// Building Safe Communities

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MEASURING SUCCESS

Measuring success is an essential component of the Safe Communities approach. Participants in Safe Communities coalitions have limited amounts of time, energy, and resources to devote to program efforts. These assets must be used effectively. In addition, demonstration of program success maintains the enthusiasm and support of institutional partners and individual participants, attracts additional partners and resources, and encourages media interest that can be used to educate the public about traffic safety.

Many Safe Communities programs lack the time, expertise, and resources necessary for full-scale program evaluations. Fortunately, programs can avail themselves of cost- and time-efficient methods of measuring success and demonstrate to themselves, their collaborators, and the public that they are making their communities safer places in which to live.

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PLANNING FOR SUCCESS IN MINNESOTA

Anita Berg of Allina Health Systems works with Safe Communities of Wright County (Minnesota). Ms. Berg spoke to us about the advantages of planning to measure success from the very start of a project.

An important area of measurement is baseline data that allow you to measure the effects of interventions as you put them in place. Such data are also essential for targeting your activities. It is important not to be led down a wrong path by impressions about a traffic safety problem without at least some attempt at validating these perceptions through data analysis. People may think they know what is going on based on their own personal experience, but it's important to have mechanisms for getting some sort of objective look at the data and letting that analysis guide further interventions. We've done baseline data analysis to look at crash rates by multiple factors—things like the ages of people involved in crashes, the time of day, or the day of the week. We looked for patterns of severe injuries and how these patterns related to other factors. We found that nearly half the crashes in the study area occurred on 55-mile-an-hour roadways. And we found that young drivers, especially the 15 to 19 age group, were significantly overrepresented in the data. We formed a group to work on each of these issues.

Anita Berg, accepting the Minnesota Hospital and Healthcare Partnership's 1998 Community Health Award.

The "55-mile-an-hour" group is going to do targeted speed enforcement on sections of roadway where there is a speeding problem. We are in the process of purchasing a traffic measurement system. It is a black box that sits on the side of the road and is connected to a wire running across the roadway. It measures speed, type of vehicle, and time of day. We'll use this traffic measurement system to decide exactly where to target our enforcement efforts. Then we will use the system to see if the enforcement was able to create any

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MEASURING SUCCESS

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The first step in measuring success is setting reasonable and measurable objectives. Unrealistic objectives will set up a program for failure and contribute to frustration and low morale. Unmeasurable objectives will not allow a program to determine whether it is in fact making a difference. Although programs may not always be able to measure statistically significant changes in injury rates, research has shown some behaviors to be so intrinsic to injuries that their presence can be taken as proxy indicators of success. People who, for example, use safety belts, child safety seats, and motorcycle and bicycle helmets are not as likely to be injured as those who do not. People who do not drive after drinking, drive while fatigued, speed, or drive aggressively are less likely to be involved in injury-producing collisions than those who engage in these behaviors. An increase in safe behaviors (or a decrease in unsafe behaviors) should be seen as an indication of success.

Success can also be measured in terms of environmental or policy changes. A new stoplight at a dangerous intersection or a hospital policy to provide new parents with a child safety seat and instructions in its proper use are also successes in the struggle against injuries.

The ultimate goal of every Safe Communities coalition is to prevent injuries. But these coalitions also need to establish themselves as effective and self-sustaining community-based injury prevention programs. Thus, programs can also measure success using indicators such as the number of coalition partners and individuals who actively participate, the coalition's ability to obtain funds and other resources, and the level of media, public, and political attention garnered.

This issue of *Building Safe Communities* is devoted to exploring some of the ways in which Safe Communities programs can measure success and then use these measures to create greater success in the future.

PLANNING FOR SUCCESS

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sustained changes in driving behavior. We'll look for reductions in total number of crashes, reductions in the severity of those crashes that do occur, and reductions in the number of crashes on specific sections of roadway.

One of the interventions for teens concerns seat belt use. We had some teens conduct surveys and observational studies at the high school. We recruited the teens through the driver's education instructors, who offered extra credit to students. The students found that 60 percent of teens said they used their seat belts 100 percent of the time. We're going to promote seat belt use through driver's education classes, signs at the exits of the high school parking lots, posters in the school, messages on the high school cable TV system, and take-home flyers. And then we are going to conduct another survey to try to see whether we've made an impact on the percentage of teens using seat belts.

Recognition of their success has come to Allina and its partners. The Minnesota Hospital and Healthcare Partnership has bestowed its 1998 Community Health Award on Safe Communities of Wright County.

