The Best Practices
Use of the Guidelines by Ten State Tobacco Control Programs


Background: The Best Practices for Comprehensive Tobacco Control Programs by the Centers of Disease Control and Prevention was the first national resource to define the nine required components of a comprehensive state tobacco control program. This evaluation examined how states used the guidelines in their program planning, and identifies strengths and weaknesses of the guidelines.

Methods: During 2002–2003, data were collected and analyzed from ten state tobacco control programs on familiarity, funding, and use of the guidelines. Data were collected via written surveys and qualitative interviews with key tobacco control partners in the states. The typical number of participants interviewed was 17, representing an average of 15 agencies per state.

Results: Lead agencies and advisory agencies were the most familiar with the guidelines, while other state agencies were less aware of the guidelines. Participants’ prioritization of the nine components was closely related to the lead agencies’ estimated category expenditures. Three states modified the guidelines to develop more-tailored frameworks. Major strengths of the guidelines included providing a basic program framework and state-specific funding recommendations. The guidelines did not address implementation strategies or tobacco-related disparities, and had not been updated with current evidence-based research.

Conclusions: The guidelines are important recommendations for state tobacco control programs. To continue to be useful to states, the guidelines need to be updated to address implementation and tobacco disparities, and include additional evidence-based examples. Active dissemination of updated guidelines needs to be increased beyond typical consumers to other tobacco control partners such as coalitions and other state agencies.

Introduction

In 1998, the Master Settlement Agreement (MSA) provided states with significant financial resources, some of which was intended to fund efforts to reduce tobacco use. In preparation for the anticipated influx of funds, the Centers for Disease Control and Prevention (CDC) Office on Smoking and Health (OSH) published the Best Practices for Comprehensive Tobacco Control Programs (Best Practices) in August 1999. In recent years, there have been several guidelines or reviews published that provide practitioners with recommendations about evidence-based interventions. However, the Best Practices was the first resource to outline the nine core components of a comprehensive tobacco control program and provide specific funding recommendations for states to use in program planning, management, and advocacy. The following are the nine Best Practices components:

Cessation programs—Activities that help individuals quit using tobacco
Chronic disease programs—Activities that focus on prevention and early detection of tobacco-related diseases
Community programs—Activities that are primarily delivered at the local or regional levels
Countermarketing—Activities that attempt to counter pro-tobacco influences and increase pro-health messages
Enforcement—Activities that enforce or support tobacco control policies in the areas of minors’ access to tobacco and ensuring clean indoor air
School programs—Activities implemented in an academic setting to reduce youth tobacco use and prevent initiation
Statewide programs—Activities accessible to individuals and/or organizations across a state and supported by the state

From the Center for Tobacco Policy Research, Saint Louis University School of Public Health, St. Louis, Missouri
Address correspondence and reprint requests to: Nancy Mueller, MPH, Center for Tobacco Policy Research, Saint Louis University, 3545 Lafayette Avenue, Suite 300, St. Louis MO 63104. E-mail: mueller@slu.edu.
Surveillance and evaluation—Activities that monitor tobacco-related behaviors, attitudes, and health outcomes or program success

Administration and management—Activities that facilitate the coordination of the program components and provides fiscal oversight

The guidelines have also been an important technical assistance tool for CDC OSH. The Best Practices not only provides a formalized set of funding recommendations that shapes state tobacco control programs but also helps to establish national frameworks and standards. CDC’s National Tobacco Control Program is guided by logic models that address each of the program’s four goals: (1) preventing initiation, (2) promoting cessation, (3) eliminating exposure to secondhand smoke, and (4) addressing tobacco-related disparities.7 Guidelines like the Best Practices and the Guide to Community Preventive Services4 are important information resources that help define the activities component of these logic models.

