

# The **Indiana** Profile:

*Prioritizing policy change*

Use of Evidence-based Guidelines in  
State Tobacco Control Programs

*Prepared by*  
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# Executive Summary

## Introduction

There has been a significant amount of research done on what works to curb tobacco use. Many agree that the evidence-base for tobacco control is one of the most developed in the field of public health. However, the advancement in the knowledge base is only effective if that information reaches those who work to reduce tobacco consumption. Evidence-based guidelines, such as the Centers for Disease Control and Prevention's *Best Practices Guidelines for Comprehensive Tobacco Control Programs (Best Practices)*, are a key source 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. Indiana served as the fourth case study in this evaluation. The project goals were two-fold:

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

## Findings from Indiana

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

- The Indiana Tobacco Prevention and Cessation (ITPC) agency served as the main source for the dissemination of evidence-based guidelines in Indiana, particularly *Best Practices*.
  - ITPC referenced *Best Practices* in new coordinator trainings. Statewide trainings hosted by ITPC served as an arena for *Best Practices* dissemination and implementation planning.
- Evidence-based guidelines were seen as providing credibility to the work of Indiana partners and brought consistency to their efforts.
- Despite these benefits, partners identified challenges with the implementation and understanding of evidence-based guidelines, such as:
  - Resistance from some partners who thought that the guidelines did not apply to a specific community or population.
  - The challenge of sifting through an overwhelming amount of information to find the appropriate information for an individual's efforts.
- Due to the separation of ITPC from the Department of Health, Indiana partners directly communicated with policymakers.
  - This allowed for more frequent communication with policymakers, making policy change a central aspect of Indiana partners' efforts.
  - Evidence-based guidelines, data, personal testimonies, and health and economic benefits were identified as common sources used in communication with policymakers.





# Introduction

## Project overview

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

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

## State profiles

This profile is part of a series of profiles that aims to provide readers with a picture of how states accessed and utilized evidence-based guidelines. This profile presents data collected in April and May 2010 from Indiana partners. The profile is organized into the following sections:

- **Program Overview** – provides background information on Indiana's tobacco control program.
- **Evidence-based Guidelines** – presents the guidelines we asked about and a framework for assessing guideline use.
- **Dissemination** – discusses how Indiana partners learned of new guidelines and their awareness of specific tobacco control guidelines.
- **Adoption Factors** – presents factors that influenced Indiana partners' decisions about their tobacco control efforts, including use of guidelines.
- **Implementation** – provides information on the critical guidelines for Indiana 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

## Indiana's tobacco control program

In 2001, the Indiana Tobacco Prevention and Cessation (ITPC) agency was created by the Indiana General Assembly. For many states, tobacco control programs are housed in state health departments. However, Indiana provided a unique example in that ITPC was established as a separate state agency. ITPC was responsible for providing direction to Indiana's tobacco control program, overseeing operations, and providing technical assistance to partners. Serving as a separate state agency also allowed for more direct communication with policymakers.

ITPC received a majority of its financial support from Master Settlement Agreement (MSA) funding. Due to significant budget cuts in recent years, funding fell from \$35 million in FY 2000 to \$10.2 million for FY 2010, representing 15% of the CDC's recommended funding level for a comprehensive tobacco control program in Indiana. In order to lower costs, state lawmakers proposed that ITPC be absorbed into the Indiana Department of Health. However, strong support helped maintain the current organizational structure of Indiana's tobacco control program.

Although a number of communities throughout Indiana had passed smokefree policies, no statewide law existed at the time of our evaluation. As such, many Indiana residents remained unprotected from secondhand smoke. Although ITPC supplied a great deal of leadership and direction focused on policy change, there had been resistance from both residents and legislators to enact a statewide comprehensive smokefree air ordinance. Thus, this remained a priority for Indiana partners.

