CHAPTER 6

Taking Action

Contents

Note: Citations are listed by chapter in the reference section at the end of the document.

Meaningful information and insight about youth in the community have been gained through the processes of coalition building and needs assessment. The next step in the planning process is for the coalition to decide how it will use this information and how it will work towards addressing the selected Critical Health Objectives for adolescents and young adults. At this point, the coalition should consider the following questions:

- *On which aspect of the issue should the group focus?*
- *How can the assessment and available data be used to direct efforts?*
- *How can research guide the effort?*

The needs-and-assets assessment yields information about many aspects of the problem, suggesting several possible solutions or strategies as well as potential challenges in responding to the four levels of intervention (individual/family, school/peers, community, and policy/society). With limited resources, most communities cannot address every risk and protective factor, but it is important to be as comprehensive as possible. In some cases, findings from the needs-and-assets assessment point to a clear strategy from which to develop a detailed program plan. More often, however, coalitions will need an intermediate step before selecting strategies. This section aims to help communities identify priority issues and determine the most feasible strategies to pursue. The strategies will guide the development of the next stages of planning. Some questions to consider when prioritizing strategies include:

- *Which strategies reflect a sound understanding of the problem and its causes as identified by the needs assessment?*
- *Do the strategies reach teens and young adults most at risk?*
- *Do the strategies focus on reducing risk factors and promoting protective factors?*
- *Are the strategies consistent with community values and priorities?*
- *Do the strategies draw on the strengths of the community and the coalition?*
- *Do the strategies complement rather than duplicate concurrent efforts that address the same issue?*
- *Do the strategies draw on readily available resources?*
- *Will the strategies be likely candidates for funding?*
- *Do the strategies address levels of influence not being addressed by current community efforts?*

Although not meant to be a strict guideline for prioritization, this list may help coalitions consider important factors related to the strategies they choose. It is most important for the coalition to respect the community and choose strategies that reflect local priorities. An intervention is destined to backfire if outsiders impose it on a community.

Using Information From the Needs-and-Assets Assessment

Findings from the needs-and-assets assessment should help inform the prioritization process. The coalition should assess both quantitative data about the Critical Health Objectives and qualitative data about community perceptions.

CASE STUDY

As with needs assessments, the prioritization process comes in numerous shapes and forms. Regardless of the method chosen, the process should take into account financial and human resources, likelihood of success, timeline, and community interest and acceptance. Every prioritization process should have a well-defined system that all participating members understand, deem fair, and follow. Here is how one coalition decided to prioritize its problem areas:

Mason Matters (*http://www.masonmatters.org/*) is a nonprofit organization consisting of community citizens and health care providers concerned with addressing the health and social needs of Mason County, Washington—a small county of approximately 47,000 persons. This coalition strives to develop local solutions for local problems using the strengths of all sectors of the community. In January 1998, 30 community members representing diverse interests convened to decide upon the health and social issues most affecting county residents. Using a previous assessment, the *1997 Mason County Health Profile,* the members highlighted 25 issues of general importance, including teen pregnancy, teen smoking, cancer, child abuse, domestic violence, and HIV/AIDS. In May 1998, these issues were further prioritized by Mason Matters using five criteria:

1. How many people in Mason County are affected?
2. Is Mason County faring less well than the rest of the state on this issue?
3. How severe is the impact on individuals or the community?
4. Is this an issue that can be addressed through community action? (Would an intervention make a difference?)
5. Will there be community support?

The top seven issues were prioritized as follows:

1. Teen pregnancy. 2. Drug and alcohol use. 3. Domestic violence. 4. Water quality. 5. Community support for schools. 6. Economic opportunities. 7. Dental access.

Teen pregnancy and domestic violence were selected as the first two foci because both received the highest rating on the "community support" question. Two work groups addressing these issues were formed in May 1998. Since that time the teen pregnancy work group has conducted teen focus groups, increased the availability of medical services, and created an information package for parents titled "T.I.P.S.: Teen Information for Parenting Success."

The remaining high-priority issues underwent another prioritization process in September 2000. The issues of water quality and community support for schools were ranked highest in the areas of "impact on individuals and the community," "impact of community action on the problem," and "community support." Two work groups were formed to address these issues.

Who is most affected by the problem?

A good way to use limited funds is to focus on the young people who are most at risk. The needs-and-assets assessment should indicate whether specific geographic clusters, age or income classifications, or ethnic or racial groupings are associated with particularly high rates of the problem. The communities identified by these variables, however, may already be saturated with programs. The assessment will also indicate gaps in services that may be better points of intervention for the coalition. By concentrating on a specific group or area of service delivery, the coalition can prioritize appropriate strategies. Alternatively, a broader approach may be appropriate.

What factors contribute to the problem?

