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The Arkansas Profile: Aligning with Best Practices

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The **Arkansas** Profile:

Aligning with Best Practices

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. Arkansas served as the sixth case study in this evaluation. The project goals were two-fold:

- Understand how Arkansas used evidence-based guidelines to inform their programs, policies, and practices; and,

- Produce and disseminate findings and lessons from Arkansas and other states so that readers can apply the information to their work in tobacco control.

Findings from Arkansas

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

- Partners looked to the Tobacco Prevention and Cessation Program (TPCP) at the Arkansas Department of Health for program direction and information on evidence-based strategies.

- Every Arkansas partner was aware of the CDC's *Best Practices* and partners used the guideline to inform program development and funding allocation.

- Despite their acknowledged importance, some challenges were identified with using evidence-based guidelines, such as:

  - Partners perceived the translation of new research into evidence-based materials to be a lengthy process.

  - Partners believed evidence-based guidelines did not adequately address how to work with populations with tobacco-related disparities.

- Partners stressed the need for additional technical assistance and support from the CDC.

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 used 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 July 2010 from Arkansas partners. The profile is organized into the following sections:

- **Program Overview –** provides background information on Arkansas' tobacco control program.

- **Evidence-based Guidelines –** presents the guidelines we asked about and a framework for assessing guideline use.

- **Dissemination –** discusses how Arkansas partners learned of new guidelines and their awareness of specific tobacco control guidelines.

- **Adoption Factors –** presents factors that influenced Arkansas partners' decisions about their tobacco control efforts, including use of guidelines.

- **Implementation –** provides information on the critical guidelines for Arkansas 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

Arkansas' tobacco control program

In November 2000, Arkansas voters approved a ballot initiative that allocated 100% of the state's Master Settlement Agreement (MSA) funds to health-related programs, including 31.6% to the Tobacco Prevention and Cessation Program (TPCP) at the Arkansas Department of Health. The initiative also established the Arkansas Tobacco Settlement Commission (ATSC), an external contractor that oversaw and evaluated all MSA funded programs. TPCP provided ATSC with quarterly reports on current program activities and progress, the program's short- and long-term goals, and program finances.

TPCP worked to reduce the burden of tobacco use through the development of a comprehensive tobacco prevention, education, and cessation program aligned with the five components of a comprehensive program as outlined in the CDC's *Best Practices* guideline. These components were integrated into TPCP's program goals to be met by 2014: 1) Reduce youth tobacco use to 17.5%; 2) Reduce adult tobacco use to 17.5%; 3) Reduce tobacco use by pregnant women to 12.5%; 4) Reduce employee exposure to secondhand smoke in workplaces to 2%; and, 5) Pass statewide comprehensive smokefree legislation.

At the time of this evaluation, Arkansas was funded at $16.4 million, meeting 45% of the CDC's recommended annual funding level for a comprehensive tobacco control program in Arkansas. Like most states, TPCP had experienced significant budget cuts. However, TPCP had made great strides towards reaching its goals. In 2005, Arkansas' legislature passed Act 134, making all hospital grounds tobacco free and in 2006, Arkansas became the first state to implement a law protecting children from secondhand smoke in cars. Additionally, with the passage of a 56¢ cigarette tax increase in 2009, Arkansas' cigarette tax had reached $1.15 per pack. In March 2010, Free & Clear was contracted to design and develop a statewide training program to assist Arkansas' healthcare providers and organizations with their cessation interventions. Although no statewide comprehensive smokefree policy existed, the Arkansas Clean Air on Campus Act of 2009 went into effect in August 2010 in an effort to reduce secondhand smoke exposure on all state-funded campuses.

Arkansas' tobacco control partners

Arkansas' tobacco control efforts involved a variety of partners. Partners included voluntaries and advocacy groups, coalition members, marketing agencies, and other state government departments. Some partners also had secondary roles as members of the ATSC. Sixteen individuals from 14 organizations were identified as a sample of key members of Arkansas' tobacco control program. On average, partners had been involved in Arkansas' tobacco control efforts for more than seven years, with a range of two to thirteen years. Table 1 presents the list of partners who participated in the interviews.