## Indiana's tobacco control partners

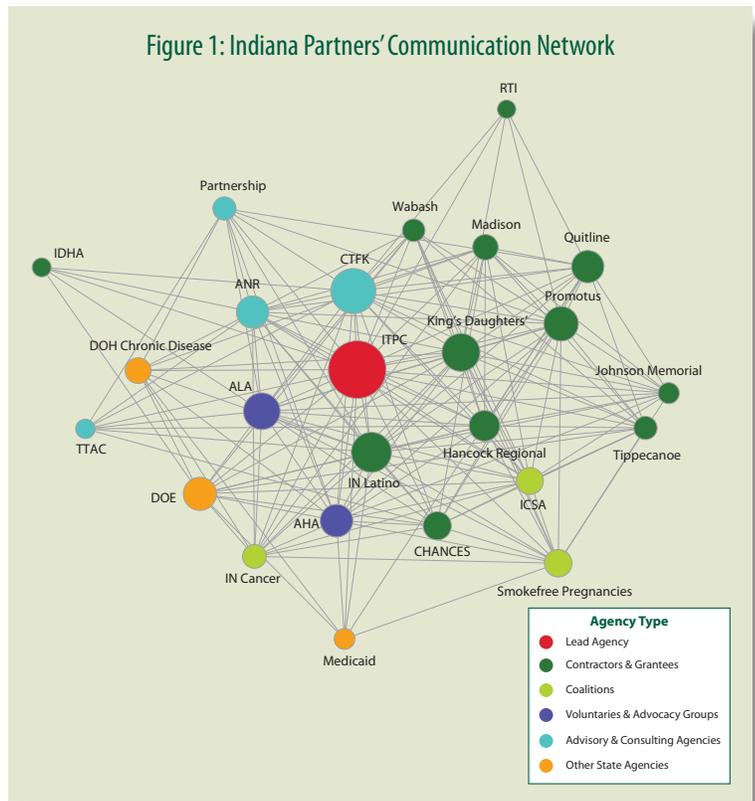
Indiana's tobacco control efforts involved a variety of key partners. Partners included health voluntaries, program evaluators, community and statewide organizations, and a marketing agency. Additionally, ITPC funded and worked with regional coalition coordinators throughout the state who focused on preventing youth initiation and promoting cessation services. Twenty-nine individuals from 24 organizations were identified as a sample of key members of Indiana's tobacco control program. On average, Indiana partners had been involved in tobacco control for eight years; 40% of partners interviewed had been involved in tobacco control for more than ten years. Table 1 presents the list of partners who participated in the interviews.

Table 1: Indiana Tobacco Control Partners

Agency	Abbreviation	Agency Type
Indiana Tobacco Prevention and Control	ITPC	Lead Agency
Promotus Advertising	Promotus	Contractors & Grantees
RTI International	RTI	Contractors & Grantees
Free & Clear	Quitline	Contractors & Grantees
Indiana Dental Hygienists Association	IDHA	Contractors & Grantees
Indiana Latino Institute	IN Latino	Contractors & Grantees
King's Daughters' Hospital	King's Daughters'	Contractors & Grantees
Hancock Regional	Hancock Regional	Contractors & Grantees
Madison Health Partners	Madison	Contractors & Grantees
Tobacco Free Wabash County	Wabash	Contractors & Grantees
Tobacco Free Tippecanoe County	Tippecanoe	Contractors & Grantees
CHANCES for Indiana Youth	CHANCES	Contractors & Grantees
Johnson Memorial Hospital	Johnson Memorial	Contractors & Grantees
Indiana Campaign for Smokefree Air	ICSA	Coalitions
Indiana Cancer Consortium	IN Cancer	Coalitions
Coalition to Promote Smokefree Pregnancies	Smokefree Pregnancies	Coalitions
American Lung Association	ALA	Voluntaries & Advocacy Groups
American Heart Association	AHA	Voluntaries & Advocacy Groups
Indiana State Department of Education	DOE	Other State Agencies
Indiana State DOH/Diabetes Prevention and Control	DOH Chronic Disease	Other State Agencies
Office of Medicaid Policy and Planning	Medicaid	Other State Agencies
Partnership for Prevention	Partnership	Advisory & Consulting Agencies
Tobacco Technical Assistance Consortium	TTAC	Advisory & Consulting Agencies
Campaign for Tobacco Free Kids	CTFK	Advisory & Consulting Agencies
Americans for Nonsmokers' Rights	ANR	Advisory & Consulting Agencies