The needs-and-assets assessment will uncover a host of contributing factors that could be the focus of an intervention. The coalition should take into account what experts, parents, and teens themselves have to say about the factors that matter most. Ultimately, the coalition should target those risk factors known to be related to the issue that are the most prevalent and that the community will support addressing. Harder issues can be addressed after the coalition has laid the groundwork and gained more support. The coalition should also address the protective factors that are most lacking in the community.

What strategies will the community support?

The needs-and-assets assessment should have shed light on where the community stands on the selected Critical Health Objectives and what strategies it would support. The coalition may want to garner more input from community members, other stakeholders, and the coalition itself on how to proceed through a process of participatory planning and prioritization.

The Prioritization Process

The prioritization process consists of brainstorming which antecedent factors might be addressed, determining feasible strategies given current resources and community support, and coming to consensus about strategies to pursue. The initial prioritization process allows the group to creatively brainstorm all ideas without worrying about what resources it actually has. Fine-tuning will occur later in the action planning process. Although all the strategies brainstormed will not be used, discussing each of them encourages the group to assess its options. One prioritization process a coalition might use is the "Force Field Analysis" (adapted from Kurt Levin, see Appendix 6-1). Some coalitions may elect to work with a steering committee to draft priorities and then present them to the coalition for decision-making. Other coalitions might distribute a questionnaire to community members, the coalition, and other stakeholders, asking them to rank the strategies on their effectiveness and level of community support (see Worksheet 6 at the end of this chapter). Another option is to hold community forums where the results of the needs-and-assets assessment are presented and community input is sought.

Prioritization processes such as the Force Field Analysis provide a logical and structured framework for defining how to reach the selected Critical Health Objectives. They also help when the coalition is having difficulty reaching consensus. The process can also initiate dialogue about other logistical issues, including how to involve other groups and organizations in the process of meeting the Critical Health Objectives. For example, a group may rank a media literacy campaign about tobacco use as its highest-priority strategy but not have any relevant expertise. The prioritization process may lead it to involve new partners from the media, marketing, and education sectors.

During the prioritization process, it will be helpful to consider several questions about the coalition:

- How can the roles and resources of the group be maximized?
- Who will be important allies in the implementation phase?
- How can the multiple ongoing efforts be connected with new ones?
- Should some existing members take a stronger role and commit more of their resources?
- Is this the right time to expand or change group membership?

- Should the coalition apply for a planning grant to obtain sufficient time and money to focus on specific Critical Health Objectives?
- What are the strengths and assets of our community and how can we best use them in our new efforts?
- How can we engage youth in the prioritization process?

Once the group has established how it will focus its intervention(s), it also needs to consider at what levels it plans to direct its initial energy. Ideally, the collaborative will adopt strategies at the four levels (individual/family, schools/peers, community, and policy/society). In considering each of these primary strategies, the coalition needs to consider who else can assist, what resources are available, and in what time sequence the actions should be completed. If the group believes it has reached consensus, it is ready to proceed to the next step, creation of a logic model.

EAT RIGHT COALITION (ERC) CASE STUDY (continued)

Approximately 60 people attended the second ERC meeting, which included attendees from the previous meeting as well as newcomers. The meeting had been designed to decide on a course of action for the coalition, but because of the many possible avenues for action as well as the numerous persons supporting each avenue, criteria had to be set for prioritizing each proposed area for change. The director of the health department, who was serving as the moderator of the meeting and the "de facto" leader of the coalition, proposed several statements that could help decide which strategy should be chosen. The statements were prioritized by the attendees according to their perceived value (1-7, with 7 being the most highly valued):

1. The community will support any changes in this area.
2. The community has resources available for these changes.
3. Addressing this area will improve the problem.
4. Changes in this area are financially viable.
5. It will not take a long time to create changes in this area.
6. The coalition is prepared to commit for a substantial length of time.
7. Addressing this area is a long-term solution.

Each question could be answered on a scale of 1 to 5 (5=strongly agree; 1=strongly disagree). Thus, the total score received for a particular question was the result of multiplying each attendee's rating (1-5) by the average, or mean, priority score and then deriving a group average, or mean.

After hearing a presentation about the needs assessment and the best practice findings, the attendees split into small groups and were asked to think of three ways to approach the problem. After a short discussion, each group gave a brief presentation of its ideas.

The proposals, by level, included:

Individual:

- Offer free local community nutrition and cooking classes.

School:

- Offer comprehensive cooking and nutrition classes where students have a role in developing and selecting the menus.
- Add healthy options to the breakfast and lunch menus that students help to select.

- Prohibit sodas and snacks devoid of nutritious value other than calories from being sold on the campus.
- Limit access to area restaurants during school hours.
- Integrate nutrition information in academic classes (e.g., health, math, science).
- Develop healthy-eating campaigns.
- Have health clinic personnel plan individualized strategies to address nutrition.
- Use subsidies to lower the price of healthy foods.