Table 1: Arkansas Tobacco Control Partners

Agency	Abbreviation	Agency Type
Tobacco Prevention and Cessation Program	TPCP	Lead Agency
Advantage Communications, Inc.	Advantage	Contractors & Grantees
Arkansas Tobacco Control	AR Tobacco Control	Contractors & Grantees
Cranford Johnson Robinson Woods	CJRW	Contractors & Grantees
Free & Clear	Quitline	Contractors & Grantees
University of Arkansas, Little Rock	UALR	Contractors & Grantees
University of Arkansas, Pine Bluff	UAPB	Contractors & Grantees
Arkansas Cancer Coalition	ACC	Coalitions
YES Team	YES	Coalitions
American Cancer Society	ACS	Voluntaries & Advocacy Groups
American Heart Association	AHA	Voluntaries & Advocacy Groups
Arkansas Center for Health Improvement	Health Improvement	Voluntaries & Advocacy Groups
Arkansas Department of Health, Office of Oral Health	DOH Oral Health	Other State Agencies
Department of Community Corrections	DCC	Other State Agencies

Communication between Arkansas partners

To gain a better understanding of partner relationships within Arkansas' tobacco control network, partners were asked about their interaction with other tobacco control organizations within the state. Partners were asked how often they had direct contact (such as meetings, phone calls, or e-mails) with other partners within the 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 DOH Oral Health, TPCP, and DCC. DOH Oral Health did not have direct contact with DCC, but both had contact with TPCP. As a result, TPCP

Figure 1: Arkansas Partners' Communication Network

Agency Type
- Lead Agency
- Contractors & Grantees
- Coalitions
- Voluntaries & Advocacy Groups
- Other State Agencies
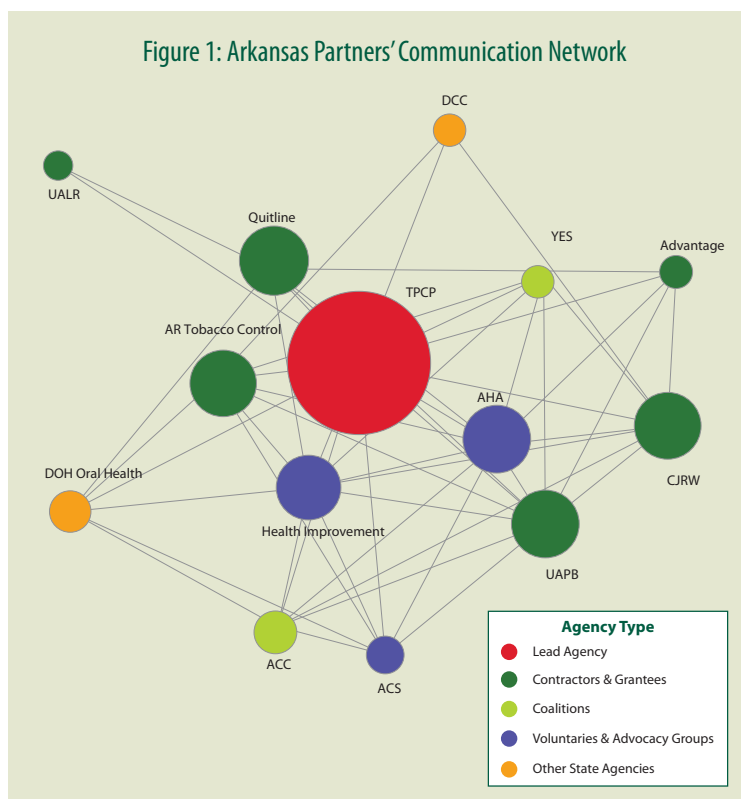
acted as a bridge between the two and had more influence within the network. Communication within Arkansas indicated a relatively decentralized structure among partners in which members of the network had contact with many others agencies throughout the state.

Collaboration between Arkansas 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 signifies that they at least worked together informally to achieve common goals. Partners were not linked if they did not work together or only shared information. The node size is based on the amount of influence a partner had over collaboration in the network. A partner was considered influential if he or she connected partners who did not work directly with each other. For example, UALR and ACS did not work directly with each other, but both worked with TPCP. TPCP acted as a "broker" between the two agencies, resulting in its larger node size. Collaboration within Arkansas indicated a fairly centralized network. Although members collaborated with multiple agencies throughout the state, TPCP played a more central role connecting partners.

