation efforts. Specifically, this guide was used to measure the goals and objectives of the state's tobacco control program.

> We've used [the *Key Outcome Indicators*] as the original formation of what is tobacco prevention control trying to do and where can we look for its impact?

Other Resources

Additional resources cited as critical by Wyoming partners included the National Cancer Institute's *Tobacco Control Monograph Series* and the *Clinical Practice Guidelines: Treating Tobacco Use and Dependence* (the *Clinical Practice Guidelines*). Partners utilized the *Clinical Practice Guidelines* as a reference to aid in cessation treatment plan development.

> I've used [the *Clinical Practice Guidelines*] as a knowledge base. That's what I base my treatment plans on.

Despite being housed in the Mental Health and Substance Abuse Services Division, SAMHSA's *Strategic Prevention Framework* was infrequently used by Wyoming's tobacco program. Although the guideline itself was not referenced frequently, the general concepts of the Framework were useful for guiding efforts.

> I don't refer to it often, but I have the Framework in my head, so it's sort of the model of what I do.

What resources were used to address tobacco-related disparities?

Wyoming partners identified populations with tobacco-related disparities based on available data from sources such as the Behavioral Risk Factor Surveillance System (BRFSS), the Youth Risk Behavior Surveillance System (YRBS) and information from the Wyoming Survey and Analysis Center (WYSAC). Since Wyoming partners observed that the state population was not particularly racially diverse, they believed that focusing on populations with tobacco-related disparities would not significantly affect overall tobacco use rates in the state. Partners also found it difficult to define what they understood as "populations with tobacco-related disparities," although several partners identified American Indian populations, low socio-economic status individuals, smokeless tobacco users, and pregnant women as populations in Wyoming experiencing tobacco-related disparities.

> "In Wyoming, [populations with tobacco-related disparities] are still such a small part of the population. Targeting them for cessation efforts will not move the needle very much."

> We find that the majority of our smokers are low socioeconomic status, but then at the same time, you've got to take into effect some of those certain minority groups at the same time. So trying to balance that out when working with disparities overall is really tough.

Partners found that both local and national organizations, including information from the DOH and other state departments, provided helpful resources to guide their work with these populations.

> The National Native Network [information] I use, just being connected to colleagues around the country and to what works [is helpful].

> One [population with tobacco-related disparities] would be maternal smokers and so we have partnered with Family and Maternal Health. Youth would be the other [population experiencing tobacco-related disparities], so that would be partnering with the Department of Education.

The majority of partners had not referenced *Best Practices* in their work with populations with tobacco-related disparities. Partners noted that the guideline lacked the specificity necessary for it to be useful for working with these populations.

> [*Best Practices*] really don't say anything about the American Indian population.

As a result, many partners expressed the need for additional information or trainings to guide their work with populations with tobacco-related disparities, particularly American Indian populations. Additionally, Wyoming partners desired more information on developing culturally competent interventions.

> Maybe training, like when we have our state training, would be nice to work on disparate populations. How can we help? Who are they? Where are they? Different approaches that work.

> I think a guide; an actual guide to evidence-based strategies in working with American Indians would be amazing.

What resources were used to communicate with policymakers?

The majority of partners in Wyoming communicated with policymakers, both at the state and local level. Partners noted working with the Governor's office as well as with local policymakers, such as mayors and city and county council members. In this communication, partners most often cited data provided by WYSAC. This information was compiled from reputable sources such as BRFSS, YRBS, and the Campaign for Tobacco Free Kids. Partners used this data to support their case for tobacco control. Additional sources of information referenced by partners during their discussions with policymakers included testimonials and information from other states.

> "Anytime that we're talking about a program we have to present evidence-based practice, because if it's not evidence-based, a lot of legislators won't even listen to us."

> The harmful effects of secondhand smoke, what our rates are according to the YRBS and BRFSS use rates and the information that is sent to us through the state.