Family:

- Offer free cooking and nutrition classes and cookbooks for parents and adults.
- Provide healthy food coupons to parents.

Community:

- Provide local physicians and health care workers with ready-made materials on nutrition and physical activity to give to their patients.
- Restrict the placement and operating hours of restaurants near area schools.
- Work with restaurants to add healthy options to their menus.
- Restrict sponsorship of school events by area restaurants (or at least the type of food they offer).
- Increase the accessibility of grocery stores, particularly those with quality produce.
- Reduce the presence of fast-food restaurants in low-income neighborhoods.
- Develop a cooking club for families to share responsibilities for healthy meals.
- Develop community gardens.

After hearing the various proposals, each attendee selected the two proposals that scored the best (i.e., had the highest numerical scores) according to the criteria outlined earlier. The two proposals that received the higher rankings from the average scores of individual attendees, were chosen as the direction/strategy the coalition would use to achieve its goals:

- Have a supportive school food service environment (e.g., conduct healthy-eating campaigns and offer healthier, appetizing options in the cafeteria).
- Offer comprehensive school nutrition and cooking classes.

Two school-based approaches, lowering the price of healthy foods and restricting sales of unhealthy foods, were seen as very important, but most attendees felt that other, more amenable issues should be addressed before moving on to such emotionally charged concerns. Many attendees felt that these two proposals, while useful, did not address enough parental, community, or policy issues.

Because schools were heavily involved in each of the proposals and because many principals and teachers already supported the coalition's efforts, the school board chief decided to take the lead in the coalition's activities along with the health department. Most attendees, however, felt it was important not to create a formal power structure, so as to foster collaboration both within and outside the coalition and avoid power struggles.

Developing an Action Plan

The 21 Critical Health Objectives reflect complex health issues that can be approached in a variety of ways (e.g., outreach services, policy change). In the prioritization process, the coalition should have identified general strategies from which to create a specific action plan. Action plans include goals and objectives, program components, action steps, timelines, and resources; in brief, the plan guides future actions. The coalition should involve various stakeholders in developing the intervention in order to foster a sense of commitment to the community and vision among key players. Furthermore, bringing in diverse backgrounds and viewpoints helps elicit underlying assumptions early, when they can be more easily addressed. There are a variety of ways to carry out this process – an organization may decide, for example, to have a smaller group develop the plan and then bring it back to the larger group for discussion, suggestions, and adaptations. This strategy can be helpful especially when too many diverse opinions stagnate the group.

Action planning consists of a three-stage process that will be described in this section:

1. Defining goals and objectives.
2. Designing an intervention.
3. Creating an action plan.

Creating an action plan has many advantages: First, following this systematic method will allow the coalition to lay the groundwork for evaluation of the program it designs. The action plan will also help the coalition stay on track as it begins to implement the program and will allow members to communicate one clear message when communicating their work to others. An action plan can also help by clarifying partners' time and energy commitments, thereby promoting partner understanding and accountability. Developing an action plan will also illustrate to the community, funders, and partners that the coalition is organized.

Benefits of developing an action plan include:

- **Developing understanding and consensus** among the coalition members regarding strategies, role expectations, and the selection of indicators to measure effectiveness.
- **Developing strategies at each of the four levels** (individual/family, school/peers, community, and policy/society) that focus on observable behavior and antecedent factors.
- **Ensuring that the program goals and objectives and the resulting intervention flow directly from the needs-and-assets assessment data.**
- **Imparting a realistic view** of what the program can achieve. With an action plan, program planners must think about the limits and potential of their proposed strategies given the resources available, timelines, and the magnitude of the health problem.
- **Facilitating possible replication of effective programs and best practice approaches.**

There are a variety of ways to organize the action planning process. The coalition may want to consider forming workgroups for different activities, creating one smaller planning committee, or restructuring the composition of the coalition to be sure the right people are at the table when creating the action plan. It is likely that different members within the coalition may take on stronger roles at this time (e.g., if a strategy involves developing a media campaign to create awareness of teenage depression and suicide, a member with journalism skills or media connections may increase his/her level of involvement).