Figure 2: Arkansas Partners' Collaboration Network

Agency Type
- Lead Agency
- Contractors & Grantees
- Coalitions
- Voluntaries & Advocacy Groups
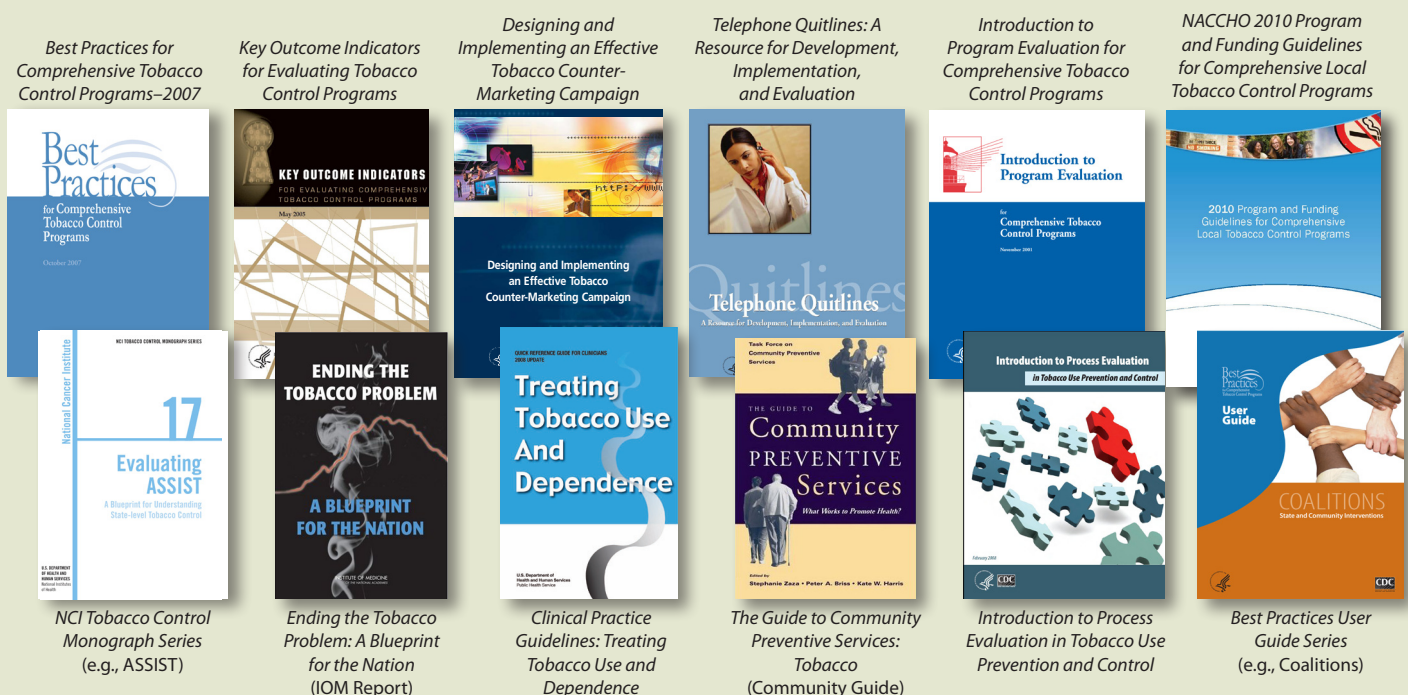- Other State Agencies
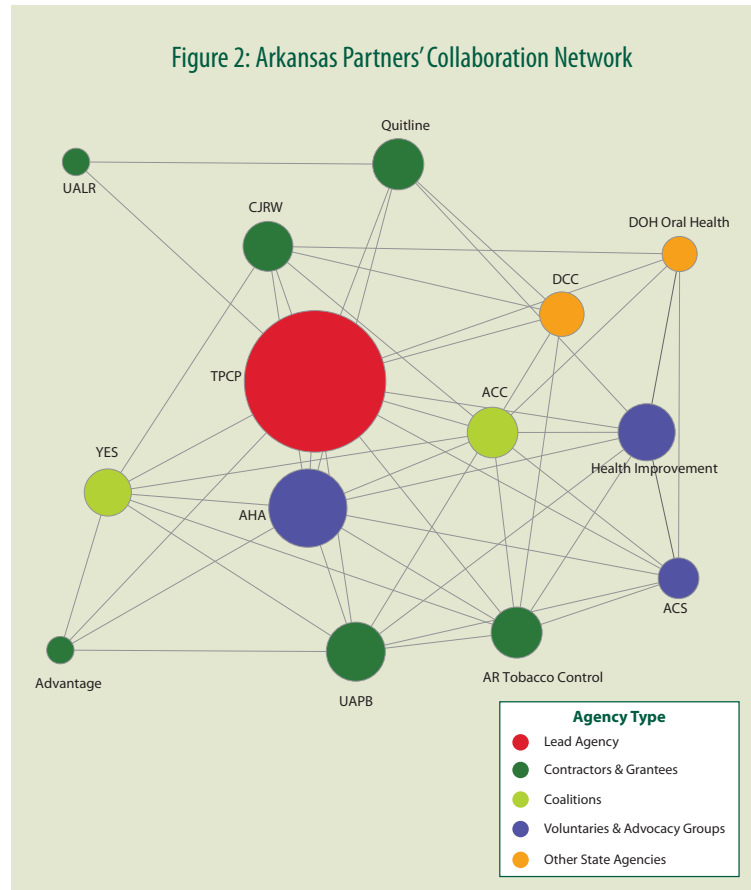
Evidence-based Guidelines

