

-- DRAFT --

Injury Prevention Program Planning Guide

A primer for making plans, drafting proposals, and demonstrating success

Center for Injury Prevention Policy & Practice
San Diego State University
College of Health and Human Services
Graduate School of Public Health
6475 Alvarado Road, Suite 105
San Diego, CA 92120

(619) 594-3691

Website: <http://www.cipp.org>

Table of Contents

1. Introduction.....	3
2. Phase I: Needs Assessment.....	4
3. Phase II: Determining Intervention Strategies..	7
4. Phase III: Action Plan.....	10
5. Phase IV: Implementation.....	13
6. Phase V: Evaluation.....	14
7. References.....	17

Injury Prevention Program Planning Guide

Introduction

This Guide is designed to provide a systematic approach to planning and implementing childhood injury prevention programs that are both priority- and value-driven. Five phases are described to help move the practitioner through this process.

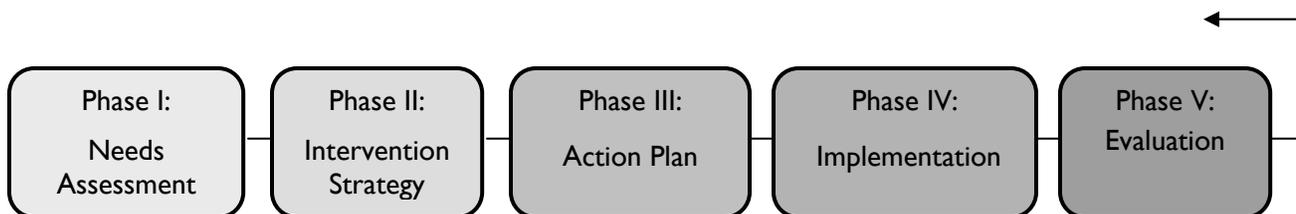
Phase I: Conducting a Needs Assessment - A needs assessment can be done on a small or large scale using a systematic set of procedures for setting priorities and making decisions about a program. A needs assessment will include a review of demographic data, and often some new information, gained through surveys of the population or other relevant sources.

Phase II: Determining Intervention Strategies- It is always necessary to determine: 1) the injury problem that 1) is significant and solvable with your limited resources and 2) has interventions that are proven to be appropriate for your chosen population.

Phase III: Developing the Action Plan- The Action Plan maps out how you are going to do what you want to do. It is based upon your choice of target injury, target population and intervention strategies. An Action Plan is designed to reach program goals and objectives. It specifies the implementation of key activities and guides the use of resources within a specified timeframe.

Phase IV: Implementing the Plan- This phase involves the commitment community agencies and implementation of program activities.

Phase V: Evaluating Progress and Success- The ongoing monitoring of program progress and assessment of the results of the program activities and objectives.



Each of these steps will be discussed in the following chapters.

Phase I: Needs Assessment

The needs assessment is a vital tool and is the first step in the development of any good program plan. It involves reviewing many kinds of information about a target group or community. One benefit of a needs assessment is its ability to define local needs, so that programs are not started inappropriately. The steps associated with this phase involve gathering local data, creating a community profile, and, in the process, fostering community ownership of the injury problem. While certain kinds of injuries are endemic, each local region will have its own unique epidemiology of injury.

Injury data can provide the information needed to make informed decisions regarding which injuries, populations and geographic locations should be prioritized for intervention efforts. Injury data also help identify possible intervention points, select appropriate prevention strategies, garner support for the injury prevention strategy chosen and monitor, track and evaluate injury prevention efforts.

- I. Begin your data search by focusing on the answers that identify the major injury problems and their significance in your county. You probably will need to utilize multiple sources, since not all of the data are computerized or centralized.

Examples:

- Hospital and Emergency Department Records
 - Health Department Vital Records
 - EMS Run Reports
 - Household Surveys
 - Traffic Records (SWITRS)
 - Case Management Records
 - Health Educator Reports
 - Child Death Review Team
 - Poison Control System Reports
- Please see <http://www.cipp.org/pubs/datasource.htm> for an online resource of California- specific injury data sources.
 - II. Convene a data workgroup to facilitate access to the data. This workgroup could consist of data owners and users such as physicians, nurses, hospital administrators, EMS providers, public health experts, insurance company representatives and others.
 - III. Determine the patterns of injury in your target population. The types of information you will need to determine the extent of your injury problem include: age, nature of injury, external cause of injury, and intent (unintentional vs. intentional). You may also want to collect information on race, gender, geographic location, cost, and key risk or protective factors such as alcohol or drug use at the time of injury or the use of safety equipment (i.e., bicycle helmets, car safety seats, seat belts, smoke detectors, etc.).

