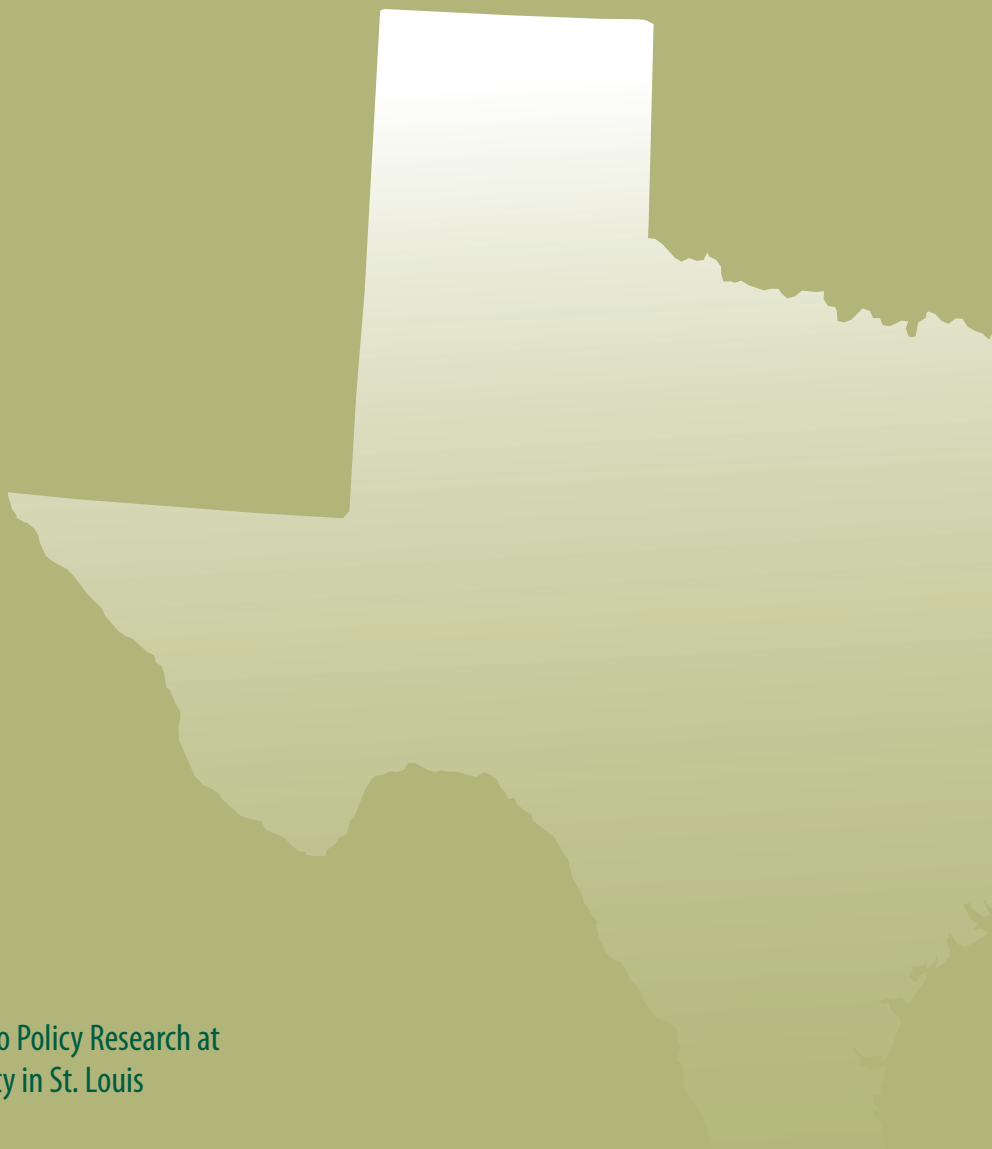
The Texas Profile:

Merging best practices from two sides

Use of Evidence-Based Guidelines in State Tobacco Control Programs



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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**