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 Arkansas partners included:

- The World Health Organization's International Agency for Research on Cancer (IARC), *IARC Monographs on the Evaluation of Carcinogenic Risks to Humans, Tobacco Smoke and Involuntary Smoking*;

- Cochrane Reviews;

- Rand Corporation's *Evaluation of the Arkansas Tobacco Settlement Program*;

- The Association of State and Territorial Dental Directors' (ASTDD) 14 Best Practice reports;

- American Cancer Society's *How Do You Measure Up?: A Progress Report on State Legislative Activity to Reduce Cancer Incidence and Mortality*; and,

- The CDC's *Guidance for Comprehensive Cancer Control Planning*.

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 Arkansas. The framework below will guide the discussion, specifically looking at which guidelines Arkansas 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"?

Arkansas partners defined evidence-based guidelines as practices that had been scientifically proven to be effective. Additionally, partners frequently associated evidence-based guidelines with the CDC due to the organization's strong presence in the field of tobacco control.

> [Evidence-based guidelines are] proven model programs or activities or standards that have been vetted and proven and have shown and demonstrated success.

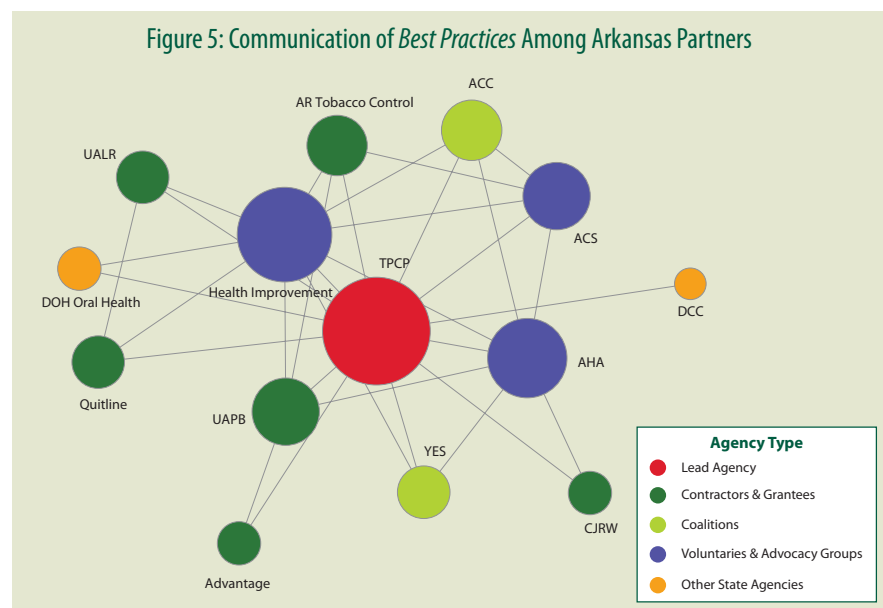> [An evidence-based guideline is] a tool or a process that has been studied and found to be effective.