During the needs assessment phase, the intent is to gain an understanding of the magnitude of the injury problem within the community (or the area of the community) that you plan to serve. It is also important to understand the distribution of different types of injuries among your target population (i.e. a basic picture of who, where, when and how people are being injured). This information is needed to make the "first pass" in terms of which injuries, population and geographic area should be the focus of prevention efforts. The data used to accomplish this step will come from existing population-based sources. Data will usually be relatively easy to obtain but may cover a population that more broad than is ideal.

First, examine your data separated into developmental age groups. Frequently 5-year age categories are used for health and other data systems. However, EPIC's Epicenter provides standard fatal and nonfatal data tables for California and each county by developmental age and leading causes of injury. You can also create custom tables using EPIC's fatal, nonfatal, or linked homicide data sets:

<http://www.applications.dhs.ca.gov/epicdata/default.htm>. The results should guide you with your first selection of priority injuries and populations.

IV. In addition to the frequency and rate of injury data (see III above), you will need answers to the following questions when determining your focus:

- Does the injury result in severe disability or death among one or more age / population groups?
- Does the injury contribute a large proportion of the trauma hospitalizations?
- Does the injury result in high health care or societal costs?

These questions are important because you want to be sure you are spending your scarce resources to prevent a problem that has a major impact on the health and well-being of the target population. If the death rate for a particular injury is high, you know it is something you need to consider. Likewise, if the injury results in high medical or societal costs, you need to consider addressing the problem. Thus, you should think in terms of the direct impact upon the health and well being of your jurisdiction's population, but also how preventing injuries or lessening their severity could save money and resources that can be used to address other health issues.

V. Is there an effective intervention strategy? Is the injury amenable to prevention? Choosing an injury for which there is a proven intervention strategy will improve your chances of developing and implementing a successful intervention program. The intervention should be cost-effective and appropriate for the developmental age and demographic you are considering. The success of your initial effort will help you to gather the resources and political commitment you will need to expand your injury prevention efforts and address injuries that are more challenging to prevent. The Harborview Injury Prevention and Resource Center has developed an online resource of Best Practices and Intervention Strategies for different injury types and causes.¹ This

resource is frequently updated as new research is published. The resource is available at: <http://depts.washington.edu/hiprc/practices/index.html>.

- VI. Is there a community/agency desire to prevent the injury? In other words, is the political atmosphere right? A period of budget cuts and deregulation may not favor the introduction of new programs or legislation. Many injury prevention workers express the need to link opportunistic planning and strategic planning. There are times that it may be better to intervene after an event that causes many injuries and receives heavy media coverage, or when a law is passed and is to be enforced.
- VII. What are others doing to address this issue? Are there existing programs in your agency or another local agency to address the issue? If so, not only may a variety of materials already exist, but this provides a natural opportunity to work with other agencies. Consider calling the program directors or managers of any programs that have impressed you. Talk with them directly regarding the costs and benefits of their programs and how you can offer support. Ask for copies of some of their program materials. Ask them for evaluation reports to determine how well the program actually works.
- VIII. Are you able to obtain support from the community? A crucial factor in injury selection is stakeholder buy-in. You may identify a common, serious injury that is amenable to intervention and that your staff are willing to address, but if community members do not think that particular type of injury is important, you may have little or no success. It is helpful to convene a group of community members to determine what *their* priorities are and to gauge their opinion of your plans.

Once preliminary priorities are chosen, you are ready for the local surveillance phase. The intent here is to gain an understanding of the scenarios under which the priority injuries occur in your county. What is needed for this phase is a more detailed understanding of the who, what, where, when, as well as the how, and why the priority injuries occur. It is this type of circumstances data that has guided the injury field's most stunning successes, i.e., collapsible steering columns and head rests in cars, flame retardant sleepwear, break-away baseball bases and softer core baseballs and the multiple local successes in redesigning roadways and lighting to prevent traffic-related injuries, promoting home smoke alarms, etc.

