

Arizona Department of Health Services Bureau of Tobacco and Chronic Disease Community Partner Concept Mapping Project

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Table of Contents

Introduction.....	1
Concept Mapping Process.....	2
Generating and Structuring Ideas.....	2
Analysis.....	3
Interpretation.....	5
Findings.....	7
Dialogue.....	12
Reaction to Logic Model	12
Sustainability.....	12
Place in Policy Work	14
Moving Forward	15
Appendix A. Brainstormed Statements.....	17
Appendix B: Point Map	20
Appendix C: Cluster Map	21
Appendix D. Statements Sorted by Cluster	22
Appendix E. Point Rating Map (Importance)	24
Appendix F. Cluster Rating Map (Importance)	25

List of Figures

Figure 1. Go Zone Analysis of Cluster 1, Comparing Importance and Feasibility	4
Figure 2. Comparison of Perceived Importance of Clusters between Stakeholder Groups.....	5
Figure 3: Cluster Map with Labels	7
Figure 4. Summary Concept Map.....	8
Figure 5. Logic Model Resulting from Concept Map.....	9
Figure 6. Comparison of Perceived Importance between Stakeholder Groups, with Cluster Labels	10

Introduction

The goal of the current project was to develop an evaluation framework for BTCD Community Partners that could guide efforts to determine effectiveness and promote sustainability of Arizona's community-based tobacco control and chronic disease management programs. We followed the guidelines set out by the Center for Disease Control and Prevention's (CDC) *Developing an Effective Evaluation Plan*, which encourages engaging stakeholders in the development of a collaboratively-derived program description and understanding, which can then be used to guide further program evaluation efforts.

In order to accomplish this, we used a concept mapping process which provides a structured way to incorporate input across stakeholders to develop a visual representation of relationships among ideas. Concept mapping has been used to develop logic models and evaluation frameworks across a number of health and social science domains, including for the CDC Prevention Research Centers (Anderson, et al, 2006), and the NIH-funded Transdisciplinary Tobacco Use Research Centers (Stokols, et al., 2003). For this project, we incorporated ideas identifying aspects of a successful community-based tobacco control project that were generated by Arizona Department of Health Services Bureau of Tobacco and Chronic Disease (BTCD) staff and BTCD-funded community partner agency staff.

This document outlines the concept mapping process which produced products (concept maps, pattern matches and go-zones) that were interpreted through meetings with multiple groups of stakeholders¹. The findings and a resultant logic model were discussed in a subsequent larger group meeting, where further directions for program planning and evaluation were identified. These findings and proposed next steps are summarized here.

¹ These products are included in appendices for reference.

Concept Mapping Process

Concept mapping is an interactive technique which relies on the insights of participants to define important issues. It is a group process of generating ideas and articulating the relationships between those ideas. Multidimensional scaling and cluster analysis are applied to this information resulting in a pictorial representation of the group's thinking that displays the group's ideas, how they are related to each other, and which ideas are considered more relevant, important or appropriate for study. These pictures can then be discussed by the participants and used to convey to others the issues that the group found to be important.

Generating and Structuring Ideas

The first step in any concept mapping process is to generate a focused list of statements representing a variety of aspects of the topic of interest, in this case, about what a successful community-based program entails. An in-person group brainstorming session was conducted on September 11, 2012, as part of an BTCD Community Partners Meeting. Participants from six community partner agencies and from the majority of programs subcontracted through the Inter Tribal Council of Arizona, one technical support agency, and BTCD staff were asked to complete the stem: "A successful community-based tobacco control and chronic disease management project would...". Participants were asked to continue to reflect on the topic and to invite any other agency staff or community members to participate in statement generation on-line. A total of 85 statements were generated through both in-person and on-line processes. These 85 statements are included in Appendix A

All community partner agency leads were then sent a URL and asked to involve as many staff as they felt appropriate (with a minimum of two requested) in a web-based process of structuring the statements. The statement structuring process had two components: sorting (grouping) and rating.

Sorting: Each participant was asked to group the ideas into as many virtual piles (lists) of statements in a way that "makes sense to you," where the statements in the same pile have more in common with each other than they do with statements in other piles.ⁱⁱ They were asked not to sort all items into one pile, not to sort each into its own pile (though some could be sorted individually), nor to sort any item into more than one pile. They were also asked to provide a label for the pile that "named" what they had in common in the view of that that participant.

Rating: Each participant was asked to rate each statement along three different dimensions: importance, feasibility, and responsibility for evaluation. The prompts for each are given below:

Importance – "Rate each statement in terms of how important you believe it is as a factor in the success of a community-based tobacco control and chronic disease management program (1= relatively unimportant; 5= extremely important)"

Feasibility – "Rate each statement in terms of how feasible you believe it is for a community-based tobacco control and chronic disease management program to accomplish this (1=not feasible; 3= very feasible)"

ⁱⁱ This was done by clicking on an item in the full list, and dragging it to an appropriate new grouping list

Responsibility – “Indicate who you think should primarily be responsible for evaluating each item (1=community-based program; 2= BTCD)”

Participants were also asked to identify themselves as either community partner agency staff, or BTCD staff, to allow for comparisons between stakeholder groups.

Table 1 displays the numbers of participants who began and completed each phase of the structuring. One community agency chose to do the tasks jointly, so that although several staff participated, they are counted as just one participant in the table. Follow-up with staff who began but did not complete the phases indicated that they found the sorting task in particular to be time consuming and, in some cases, difficult to understand.

Table 1. Statement Structuring Participation

	Started	Finished
Sorting	16	12
Importance rating	14	14
Feasibility rating	12	11
Responsibility for evaluation	11	10

Analysis

The individual sortings were combined into a group similarity matrixⁱⁱⁱ. This matrix provides the relational structure of the groupings and was represented graphically in three different map formats: point maps, cluster maps, and rating maps (point and cluster).

The point map represents each statement as a separate point on the map. Statements which are closer together on the map were sorted together more frequently, and statements which are far apart on the map were generally sorted together less frequently. The point map is constructed by applying two-dimensional nonmetric multidimensional scaling analysis to the group similarity matrix. The numbers presented on the point map in Appendix B correspond with the statement numbers in Appendix A.

ⁱⁱⁱ First, a binary matrix of similarities was constructed where for any two items *i* and *j*, a 1 was placed in X_{ij} if the two items were placed in the same pile by the participant, otherwise a 0 was entered (Weller and Romney, 1988). The total similarity matrix was obtained by summing across the individual X_{ij} matrices. Any cell in this matrix could take integer values between 0 and 12 (i.e., the 12 people who sorted the statements), with the value indicating the number of people who placed the *i,j* pair in the same pile. A high value in this matrix indicates that many of the participants put that pair of statements together in a pile and implies that the statements are conceptually similar in some way. A low value indicates that the statement pair was seldom put together in the same pile and implies that they are conceptually more distinct. (Trochim, 1989)