How did partners learn of evidence-based guidelines?

Leadership within partners' organizations was most often identified as a source for learning about new evidence-based guidelines. Within TPCP, this included the Program Director and the Section Chief for State and Community Interventions. Partners also noted learning of new guidelines during in-state meetings, specifically those hosted by TPCP. Additionally, some partners were informed of new guidelines through the CDC, including CDC conferences during which guidelines were referenced. Partners then shared information about new evidence-based guidelines internally through e-mail and regular staff meetings.

> If it's something that [staff] need to act upon then we send e-mails and we do conference calls.

To get a better sense of the dissemination of *Best Practices* within the state, Arkansas partners were asked who they talked to about the guideline. In Figure 5, a line connecting two agencies indicates they talked about *Best Practices* with each other. The size of the node indicates the number of agencies each partner talked to about the guideline. For example, TPCP talked with the most partners about *Best Practices*, resulting in the largest node size. Arkansas' network represents a fairly centralized network.

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

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

What tobacco control guidelines were partners aware of?

The *Best Practices* was the most well-known guideline in Arkansas. All partners interviewed recalled at least hearing of *Best Practices*. Partners referred to *Best Practices* on a daily to annual basis and were made aware of the guideline primarily through the CDC and TPCP. There was a drop in awareness for most of the remaining guidelines, with only 50% or fewer partners aware of the majority of the remaining guidelines.

Table 2: Number of Partners Aware of Tobacco Control Guidelines

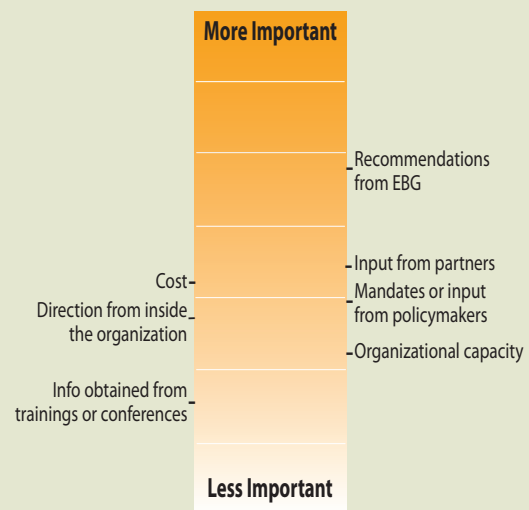| Guideline	# of Partners
Best Practices for Comprehensive Tobacco Control Programs	16/16
Best Practices User Guide Series	11/16
Designing and Implementing an Effective Tobacco Counter-Marketing Campaign	10/16
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	9/16
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	8/16
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	8/16
Introduction to Process Evaluation in Tobacco Use Prevention and Control	8/16
Key Outcome Indicators for Evaluating Tobacco Control Programs	7/16
The Guide to Community Preventive Services: Tobacco	7/16
Tobacco Control Monograph Series	6/16
Ending the Tobacco Problem: A Blueprint for the Nation	5/16
NACCHO 2010 Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs	4/16

Adoption Factors

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

Arkansas partners took several key factors into consideration when making decisions about their tobacco control efforts. These factors included the political climate, areas with the greatest tobacco use burden, and input from partners. Partners particularly valued input from the Department of Health, clients, and funders.

> [We] gauge the appetite of the state legislature to readdress current issues. We have to look at the political landscape.

> [The Department of Health is] typically our primary source. And they usually drive our tobacco control agenda. One, because we receive money from them, two, because they've been a very vested partner for the last several years.