Unfortunately, this type of cause and circumstances data is usually absent from large population-based databases. Local data sources need to be used. For example, information from child death review teams or EMS ambulance run-reports (EMS folks are usually the first to arrive at the scene of an incident so they can tell you for example in a motor vehicle situation whether alcohol was involved, whether safety restraints were in place etc). Data for your project may be available from injury-specific registries (such as those for burns, poisonings, and traumatic brain injuries), local police or fire department reports, or other sources of local data.

You may find information in journal articles or agency reports that can provide some of what you need.

It may be necessary to collect local data via surveys or case investigations to obtain the level of detail needed to design an effective intervention. This level of detail will not be collected on all injuries across all ages, but only on the selected priority injury and population within the focus areas. This allows an in-depth look at the problem and helps in gathering circumstantial information needed for program design without the local surveillance effort becoming prohibitively costly or time consuming.

Phase II: Determining Intervention Strategies

The term "intervention" refers to an activity or device employed with the goal of reducing or preventing injuries. When choosing an intervention strategy, it is extremely important to make sure the data you have collected supports the intervention(s) you are considering. Is the intervention feasible? Is it appropriate for your population? Does your coalition or community have sufficient support for the intervention to sustain it?

The Harborview Injury Prevention and Research Center's online publication *A Community Guide to Injury Prevention*² provides tips for identifying the right intervention strategies for your program. It is almost always best to choose an intervention that has already been designed and evaluated for effectiveness and efficacy within a population quite similar to your own. Your role will involve shaping and tailoring this strategy to fit your community's resources and needs. You may decide that you want to narrow the focus of the target audience. For example, an existing proven strategy may be designed for the general population but you want to really focus on adolescents. This tailoring will help to make an intervention strategy work best for your program and help to provide a sense of ownership for all involved. However, be careful. An intervention with demonstrated success in one population may not be appropriate in others.

When determining your intervention strategy, it is vital to:

1. Consider who will implement the intervention.

The selection of the intervention should depend on who in the community will be doing it. *Example:* Given the goal of improving pedestrian safety, schools are likely to choose educational techniques such as a pedestrian safety curriculum. On the other hand, city engineers might install a walking signal and crosswalk (technology) to improve a dangerous street crossing, whereas police may choose to strictly enforce speed limits in school zones (policy). Perhaps, several simultaneous approaches should be considered.

2. Target your message.

Tailor your interventions to the specific population and need.

Example. Adolescents might respond better to a fast paced video than a brochure. Make sure your message is culturally sensitive, is in the right language for your population, and pitched at the right reading level for the community you wish to engage.³

3. Make the intervention acceptable to the target population.

Be sure that you are promoting something reasonable and practical for your target audience. For example, if you want to reduce motor vehicle occupant injuries, you may consider encouraging drivers and passengers to wear helmets while in their cars. While race-car driver data demonstrate that wearing helmets will reduce injury severity, it is not very practical to think that the public would be amenable to this idea.

There are three different types of intervention strategies you can use to develop your injury prevention program².

I. Educational Strategies

Many programs rely heavily on education as a technique. The most effective educational efforts couple personal interaction with printed educational materials and a media campaign. The more ways and places a person sees and hears the injury prevention message, the more likely it will produce an effect.

- **Printed Materials:** Printed materials such as posters, brochures, flyers, or guides may help in educating about injury causes and prevention strategies.
- **Media:** Public information through the media can act as an effective complement to your other program strategies and allows you to get your message out to many people. Comments within news stories on how a tragedy could have been prevented have been shown to be effective at changing behavior.
- **Personal Interaction:** Personal interaction is the most effective educational tool and must be used in addition to printed materials and media messages. Assembly programs in schools, presentations at meetings, and counseling by health care providers are ways to relay a personal message to many people. Assembly-based programs, however, are rarely effective and are often demonstrated to be harmful.

Keep in mind that educational strategies are seldom successful unless combined with other program components.

2. Legislative strategies

Regulatory law-making can occur at the state, county, or local level. Policies and rules can be developed and implemented for groups and private entities (such as homeowners' associations or private schools). These laws and regulations can be very effective once enacted and enforced. However, extensive planning and long-term effort is usually required to influence the legislative process. The following specific tools can be helpful:

- I. **Information for legislators.** An informational packet designed for legislators that clearly and concisely present the facts, costs, all sides of the injury issue, and the legislation being proposed as an intervention is necessary. Ideas about how this legislation could be enforced should be included. This should be summarized on one side of one page -- this is probably the only part that the legislator will read. The packet should include a

somewhat more detailed presentation for the legislator's staff member. Even this should be concise and visually appealing. Limit this to four printed pages.