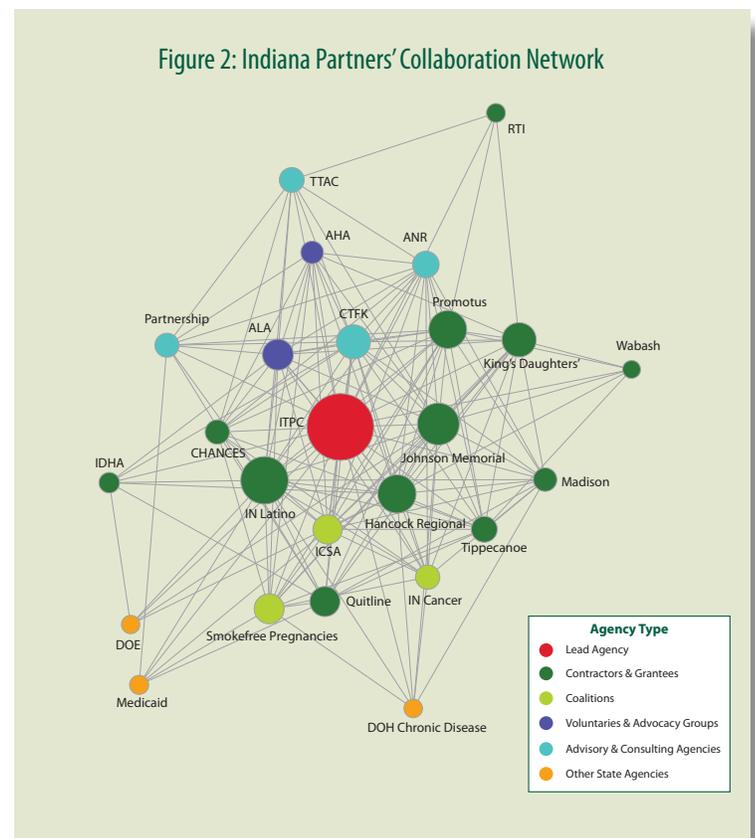
## Communication between Indiana partners

Partners were asked how often they had direct contact (such as meetings, phone calls, or e-mails) with other partners within their network in the past year. In the figure to the right, a line connects two partners if they had contact with each other on more than a quarterly basis. The size of the node (dot representing each agency) indicates the amount of influence a partner had over contact in the network. An example of having more influence, or a larger node, was seen between CTFK, ALA, and RTI. ALA did not have direct contact with RTI, but both had contact with CTFK. As a result, CTFK acted as a bridge between the two and had more influence within the network. Overall, Indiana partners frequently engaged with one another, resulting in a fairly even distribution of communication among partners.



## Collaboration between Indiana partners

Partners were asked to indicate their working relationship with each partner with whom they communicated. Relationships could range from not working together at all to working together on multiple projects. A link between two partners indicates that they at least worked together informally to achieve common goals. Partners were not linked if they did not work together or only shared information. Node size is based on the amount of influence a partner had over collaboration in the network. A partner was considered influential if he or she connected partners who did not work directly with each other. For example, ANR and Wabash did not work directly with one other, but both worked with ITPC. ITPC acted as a “broker” between the two agencies, and as a result, is characterized by a larger node size. ITPC and IN Latino had the most influence over collaboration among partners as demonstrated by their large node sizes. This indicates that they were central to the network and had working relationships with many partners in the state.



# 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. Indiana partners identified the following resources:

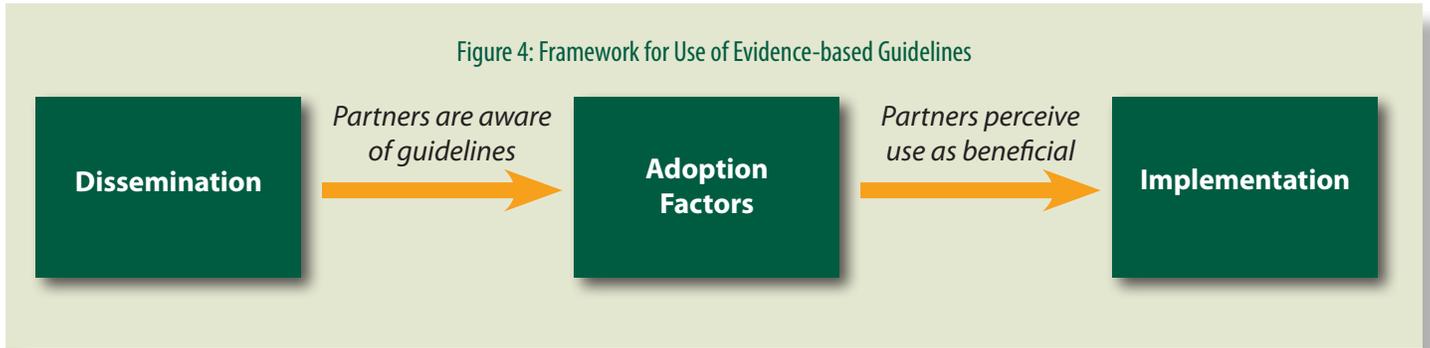
- Surgeon General’s Reports;
- Americans for Nonsmokers’ Rights *Model Ordinance Prohibiting Smoking in All Workplaces and Public Places*;
- Published materials from the Partnership for Prevention; and
- Indiana’s *Fundamentals of Smokefree Air Policy Development for Hoosier Communities*.