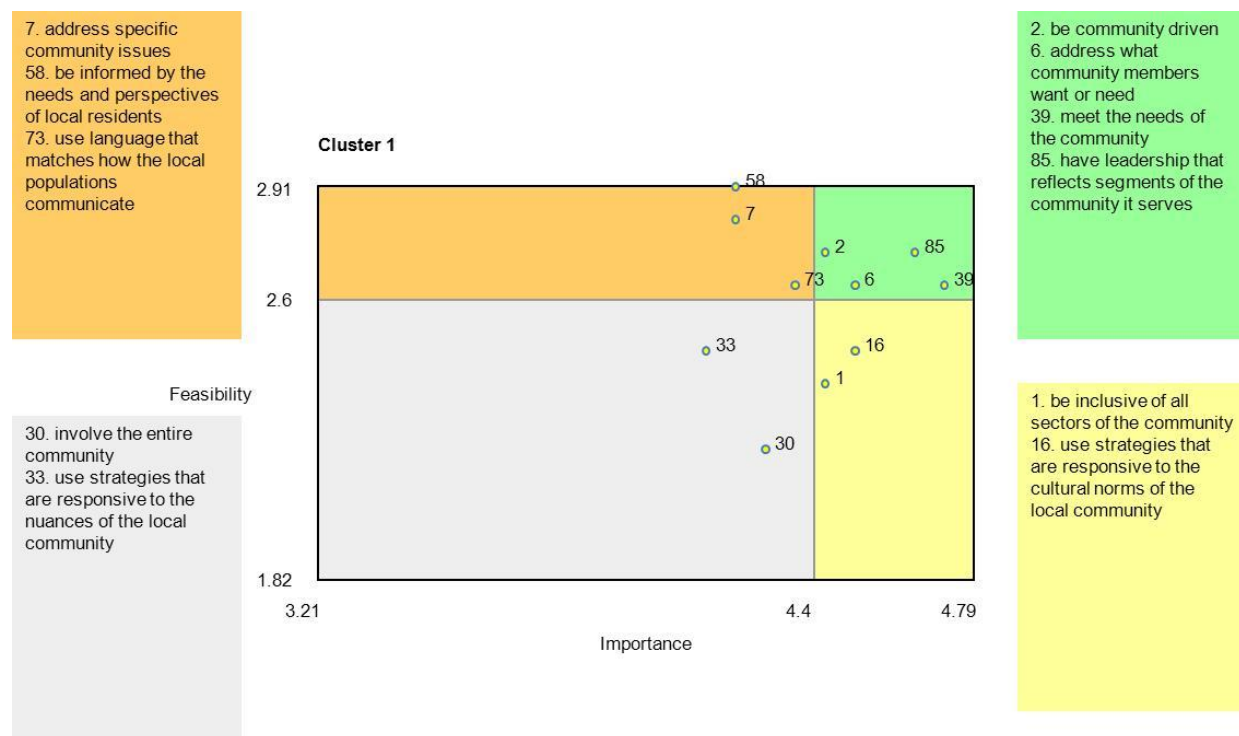
The *cluster map* displays the statements as clusters that represent the higher order conceptual groupings of the original set of statements (Appendix C). This is accomplished using hierarchical cluster analysis on the X-Y coordinate data obtained from multidimensional scaling. There is not a straight-forward mathematical criterion for selecting an optimal number of clusters. We followed the procedure outlined in Trochim, Cook, & Setze (1994), whereby a cluster solution that on average placed five statements in each cluster was examined initially by the research team. Successively lower and higher cluster solutions were examined, with a judgment made at each level about whether the merger/split seemed substantively reasonable. It was determined that the nine-cluster solution preserved the most detail and yielded substantively interpretable clusters of statements.

The *point rating map* is the point map with the average individual statement rating overlaid (Appendix E).

The *cluster rating map* is the cluster map with the average rating across the statements in the cluster overlaid (Appendix F).

Go Zone Analyses allowed for within cluster analysis across two dimensions. The example in Figure 1 below shows the ratings for importance against the ratings of feasibility for each of the statements in Cluster 1. Those in the upper right, green, quadrant are statements which were rated, on average, as high in both feasibility and importance. These are considered as ideas that are in the “go-zone,” that is, items to focus on as potentially important and attainable.

Figure 1. Go Zone Analysis of Cluster 1, Comparing Importance and Feasibility



In addition, we also used *pattern matching* to compare how BTCD staff rated the clusters compared to how community partner agency staff rated them, as a way to examine any differences in priorities between the two stakeholder groups. An example of how these were used is presented below.

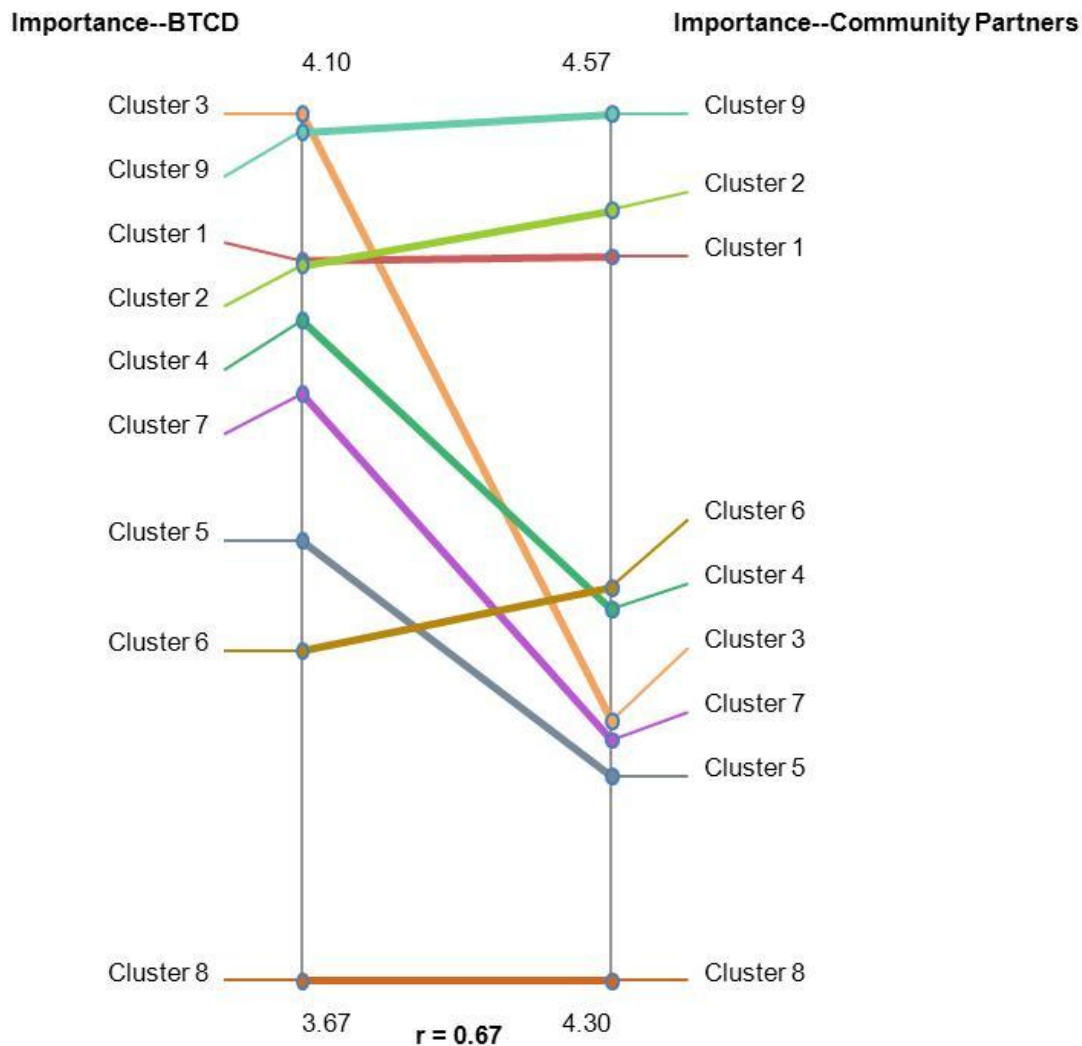
Figure 2. Comparison of Perceived Importance of Clusters between Stakeholder Groups

Figure 2 illustrates that, overall, there is agreement that clusters 9, 2, 1 represent important aspects of community tobacco control and chronic disease programs, and that cluster 8 represents a relatively less important aspect. There is, however, a discrepancy in how Cluster 3 is perceived of between stakeholder groups, with BTCD staff seeing it as a relatively more important aspect than do community partner agency staff. These types of analyses open the door for discussions about what the discrepancy might represent.