2. Convincing data. Injuries are expensive. Often the economic argument is more persuasive than death statistics. *Example:* At a major trauma center in the state of Washington, 63% of the cost of treatment for motorcycle injuries is paid for by public funds. This was an influential fact in the passage of the 1989 legislation requiring motorcycle helmets.
3. Legislator as educator. One or more legislators who will sponsor the bill can work to influence other legislators.
4. Lobbyist as educator. Close contact with a legislative staff person and the services of an organizational lobbyist such as that of a state or county medical association can be invaluable.
5. Grass roots involvement. Legislators need to hear that their constituents want the bill to pass or fail. Every person on a coalition must contact their own stakeholders to explain the legislation and encourage letters and telephone calls to legislators. This is a final step but must be done quickly and efficiently as the bill comes before the decision-making body.

3. Technological strategies

There are two vital steps to implementing technological strategies. One step is to develop and produce the technological method and the second is to market it. Development and production of the technological device certainly may be beyond the capabilities of your community's or coalition's abilities. However, a community-based program can be extremely effective in distribution of the item and promotion of its use once it has been developed. *Example:* Life jackets are comfortable to wear, relatively inexpensive, and mandatory in some situations. The boating public needs to know that and be educated about the importance of buying and using life jackets. Creating a demand can also result in lowering the cost -- an additional benefit to the public.

Incorporating a coupon discount plan into your prevention program may increase the program's success. You can work with a manufacturer or distributor to negotiate a discount. The coalition may also want to raise funds to buy the prevention item, such as bike helmets or smoke detectors. A bulk purchase can make the item less expensive. You can help create personal acceptance by selling the item to the public for a nominal charge and, at the same time, you can support some of the costs of the program.

When you have identified the strategies to help prevent your target injury and have decided upon the interventions and techniques to accomplish these strategies, you are ready to proceed to the next step of your program -- developing an Action plan.

Phase III: Action Plan

Having a clearly defined injury prevention goal will make planning and evaluating your program much easier. While developing objectives and activities to meet your goal, you should be continually asking how you will measure these and how you will show that you've changed something. The Action Plan maps out how you are going to do what you want to do. It is based upon your choice of target injury, target population and intervention strategies.

Developing an Action Plan

An Action Plan is your roadmap for reach program goals. It specifies the implementation of key activities and guides the use of resources within a specified timeframe.

1. **What is your goal?** There is no single definition for a goal. Some funding entities (such as the California Office of Traffic Safety) prefer *measurable* goals. A measurable goal specifies exactly what you plan to do, for whom and in what time period. The more focused and specific the goal, the more guidance it will provide for your program implementation and evaluation measurement²

EXAMPLE OF MEASURABLE GOAL: "Reduce childhood death and hospitalization due to head injury by increasing the wearing of bicycle helmets 30% among children 5 - 12 years in Sonoma County over the next five years."

Another and more standard definition for the public health field is more general in nature. In this case, a goal is an expectation that is written to include all aspects or components of a program, provides overall direction for a program, does not have a deadline, and is often not measurable in exact terms.

EXAMPLE OF GENERAL GOAL: "To reduce childhood death and hospitalization due to head injury in Sonoma County."

2. **Write Objectives.** Once you have determined your goal(s), the accompanying objectives should be more precise, representing smaller steps, which, when achieved, will lead to achieving the program goal. Objectives specify intermediate accomplishments or benchmarks that represent progress toward the goal. Objectives outline, in measurable terms, the specific changes that will occur in the priority population at a given point in time as a result of exposure to the program. These objectives should be written in a way that allows you to monitor the progress of your project and make frequent checks to determine if your intervention is on-track or if problems are developing. Useful, measurable objectives are essential for a successful program. Thus, great care should be taken when selecting them. There are several ways to help you to develop useful objectives. One of these is the SMART process.

A well-written and clearly defined objective is a SMART objective, which is:

- **S**pecific
- **M**easurable
- **A**chievable
- **R**ealistic
- **T**ime-Phased

The two major kinds of objectives associated with program planning include:

- **Process Objectives** – describe the daily tasks, activities and work plans that lead to the desired outcomes. These objectives are generally measured by record-keeping, counting, and/or materials tracking.

Example: By January 1, 2010, conduct at least 20 seminars for parents about the risks and benefits of bicycle-riding, the protective nature of helmets, and ways to encourage children to wear helmets when not directly supervised.