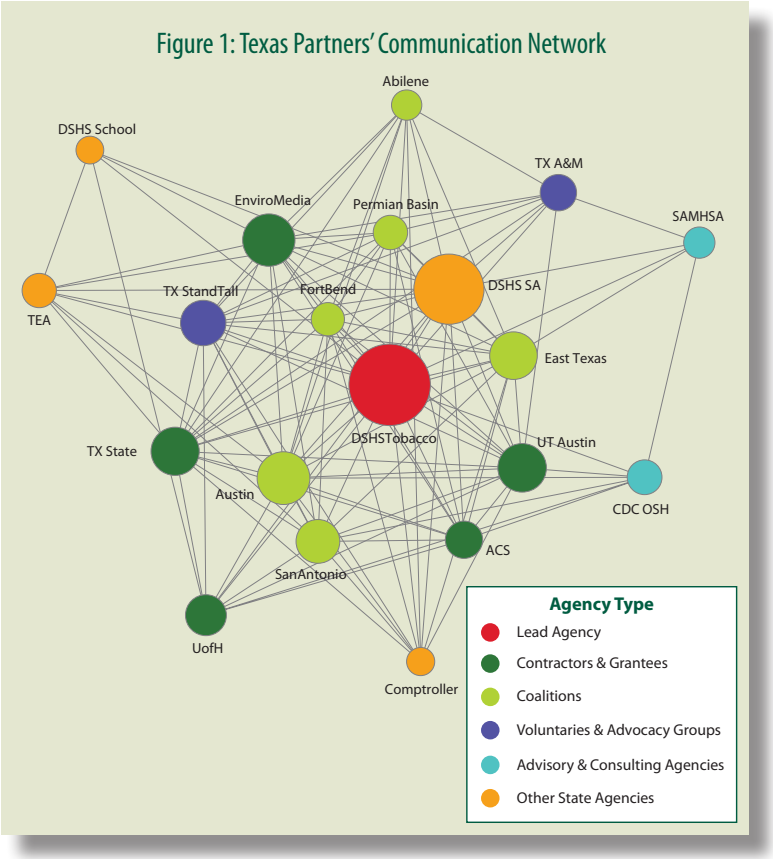
Table 1: Texas Tobacco Control Partners (continued)

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.

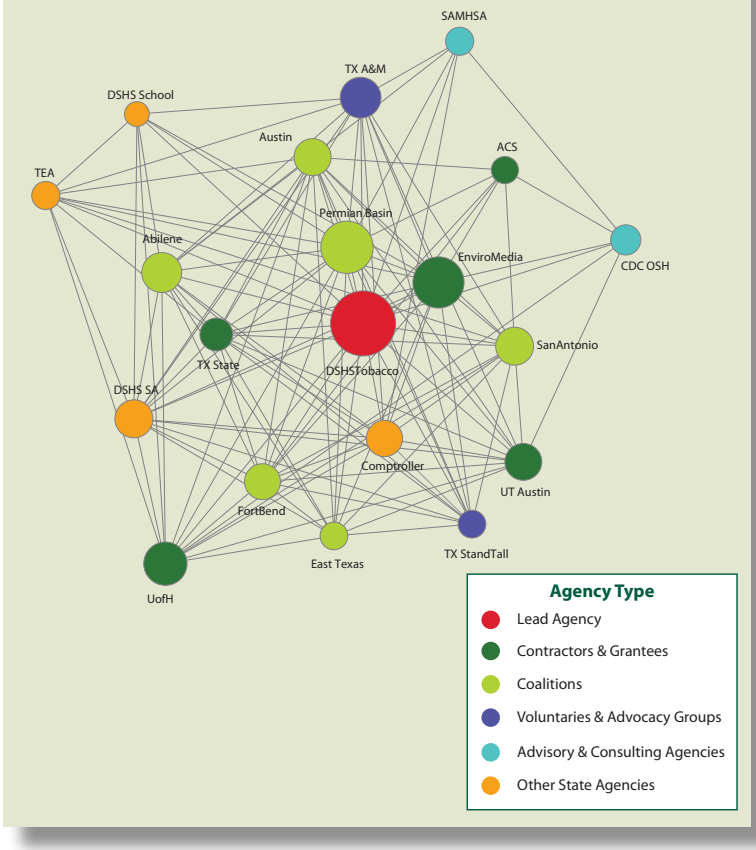
Figure 1: Texas Partners' Communication Network



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

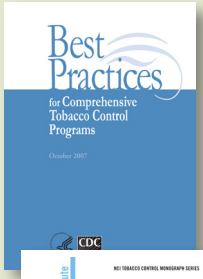
There are a number of evidence-based guidelines for tobacco control, ranging from broad frameworks to those focusing on specific strategies. Below in Figure 3 are the set of guidelines partners were asked about during their interviews.

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

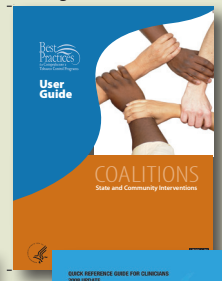
- Substance Abuse and Mental Health Services Administration (SAMHSA) *Administrative Directive of Promising Practice*;
- Surgeon General reports;
- Community-based guidelines or tools:
  - Texas DSHS *Community Tobacco Prevention and Control Toolkit*;
  - University of Kansas *Community Toolbox*;
- RAND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

Figure 3: Evidence-based Guidelines for Tobacco Control

Best Practices for Comprehensive Tobacco Control Programs–2007

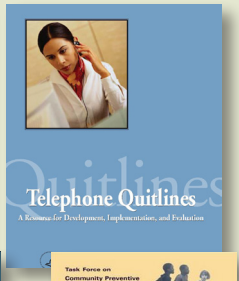


Best Practices User Guide Series (e.g., Coalitions)