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 Indiana. The framework below will guide the discussion, specifically looking at which guidelines Indiana 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”?

When asked to define the term “evidence-based guidelines,” the majority of Indiana partners described them as proven and effective practices. Partners further defined “evidence-based guidelines” as documents that described practices that had been tested, published, and transformed into practical, results-oriented recommendations.

- When I hear [evidence-based guidelines] I think of something that has been developed scientifically and peer reviewed and is seen as a best practice, something that’s been proven to hold value and merit and accomplish the goals, and it’s recognized in the professional or scientific world as something that’s got value and credible and can be used as a model program because it has been shown to work.

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

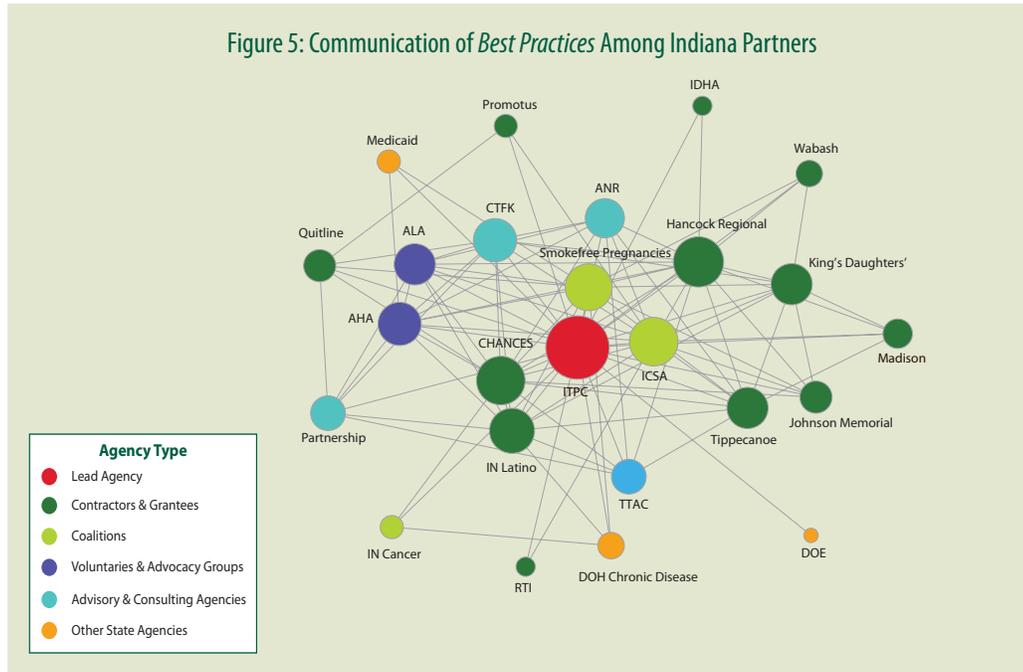
Partners were often made aware of relevant guidelines when they started their current position or when they first started working in tobacco control. The CDC’s *Best Practices* was a common guideline for partners to receive as part of their orientation. For example, ITPC included *Best Practices* in its new coordinator trainings.

- [*Best Practices* is] incorporated into our training, because it is the foundation [of our program]...It’s definitely a part of our new coordinator training.

ITPC, particularly the agency’s program manager, served as the main source for guideline dissemination to Indiana partners. ITPC informed partners of new guidelines through presentations, meetings, and e-mails. Additionally, partners frequently attended ITPC-sponsored statewide trainings on evidence-based guidelines during which *Best Practices* was the most frequently referenced guideline.

- I think every training that we’ve had from the ITPC as far as writing the new work plan or evaluating the work plan or orientation for new coordinators, they always refer to *Best Practices*. I think that’s something that has been a key component and a cornerstone.
- I would say that most of [the evidence-based guidelines], I’ve learned through ITPC...I feel like they’re the direct contact to receive that information.

To gain a better understanding of the *Best Practices* guideline diffusion, Indiana partners were asked whom they talked to about the guideline. In Figure 5, a line connecting two agencies indicated they talked about *Best Practices* with one another. The size of the node reflects the number of agencies each partner communicated with about the guideline. For example, ITPC talked most often to other agencies about *Best Practices*, resulting in the largest node size. This falls in line with ITPC frequently being identified by partners as a major source for guideline dissemination. However, ITPC did not act as the sole resource for information regarding *Best Practices*, as other partners spoke with one another about the guideline as well.