DEMONSTRATING SUCCESS IN THE NEIGHBORHOOD

The Greater Dallas Injury Prevention Center (GDIPC) has created Safe Communities programs with a somewhat different focus from that of many other programs. Rather than organizing programs on a city- or countywide basis, GDIPC has created neighborhood-based programs in several primarily Hispanic neighborhoods of West Dallas, working through institutions that already exist in and are trusted by those communities. These include day care centers, community health clinics, housing projects, and high schools. Many of these programs are focused on the proper use of safety belts and child safety seats.

Small, neighborhood-based efforts cannot expect to make the level of changes that will show up in state, county, or even municipal injury or crash data. While GDIPC is collecting data from trauma centers, police reports, and EMS runs, it will take a long time to statistically demonstrate that programs conducted in particular neighborhoods are actually reducing the number (or severity) of injuries resulting from motor vehicle crashes. GDIPC is using restraint-use data taken from observations near the participating community agencies to prove that Safe Communities can dramatically affect behavior at the neighborhood level. Demonstrating this level of local success would be extremely difficult using police reports or hospital records. Martha Stowe, GDIPC's acting director, reports that the observational studies allow coalition members and community residents to see that their efforts are making an immediate difference in their neighborhoods.

PRESENTING SUCCESS

Being successful is not enough. Safe Communities programs need to show others in their communities that their efforts are making a difference. Evaluation data or other measures of success need to be packaged in ways that will affect those who are not versed in statistics or epidemiology. The following suggestions about presenting success are based on a conversation with Pat Nechodom, director of the University of Utah CODES Project at the Intermountain Injury Control Research Center.

Compare your community with others. If, for example, you can show that seat belt use increased dramatically in your community during the course of a seat belt campaign, also show that no such increases took place in other communities in your state during the same period.

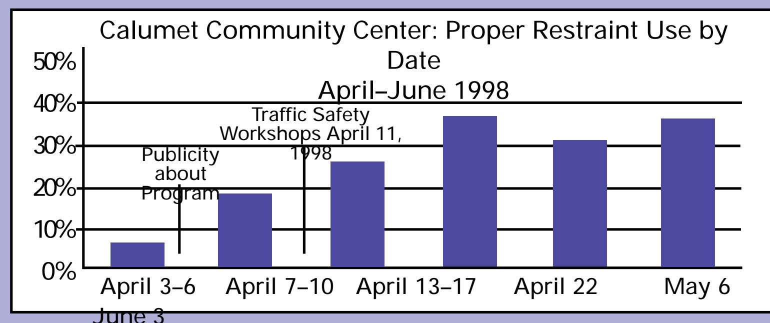
Use simple charts and graphs and dramatic bullet points. Let people know, for example, that the increase in seat belt use resulting from your program saved your county $3 million in medical, EMS, and police costs. Don't use complicated spreadsheets.

Know your audience. How you present your measures of success depends on who you are trying to reach. Is it the general public? Researchers? Other program directors? Legislators? The media? Think about your audience, how they look at the world, and how you can package your measures of success so that they will understand them. Researchers are interested in statistics. Legislators are interested in tax dollars.

Don't underestimate the power of anecdotes. Pat Nechodom related this experience:

At one workshop I asked the question, How do you know your program is successful? In response, a gentleman told me that he was in a grocery store, and a friend of his came up to him and said, "You and your darn bike rodeos. You told my little grandson about seat belts. Now every time I get into the car with him, he makes me buckle up." And while he told me this story, he was grinning ear to ear, because this was an indication that the little children were actually hearing his message and acting on it. And it helped convince him that his bike rodeos were making a difference.

While an anecdote like this alone cannot prove that your program is successful, it can help personalize and add impact to the story told by your outcome evaluation data.



SOCIAL DEVELOPMENT STRATEGIES

Sandra Del Sesto, who works with the Providence (Rhode Island) Safe Communities Partnership, has identified two "social development" techniques that she finds highly useful in measuring programmatic success when quantitative evaluation data are not available or appropriate. The first of these, results-based mapping, measures changes in community-based organizations by looking at "milestones" or "benchmarks" of behavioral change.

Del Sesto cited the example of child safety seats to explain how results-based mapping could be used to measure success: "The first milestone could be a person's ability to give accurate information about child safety seat use. The second could be when people actually use a child safety seat with their children while in their cars. The third might be using a child safety seat in other vehicles. The next two could be encouraging other people to use safety seats and becoming a child safety seat peer educator."

Another method recommended by Del Sesto is "stages of change theory," which uses six stages to describe how attitudes and behaviors change. Del Sesto used the example of bicycle helmets to show how this theory would be used to measure progress. People at the first stage, *precontemplation*, would not even consider using a bike helmet. Those at the second stage, *contemplation*, might consider buying or wearing a helmet. People at the third stage, *preparation*, would decide to buy a helmet. Those at the fourth stage, *action*, would wear helmets. The fifth stage involves *maintenance*, or making the behavior a regular part of riding a bike. The final stage, *termination,* occurs when the behavior is so ingrained that the person does not even think about it.