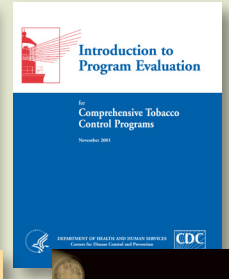


Designing and Implementing an Effective Tobacco Counter-Marketing Campaign

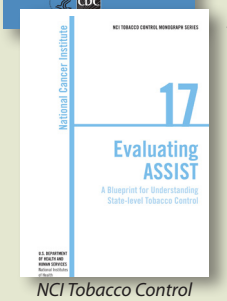
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation



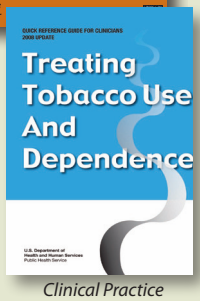
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs



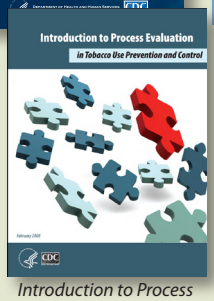
SAMHSA Strategic Prevention Framework



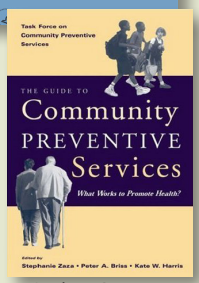
NCI Tobacco Control Monograph Series (e.g., ASSIST)



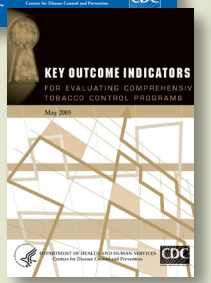
Clinical Practice Guidelines: Treating Tobacco Use and Dependence



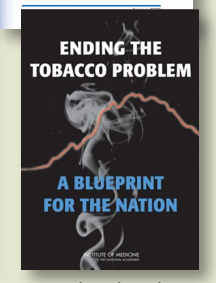
Introduction to Process Evaluation in Tobacco Use Prevention and Control



Guide to Community Preventive Services: Tobacco (The Community Guide)



Key Outcome Indicators for Evaluating Tobacco Control Programs



Ending the Tobacco Problem: A Blueprint for the Nation (IOM Report)

- 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.

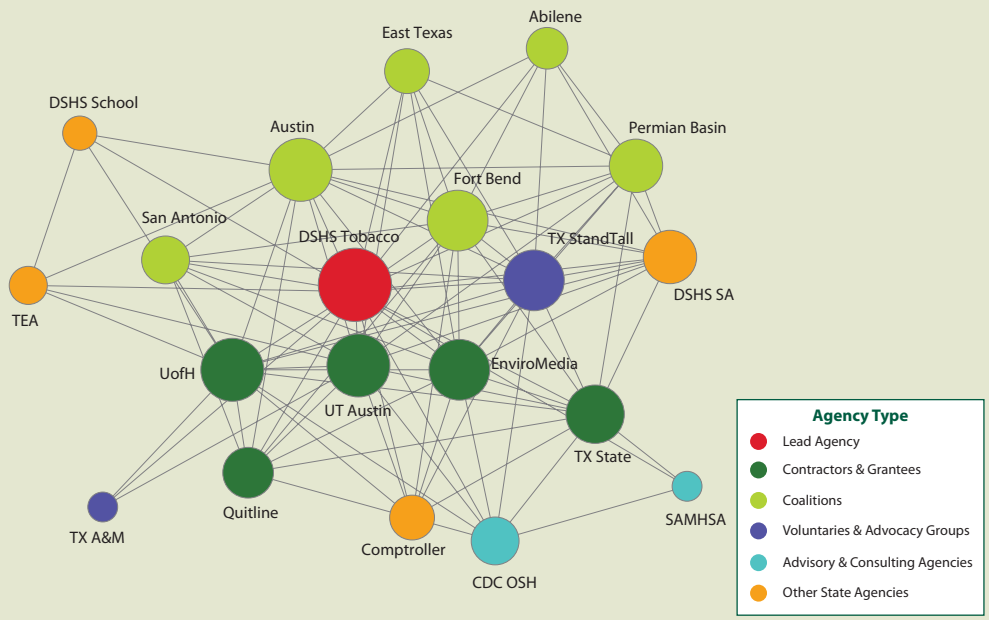
> We get a lot of communication from the state from the grant program directors…And they have a listserv that's for coordinators and evaluators. Then we also hear about things through our direct services contractor, because they get a lot through the substance abuse side of things as well…Our Prevention 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.

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



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.

> 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.

Figure 6: Ranking of Decision-making Factors

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.

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.

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

> 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.