Interpretation

The various products (maps, go-zones and pattern matches) were presented to stakeholders in four separate sessions for discussion and interpretation. The goals of these sessions were to assure that the participants had a broad view of the data and the underlying relationships behind them, and to interpret them in ways that could drive planning and evaluation processes.

Three sessions were held in the Phoenix area: one involved four BTCD staff members; one was hosted by Tanner Community Development Corporation (Tanner) and included agency staff

from Tanner, from Asian Pacific Community in Action, and from La Paz Regional Hospital; and one was hosted by the Inter-Tribal Council of Arizona, and included ITCA staff and their tribal and urban Community Tobacco Advisory Council subcontractors. The fourth session was hosted by Campesinos Sin Fronteras in San Luis, AZ, and included many staff whose preferred language is Spanish; to enable all staff members to participate fully, this session was conducted primarily in Spanish.

Participants in each session were asked to consider the statements that made up each of the clusters (from the cluster list) and, through discussion, group consensus was established on a name for each cluster that best captured the concepts suggested by the aggregate of the statements.^{iv} The cluster map was then labeled with each of the cluster names, and a general discussion about the meaning and usefulness of the resulting graphical representation was held.

Using the cluster map as a conceptual framework, participants were then asked to review and discuss the rest of the analyses (cluster rating maps, go zone analyses, and pattern matches) while considering a few questions:

- Although all the aspects of community programs are important, which are relatively most important? Are there a smaller number of clear priorities?
- What aspects are the most feasible to implement?
- What is the relationship between importance and feasibility?
- Where should the responsibility for evaluation of the different aspects lie?
- Do funding staff and community partner staff see different priorities or responsibilities?

The evaluation team summarized these discussions and produced new materials that incorporated the findings from the four sessions into materials that addressed the questions laid out above. These materials were then reviewed and discussed at a subsequent meeting that included representatives from each of the community partner agencies and from BTCD. The findings from the four interpretation sessions (in *Findings*) and from the larger, all-partner meeting (in *Dialogue*), are presented in the next sections.

^{iv} Due to time constraints, not every session developed a label for each cluster. However, each participant group considered at least some clusters, and labels had been generated for each cluster by the completion of all sessions.

Findings

There was considerable consistency in the interpretation of the clusters across sessions and across stakeholders. After integrating the labels across those generated in each session, the following nine labels were suggested and reviewed at the all-partner meeting.

- Cluster 1: **Community driven:** includes ideas of knowing the community and being sensitive to the needs of the community.
- Cluster 2: **Community engagement:** includes ideas of inclusiveness, cultural accessibility and trust in the provider.
- Cluster 3: **Organizational structure and capacity:** includes ideas of strategic direction, accountability and sustainability.
- Cluster 4: **Evidence-based activities:** includes ideas of public accountability.
- Cluster 5: **Coordination of efforts:** includes ideas having a holistic approach.
- Cluster 6: **Information dissemination:** includes ideas of making information accessible.
- Cluster 7: **Health impacts:** includes ideas of vision of the future.
- Cluster 8: **Public policy and systems change:** includes ideas of legal environment change and enforcement.
- Cluster 9: **Changing community norms:** includes ideas of decreasing the acceptability of smoking and creating community environments that support not smoking.

Figure 3: Cluster Map with Labels

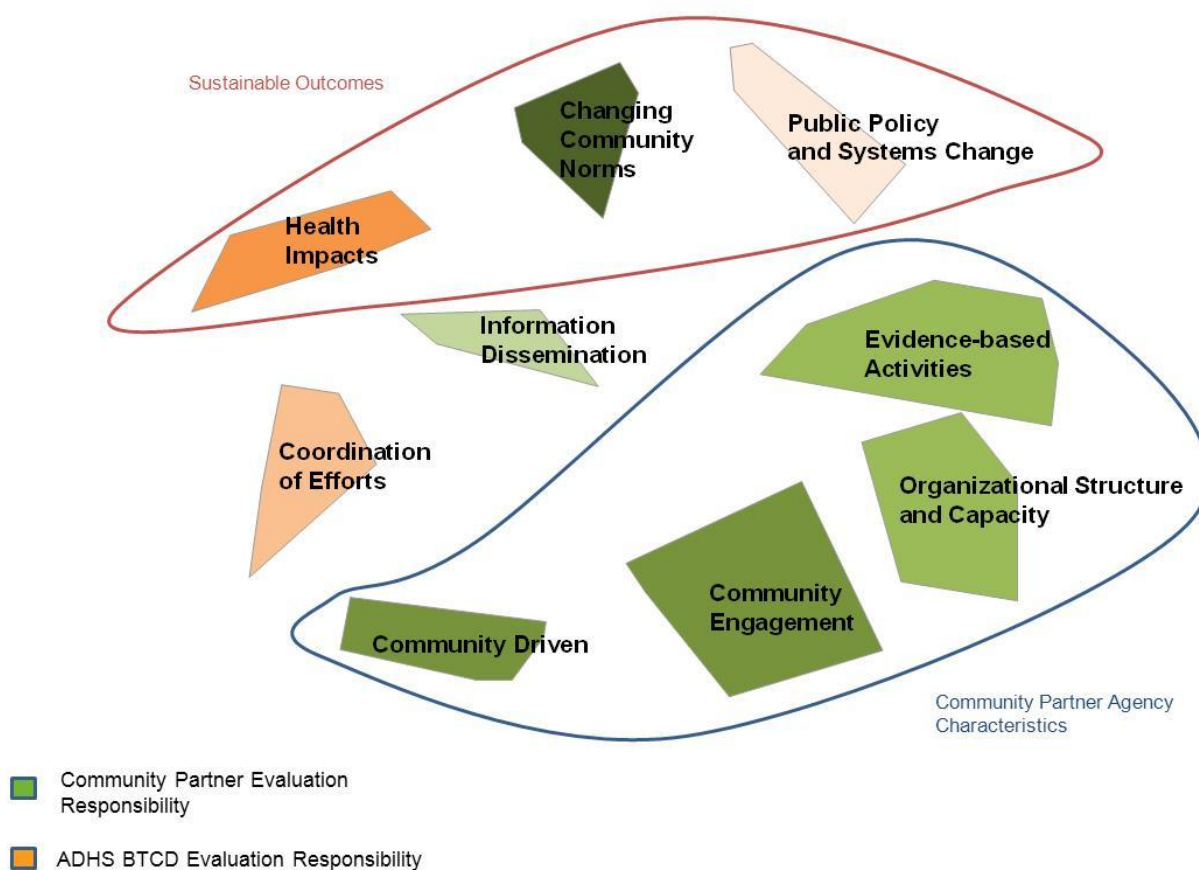


The resulting cluster map is shown in Figure 3. Working from this map, we incorporated additional information from the analyses to produce a composite figure that gives a summary snapshot of the findings from the interpretation sessions, and helps answer two of the questions posed in the interpretation sessions:

- Although all the aspects of community programs are important, which are relatively most important?
- Where should the responsibility for evaluation of the different aspects lie?