Before 2001, there had been no formal evaluation of the implementation of the Best Practices by state tobacco control programs. From 2002 to 2003, the Center for Tobacco Policy Research conducted a process evaluation, funded by the American Legacy Foundation, examining ten state tobacco control programs. Although the evaluation of tobacco control programs is not new, most evaluations have focused on only one state.8–10 The American Stop Smoking Intervention Study (ASSIST) evaluation was the first multistate evaluation that compared the 17 ASSIST states and the 33 non-ASSIST states on a number of outcomes.11,12 Similar to ASSIST, a cross-sectional, multistate evaluation was conducted examining the following four areas of states’ implementation and evaluation of the Best Practices: (1) description of states’ usage of the guidelines, (2) identification of specific strategies, (3) assessment of the utility of the guidelines in addressing tobacco-related disparities, and (4) evaluation of the Best Practices (i.e., strengths, weaknesses, and improvements) by study participants. This paper presents the results of that evaluation.

**Methods**

**Sample**

A diverse sample of ten states was selected based on (1) geographic location, (2) level of program capacity, (3) presence of tobacco farming, and (4) type of lead agency (i.e., health departments vs independent organizations). This paper presents the implementation of the Best Practices from the following tobacco control programs evaluated in 2002–2003: Washington, Oklahoma, Indiana, Wyoming, New York, Michigan, Pennsylvania, Mississippi, Hawaii, and Missouri (presented in chronologic order of evaluation) (Table 1).

A modified snowball sampling method was used to identify key partner agencies of each state’s tobacco control program.13 A lead agency of the tobacco control program, typically the organization receiving the majority of tobacco control funds was first asked to participate. The tobacco control program manager from the lead agency compiled a list of partners who contributed substantially to the program or had a unique role. The research team, the tobacco control manager, and usually the statewide coalition director reviewed the list and finalized the agencies and individuals who would be invited to participate in the evaluation interviews. The average number of participants interviewed was 17 per state, representing an average of 15 partner agencies.

**Data Collection**

Data were collected using two instruments. The background survey was completed by the tobacco control program manager and provided descriptive program information, including program finances, organizational capacity, and surveillance and evaluation activities. The partner interview was an in-depth semistructured interview used to collect qualitative and quantitative information from all program partners. In

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**Table 1. Characteristics of ten evaluated state tobacco control programs**

<table>
<thead>
<tr>
<th>State (fiscal year)a</th>
<th>Total tobacco control funds ($millions)b</th>
<th>Per capita spending ($)</th>
<th>% of CDC’s minimum recommendationc per capita</th>
<th>Tobacco growing state (yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington (FY2002)</td>
<td>20.8</td>
<td>3.53</td>
<td>62</td>
<td>no</td>
</tr>
<tr>
<td>Oklahoma (FY2002)</td>
<td>3.8</td>
<td>1.10</td>
<td>17</td>
<td>no</td>
</tr>
<tr>
<td>Indiana (FY2003)d</td>
<td>33.9</td>
<td>5.54</td>
<td>97</td>
<td>yes</td>
</tr>
<tr>
<td>Wyoming (FY2003)</td>
<td>4.2</td>
<td>8.47</td>
<td>57</td>
<td>no</td>
</tr>
<tr>
<td>New York (FY2003)</td>
<td>52.3</td>
<td>2.90</td>
<td>55</td>
<td>no</td>
</tr>
<tr>
<td>Michigan (FY2003)</td>
<td>5.3</td>
<td>0.53</td>
<td>10</td>
<td>no</td>
</tr>
<tr>
<td>Pennsylvania (FY2003)</td>
<td>53.9</td>
<td>4.37</td>
<td>82</td>
<td>yes</td>
</tr>
<tr>
<td>Mississippi (FY2003)d</td>
<td>20.4</td>
<td>7.29</td>
<td>108</td>
<td>no</td>
</tr>
<tr>
<td>Hawaii (FY2003)</td>
<td>9.0</td>
<td>7.39</td>
<td>83</td>
<td>no</td>
</tr>
<tr>
<td>Missouri (FY2003)</td>
<td>1.8</td>
<td>0.32</td>
<td>5</td>
<td>yes</td>
</tr>
</tbody>
</table>

aStates listed in chronological order of when the evaluation occurred.
bRobert Wood Johnson Foundation Smokeless States grant funds are included in total tobacco control funds.
cCDC’s Best Practices for Comprehensive Tobacco Control Programs.
dStates with independent (non-health department) lead agencies.

