The
Washington, D.C. Profile:

Focusing on sustainability

Use of Evidence-based Guidelines in State Tobacco Control Programs

Acknowledgements

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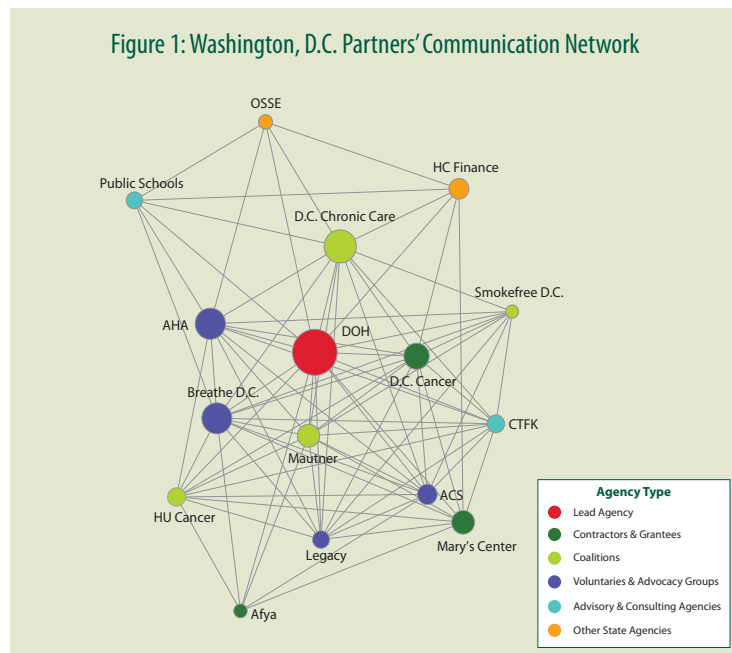
Table 1: Washington, D.C. Tobacco Control Partners

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

Agency Type
- Lead Agency
- Contractors & Grantees
- Coalitions
- Voluntaries & Advocacy Groups
- Advisory & Consulting Agencies
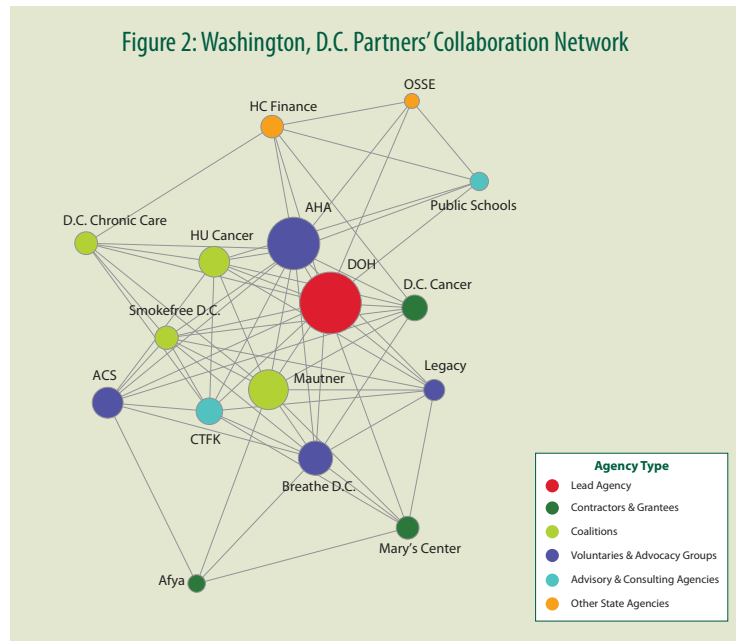- Other State Agencies

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

Agency Type
- Lead Agency
- Contractors & Grantees
- Coalitions
- Voluntaries & Advocacy Groups
- Advisory & Consulting Agencies
- Other State Agencies

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

Best Practices for Comprehensive Tobacco Control Programs–2007

Key Outcome Indicators for Evaluating Tobacco Control Programs

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

NACCHO 2010 Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs

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

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

Clinical Practice Guidelines: Treating Tobacco Use and Dependence

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

Introduction to Process Evaluation in Tobacco Use Prevention and Control

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

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 → *Partners are aware of guidelines* → **Adoption Factors** → *Partners perceive use as beneficial* → **Implementation**