## What tobacco control guidelines were partners aware of?

All Indiana partners interviewed recalled at least hearing of the *Best Practices* guideline. Partners' frequency for referencing *Best Practices* ranged from a weekly to annual basis, with those at ITPC referring to it most often. At least half of Indiana partners were aware of the remaining guidelines. Additional resources, such as internally-developed guidelines, were also used in partners' tobacco control efforts.

Table 2: Number of Partners Aware of Tobacco Control Guidelines

Guideline	# of Partners
Best Practices for Comprehensive Tobacco Control Programs	28/28
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	23/28
Designing and Implementing an Effective Tobacco Counter-Marketing Campaign	21/28
Best Practices User Guide Series (e.g., Coalitions)	18/28
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	18/28
Ending the Tobacco Problem: A Blueprint for the Nation	18/28
The Guide to Community Preventive Services: Tobacco	17/28
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	17/28
Introduction to Process Evaluation in Tobacco Use Prevention and Control	17/28
Key Outcome Indicators for Evaluating Tobacco Control Programs	14/28
Tobacco Control Monograph Series	14/28

# Adoption Factors

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

Numerous factors were taken into consideration by Indiana partners when making decisions about their tobacco control efforts. When asked to rank several decision-making factors by their importance, 43% of partners ranked recommendations from evidence-based guidelines as the most important factor, with 79% ranking it in their top three. On average, partners listed direction from inside their organization as the second most important factor. Partners further emphasized the significance they placed on ITPC as a leader in Indiana's tobacco control efforts.

With ITPC we look at the CDC *Best Practices* and recommendations and long-term policy interventions to reduce tobacco control. And how to not only understand them, but the tools to actually implement them.

We look back to ITPC for guidance. They have pretty much stayed with the same four goals which I believe are best practices as far as reducing tobacco use.

Additionally, organizational capacity and input from partners were ranked as important decision-making factors for Indiana partners. Input from other partners, including out of state guidance, aided in program implementation.

A lot of what we do when we're trying to figure out our planning is also looking at, what is our capacity in the state? What are our relationships with other groups? How can we... make sure that we partner with the right groups of people to get these projects implemented?

We do work closely with a number of organizations so we get input from them, but, we look inside [our organization] first and then go outside.

Figure 6: Ranking of Decision-making Factors



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

Indiana partners noted that extensive experience in tobacco, as well as diversity in partners' backgrounds, enhanced their tobacco control efforts.

- We've been doing [tobacco control] well, and we continue to be a resource for so many people in a lot of different ways. . . that I think it gives us a certain amount of street credit when we're working with coalitions, and it really does help get buy-in and support from the local groups.
- There are a diverse group of people that present from prevention; from medical doctors, to researchers in prevention, to state health commissioners with knowledge of this entity, to hospital administration, we bring diverse backgrounds to the [ITPC] board.

Furthermore, partners described a positive relationship with ITPC as a facilitating factor to their efforts. Partners felt that ITPC was approachable and open to new ideas. This type of relationship fostered creativity, communication, and trust amongst partners when making decisions for their tobacco control efforts.

“[ITPC is] always really open to new ideas and recognizing things that could improve the program.”

- What helps us implement new ideas and expedite changes or bring on new techniques is the fact that I have a long-standing personal relationship with [ITPC]. . . over the years we've built trust. We certainly built our knowledge base on the industry, and [the program manager] recognizes that. . . So what we're able to do is really just go straight to the top and lay out what we see and what we believe is the best route to take.

Conversely, partners identified limited funding and state agency processes as primary barriers to their efforts. The budget cuts made it more difficult to implement programs for Indiana partners. Additionally, the state review process was perceived as lengthy, which hindered partners from moving forward as quickly as possible.

- [The government] cuts our budgets every year, so it is harder to accomplish more when you don't have as many resources.
- We're a state agency, and all of the obstacles that I think slow us down have a lot to do with the state agency processes. . . I would be crazy not to mention that we've had challenges just with the administration in the past few months, and so we've had to battle just for the life of the program, and getting support from this current administration in the program.

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

Evidence-based guidelines were beneficial to Indiana partners and provided a solid foundation on which to base their efforts. Partners felt that the guidelines were reliable, scientifically proven, effective strategies that provided credibility when defending their efforts.