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*CDC, Centers for Disease Control and Prevention.*
general, one key informant was chosen from each partner agency based on his/her knowledge of the state tobacco control program. The partner interview collected information on network characteristics, state political and financial climates, Best Practices, and organizational capacity. Fifty-four percent of the interviews were conducted in-person with the remaining interviews conducted via telephone. Interviews lasted an average 73 minutes.

**Measures**

**Best Practices funding, familiarity, and usage.** The lead agency provided estimated expenditures by Best Practices category for the previous fiscal year. During the interviews, participants were asked to describe their level of familiarity and utilization of the Best Practices. Participants were then assigned to one of four levels of familiarity: (1) none (i.e., not aware of document), (2) low (i.e., heard of document but had not read it), (3) moderate (i.e., read document but had not used it), and (4) high (i.e., used document). They were also asked to describe how their states used the guidelines to influence tobacco control activities and whether they thought their state was implementing all nine components.

**Best Practices prioritization.** Participants were asked to rank the Best Practices components from highest to lowest based on how they thought the components should be prioritized for their state. They were then asked to explain their rationale for assigning their highest and lowest priority components and if their identified priorities were consistent with actual priorities of their states.

**Best Practices evaluation.** Participants were asked to identify the biggest strengths and weaknesses of the guidelines and suggest improvements. During the tobacco-related disparities section of the interview, participants were asked to assess how useful the Best Practices had been in addressing disparate populations and how tobacco-related disparities should be addressed in the guidelines.

**Data Coding and Analysis**

The majority of the data collected was qualitative. The 162 semistructured interviews were transcribed and imported into NUD*IST 4 (QSR International, Inc. NUDIST 4.0, Durham, United Kingdom, 1997). The research team developed a qualitative analysis codebook containing 42 descriptive codes based on the topic areas and interview questions. Codes were applied to the text units of each transcript. A text unit was defined as a block of text containing both the interviewer’s question and the participant’s response. Multiple codes could be assigned to each text unit depending on the content.

Two team members were trained on coding to ensure reliability among raters. Raters coded the transcripts independently and then came to consensus about the final codes for each transcript. Inter-rater agreement with ten transcripts was 84% across all codes. Raters did not code the interviews that they conducted to reduce the likelihood of inferring meaning based on the interview experience. A trained third rater was responsible for reviewing the codes and resolving coding differences. Thematic content analysis was used to analyze the data by topic. Emerging themes were identified from the aggregated responses for a particular code or topic. Once analysis of state-specific data was completed, the themes were examined across all ten states. In the results section, the qualitative thematic results are presented, supporting quantitative analyses, and representative quotes from the interviews.

**Results**

**Tobacco Control Program Characteristics**

Table 1 presents descriptive data for each state tobacco control program. Total funding for the programs ranged from $1.8 million in Missouri to $53.9 million in Pennsylvania in fiscal year 2003. According to the Best Practices minimum funding recommendations, three states (OK, MI, MO) were meeting <20% of their recommended minimum funding levels. Four other states (IN, PA, HI, MS) had funding levels >80% of the minimum recommendations. In fiscal year 2003, Mississippi was the only state exceeding the minimum recommendations. Per capita spending on tobacco control ranged from $0.32 (MO) to $8.47 (WI). It is important to note that funding recommendations are based on state-specific characteristics such as demographic factors and tobacco use prevalence. Some states (e.g., WI) showed higher per capita spending than other states (e.g., MS), but did not meet the minimum recommendations.

**General Usage of Best Practices Guidelines**

The interviews and analyses focused on two primary areas of the guidelines: (1) usage and familiarity, and (2) funding and prioritization of the Best Practices components. Familiarity with the Best Practices guidelines varied significantly by agency type (F = 3.037, df = 5,156, p = 0.012). Lead tobacco control agencies (mean score 2.33) and advisory/consulting agencies (mean score 2.33) were the most familiar with the Best Practices. Other state agencies were the least familiar with the guidelines (mean score 1.43).