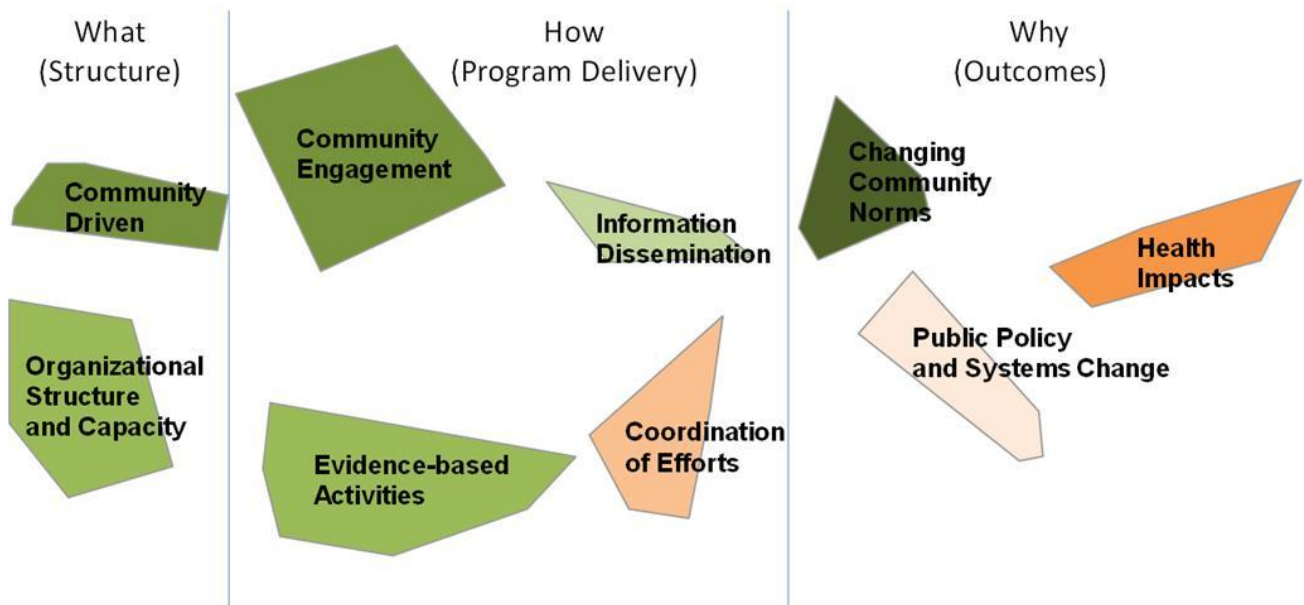
Participants identified two broad “regions” of conceptual space—clusters that represented community partner agency characteristics that contribute to program success, and elements of sustainable outcomes that represent program successes. The clusters in Figure 4 are color coded green to represent areas that were seen to be primarily the responsibility of community partners to evaluate, and orange if they were seen as areas that should be evaluated primarily by BTCD. The deeper the color, the more important that element was seen as being in the success of a community partner agency’s work in tobacco control and chronic disease prevention and management.

Figure 4. Summary Concept Map



By essentially rotating this map clockwise, we were able to develop an outcome logic model for considering what a “successful” community partnership would look like with regards to having an impact on tobacco use and chronic disease management. Such a model can be useful as a framework for program evaluation, by identifying important elements to address and measure.

Figure 5. Logic Model Resulting from Concept Map



This model suggests that, for community partner agencies, “*success*” means a primary focus of their activities is on knowing and being accessible and trustworthy to the community, and so engaging and motivating community members about the importance of tobacco control and chronic disease management in order to change community norms around those topics. The idea is that they produce fertile ground for public policy and systems change that can lead to health impacts. As one partner pointed out, health impacts result “when everything else is in place and functioning.” This is aligned with the CDC’s Best Practice Guidelines, which state “Effective community programs **involve** and **influence** people in their homes, work sites, schools, places of worship, places of entertainment, health care settings, civic organizations, and other public places.”^v (emphasis added).

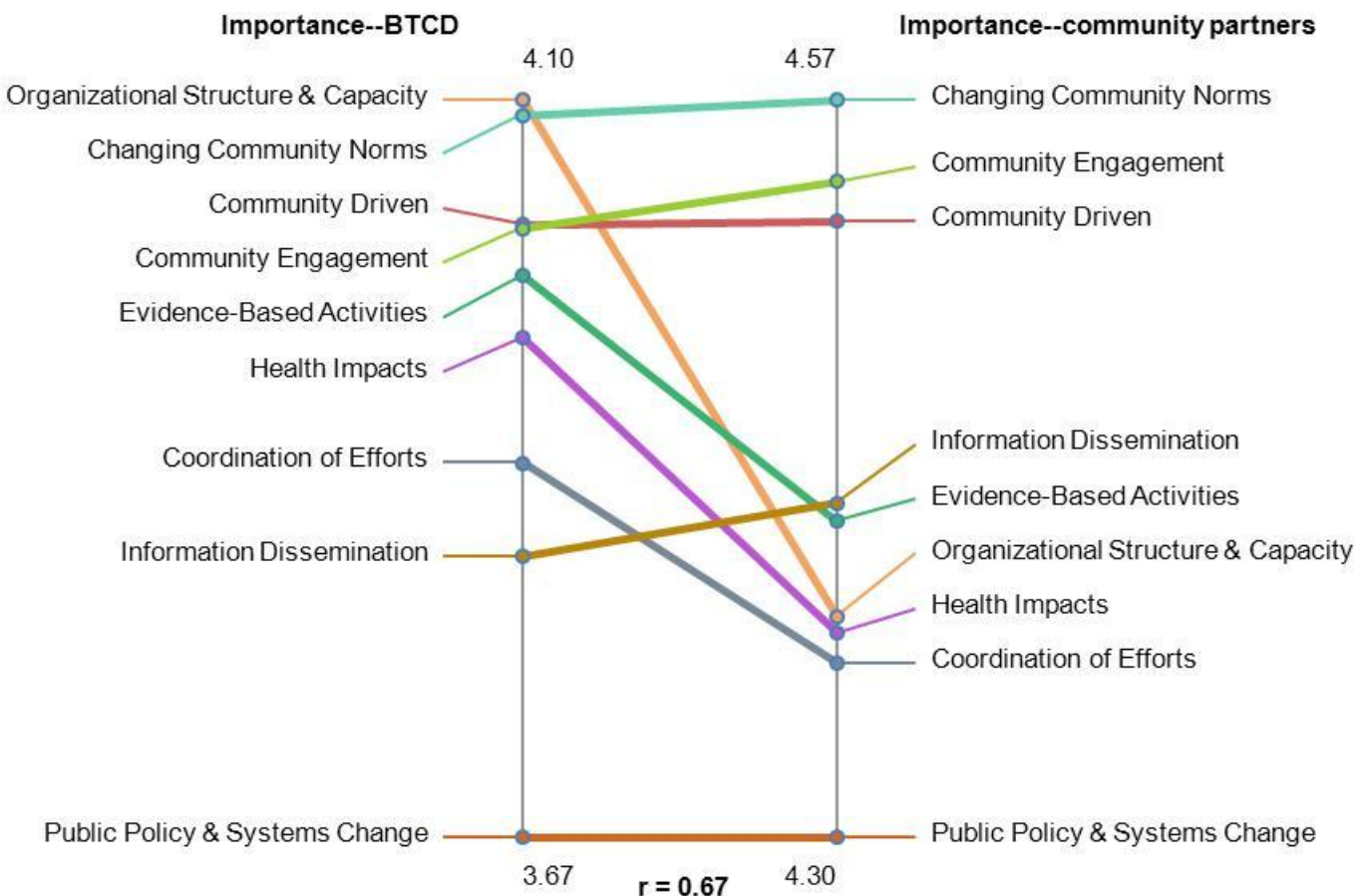
The logic model represents the input of all the participating stakeholders, and as such, should provide common ground for moving forward with discussions about the place of community partner agency work in the BTCD program “portfolio.” Another question raised in the interpretation session, however, was:

- Do funding staff and community partner staff see different priorities or responsibilities?