- **Outcome Objectives** – describe the tangible results that will occur due to the program. Common outcome measures include knowledge gain, attitude change, skill development, behavior change, and change in injury/disease/death rates.

Example: By November 1, 2011, the prevalence of bicycle helmet use among children 5 to 12 years of age in Sonoma County will increase by from the current nn% to nn% when measured at (named) parks, (named) schools, and (named) neighborhoods.

Note that this objective is not based on a health outcome measurement. It is almost always unwise to use health outcome metrics to assess program progress and eventual success. You should use intermediate outcome measures, called *proxy measures*, instead so that you measure what you can control.

- Although your program is likely to focus upon specific sub-populations, health outcome data are typically reported for the entire county. Thus, although you may have successfully delivered your intervention, your success will be underestimated if county-wide data are used.
- It typically requires at least two years for health statistics to be published. A two-year delay in your ability to evaluate your success is probably unacceptable.
- Injuries are rare events. Unless your target population is very large, you can expect to prevent, at most, a few deaths each year. These small numbers make it difficult to demonstrate statistical significance.
- Something completely beyond your control may have an affect upon the health outcome of your program population. For example: two or more bike riders are struck in a single unsurvivable event (such as by a car fleeing from the police); road construction-related changes in traffic patterns cause bike lanes that were once safe to become hazardous; etc.

- The outcome of any patient is strongly affected by EMS availability, emergency department crowding, and delays before surgery. The health outcome of a child injured on a busy day may be more related to the health care system than any other factor.
 - By selecting interventions that are known to successfully affect the health outcome of your goal, you may feel assured that your goal is being achieved when you demonstrate that your program objectives have been reached.
3. **Develop Actions.** Use your objective statements to guide you in the selection of activities. In other words, each objective needs specific actions to accomplish it. Developing actions will formalize each of your team members' commitment to specific activities and how they will contribute. Members of your team should select activities they are accustomed to doing and have the necessary resources and skills to accomplish.

Examples of the above objectives with specific actions:

- **Objective:** Educate parents and caregivers (see above).
 - **Action:** Hold meetings and distribute educational flyers to parents on the effectiveness of bicycle helmets during Open House at the beginning of the school year. Follow-up with a phone call to check whether child is wearing a helmet and if parents have any questions.
 - **Action:** Educate parents during pediatrician visits on how bicycle helmets can reduce serious injuries to their children. Have physicians/nurses emphasize that parents who wear helmets serve as good role models for children.
 - **Objective:** Improve the prevalence of helmet wearing (see above).
 - **Action:** Host a bike rodeo and distribute bicycle helmet rebate coupons.
 - **Action:** Conduct a bicycle helmet give-away-day. Fit and distribute 1000 helmets.
 - **Action:** Educate public attending health fair at a local hospital regarding the importance of wearing a bicycle helmet.
 - **Action:** Have a newspaper publish an article announcing your bicycle helmet day. Include educational material in the newspaper article.
 - **Action:** Organize activities designed to make helmet-wearing more acceptable to children.
 - **Action:** Work with local police agencies so that they will enforce helmet laws.
4. **Make a Timeline.** A timeline is an excellent organizing tool for both the overall project and for community activities. It is a good idea to put your time line in written form so that the project staff and community agencies can see where their commitment to an activity falls in the grand scheme and when they must perform it. This also helps ensure that the task gets done on time. Activities are often keyed to community events and a timeline ensures forethought necessary so that these opportunities are not missed.

Example: For your bicycle helmet promotion program, the annual hospital health fair in October will distribute educational packets, prescriptions for helmets by pediatricians, discount coupons for bicycle helmets, and free helmets for the first 200 visitors. The timeline should include steps for obtaining suitable educational materials, coupons, and helmets.

Evaluation (discussed in Phase V) should be closely linked with your objectives. It is important to consider how you are going to measure your objectives when you are developing them. Thus, your evaluation plan provides direction during the development of the action plan. The aim is to tie the activities in the action plan to the objectives which will ultimately lead to progress in reaching the desired outcomes.

Phase IV: Implementation

With the above tools for program implementation, your community or coalition members can go forward to activate the injury prevention plan. You will want to make sure that your members are knowledgeable about and ready for the upcoming activities. Educate your group and spread the word regarding the program to all those it will affect. You and your agency cannot successfully implement an entire injury prevention program without outside help. A coalition of community agencies can achieve more because of the opportunity it provides to pool resources and draw from the skills of many people.