Agencies used the Best Practices in primarily four ways: (1) as a model for the tobacco control programs, (2) in advocacy efforts, particularly for funding, (3) for program implementation, and (4) as a general resource for grant writing (Table 2). The guidelines were less often used for program accountability, public education, and as a new staff training resource. Lead agencies, contractors, and grantees frequently used the guidelines as a model for program development. Voluntary health organizations and advocacy groups used the Best Practices in their advocacy efforts.

In addition to general usage of the guidelines, funding expenditures were examined for each Best Practices component. Figure 1 shows that states spent the most funding on community programs and countermarketing efforts, meeting approximately 84% and 77% of the CDC recommended levels, respectively. Spending for
statewide programs was also high, meeting 82% of the recommended level. Not only did state tobacco control programs report the smallest expenditures for chronic disease programs (≈$600,000), but the gap between the recommended level and estimated expenditures was the largest (≈$5.4 million) compared to the other components. Cessation and school programs also showed large differences between recommended levels and actual expenditures.

There was a close correspondence between Best Practices spending levels and the self-reported prioritization of the Best Practices components. Every state identified either community programs (mean score 6.36) or countermarketing (mean score 5.31) as the highest priority category. Community programs were a high priority because partners felt that changes in policies and social norms occurred at the community level. Countermarketing was ranked high for a number of reasons, including its high visibility to the public and political leadership, its effect on social norms, and the impression that it provides the “biggest bang for your buck.”

Chronic disease programs and enforcement received the lowest priority scores (mean scores 2.84 and 3.44, respectively). Chronic disease programs were viewed as a low priority due to their emphasis on prevention efforts, and the perception of not being cost effective. Many participants were uncertain about the definition of chronic disease programs in relation to tobacco control. As one participant explained: “I’m not quite sure what it meant. When I see chronic disease programs I assume that that has something to do with sort of more traditional public health and medical intervention.” This lack of familiarity with chronic disease programs may be an additional reason for its low ranking.

Specific State Strategies

A major finding of the evaluation was how states modified the Best Practices to better serve the needs of their citizens and programs. The primary reasons for modifying the guidelines were (1) to present a less-complicated model to the public and policymakers, and (2) to make components mutually exclusive to reduce perceived overlap.

New York divided activities into three main strategies (community mobilization, media, and cessation) and fit the Best Practices components to the strategies. Oklahoma repackaged the components into the Four Cornerstone approach: community, classroom, countermarketing, and cessation. Statewide, chronic disease programs were a high priority because changes in policies and social norms occurred at the community level. Countermarketing was ranked high for a number of reasons, including its high visibility to the public and political leadership, its effect on social norms, and the impression that it provides the “biggest bang for your buck.”

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Table 2. Utilization of Best Practices guidelines by type of agency

<table>
<thead>
<tr>
<th>Type of agency where participants worked</th>
<th>Utilization of guidelines (%)&lt;sup&gt;a&lt;/sup&gt;&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Model for program</th>
<th>Program evaluation</th>
<th>Advocacy</th>
<th>Training new staff</th>
<th>Public education</th>
<th>Program accountability</th>
<th>Program implementation</th>
<th>Grant-writing resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead tobacco control agency</td>
<td>67</td>
<td>4</td>
<td>17</td>
<td>13</td>
<td>8</td>
<td>0</td>
<td>13</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Contractors and grantees</td>
<td>43</td>
<td>11</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>19</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Coalitions</td>
<td>36</td>
<td>9</td>
<td>18</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>15</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Voluntary health and advocacy agencies</td>
<td>38</td>
<td>6</td>
<td>41</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>9</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Other state agencies&lt;sup&gt;c&lt;/sup&gt;</td>
<td>21</td>
<td>0</td>
<td>21</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Advisory and consulting agencies&lt;sup&gt;d&lt;/sup&gt;</td>
<td>50</td>
<td>8</td>
<td>17</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>25</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>43</td>
<td>7</td>
<td>19</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>15</td>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup>Row percentages add up to more than 100% because each participant was allowed to list multiple uses of the Best Practices guidelines.

<sup>b</sup>Denominator is the number of individuals interviewed.