Figure 6: Ranking of Decision-making Factors

More Important

Recommendations from EBG

Input from partners
Mandates or input from policymakers

Cost
Direction from inside the organization

Organizational capacity

Info obtained from trainings or conferences

Less Important

When asked to rank specific 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 most important, with 87.5% of partners ranking it in their top three. Partners stated that evidence-based guidelines not only provided a general framework for their efforts, but also promoted effective strategies. Partners reported that leadership within their organization as well as at the Department of Health required programs to be supported by evidence.

> [Evidence-based guidelines] provide us with a structure for what we are going to look like and then we try to design our programs around those kinds of things.

> Recommendations from evidence-based guidelines are always number one, because it's our agency culture and a requirement from all leadership that you can come in with a great idea, but if you really want it to be considered, then it has to be based on something substantive and fact-based.

Input from partners was also highly valued and was consequently ranked as the second most important decision-making factor. Input from partners, in addition to direction from inside partners' organizations, was used to guide programmatic decision-making.

> I think what [partners] have to say has a big influence on what we put into our programs, our plan of work for the year.

Additionally, cost and input from policymakers, which were perceived as closely linked, played a role in decision-making for Arkansas partners. Cost ultimately determined what programs could be implemented and partners relied on policymakers for the necessary funding. In order to maintain adequate funding and justify spending, partners considered programs supported by the state legislature when determining what interventions to implement. Cost was also viewed as important because funding influenced organizational capacity, specifically the staffing and resources needed to implement tobacco control efforts.

> If we are going to implement something we usually start out with how much it's going to cost.

> We do go before the legislature so often and we don't want to lose our funding; therefore, we do take into consideration what they say and what they would like to see before we implement things.

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

Partners stated that their dedication to research and knowledge of current scientific evidence enhanced their tobacco control efforts. These organizational characteristics ensured that partners were aware of new research and the release of new guidelines.

> We have a very robust clinical team who continually monitor scientific evidence related to treating tobacco use and dependence, so we're very well connected in the treatment and research community.

> We have a culture with our organization of fact-based decision-making. So when we're brainstorming ideas, it has to be supported by something that is fact-based, that is research-based.

Additionally, support from leadership within the Department of Health facilitated partners' tobacco control efforts. Partners particularly valued the experience of TPCP's program director and viewed her input as critical to program and policy development.

> "The fact that state organizations do have red tape, they do answer to legislators, is a process that sometimes is lengthy."

> Having [TPCP's program director] on board and her vast knowledge of tobacco control helps us a lot in moving things forward.

Conversely, the policies and red tape inherent to bureaucratic organizations, such as the lengthy legislative review process, often hindered Arkansas partners' efforts. Additionally, Arkansas' political climate was not particularly receptive to tobacco control efforts, which limited what partners could do.

> One of the things that we have to do annually [is] report to the legislature. And of course it's an opportunity, but sometimes it serves as a barrier because policymakers don't always relate to the overall goal of the program.

What facilitated or hindered use of evidence-based guidelines?

Arkansas partners often looked to evidence-based guidelines to inform their efforts and guide program direction. Since the guidelines were thought to promote effective and proven strategies, Arkansas partners felt confident using them to support their efforts and justify spending, especially when communicating with policymakers. Evidence-based guidelines provided a sense of authority and something substantial upon which to base their work.

> [Evidence-based guidelines] help me support what we're doing. So if we get challenged on something, I have a reference point that I can go to and say, "Based on this…"

> The guidelines are a very useful way of grounding people to help them understand what is proven to work.

While evidence-based guidelines provided a solid foundation for Arkansas' tobacco control efforts, partners also faced several challenges with using the guidelines. Partners noted that the translation of research into evidence-based practice was a slow process. Therefore, at times, partners felt that adhering to evidence-based guidelines limited creativity.

> Recognition of what is evidence-based is a little slower than what we'd like.

> Sometimes when you're being creative, it can't be based on science. Sometimes you've got to let us work outside the box…it can hinder us in delivering the right, appropriate message that's going to resonate with our audience.

The slow release of new guidelines was particularly problematic when catering to the needs of populations with tobacco-related disparities. Partners felt that the guidelines did not promote the most effective or timely approaches for working with specific populations, therefore making the guidelines inapplicable to the populations with whom they worked.