Three elements are essential for an effective coalition².

The **lead agency** takes responsibility and leadership for the injury prevention program. Within the lead agency there should be a designated coordinator. This is preferably a paid position.

The **coordinator** is responsible for planning the goal and objectives for the project and ensuring that they are accomplished. The coordinator may draw upon his/her lead agency or a consultant for assistance, direction and advice. The coordinator plans and leads meetings, serves as a communications hub for the coalition members, motivates the members to perform activities and moves the project along toward completion.

Enthusiastic and committed members are vital to the project. They are the individuals who will disseminate information and conduct activities. As the lead agency, you will already have developed the program objectives and framework. Describe the program objectives and framework for the members, and then discuss the activities -- what they will actually do to make the program a success. Get input from the team. This will help to assure their agreement and buy-in to the value of the program and their contribution.

Before rolling out the program in full, it is a good idea to conduct one or more pilot tests. You will want to make sure that the materials or strategies you have chosen to target your priority injury are sending the right message and that the intervention is easy to implement.

Example: Our example goal is to reduce childhood death and hospitalization due to head injury by increasing the wearing of bicycle helmets among school-age children. One objective to accomplish this goal is to educate parents that their children can be seriously injured from bicycle crashes. Pilot test the educational flyer to be distributed to parents. Distribute flyers to the parents of students attending summer day camp. Observe if there is a change in the number of students wearing helmets by the end of the camp. Convene a small group and seek their input.

After the pilot test, your coalition can come together and discuss what worked and did not work. Then, adjust your program plan accordingly. You may need to repeat the pilot test until you get the program right.

Phase V: Evaluation

Why is it important to evaluate? There are important practical and ethical reasons to conduct an evaluation. Funders increasingly require programs to conduct evaluations. Policy makers want to see improvement and want accountability if they are to allocate funds to a project. As Program Managers, you need to evaluate so that you can make informed decisions about whether you are on the right track, to effectively manage your budget funds and to assess whether or not your program is making a difference. You must make sure that your program isn't causing harm.

There are two parts to program evaluation: outcome evaluation and process evaluation.

I. Outcome Evaluation: Is what you are doing making a difference?

Outcome evaluation of your program objectives can answer the questions:

- What did the program set out to do? (e.g. reduce death and hospitalization due to head injury by increasing the wearing of bicycle helmets 30%)
- Who was the target population? (Children in Sonoma County ages 5-12)
- What was the outcome of the program?
- Did the program have an impact?
- Did the program reduce deaths and hospitalizations in this population?

Going back to the example in Phase III, the GOAL is “To reduce childhood death and hospitalization due to head injury in Sonoma County.”

For this program goal, Sonoma County would want to see a reduction in the number of children ages 5-12 who are admitted to a hospital or are fatally injured as a result of not wearing a bicycle helmet. The County would have to wait several years for enough death certificate and hospital discharge data to measure this ultimate outcome. In lieu of waiting for this type of data, proxy measures can be used to demonstrate program effectiveness.

Using your program objectives, set up proxy measures for accomplishment of the goal – the assumption is that if the objectives are successfully accomplished, then the ultimate goal will be accomplished. Again, using the first example objectives from Phase III,

- Educate parents that their children can be seriously injured from bicycle crashes.

Proxy measurement: After conducting your school-based interventions:

1. Observe and count how many children are wearing helmets while riding to school **before** the school-based interventions
2. Compare to how many are wearing them **during** the intervention.
3. Compare to how many are wearing them immediately **after** the intervention.
4. If a steady increase in the number of children wearing helmets to school is not observed, then revisions to your work plan may need to be made.
5. Compare how many children are wearing helmets to school by the end of the school year.

As you can see from this example, you may evaluate as you go, or at certain set time intervals depending on the frequency of the intervention. This type of outcome evaluation of program objectives using proxy measures will help you determine whether each objective worked (create a change) towards accomplishing your program goal.

II. Process Evaluation: Are you doing what you said you would do?

Outcome evaluation shows whether the program worked. Process evaluation reflects how it was done.