<sup>c</sup>For example, Department of Education, or Department of Public Safety.

<sup>d</sup>For example, executive board for lead agency, or Centers for Disease Control and Prevention, Office on Smoking and Health.

Figure 1. Average state funding expenditures by Best Practice component compared to lower recommendations by Centers for Disease Control and Prevention.
and enforcement components were captured under the community cornerstone. In Indiana’s Hoosier model, community programs included cessation, school, and statewide programs. Community programs were then organized into three components: local, county-level community-based programs; minority programs; and statewide programs to support the local and minority programs. The surveillance and evaluation and the administration and management components were umbrella categories for all three models.

A common theme among the three tailored models was that community programs served as an umbrella category encompassing other components, such as school and statewide programs. As one participant described the Hoosier model: “We felt like a lot of people really meant when they said they wanted to do school programs, is that they wanted to work with youth. We didn’t want to pigeonhole them into working with schools, if that wasn’t the best way. The other thing is we felt like nine components were too complicated for someone who doesn’t live, breathe, eat and sleep tobacco control. . . . We wanted to condense it down. . . . [C]essation [and] school programs really happen in the community, so we merged those things into the community and then we divided our community programs into three categories.”

Tobacco-Related Disparities

One goal of the CDC OSH National Tobacco Control Program is to identify and eliminate disparities among population groups; therefore, we evaluated how useful the Best Practices were in addressing tobacco-related disparities. The lead agencies were asked to identify three populations experiencing tobacco-related disparities that were priorities for their programs. The populations most often identified were specific minorities (e.g., African Americans, Native Americans), low socioeconomic-ranking populations, youth, and pregnant women. The majority of participants agreed that the populations identified by their lead agency should be priorities for their states. Most (90%) of the states used epidemiologic data to help identify the populations. Only two states reported using the Best Practices to assist in identifying the populations, while six states used other evidence-based guidelines. Additional resources used by states to identify populations included needs assessment data (five states), evidence-based disparities literature (four states), and anecdotal information from tobacco control partners (three states).

Participants were asked to evaluate the utility of the Best Practices when addressing tobacco-related disparities. They reported that the guidelines were helpful as a basic framework, but they lacked specificity. Therefore, most participants found that the guidelines were not helpful when addressing specific populations. Additionally, some states struggled with accurately defining “disparate and diverse populations.” As described by one participant: “[T]here really was very little guidance in terms of what we mean by disparity. It instantly got mucked up with race, ethnicity, and minority status. Diversity and disparity kind of started being used interchangeably, and they’re not interchangeable.”

States’ Evaluation of Best Practices Guidelines

States were asked to identify the guideline’s strengths and weaknesses, and ways to improve the Best Practices. The biggest strength identified by participants in all ten states was that the guidelines provided the basic planning framework. The emphasis on a comprehensive approach to tobacco control (nine states), the state-specific funding recommendations (nine states), published by a reputable organization (eight states), and the use of evidenced-based strategies to develop the guidelines (nine states) were also identified. One strength described by a participant “is to give people a framework to understand what tobacco prevention and control is all about. It’s broad enough to include everything in there, so that’s the real strength. People in this field need to have common language to understand what you’re talking about. Because if you don’t have a shared framework. . . ., you’re comparing apples to oranges and you don’t really know which ones are working or which ones are not working.”

A number of weaknesses of the Best Practices were also identified. Participants in nine states reported that the guidelines did not provide guidance on implementation of the components, making it difficult for practitioners to translate the components into practice. The guidelines were also not updated (six states) and did not address special populations (six states). “It’s just a framework. It really doesn’t provide the direction of how to. . . . [T]here’s not a lot of information about to what degree do you need to fund each component in order for it to be most effective. So the level and intensity of activity within each of the components seems to be lacking, and how you go about getting that done.”