Measuring success with "stages of change theory" involves using pre- and posttests, focus groups, or questionnaires to determine a target audience's current stage. "Once you have a sense of where the group is," says Del Sesto, "you can tailor interventions to them. For example, if the majority of the community is at 'precontemplation,' you will want to provide information so that you can increase their awareness and get them up a stage a two." Like results-based mapping, the success of a "stages of change"-type intervention is measured by whether and how far people have moved along a continuum, rather than the ultimate goal. "You're not going to get a radical behavior change in a short time," says Del Sesto. "These social development models are useful in capturing and measuring shifts in behavior and belief."

For more information on how to use social development strategies to measure success, Del Sesto recommends the following resources:

"In Search of the Structure of Change" by J. Prochaska, C. DiClemonte, and J. Norcross, in *Self Change,* edited by Y. Klar, J. Fisher, J. Chinsky, and A. Nadler.

"The Push for Outcomes" by B. Kibel, in *Georgia Academy Journal*, Spring 1998.

NHTSA maintains a database of Safe Communities programs. If you have not registered your program with NHTSA, please contact:

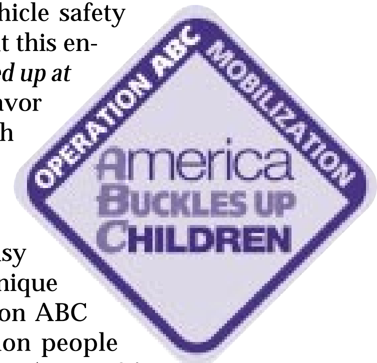
Safe Communities Service Center
NHTSA Region VI—Room 8A38
819 Taylor Street
Fort Worth, TX 76102
Telephone: (817) 978-3653
Fax: (817) 978-8339
E-mail: Safe.Communities@nhtsa.dot.gov

SAFE COMMUNITIES

PROGRAMS AS OF SEPTEMBER 1998

OPERATION ABC MOBILIZATION

Operation ABC Mobilization combines rigorous enforcement of child motor vehicle safety restraint laws with an intensive media campaign designed to alert the public about this enforcement. The Mobilization's critical message is that *children must be properly buckled up at all times. It's the law. No exceptions, no excuses.* Such a coordinated nationwide endeavor creates a synergy that makes the efforts of all the participating agencies that much more effective.



National Highway Traffic Safety Administrator Ricardo Martinez points out that "state and local enforcement agencies have focused on highway safety during busy holiday travel periods in the past, but this national effort to protect children is truly unique and is demonstrating significant changes in safety behavior." The first Operation ABC Mobilization, which took place in May 1998, resulted in an increase of 6 million people buckling up (over what would have been expected had the campaign not taken place). NHTSA estimates that this saved 670 lives. Fatalities over Memorial Day weekend dropped by 35 percent from the previous year.

Three more mobilizations will follow on the success of the initial campaign. The next will occur November 23–29, 1998. Participating law enforcement agencies and their partners agree to devote special emphasis to state child passenger safety laws during this period by setting up child passenger safety checkpoints, increasing enforcement of seat belt violations, and participating in media campaigns and other public awareness efforts. Enforcement of adult seat belt laws is also encouraged, since research demonstrates that children being properly restrained in a vehicle is statistically related to whether the driver is using a seat belt.

Operation ABC Mobilization kits are available and include template media materials, air bag and seat belt flyers, banners for events, and other materials. Mobilization and NHTSA staff will also work with participating agencies to help prepare for the Mobilization week and support media outreach efforts.

To obtain an Operation ABC Mobilization kit and other assistance, fax NHTSA at (202) 338-0415 or call the Air Bag & Seat Belt Safety Campaign at (202) 625-2570.

RESOURCES

Demonstrating Your Program's Worth: A Primer on Evaluation Programs to Prevent Unintentional Injury. Available from the National Center for Injury Prevention and Control, Office of Communication Resources, Mailstop K65, 4770 Buford Highway, NE, Atlanta, GA 30341-3724. Telephone: (770) 488-1506; WWW: <www.cdc.gov/ncipc/>.

Evaluation Guidebook for Community Youth Safety Programs. Available from CSN Rural Injury Prevention Resource Center, National Farm Medicine Center, 1000 North Oak Avenue, Marshfield, WI 54449-5790. Telephone: (715) 389-4999; WWW: <www.marshmed.org/nfmc/projects/csnriprc/CSNRIPRC.HTM>.

NHTSA's 1998 Traffic Safety Materials Catalog can be obtained by faxing a request to (202) 493-2062. A searchable version is also available on the NHTSA website at <www.nhtsa.dot.gov>.

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