

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

Acknowledgements

This profile was developed by:

Laura Bach
Lana Wald
Jennifer Cameron
Max Bryant
Stephanie Herbers
Laura Brossart
Douglas Luke

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

For more information or to obtain a copy of this report, please contact:

Center for Tobacco Policy Research
George Warren Brown School of Social Work
Washington University in St. Louis
700 Rosedale Ave, CB 1009
St. Louis, MO 63112
<http://ctpr.wustl.edu>

Suggested Citation:

Center for Tobacco Policy Research. *The Florida Profile: Mandating the Best Practices*. St. Louis, MO: Washington University in St. Louis; 2011.

Funding for this project was provided by the National Association for Chronic Disease Directors (NACDD). The information presented in this profile does not necessarily represent the views of NACDD, their staff, or Board of Directors. This evaluation was done in collaboration with Washington University in St. Louis and approved by the Washington University Institutional Review Board.

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.

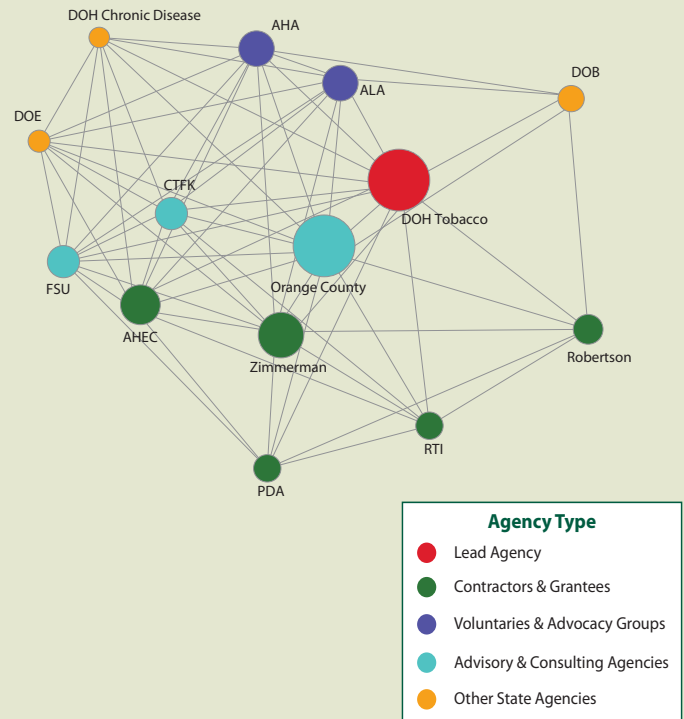
Table 1: Florida Tobacco Control Partners

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.

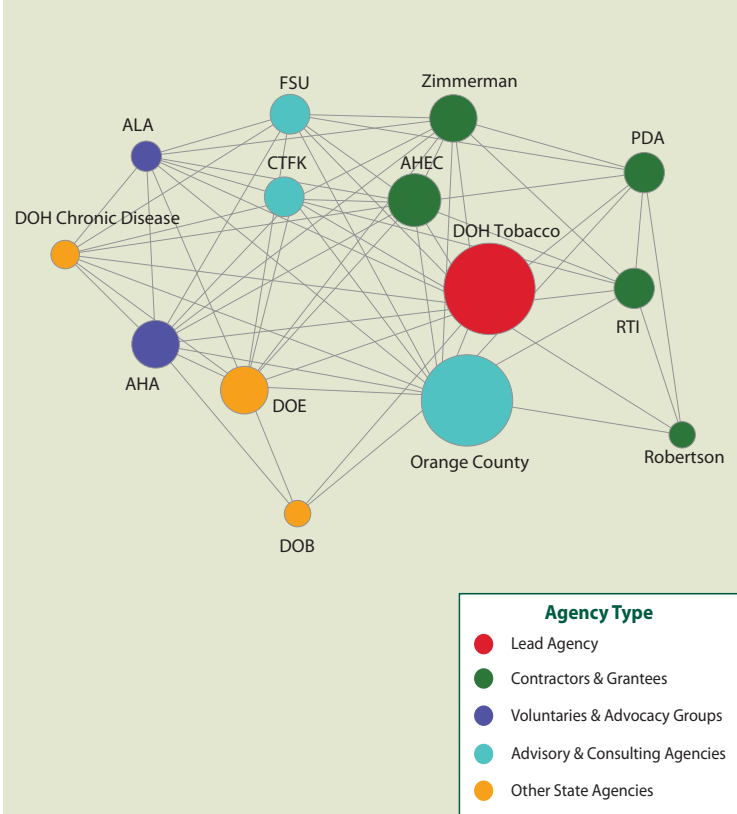
Figure 1: Florida Partners' Communication Network



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?

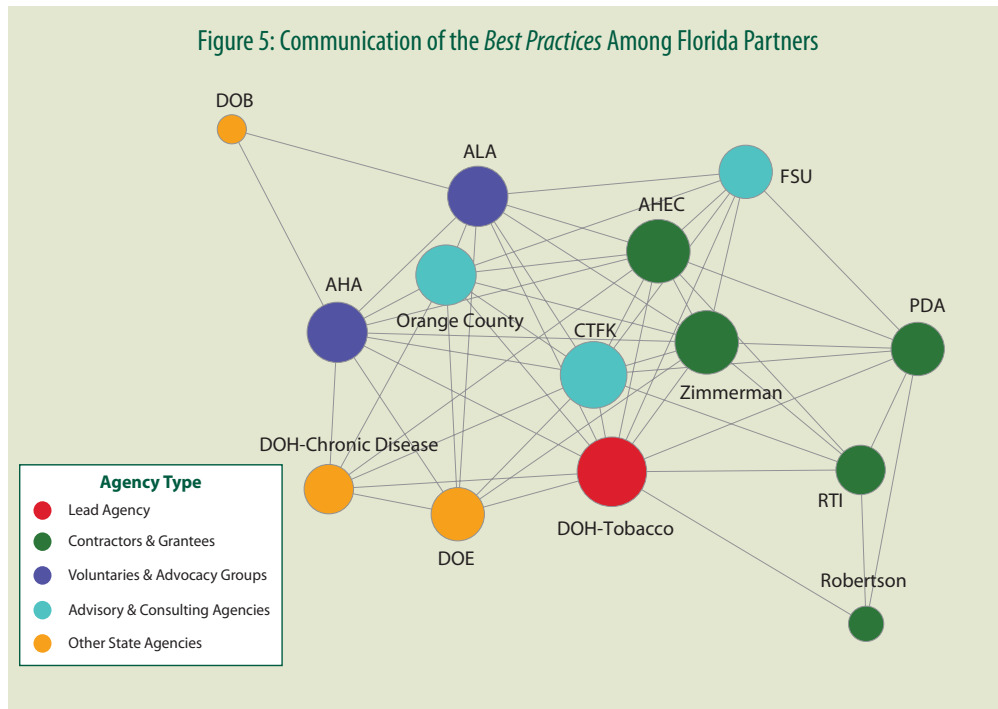
Partners were made aware of new guidelines through meetings, conferences, and contacts at both the national (e.g., CDC OSH) and state level. Staff members at the Florida Department of Health’s Bureau of Tobacco Prevention Program, especially the Bureau Chief and the Community Grantee Manager, were a 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 listserv 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 listserv which is another e-mail listserv 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.



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.

Figure 6: Ranking of Decision-making Factors



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.

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 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?”

- ⋮ 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.

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*.

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

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."

A stylized map of Florida in a light green color, positioned behind the word "Conclusions".

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.