> Especially during election time periods, we get a lot of requests for general data. A lot of legislators are surprised to learn the average age that youth start using tobacco in the state of Wyoming. [We provide] a lot of data, a lot of what's going on in the community.

Although evidence-based guidelines were not frequently cited sources of information during discussions with policymakers, some partners did refer to them during conversations regarding new programming activity proposals as a means of providing credibility.

> If we have a new intervention, or a new proposal that we want to try to get in and get passed, we do refer to evidence-based information.

What other resources were needed?

When asked what the CDC could do to support Wyoming's tobacco control efforts, partners expressed the need for continued provision of up-to-date resources, specifically those that would be useful in enhancing efforts to pass smokefree ordinances in the state. For example, partners stated that additional data, guidance on communicating with policymakers, and information from other states would be useful resources for guiding policy change efforts.

> It's keeping us informed of what's going on and what works in other states.

> We tried for a smokefree policy in Wyoming last year and got beat up over it really, really, really bad. I would like to see [the CDC] come up with . . . what do you do in states that [passing a smokefree policy] is just not possible to get that passed? How do you approach the legislators? How do you sway their vote? What does it take? That's the thing that I think we're lacking in this state.

Finally, partners suggested distributing such information and other future resources via electronic copy, hard copy, and at national conferences.

> Well I would say [we need] e-mail and a hard copy [of guidelines]. It's like we almost need it together [to make greatest use of guidelines].

Conclusions

While overall awareness of evidence-based guidelines was low among Wyoming partners, they did find guidelines useful as general references for guiding their tobacco control efforts and considered recommendations from evidence-based guidelines to be an important factor in their decision-making process. Partners in leadership positions were often the first to learn of new evidence-based guidelines, particularly the Wyoming DOH tobacco program manager. Due to the emphasis on local tobacco control efforts in Wyoming, the Tobacco Free Wyoming Communities program managers also played a key role in the diffusion of guidelines, particularly *Best Practices*. The guidelines, especially *Best Practices*, were utilized during the strategic planning process to provide overall guidance to ensure a comprehensive approach to DOH's Tobacco Prevention and Control Program and to local level programs. Additional factors contributing to the adoption of *Best Practices* and other evidence-based guidelines included:

- Guidelines provided credibility to partners' efforts due to their promotion of proven and effective practices.
- The implementation of evidence-based practices provided a cost-efficient approach to tobacco control activities.

Despite the listed benefits of evidence-based guidelines, Wyoming partners noted several challenges to using the guidelines in their tobacco control work, particularly at the local level.

- Application of the guidelines occasionally met resistance from the community and some partners, particularly when working toward comprehensive smokefree policies at both the state and local levels.
- Partners found the guidelines to be minimally useful in their work with populations with tobacco-related disparities and found it difficult to apply the guidelines to specific populations or communities.
- Partners felt guidelines were geared more toward urban communities and lacked the necessary guidance to be useful for their local efforts, which were often in rural settings.

An abundance of information is available to inform the work of those involved in tobacco control. In Wyoming, recommendations from evidence-based guidelines, input from policymakers, and organizational capacity played important roles in guiding the state's tobacco control efforts. The degree to which particular evidence-based guidelines were incorporated into partners' work was dependent upon factors tied to three main phases of information diffusion highlighted throughout this report: dissemination, adoption, and implementation. Such factors included avenues of guideline dissemination to stakeholders, presence or absence of support by other individuals or policies, and the feasibility of applying that information to one's work. As an example, many Wyoming partners cited the need for additional information on culturally competent interventions to best address the state's populations with tobacco-related disparities. Partners believed such information would increase the applicability of evidence-based guidelines to their work. Additionally, by increasing access to current resources from national organizations, partners believed they would be better prepared to promote policy change for tobacco control. Taking these factors into consideration when developing and releasing future guidelines will help to optimize use of the guideline by intended stakeholders.