- [Evidence-based guidelines] are proven...it's not like you're going in blind and not knowing what the results will be. I know that they are effective, and so I know that it's an effective use of my time, so that's why I feel like using the evidence-based guidelines is important, so I'm not recreating the wheel myself.
- As a field, you're constantly under scrutiny from the opposition about what it is that you do. People are skeptical, and being able to go back to the science for all of the interventions that you're doing is critical. Everything you do is based on science.

The utilization of evidence-based guidelines also ensured consistency among partners' efforts. Partners felt that having unified goals both locally and nationally compounded the impact of their efforts.

**"[Evidence-based guidelines] give you a foundation. They give you something to anchor your reasons on."**

- We have to be consistent in this movement. The tobacco industry would love to see us divided and going in different directions, so we are fortunate that there has been an investment in science and it's policy research related to what we do, and so it's up to the leaders in the movement to consistently package it, and train it, and use it, and discuss it, and keep it current, and push for more, and that's why we do it.
- I think that [utilizing evidence-based guidelines is] a way to standardize all the different vendors and people that are doing the same thing across the nation if you have one central source for recommendations.

Despite the advantages to using evidence-based guidelines, partners encountered resistance from some stakeholders and communities to certain evidence-based practices. They often continued to rely on ineffective programs rather than evidence-based practices because of a belief that the guidelines were not applicable to their unique community.

- I think there's a set of our partners who just don't think [evidence-based guidelines] work for their community for any particular reason.
- Oh the general, "That works in California and New York, but we're Indiana, and everything is different here." That's probably the biggest [challenge]; people don't like outsiders telling them what to do.

Finally, partners felt that some evidence-based guidelines contained an overwhelming amount of information that was difficult to grasp. A lack of understanding further increased the challenge of implementing the guidelines for partners.

- I think sometimes pulling out the information that you need can be difficult. Even in an executive summary, if it's 75 pages long, I'm not really interested in reading it. So I think that that could be a barrier. If you're not well-versed in the terms that are used in the books, it's going to be a little difficult to be able to translate how it's going to work in real life.



# Implementation

## Which guidelines were critical for Indiana’s tobacco control partners?

Indiana partners were aware of a number of evidence-based guidelines and reports. However, a smaller number of those guidelines were identified as critical resources when partners were asked to group guidelines into one of three categories: 1) *Critical* for their tobacco control efforts; 2) *Not critical, but useful* for their tobacco control efforts; and 3) *Not useful* for their tobacco control efforts. Two of the top 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 Indiana partners.

### Best Practices for Comprehensive Tobacco Control Programs

All Indiana partners were aware of *Best Practices*, and 82% identified it as a critical resource to their tobacco control efforts. Most often used as a reference for program and strategic planning, *Best Practices* provided the framework for Indiana’s tobacco control program. Most partners received this resource, usually from ITPC, when they started their work in tobacco control as an orientation to the basics of a comprehensive program. Partners also found *Best Practices* to be a useful resource when communicating with policymakers. They referenced the guide to support their program and funding needs.

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

Guideline	% of Partners*
Best Practices for Comprehensive Tobacco Control Programs	82%
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	74%
Ending the Tobacco Problem: A Blueprint for the Nation	67%
The Guide to Community Preventive Services: Tobacco	47%
Best Practices User Guides Series (e.g., Coalitions)	42%
Tobacco Control Monograph Series	29%
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	29%
Key Outcome Indicators for Evaluating Tobacco Control Programs	21%
Introduction to Process Evaluation in Tobacco Use Prevention and Control	18%
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	16%
Designing and Implementing an Effective Counter-Marketing Campaign	10%

\* Based on partners who were aware of the guideline

⋮ *[Best Practices]* provides an infrastructure for describing an ideal tobacco control program.

⋮ When we talk about funding with a senator or representative, I refer to the book *[Best Practices]*, or I refer partners to the book.

### Revisions to the CDC *Best Practices*

In 2007, the *Best Practices* guideline was revised. To find out how these changes were perceived, Indiana partners were asked additional questions about *Best Practices*. Most partners were not aware of the 1999 version or were not familiar with the specific changes made since the previous version. Those who remembered the changes noted that collapsing the categories from nine to five made it easier to explain the key components of the guideline to stakeholders. Several partners stated that they had collapsed the categories for their own purposes before the 2007 version was released, so they appreciated that CDC had also restructured the categories.

- ⋮ I really like the way that the model was reconfigured into five components. . . In fact, we had taken the old *Best Practices* and made our own model up that had five components, for different reasons. . . so I think that they did an excellent job in reconfiguring that.