Many of the improvements suggested by the participants paralleled the identified weaknesses of the guidelines. The most commonly suggested improvement by participants in eight states was to provide more examples of successful programs from a variety of communities and populations. Participants also felt that the Best Practices should be updated more routinely with the most recent science (eight states) and that implementation strategies should be provided (six states). Several ways to modify the guidelines to be a more useful tool for addressing tobacco-related disparities were suggested, including having links to research on culturally specific programs (seven states) and providing more technical assistance for disparities activities (five states). Finally, a more culturally competent ap-
proach should be emphasized in the guidelines (six states), as explained by the following participant’s comment: “One of the issues is the need to have a component that really speaks to cultural issues and populations. ... The disparity that does occur and the need to make sure that cultural issues have to be taken into account. ... I think that’s an important piece.”

**Discussion and Conclusions**

The Best Practices remains a vital set of guidelines for state tobacco control programs. It provides states, particularly the program lead agencies, with the basic framework to develop and manage a comprehensive program. However, there is a critical need to update the guidelines for them to remain relevant given current state economic and political climates. The evaluation results also suggest a restructuring of the nine components to provide a simpler structure for the Best Practices model.

The recommended funding levels in the 1999 Best Practices guidelines also need to be revisited. The funding recommendations were based on the assumption that states would be allocating a large portion of the MSA funds to tobacco control. Although these recommendations identify the funding goals that need to be reached to significantly reduce tobacco use, the reality was that tobacco control received very little of the MSA funds. Study participants perceived these goals as unattainable given the unsupportive financial and political environments in their states. Many states could not fund all the Best Practices components simultaneously and were forced to choose among them. In the absence of any formal guidance, many states prioritized the component funding based on a number of criteria: (1) components with the greatest impact, (2) the most politically acceptable components, or (3) components that had previously been implemented. Using the states’ previous experience as guidance, a set of funding scenarios should be included in a new version of the guidelines. However, the recommended funding levels should still be included so that state decision makers can be shown the ultimate funding goal that, if met, would achieve significant reductions in tobacco-related morbidity and mortality.

The lead agencies were most familiar with the Best Practices. Future dissemination efforts should be broader to ensure that other program partners receive training with the guidelines. This would show all tobacco control constituencies the bigger picture of a comprehensive program and allow resources to be better leveraged by community groups, leading to a stronger, more unified voice for advocating for the tobacco control program and its funding.

It was also evident that states need guidance on addressing populations with tobacco-related disparities. It was not clear whether disparities should be consid-ered a specific category (e.g., countermarketing) or a component of each of the nine existing Best Practices components. A thorough examination of the current empirical and fugitive literature will help guide the development of this area. Finally, the evaluation data showed that states were proactive in identifying populations that were not the typical racial or ethnic populations (e.g., pregnant women). A new version of the guidelines should also allow the flexibility to define disparities this way.

It is important to keep the following limitations in mind. First, we explicitly did not evaluate any of the flagship tobacco control programs (e.g., California) because these programs had already had extensive evaluation. The data are from only ten states, which may limit generalizability. Second, while we are confident about the coverage and level of agency participation among states, in most cases only one representative was interviewed per agency. Although these key informants were the individuals most familiar with their agencies’ tobacco control efforts, it provided only a single viewpoint. Despite these limitations, this study represents one of the only multistate tobacco control studies since the ASSIST study.

The future direction of the Best Practices should include updating the structure and re-evaluating the funding recommendations. In addition, the current evidence of effective strategies is much greater now compared to when Best Practices was published. Therefore, an updated version of the guidelines should include more current evidence and emphasize strategies that have been found to be effective (i.e., policy). The appropriate balance of including effective interventions and maintaining the original purpose of the document (i.e., providing states with financial guidance) need to be met. To do this, the revised guidelines should be packaged with the Community Guide, Cochrane Reviews, and other evidenced-based resources, to provide states with a complete library of tobacco control resources.

The development of the Best Practices was innovative because it defined a comprehensive program based on the extensive tobacco control science available. As such, the Best Practices model and the lessons learned have helped move forward other areas of prevention such as obesity. Even after 7 years, the guidelines remain one of the few specific sets of best practices guidelines in any chronic disease prevention area. Therefore, the results of this evaluation (e.g., including proven strategies, funding scenarios, addressing disparate populations) should be taken into account when developing new guidelines for other public health issues.

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