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."
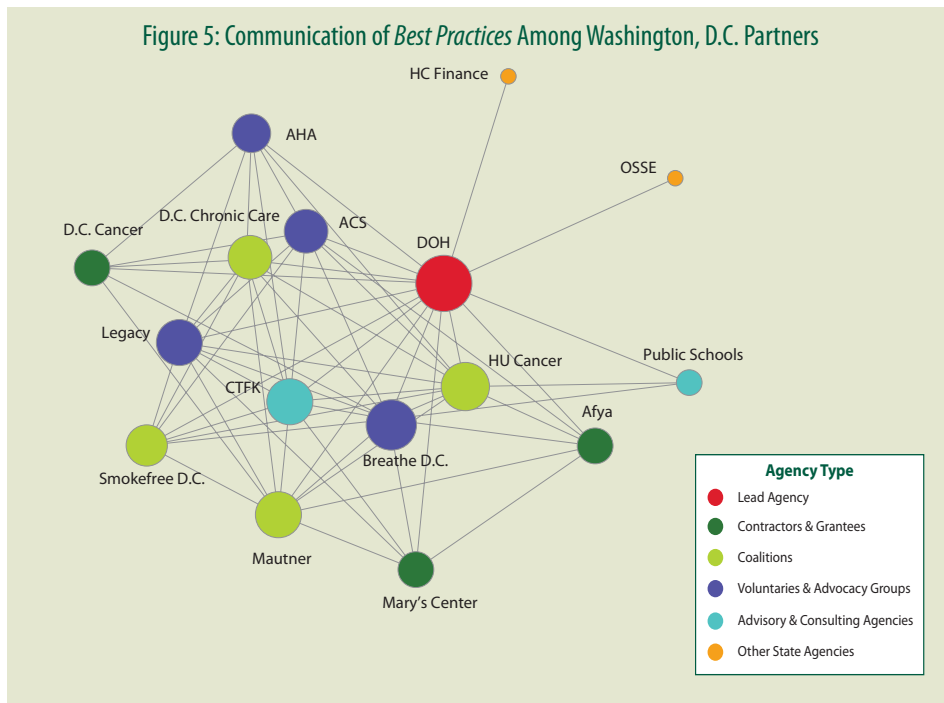
How did partners learn of evidence-based guidelines?

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.

Figure 5: Communication of *Best Practices* Among Washington, D.C. Partners

Agency Type
- Lead Agency
- Contractors & Grantees
- Coalitions
- Voluntaries & Advocacy Groups
- Advisory & Consulting Agencies
- Other State Agencies

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?
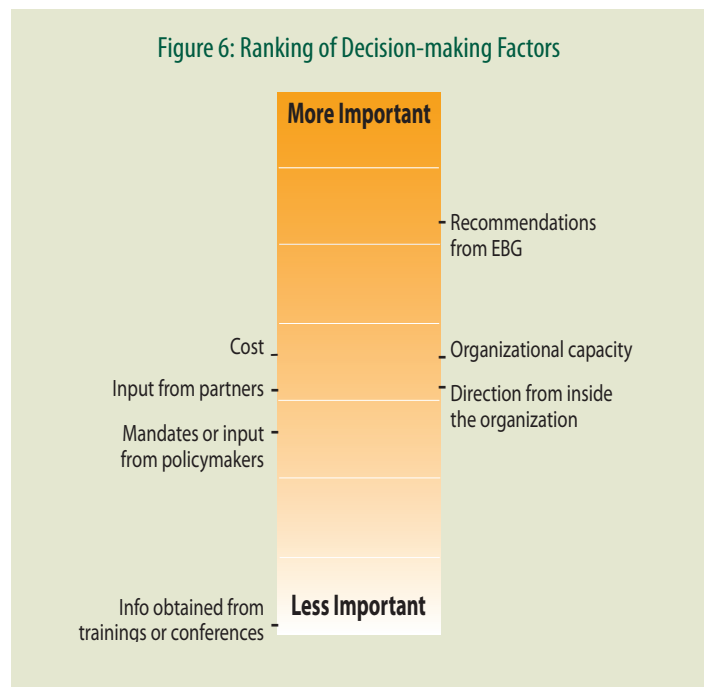
When partners were asked what they took into consideration when making decisions about their tobacco control efforts, they most often cited looking to evidence-based strategies and input from partners. It was also important for partners to take into consideration their target population and the public 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.

Figure 6: Ranking of Decision-making Factors

More Important

Recommendations from EBG

Cost

Organizational capacity

Input from partners

Direction from inside the organization

Mandates or input from policymakers

Info obtained from trainings or conferences

Less Important

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

<u>Revisions to the CDC *Best Practices*</u>

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.