Additionally, partners supported simplifying the funding recommendation to a specific dollar amount as opposed to a range. However, many commented that the funding recommendations were unrealistically high in terms of financial and political feasibility.

- ⋮ The overall funding level number is just. . . such sticker shock.

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

Seventy-four percent of Indiana partners aware of the *Clinical Practice Guidelines* ranked it as a critical resource and referenced it frequently. Partners utilized the *Clinical Practice Guidelines* for training and education purposes, especially when collaborating with healthcare providers.

- ⋮ I primarily use [the *Clinical Practice Guidelines*] to educate other healthcare providers on what we know works. And I tell them that that is their bible.
- ⋮ Because we have some statewide grants that are specifically reaching out to healthcare providers, clinicians who would use [the *Clinical Practice Guidelines*], we talk about it all the time.

### Ending the Tobacco Problem: A Blueprint for the Nation

Of those partners who were aware of the Institute of Medicine's *Ending the Tobacco Problem: A Blueprint for the Nation (IOM Report)*, 67% identified it as critical. This guideline was primarily used for strategic plan development, as well as educating partners and policymakers on the key recommendations.

- ⋮ [We pull] out specific pieces and recommendations from [the *IOM Report*] for that purpose, for our strategic plan. Also communicating what's in it at a higher level and educating our board members.
- ⋮ As we do our work in educating state and local partners or policymakers, you're always able to go back to say, "And this intervention is supported by the IOM [Institute of Medicine] as well."

### Other Resources

Additional resources cited as critical by Indiana partners included *The Guide to Community Preventive Services (Community Guide)* and the *Best Practices User Guide Series*, both useful for local level efforts. The *Community Guide* was used as a reference for programming and designing interventions at the local level, while the *Best Practices User Guide Series* was used for building coalitions.

- ⋮ We use the *Community Guide* especially with the local partners to reinforce why we do certain interventions.

- We refer to [Best Practices User Guide Series] quite a bit and use that as a resource for building our coalition, for trying to identify and help in recruiting areas that may not be represented in our coalition, to look on how to empower members to see their strengths.

Surgeon General's reports and Indiana's *Fundamentals of Smokefree Air Policy Development for Hoosier Communities* guideline were also noted as important resources. These resources were used to educate policymakers on the hazards of secondhand smoke and the benefits of smokefree policies.

- [Fundamentals of Smokefree Indoor Air Policy provides] both guiding principles for policy and also for process...a way to insure policy discipline around the country and around a state.

“[The Surgeon General's Report] uses very clear language stating that there's no safe level of exposure to second-hand smoke.”

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

Indiana partners identified disparate populations based on input or mandates from ITPC as well as the available data (e.g., the Behavioral Risk Factor Surveillance System). Partners in Indiana most frequently noted working with pregnant women, individuals of low socioeconomic status, and the mental health community.

- The ITPC [has included] pregnant woman [as] a mandate all along, and then the other areas, they made suggestions on other populations that you can work with. And so we basically chose from there what the greatest needs were in our community or the realistic type of outreach that we have.

Partners found minority organizations and community-based coalitions (e.g., Indiana Rural Health Association) to be important resources in their work with disparate populations. Information from the CDC-supported National Networks for Tobacco Control and Prevention also proved useful. Specifically, input from the Indiana Latino Institute, a partner organization of the National Latino Tobacco Control Network, was helpful to partners' tobacco efforts.

- We really look at working with our minority health partners that already exist in the state.

While some partners had referenced evidence-based guidelines in their work with populations with tobacco-related disparities, the majority did not. Specifically, most partners did not find *Best Practices* particularly useful. They noted that *Best Practices* lacked specificity and did not provide sufficient focus on practical applications of the guideline to disparate populations.

- So while I know about CDC *Best Practices* and use it, to some degree it's just not that critical because it doesn't speak directly to that population and get down to the very specific level that I need.

Consequently, partners commented on the need for additional resources to fill this gap. They suggested providing additional information or trainings on cultural competency, as well as guidance on working with specific communities and how to apply the evidence base to those populations.

- There's probably another piece that needs to be a little bit more in-depth as far as interventions that are really able to address some of those populations. More practical things with that disparities lens on it.
- Real world ideas. I need to know when I'm talking to these people what helps them to relate better to me.

## What resources were used to communicate with policymakers?

The majority of partners in Indiana regularly communicated with policymakers, specifically citing contact with the governor’s office, state legislators, mayors, and city and county council members. Much of the communication with policymakers revolved around defending ITPC’s efforts to support funding as well as emphasizing the importance of smokefree policies.