> Some of what [evidence-based guidelines] recommend may not fit very well with the population that we work with.

"[Evidence-based guidelines] give you almost a sense of authority…so it's not speculation, it's not opinion, it's pretty hard core black and white proof."

Implementation

Which guidelines were critical for Arkansas' tobacco control partners?

Arkansas partners had a relatively low level of awareness of evidence-based guidelines. However, several 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 for Arkansas partners.

Clinical Practice Guidelines: Treating Tobacco Use and Dependence

Although only half of the partners were aware of the *Clinical Practice Guidelines*, 75% of those partners ranked the guideline as a critical resource. The guide was primarily used by healthcare providers as a reference to guide their cessation treatment plans.

> We turn to [the *Clinical Practice Guidelines*] to see what else we can do differently in terms of groups, in terms of individual sessions, sometimes of tobacco therapies, and then of course in developing treatment plans. So we use this as an everyday reference.

Best Practices for Comprehensive Tobacco Control Programs

Every Arkansas partner was aware of *Best Practices*, and 73% ranked it as a critical resource for their tobacco control efforts. The guideline was primarily used as a general reference to inform program development and funding allocation. Partners aligned their efforts with the five categories outlined in *Best Practices*.

> We base our entire program around *Best Practices* and what it says that we should do. We realigned our whole program to match along...not just what they say we should do, but how they say we should do it.

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

Guideline	% of Partners*
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	75%
Best Practices for Comprehensive Tobacco Control Programs	73%
Key Outcome Indicators for Evaluating Tobacco Control Programs	71%
Ending the Tobacco Problem: A Blueprint for the Nation	60%
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	50%
Best Practices User Guide Series	46%
The Guide to Community Preventive Services: Tobacco	43%
Introduction to Process Evaluation in Tobacco Use Prevention and Control	38%
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	33%
Designing and Implementing an Effective Counter-Marketing Campaign	30%
NACCHO 2010 Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs	25%
Tobacco Control Monograph Series	17%

* Based on partners who were aware of the guideline

Revisions to the CDC *Best Practices*

In 2007, *Best Practices* was revised. To find out how changes to the guideline were perceived, Arkansas 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 they did not perceive a significant difference in the content from the original 1999 *Best Practices* to the 2007 update.

> You open up the [1999 *Best Practices*] and [the components] are all there, and then you open up the [2007 *Best Practices*], and you think, "Well where's the difference?" So you combined it together, you changed the words, but I mean, what changed here?

> [The revisions were] sort of refreshing the brand, sort of an update because [the same components] were still immersed in there…so it was just a refreshment of the *Best Practices*.

Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs

The *Key Outcome Indicators* guide was identified as a critical resource for 71% of the partners familiar with the guideline. The guide was used to inform program objectives and determine appropriate outcome measures to evaluate progress towards those objectives.

> We use [the *Key Outcome Indicators*] to determine the objectives and goals that we select every single year.

> We have to be concerned about the outcomes. This is a part of the evaluation process. In other words, if you have a program and you don't know what the outcomes are, how are you going to get there?

What resources were used to address tobacco-related disparities?

Arkansas legislation stipulated that 15% of the funds designated to tobacco control be allocated to activities aimed at reducing tobacco consumption in minority populations. This funding was allocated in the form of community grants by the University of Arkansas at Pine Bluff (UAPB) Minority Initiative Sub-Recipient Grant Office. UAPB provided administrative oversight and direction to guide these grant-funded programs targeting minority populations in Arkansas.

> There is a Minority Initiative Sub-Recipient Grant Office which provides grants to minority communities in order to do CDC's *Best Practices*…So our 15% funding is allocated in order to do that outreach to the minority communities.

Partners who worked with populations with tobacco-related disparities determined which populations to focus on by utilizing data from the Adult Tobacco Survey, the Youth Tobacco Survey, and the Behavioral Risk Factor Surveillance System. Partners did not use *Best Practices* as a resource for working with populations with tobacco-related disparities due to the guide's lack of specificity regarding ways to address tobacco control for those populations.