^v CDC (2007) Best Practices for Comprehensive Tobacco Control Programs (Section 1: State and Community Interventions, pg. 23). Accessed from http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2007/BestPractices_SectionA_I.pdf on 2-1-2013

Figure 6 shows the pattern match between perceived importance of each cluster as reported by BTCD staff, and perceived importance as reported by community partner agency staff. This is identical to Figure 2, but with the clusters now labeled. The top three clusters for community partner agency staff are represented in the top four clusters for BTCD staff. The cluster they do not share in common is that for organizational structure and capacity, which was the top-rated cluster for BTCD staff, but was placed substantially lower by community partner staff. Participants in all four interpretation sessions saw a need for dialogue to explore this discrepancy between the views of BTCD and community partner agency staff.

Figure 6. Comparison of Perceived Importance between Stakeholder Groups, with Cluster Labels



Overall, the interpretation sessions turned up three areas that participants saw as ripe for dialogue between agency staff and BTCD staff:

- **Sustainability**—need for a clearer discussion about expectations around sustainability and how both groups see funding for tobacco and chronic disease activities beyond BTCD
- **Policy**—need to clarify the role and expectations of community partners with respect to policy. Where do the partner activities fit in relation to the bigger picture around policy and systems change?
- **Collective impact**—to what degree are BTCD and community partners willing to embrace a collective impact model, and what might that look like in tobacco control/chronic disease?

The January 16, 2013, all-partner meeting was structured to begin this dialogue, and to identify productive next steps for working with the evaluation framework. In addition to time for joint BTCD-community partner discussion, there was also time provided for the community partner staff to meet as a group without BTCD staff presence. This allowed the community partner staff the opportunity to conduct frank discussions among themselves.

The issue of sustainability became very salient, as it was noted early in the meeting that the current contracts for the community partners would be ending with the fiscal year and that the current funding mechanism was no longer in place to renew any of them at this time. Although community partners had been informed in the past that the current funding cycle would end with the fiscal year, the discussion that arose at the January 16 meeting suggested it had not been clear to them that no other competitive application process would be in place. The following section summarizes the discussion, which incorporated this information, and the concept mapping findings, and proposes possible steps for moving forward.

Dialogue

This section summarizes the themes that emerged in the BTCD-community partner all-partner meeting on January 16, 2013. Because some of these were raised during the community partner staff discussions that did not include BTCD staff (mentioned above), BTCD did not have the opportunity to hear or address all of this input from community partners prior to this report. Therefore, their perspective is less well represented in this summary.

Reaction to Logic Model

Community partners felt that the logic model was a good, if somewhat generic, representation of how they saw their work in tobacco control and chronic disease management.

Community norms around tobacco are key. As reflected in its strong “importance” rating in the concept map, changing community norms was seen as the most pressing issue for community partners, and as their common challenge. Specifics of these norms vary depending on the group, but the common ground was seen to be the need for sustained work towards changing community norms around tobacco.

Examples that were given were that in south Yuma, Campesinos sin Fronteras struggles with a transient population. Consequently, they feel they need to work continuously on community awareness because they are constantly losing the “base” they work with as families move away and they need to “start from scratch” with those that move in. In contrast, on the Hopi reservation, the community is very stable but the challenge is around the traditional relationship that the community has with tobacco and its cultural relevance. They find they need to raise the awareness of the differences between commercial and traditional uses of tobacco.

Need to establish a system-wide model that places community partners within it. This is explored in the context of sustainability in the section labeled *Need for strategic direction*, below.

Sustainability

Funding ending at a time of “momentum.” Community-based partners indicated that a lot of effort and resources have been invested in some of their projects (especially around policy) over the last few years. Funding cuts would mean loss of momentum, even if funding is available in a few months. A number of partners expressed concern that when (or if) funds become available again, work might need to start from scratch. Although there was an understanding that funding was not guaranteed beyond the end of the funding cycle, there was a sense that explicitly discussing sustainability of efforts could, and should, have begun much longer ago. BTCD staff recognized this concern and discussed providing more communication, trainings, grant-writing workshops, and other opportunities to explore sustainability. BTCD also reiterated that the CDC have changed direction, to focus less on disparate populations per se and more on broader policy and systems change.

Limited current efforts could be continued without BTCD funds. Some community partners talked about efforts that have been put in place and could be sustained without funding: ASHline referrals; second-hand smoke interventions incorporated into other projects (e.g. home visitation funded by First Things First); tobacco use screening items that have been added to intake forms for other programs or initiatives; incorporation of tobacco control education into other chronic

disease management programs. However, the general consensus amongst the community partners was that the program as it is cannot be continued without BTCD funding; they did not see it as realistic to find other sources of funding to continue the work *as it is being currently done*. One point that was raised was whether programs *should* be continued as they are, or whether there is a way of working more efficiently to maximize impact with a shrinking budget.

Relevance and reach of community partners underappreciated. There was a sense among community partners that BTCD might lack an appreciation of the role they play in reaching out to disparate populations that county-based programs do not serve; or, at least, that the appreciation BTCD may have for their work does not translate into tangible resources allocated to their work in a more regular and consistent manner (i.e., from Prop 202) as it is the case with the counties. There was also a sense that the current structure of “power and decision making” does not necessarily represent the best interests of community-based organizations serving disparate populations. For instance, although it was recognized that the TRUST commission includes members from ethnic minority populations, it was stated that there was a sense that the community-level perspective was not fully represented there.

There is a strong awareness of the fact that grassroots organizations like the community partners serve a portion of the state’s population (ethnic or racial minorities) that has become or will become the majority in terms of absolute population numbers. There was discussion of the possible impact that organizing and combining forces to lobby for a more regular funding stream that allows for continuity of work could have (i.e. a creation of a coalition of organizations addressing health disparities/serving people of color). **As one partner noted “We need to collaborate. Otherwise, we’re competing against one another for the same funds.”**

There was a suggestion that BTCD work with community-based partners as a group. For instance, it was suggested that it may be more productive to bring the partners back together to work through the sustainability exercise as a group rather than just individually. It was recognized that BTCD offers to assist with more communication between partners through webinars or live meetings (noted above) could help facilitate this group identity.

Need for strategic direction. There was a sense that one substantial barrier to sustainability planning is a lack of strategic direction. Community partners would like to have a BTCD definition of what a successful community-based program looks like, how it fits in the big picture of tobacco control in the state, how it can align its programmatic work with the Bureau’s priorities and the work being done by other stakeholders like the voluntaries.

