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### The Oregon Profile: Advancing the Best Practices

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# The **Oregon** Profile:

*Advancing the Best Practices*

Use of Evidence-based Guidelines in  
State Tobacco Control Programs

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

# Acknowledgements

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# Executive Summary

## Introduction

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

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

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

## Findings from Oregon

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

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



# Introduction

## Project overview

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

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

## State profiles

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

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

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



# Program Overview

## Oregon's tobacco control program

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

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

## Oregon's tobacco control partners

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

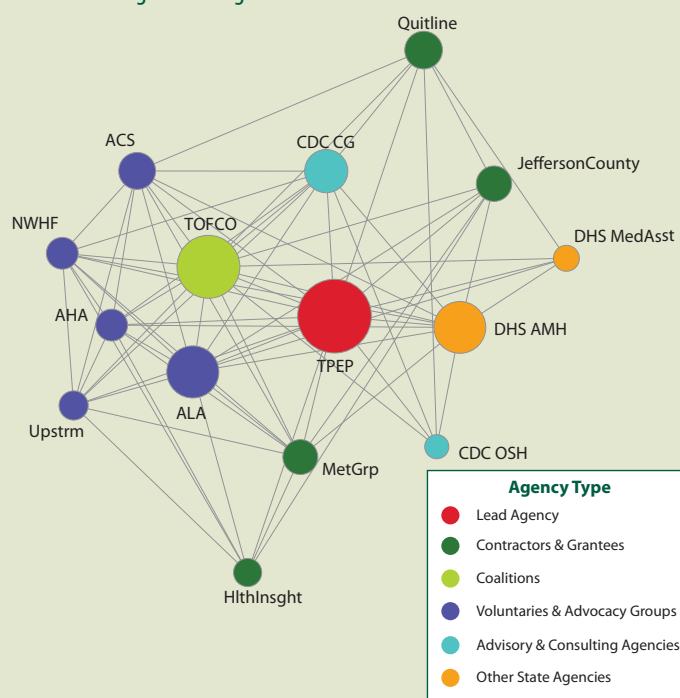
Table 1: Oregon Tobacco Control Partners

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

## Communication between Oregon partners

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

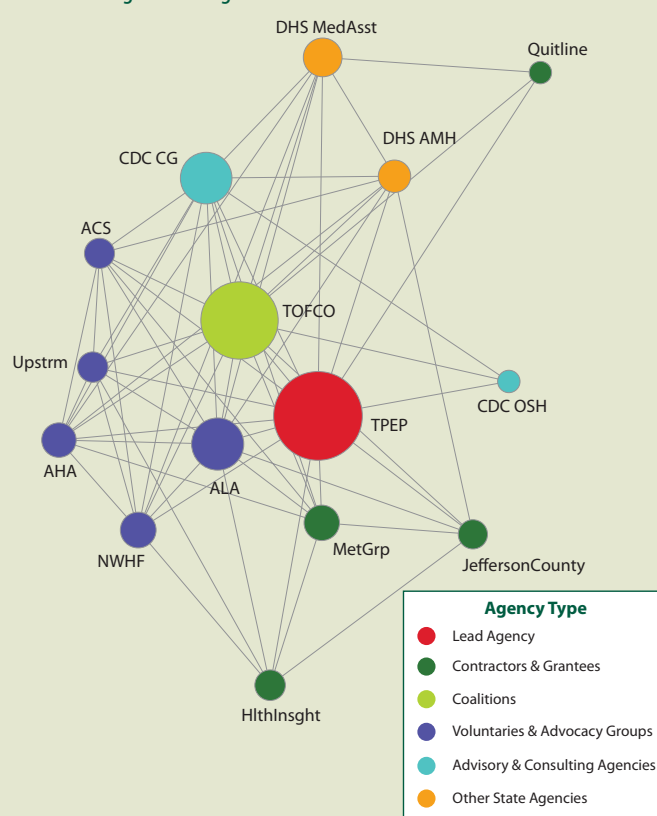
Figure 1: Oregon Partners' Communication Network