To support funding for tobacco control efforts, partners frequently referenced evidence-based guidelines, particularly *Best Practices*, the *Community Guide*, the *IOM Report*, the *Clinical Practice Guidelines* and Surgeon General’s reports. These guidelines were especially helpful in advocating for funding for the program and supporting ITPC’s activities.

- ⋮ We’re using the *Best Practices* document to defend funding [for tobacco control] and to keep our funding in place.
- ⋮ [Evidence-based guidelines are] generally the basis for having a conversation to defend what we want to do, or need to do, or need [policymakers] to do.

Partners provided personal testimony and information from other states when educating policymakers about the need to implement smokefree policies. To support their case, partners also referred to evidence-based guidelines in conjunction with available data, such as smoking rates.

- ⋮ [Policymakers] may know *Best Practices*, or evidence-based guidelines as a concept, but I try to explain to them how it translates into activities that we’re doing, and why we need for them to pass a smokefree air law.

## What other resources were needed?

When asked what the CDC could do to continue to support Indiana’s tobacco control efforts, partners expressed an interest in guidance on effective communication with policymakers. Additionally, partners thought that direct communication between the CDC and Indiana policymakers, such as writing letters or testifying to the state legislature, would have a strong influence on policymakers and would provide powerful reinforcement to their tobacco control efforts.

- ⋮ [CDC] could work more closely with the National Council on State Legislators and the National Governor’s Association to change opinions of our legislators.
- ⋮ It would be great if [the CDC] could come and testify to the effectiveness of the ITPC program in front of the legislature.

Indiana partners also wanted to see more materials produced by the CDC. Specifically, partners noted a need for resources tailored to demographic subgroups as well as research on effective strategies for working with disparate populations.

- ⋮ More information about promising practices in the specific communities.
- ⋮ Things that would help us relate better to the different demographics that we need to work with, giving us some real world ideas on what we can do.

Finally, partners noted several ways to improve the communication and dissemination of new resources. Suggestions included:

- Centralizing and improving access to CDC OSH resources through a more user-friendly website; and
- Combining trainings, webinars, and/or technical assistance with the release of new resources or information.

⋮ Well I'm beginning to be a fan of webinars and distance learning. So it would be a combination of friendly access on a website with tools and all the essential resources, and some distance learning so that individuals most interested can get the basics.

⋮ Somehow if [the CDC] could be a little bit more user-friendly, and if they could send out some sort of updates on their resources [that would help my efforts].

Several individuals mentioned that due to the important role ITPC played for partners in the state, continuing to channel new information through the lead agency would be helpful to their efforts.

⋮ I think to deliver [a new resource] through our state agency and have them disseminate to all their local partners [would be helpful].



# Conclusions

Indiana tobacco control partners demonstrated a high level of awareness of evidence-based guidelines, particularly *Best Practices*, and used them frequently in their work. Partners primarily used the guidelines to educate stakeholders, in program planning, and to advocate for funding from policymakers. The *Best Practices* guideline was seen as providing the structure and foundation for a comprehensive tobacco control program. Additional factors that contributed to the adoption of *Best Practices* and other evidence-based guidelines included:

- ITPC served as the main resource for guideline dissemination and many received the *Best Practices* guideline from ITPC when they started their work in tobacco control.
- Partners saw guidelines as a way to provide credibility to their work because of their promotion of effective and proven practices.
- Partners thought that utilizing evidence-based guidelines compounded the impact of their work by providing consistency to both local and national tobacco control efforts.
- Indiana partners used evidence-based guidelines during frequent communication with policymakers. ITPC's separation from the Department of Health facilitated communication with policymakers, allowing policy change to take a central role in Indiana partners' efforts.

Despite the importance of evidence-based guidelines to Indiana's tobacco control efforts, partners noted several challenges to using the guidelines:

- Application of the guidelines occasionally met resistance from the community and some partners.
- Some of the guidelines were seen as too dense and technical to be easily translated into partners' work.
- Partners found the guidelines to be minimally useful in their work with disparate populations and they found it difficult to apply the guidelines to specific populations or communities. Therefore, partners suggested developing guidelines targeted at specific disparate populations.

A variety of different resources were employed to inform the work of those involved in tobacco control. In Indiana, 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 to one's work. Indiana partners suggested disseminating evidence-based guidelines through ITPC and combining webinars and trainings to enhance the utilization of guidelines. Taking these factors into consideration when developing and releasing a new guideline will optimize use of the guideline by intended stakeholders.