In the more immediate sense, they felt it was unclear which of the activities that they are currently engaged in (e.g., the various projects and planned events youth coalitions have) they should concentrate on between now and October 1st, since not all of them can be sustained without BTCD funding (and many of them are supposed to take place after Oct. 1st).

As one partner put it, there is “dysfunctional dialogue”: BTCD asks the community partners to do a sustainability exercise and indicate which activities they can/plan to continue without BTCD funding. Community partners would instead ask of BTCD: “Which ones should we work on? Which of these are most relevant to you and to the overall big picture of tobacco control in the state?” They felt that knowing the role of community partners in the overall tobacco control plan in the state would also allow them to better prepare themselves for knowing how to scale back or apply for other funding (whether BTCD or a different source).

Place in Policy Work

Community partners noted that policy and systems change was rated relatively low by both BTCD and by community partners, not because policy work is not important but rather because the larger “voluntary” organizations usually do policy work. However, there was discussion that it would be worth asking: How can small organizations affect policy? How do the statewide policy efforts support the work of small organizations at the local level, and vice versa? As one community partner expressed it “With a shrinking budget, how do we maximize our impact? That is, how can we be most efficient? Perhaps going back to the “public policy systems change” box may be our best bet.”

Moving Forward

One dominant theme that ran through the discussions at the all-partner meeting on January 16, 2013 was the desire for more communication and coordination of efforts, both with BTCD and among the community partners.

Three levels of coordination were identified, along with ways to promote it:

- a. **Facilitate interaction and collaboration among funded community-based partners.** A request was made that BTCD share the contact information of all participants present during the January meeting to allow them to more freely dialogue and collaborate with each other. BTCD could also provide opportunities to discuss what efforts towards sustainability could look like as a shared process, rather than with each agency individually, by reconvening an all-partner meeting to discuss the sustainability exercise. In addition, partners may wish to convene their own meeting to discuss the possibilities of organizing as a group for more political leverage.
- b. **Facilitate interaction and collaboration between community-based programs and county-based programs.** Although community-based program staff have had the option of participating in monthly telephone calls and annual meetings these opportunities appear to be insufficient to promote communication and collaboration between these two groups. Some participants shared examples of positive exchanges of information and resources with county counterparts, after a chance encounter. There was a sense that this coordination could be improved upon by more deliberate communication about activities and goals.
- c. **Link work of community-based partners and other stakeholders.** BTCD were seen as having a role in brokering relationships among a number of stakeholders so that priorities could be aligned. For instance, there was a lack of awareness about what policy priorities voluntaries are currently working on, and how they were going about that. Improved communication and coordination could strengthen those statewide efforts by supporting them more locally. A possible “summit” of tobacco control stakeholders was proposed.

In parallel with this desire for more communication and coordination was a reiteration of the need for an explicit strategic direction to guide these efforts. In this context, the idea of exploring a **collective impact model for tobacco control and chronic disease management** was raised again. Collective impact has been defined as “the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem...collective impact initiatives are distinctly different...(in that they) involve a centralized infrastructure, a dedicated staff, and a structured process that leads to a common agenda, shared measurement, continuous communication, and mutually reinforcing activities among all participants.”^{vi} Meeting participants noted that having group consensus across stakeholders about the state priorities would allow for more innovative and sustainable approaches to addressing them.

^{vi} Kania, j. & Kramer, M (2011). Collective Impact. *Stanford Social Innovation Review*, Winter 2011. Accessed at http://www.ssireview.org/articles/entry/collective_impact on 2-1-13

Regardless of whether a full collective impact model is adopted, it is clear that the evaluation framework developed here has to be explicitly linked to the larger strategic plan for statewide tobacco control and chronic disease management in order to develop meaningful evaluation measures for community based partners. The proposed “summit” of tobacco control and chronic disease management stakeholders may be one mechanism for developing or disseminating a more inclusive strategic direction.