> There's very little that's targeted in [*Best Practices*]. [Disparities is] a concept that's out there, but as far as best practices of what's working, there's very little.

What resources were used to communicate with policymakers?

Partners stressed the importance of sharing the results of their evidence-based activities with policymakers. Partners communicated directly with the legislative body and the governor's office. TPCP was evaluated every two years by an outside contractor regarding the progress of their funded programs. The results from these evaluations were shared during annual legislative reviews in the form of brief executive summaries. Partners also illustrated their program's effectiveness by sharing surveillance data from Quitline reports.

> We [communicate with our legislators] through a series of one-page update articles. They just want us to come in and update them during legislative session.

> Because we serve at the will of the governor, anything that we do policy related is approved basically through him.

Partners found it important to communicate information directly tied to the policymaker's constituency. Therefore, tobacco control advocates used specific Quitline data and personal stories from constituents within policymakers' districts to demonstrate the need for tobacco control funding.

> We did a special report that showed all of the participants over a one-year period by what House and Senate district they were from, so each one of the Representatives could see the direct involvement of their constituents with the Quitline.

> A lot of times [we share] dollars spent within our communities so that [policymakers] understand what's being done in their communities.

> "[We are] always using *Best Practices* and evidence-based information in any of the things that we discuss [with policymakers]. As a public health agency, it's first and foremost that we present that information, that it is evidence-based."

What other resources were needed?

Partners outside of the lead agency expressed a need for more technical assistance and interaction with CDC staff. Furthermore, they stated that it would be particularly useful to have a CDC point of contact available to them at any time.

> I think the CDC might be more helpful if they could give us more resources on the ground, more people to help us in the state.

> [We] need two or three CDC fellows down here. [We] could really use them. Just get an army of people in here and just really charge this place up. That would be the single most [important] thing.

Arkansas partners also wanted information available on other states' initiatives and their outcomes. Partners stated that they could learn from other state program's challenges and successes just as other state programs could learn from them. Partners felt that exchange of this information located in an easily accessible venue would enhance their efforts.

"What's happening with the states right around us?" [Knowing] that is a big help when you're looking to draw up policy, and that's always the question, "What's going on around us?" I'd really like to see a little bit more on that.

Maintain a database or something on the outreach efforts of different tobacco programs. It's hard every year to think of something new, and maybe another state is doing that, or maybe we've got some proven programs here that reaches the youth with a prevention message that another state might want. Because we've got a couple of programs here that we've had huge success with that I'm more than willing to share with other states.

Conclusions

The use of evidence-based guidelines was perceived as an important part of the Arkansas tobacco control program and provided a foundation for partners' tobacco control efforts. Guidelines were used for program development, outcome tracking and communication with policymakers. Other factors that contributed to the adoption of evidence-based guidelines in Arkansas included:

- Partners felt that guidelines provided justification for their efforts when communicating with policymakers.

- Partners found *Best Practices*' five categories useful and aligned their program components with them.

- TPCP played a central role in Arkansas' tobacco control efforts by connecting partners who looked to them for direction and guidance. TPCP used evidence-based guidelines and partners followed their lead by implementing them in their work as well.

Despite the importance of guidelines for partners, several challenges identified with guideline use included:

- Guidelines lacked information on how to address populations with tobacco-related disparities.

- The lag time between research and new guideline development was too long.

- Strict adherence to evidence-based guidelines was thought to hamper creativity and flexibility in programming.

An abundance of information is available to inform the work of those involved in tobacco control. In Arkansas, recommendations from evidence-based guidelines, organizational direction and capacity, and input from partners played an important role in guiding tobacco control efforts. 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. Such factors included avenues of guideline dissemination to stakeholders, presence or absence of support by other individuals or policies, and the feasibility of applying that information into one's work. Arkansas partners found the release of new evidence-based guidelines to be a lengthy process, making it difficult to adhere to them as they were not the timeliest and most applicable approaches to certain populations. Partners suggested that information on other states' initiatives and their outcomes be located in a easily accessible and continually updated venue. Taking these factors into consideration when developing and releasing a new guideline will help to optimize use of the guideline by intended stakeholders.