## Collaboration between Oregon partners

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

Figure 2: Oregon Partners' Collaboration Network





# Evidence-based Guidelines

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

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

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

Figure 3: Evidence-based Guidelines for Tobacco Control





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

Figure 4: Framework for Use of Evidence-based Guidelines





# Dissemination

## How did partners define “evidence-based guidelines”?

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

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

## How did partners learn of evidence-based guidelines?

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

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

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

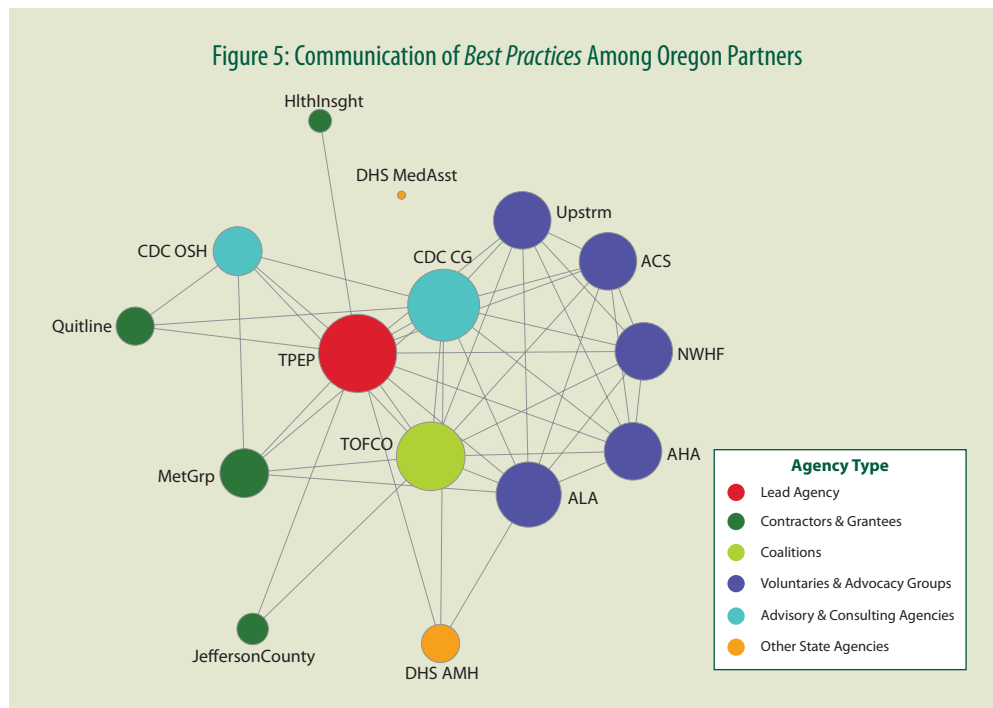
When somebody goes to a conference and brings back something like the [Best Practices] User Guides, we’ll debrief or we’ll set aside time in a meeting to go over and share what we learned.

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

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

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

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



## Which tobacco control guidelines were partners aware of?

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

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

**Table 2: Number of Partners Aware of Tobacco Control Guidelines**

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

# Adoption Factors

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

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

- All of our decisions about programs, projects, policies, etc. are based on *Best Practices*.
- It is really important to be able to continually justify our programmatic decisions. As the tobacco program, we're the most visible target for people who want to argue about funding. So we have to make sure that anything that we do, we can defend.

Figure 6: Ranking of Decision-making Factors



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

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

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

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

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

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

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

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

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

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

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

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

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

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

## What facilitated or hindered use of evidence-based guidelines?

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

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

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

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

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

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

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

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

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

Other challenges for using evidence-based guidelines included:

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

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



# Implementation

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

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

### Best Practices for Comprehensive Tobacco Control Programs

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

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

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

### Revisions to the CDC *Best Practices*

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

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

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

\* Based on partners who were aware of the guideline



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

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

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

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

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

### The Guide to Community Preventive Services: Tobacco

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

- The *Community Guide* has been helpful for us I would say in seeing the kinds of components, elements that need to be built into our comprehensive tobacco control program.
- The list of things that are recommended and things that are not recommended [in the *Community Guide*], that's really valuable for states.

### Clinical Practice Guidelines: Treating Tobacco Use and Dependence

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

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

### Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs

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

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

## Other Resources

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

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

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

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

## What resources were used to address tobacco-related disparities?

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

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

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

- CDC was able to direct us to other states that were trying to answer the same questions about what to do around disparities. [Oregon] borrowed heavily from California and the way they structured funds to community-based agencies to support policy work and coordination among communities around the state to address disparities.
- [Best Practices] is moderately useful. It provides big picture stuff, but the actual drilldown into communities with tobacco-related disparities is not sufficient.

## What resources were used to communicate with policymakers?

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

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

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

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

## What other resources did partners need?

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

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

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

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

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

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

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



# Conclusions

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

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

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

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

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