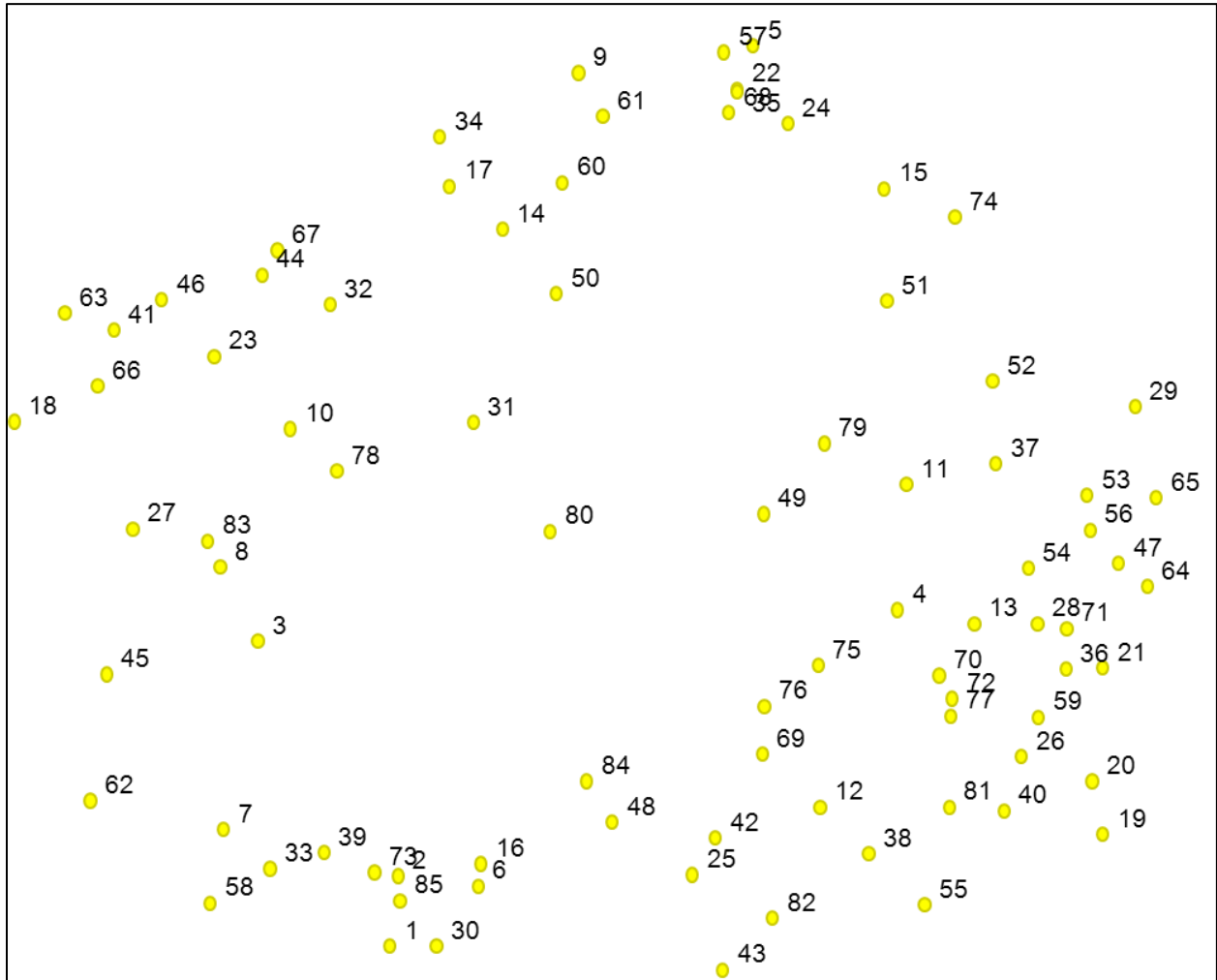
Appendix A. Brainstormed Statements

1. be inclusive of all sectors of the community
2. be community driven
3. address all health (tobacco use, chronic disease, etc.) in a coordinated fashion
4. have access to technical assistance on evaluation-related needs (e.g. survey development)
5. have smoking policies in place for parks and playgrounds to protect children and adults from secondhand smoke
6. address what community members want or need
7. address specific community issues
8. address health disparities
9. develop initiatives which would result in the reduction of chronic disease
10. disseminate information about tobacco cessation
11. follow best practices
12. be a program that people want to participate in
13. accomplish its stated goals
14. result in decreased tobacco use
15. translate policy and systems changes in terms which are easily understood by the public
16. use strategies that are responsive to the cultural norms of the local community
17. promote workplace-based cessation activities
18. focus on health equity and health disparities
19. allow for creativity and innovation in meeting the needs identified by outside funders
20. have staff with the appropriate expertise
21. develop initiatives which are sustainable and replicable
22. support enforcement of laws and policies on tobacco sales
23. decrease healthcare costs
24. put some businesses (such as smoke shops) out of business
25. be trusted by community members
26. know how to market itself
27. make the latest science on tobacco use available to the community
28. have its stakeholders involved in evaluation activities
29. advance best practices
30. involve the entire community

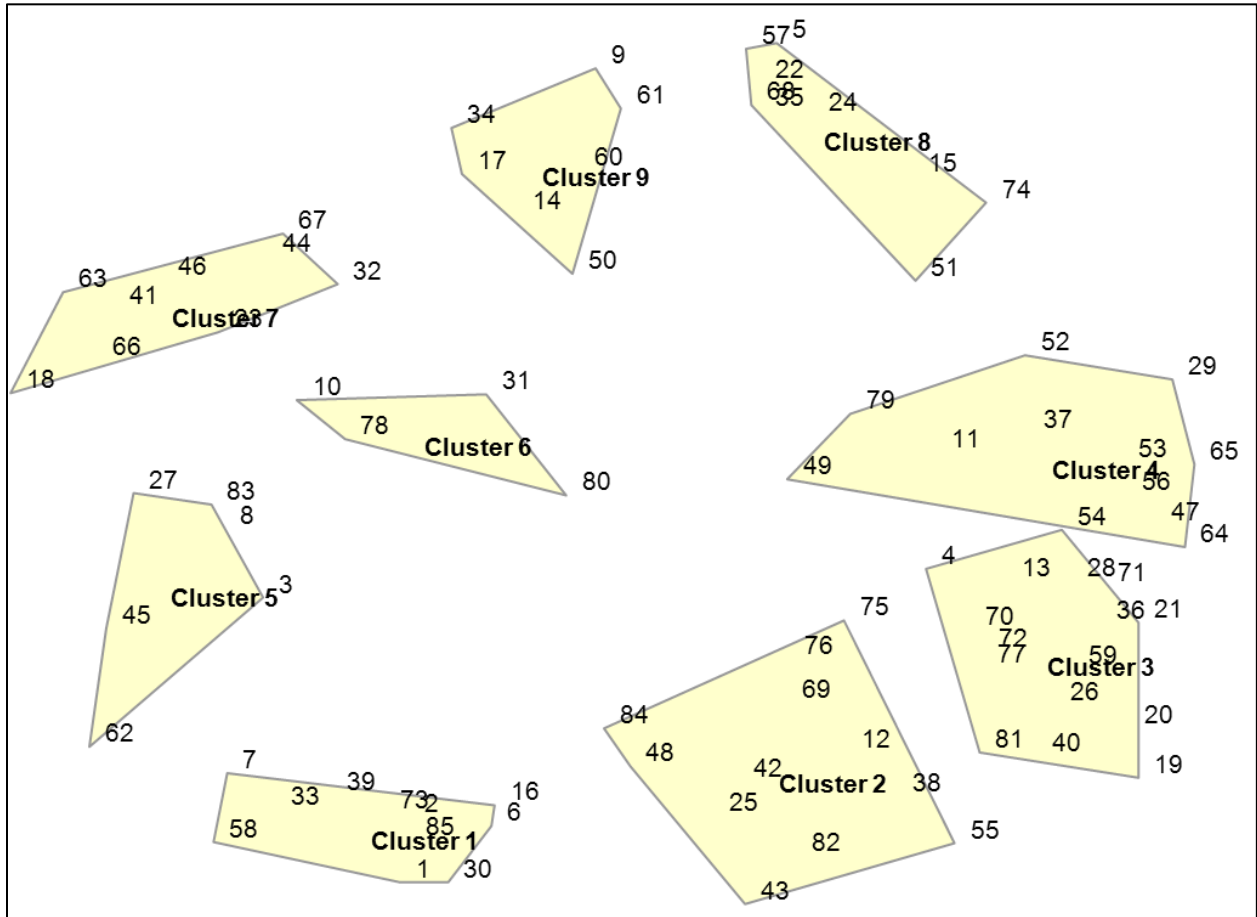
31. allow for activities related to that desired behavior change to be visible (e.g., you would see people exercising)
32. work from the latest science on the harm and consequences of tobacco use
33. use strategies that are responsive to the nuances of the local community
34. increase community support for smoke-free policies
35. increase compliance with existing tobacco laws and regulations
36. have smooth transitions whenever there is staff turnover
37. have policies and practices to ensure sustainability
38. could easily adapt itself to new cultures and communities
39. meet the needs of the community
40. share and collaborate
41. use a wellness or "whole health" approach to reduce tobacco use
42. be culturally accessible
43. involve key stakeholders (e.g., faith-based, community organizations, neighborhood associations, schools, sports teams, businesses)
44. address the reduction of tobacco use
45. develop youth to be future leaders
46. result in a decrease in chronic disease
47. be reliable because it follows evidence-based practices
48. allow for creativity and innovation in meeting the needs of the community
49. have a large reach by having a profound effect on a small number of people
50. help increase use of cessation services
51. result in physical changes
52. use evaluation results to inform decision-making
53. celebrate its successes
54. allow for success to be measurable
55. partner with other agencies and support groups
56. be evaluated frequently
57. have designated smoking areas away from playgrounds and parks
58. be informed by the needs and perspectives of local residents
59. be self-sustaining
60. increase community awareness of policies that support cessation
61. help decrease minors' access to commercial tobacco

62. involve a large number of people in the program
63. use a wellness or "whole health" approach to reduce chronic disease
64. have access to evidence-based trainings
65. be a model for other programs
66. address social determinants of health
67. reduce tobacco-related diseases and deaths
68. help increase compliance with smoke-free laws and policies
69. not assume that, as the provider, it knows best
70. recruit people into the program by celebrating its successes
71. produce tangible plans that can be followed
72. have well-established mission, vision, and goals
73. use language that matches how the local populations communicate
74. be broad-based, involving policy, systems, and environment
75. use media appropriate for the local populations
76. have a large reach by affecting a large number of people
77. have instructions for how to accomplish its goals
78. disseminate information about second-hand smoke
79. produce tangible products
80. increase the evidence base
81. have the necessary resources for conducting its activities
82. be a trusted messenger
83. disseminate health and wellness messages to the community
84. be a model for other communities
85. have leadership that reflects segments of the community it serves