Process evaluations answer the questions:

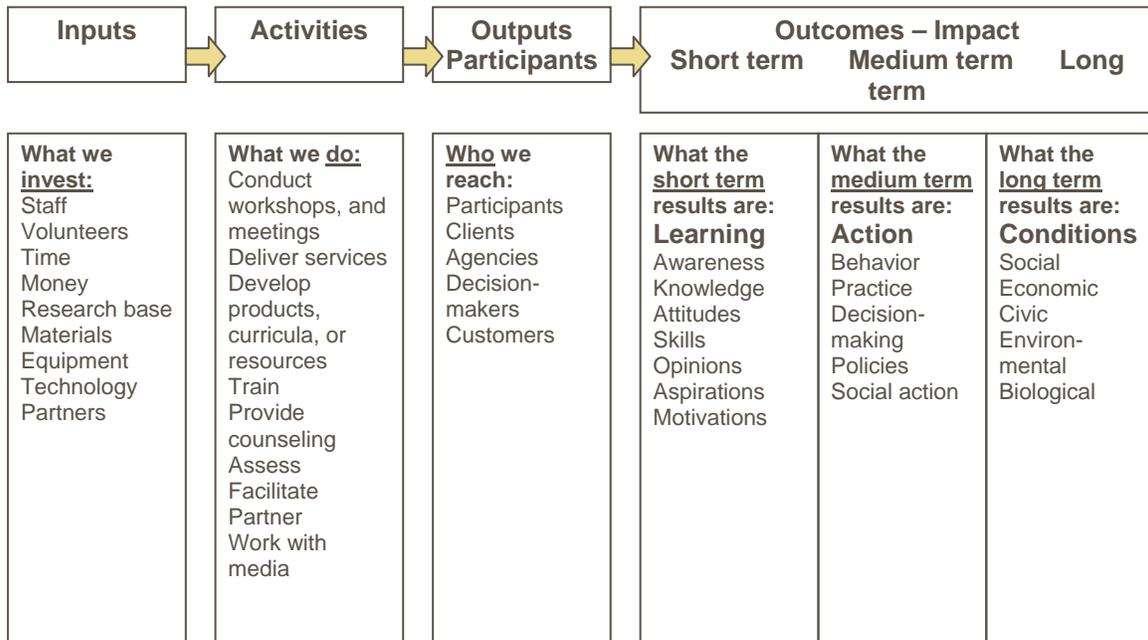
- Was the program implemented as planned?
- Who was being reached by the program?
- To what extent were they reached?
- What problems were encountered and how were they addressed?

Every method or activity to accomplish the objectives should be quantifiable and counted. This is where reports on activities from coalition members become vital. By going through this process, weak spots of implementation can be found and improved and unwanted surprises at the end of the program can be prevented. Program staff, coalition members and community volunteers can all be helpful in tracking information for monitoring each implementation activity.

Example: Track the number of educational flyers distributed at school open house, track the number of parents contacted with a follow-up phone call, monitor follow-up calls to those parent's that were not reached the first time by phone.

The following logic model is a visual representation of the relationship between what you have (resources), what you do with it (interventions), and what happens as a result (outcomes)⁵. You can use a similar model to outline how your injury prevention program works.

Generic Logic Model



Conclusion

The preceding five phases outline an approach that can help you create a successful design for your injury prevention program and ensure the best use of your resources. These steps are broad enough to be applied to any injury topic. Remember to draw on the many professionals and organizations in your County while developing and implementing your injury prevention program. For additional help with any of these steps, please feel free to contact us at the Center for Injury Prevention, Policy and Practice.

Nilam Patel npatel@projects.sdsu.edu (602) 896-4313

David Lawrence david.lawrence@sdsu.edu (619) 594-1994

References

1. Harborview Injury Prevention and Research Center. Best Practices Overview. Retrieved February 2007, from <http://depts.washington.edu/hiprc/practices/index.html>.
2. Rivera, F. You can do it. A Community Guide to Injury Prevention. Harborview Injury Prevention Research Center. Retrieved January 2007, from <http://www.aast.org/YouCan.html#10Steps>.
3. Sobo, EJ. Developing and Evaluating Injury Prevention Programs: A Beginner's Guide. Trauma Services & Center for Child Health Outcomes, Children's Hospital and Health Center, San Diego. Retrieved Feb 2007, from http://www.emsa.cahwnet.gov/emsdivision/how_to.asp.
4. Young, A. Evaluating and Monitoring Safe Communities Programs. NHTSA. 1997.
5. McKenzie JF, Neiger BL, Smeltzer JL, eds. Planning, Implementing, and Evaluating Health Promotion Programs: A Primer. 4th ed. San Francisco, CA: Pearson Benjamin Cummings; 2005.