Appendix B: Point Map



Appendix C: Cluster Map



Appendix D. Statements Sorted by Cluster

Cluster	Statement
1. Cluster 1	
	1. be inclusive of all sectors of the community
	2. be community driven
	6. address what community members want or need
	7. address specific community issues
	16. use strategies that are responsive to the cultural norms of the local community
	30. involve the entire community
	33. use strategies that are responsive to the nuances of the local community
	39. meet the needs of the community
	58. be informed by the needs and perspectives of local residents
	73. use language that matches how the local populations communicate
	85. have leadership that reflects segments of the community it serves
2. Cluster 2	
	12. be a program that people want to participate in
	25. be trusted by community members
	38. could easily adapt itself to new cultures and communities
	42. be culturally accessible
	43. Involve key stakeholders (e.g. faith-based, community organizations, neighborhood associations, schools, sports teams, businesses)
	48. allow for creativity and innovation in meeting the needs of the community
	55. partner with other agencies and support groups
	69. not assume that, as the provider, it knows best
	75. use media appropriate for the local populations
	76. have a large reach by affecting a large number of people
	82. be a trusted messenger
	84. be a model for other communities
3. Cluster 3	
	4. have access to technical assistance on evaluation-related needs (e.g. survey development)
	13. accomplish its stated goals
	19. allow for creativity and innovation in meeting the needs identified by outside funders
	20. have staff with the appropriate expertise
	21. develop initiatives which are sustainable and replicable
	26. know how to market itself
	28. have its stakeholders involved in evaluation activities
	36. have smooth transitions whenever there is staff turnover
	40. share and collaborate
	54. allow for success to be measurable
	59. be self-sustaining
	70. recruit people into the program by celebrating its successes
	71. produce tangible plans that can be followed
	72. have well-established mission, vision, and goals
	77. have instructions for how to accomplish its goals
	81. have the necessary resources for conducting its activities
4. Cluster 4	
	11. follow best practices
	29. advance best practices
	37. have policies and practices to ensure sustainability
	47. be reliable because it follows evidence-based practices
	49. have a large reach by having a profound effect on a small number of people
	52. use evaluation results to inform decision-making
	53. celebrate its successes

- 56. be evaluated frequently
- 64. have access to evidence-based trainings
- 65. be a model for other programs
- 79. produce tangible products

5. Cluster 5

- 3. address all health (tobacco use, chronic disease, etc.) in a coordinated fashion
- 8. address health disparities
- 27. make the latest science on tobacco use available to the community
- 45. develop youth to be future leaders
- 62. involve a large number of people in the program
- 83. disseminate health and wellness messages to the community

6. Cluster 6

- 10. disseminate information about tobacco cessation
- 31. allow for activities related to that desired behavior change to be visible (e.g. you would see people exercising)
- 78. disseminate information about second-hand smoke
- 80. increase the evidence base

7. Cluster 7

- 18. focus on health equity and health disparities
- 23. decrease healthcare costs
- 32. work from the latest science on the harm and consequences of tobacco use
- 41. use a wellness or "whole health" approach to reduce tobacco use
- 44. address the reduction of tobacco use
- 46. result in a decrease in chronic disease
- 63. use a wellness or "whole health" approach to reduce chronic disease
- 66. address social determinants of health
- 67. reduce tobacco-related diseases and deaths

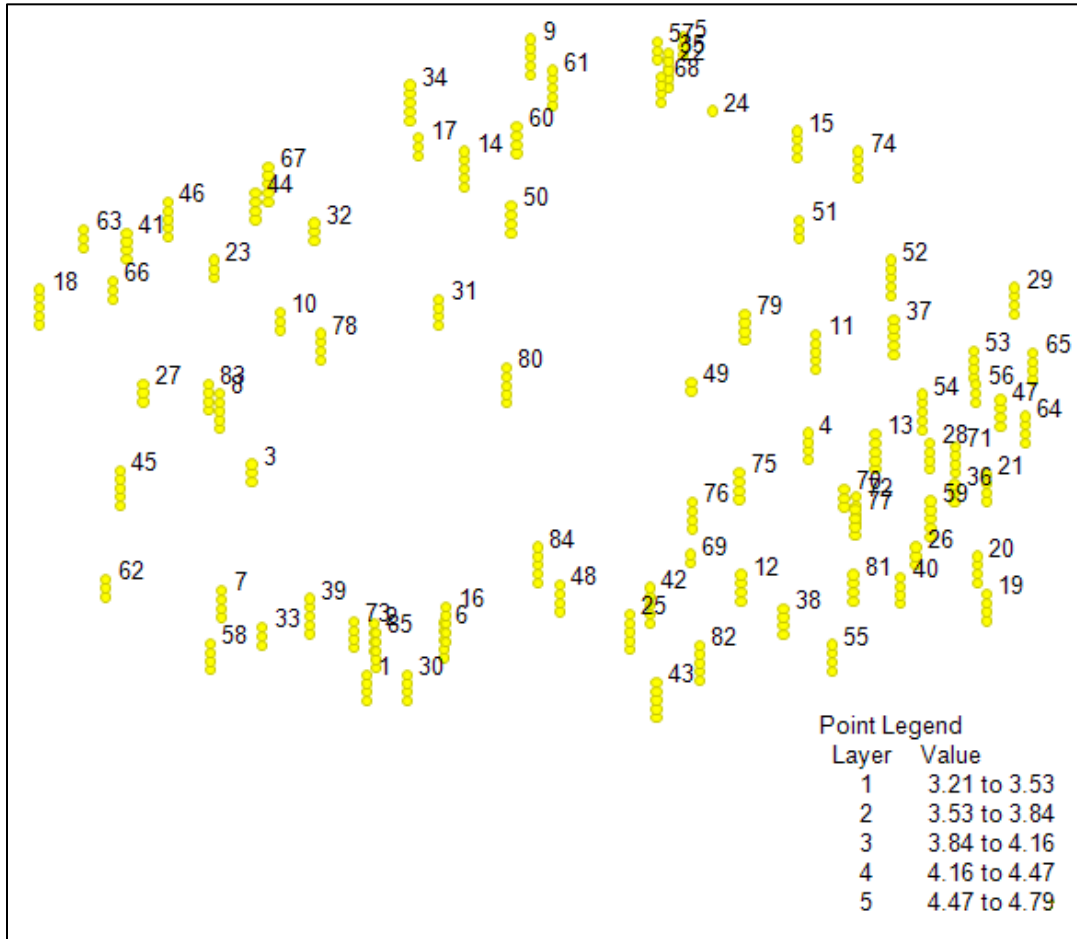
8. Cluster 8

- 5. have smoking policies in place for parks and playgrounds to protect children and adults from secondhand smoke
- 15. translate policy and systems changes in terms which are easily understood by the public
- 22. support enforcement of laws and policies on tobacco sales
- 24. put some businesses (such as smoke shops) out of business
- 35. increase compliance with existing tobacco laws and regulations
- 51. result in physical changes
- 57. have designated smoking areas away from playgrounds and parks
- 68. help increase compliance with smoke-free laws and policies
- 74. be broad-based, involving policy, systems, and environment

9. Cluster 9

- 9. develop initiatives which would result in the reduction of chronic disease
- 14. result in decreased tobacco use
- 17. promote workplace-based cessation activities
- 34. increase community support for smoke-free policies
- 50. help increase use of cessation services
- 60. increase community awareness of policies that support cessation
- 61. help decrease minors' access to commercial tobacco

Appendix E. Point Rating Map (Importance)



Appendix F. Cluster Rating Map (Importance)