Examples of Strategic Efforts: Case Study

Action plans frequently take the shape of strategic plans, incorporating discussions on the current state of affairs and proposing principles for action. In such documents, many aspects of the prioritization and needs assessment process are incorporated. In contrast, other action plans take the shape and form of a goal-oriented timeline, providing more specifics about what is to be done and when. Clearly, one of the driving forces behind the structure of an action plan is what type of organization constructs it. Here are some examples of the shapes the action plan can take:

In the Federal Office of Juvenile Justice and Delinquency Prevention's 1996 report entitled "Combatting Violence and Delinquency: The National Juvenile Justice Action Plan" (*http://ojjdp.ncjrs.org/action/*), the agency outlined eight objectives that would help strengthen state and local efforts to reduce juvenile delinquency and increase the effectiveness of the juvenile justice system. One objective was "to provide immediate interventions and appropriate sanctions and treatments for delinquent juveniles." Under each objective, an overview and current analysis of the problem was provided. In addition, each objective contained a discussion of effective and promising strategies and programs as well as recommended federal, state, and local action steps (U.S. Department of Justice, et al. 1996).

In "Being, Belonging, Becoming: Minnesota's Adolescent Health Action Plan" (*http://www.health.state.mn.us/divs/fh/mch/adolescent/exec-summ/exec-summ.pdf*), an overview of adolescent health is provided, followed by a discussion of the health status of Minnesota adolescents. General recommendations to improve adolescent health are given, followed by more specific descriptions of how to develop the recommendations. For example, under the general recommendation to "build the capacity of adolescents to become productive adults" there are more specific proposals to "strengthen schools for students of all ages" and "strengthen opportunities to connect teens to the world of work." A description of state resources for adolescent health concludes the document (Minnesota Department of Health 2002).

In contrast to these documents, the "Master Action Plan for Youth" developed by The Youth Service Action Team (YSAT) of FACES—Family Action Collaborative, Olmsted County (*http://www.cnetcf.sitehosting.net/www/area1/MAP/*), contains more specific community goals. Examples of suggested future steps for YSAT include:

1. Create an integrated, developmentally appropriate playground at the elementary school for all community members and their children to be open by June 2001.
2. Create and maintain a book-and-toy lending library for children from birth to 8 and their parents by February 2001.
3. Begin a Byron Day Care Association by planning an organization meeting and offering three training sessions in the first quarter of 2001.
4. Provide transportation to and from childcare or home to School Readiness, Byron Playgroup, and Head Start beginning September 2000.
5. Make family-based activities available, with three activities set up by November 2000 and offered in January, February, and March of 2001.

Defining Goals and Objectives

Goals and objectives should flow directly from the prioritization process, which identified the most effective and feasible strategies. They should also be consistent with community values and priorities, which should have been clarified by the needs assessment. The goals and objectives selected by the coalition should address the antecedent

factors of the selected Critical Health Objectives as well as the Objectives themselves. For example, the prioritization process may identify eating fast food as an important behavioral cause of obesity among adolescents. The intervention should take into account antecedent factors—such as lack of funding in schools for healthy lunch options, an absence of affordable healthy restaurants in certain neighborhoods, and parents' lack of knowledge or sufficient time to prepare home-cooked healthy meals—that influence adolescent obesity. If a needs-and-assets assessment confirms that these factors are present in the community, the coalition should include objectives that target school, business, and family environments to reduce adolescent obesity.

The terminology for goals and objectives varies (e.g., short-term outcomes, long-term outcomes, action steps, strategies). Coalitions should not get discouraged by the different terms. What matters is the meaning behind them. For our purposes, goals and objectives are defined as follows:

Goals are ***long-term outcomes*** a community hopes to achieve over a significant period of time. A typical intervention has only one or two major goals, which may be pursued through multiple objectives. For example, goals may be to decrease binge drinking among high school students or motor vehicle injuries among teenagers across the state. Measuring change in these outcomes will require significant time between the completion of the intervention and follow-up measurements.

Objectives are ***short-term outcomes*** that are pathways to goals. They can be measured at the completion of a program or several months afterward. For example, as a pathway to reducing motor vehicle injuries, a short-term outcome may be increasing proper seat belt use.

Worksheet 7 (at the end of this chapter) can be used to help create goals and objectives. When developing goals and objectives for an action plan, it is important to:

- Clearly link each objective to a goal.
- Be sure that both goals and objectives are measurable.
- Be specific about the geographic area, target population, and time frame of each goal and objective.

When developing objectives, consider:

- What (if any) baseline data are available to effectively monitor change over time as the strategies are implemented?
- According to the needs-and-assets assessment, how should the interventions be tailored for different groups (e.g., as defined by age groups, sex or race/ethnicity)?
- What are realistic time lines and financial parameters for the strategic plan? What resources are already in place that can be incorporated as part of the effort? What additional, crucial resources are needed to fill gaps?
- What are realistic short-term outcomes and long-term impacts?
- How can implementation of efforts be monitored (e.g., documenting activities, number of persons participating, trainings held), and what indicators can be used to measure success?

It is important to be as realistic as possible when writing goals and objectives. The coalition should consider whether the goals and objectives it has identified are achievable based on the severity of the problem and the resources available in the community. The group should be careful not to shy away from addressing issues that have a critical impact on the health of adolescents simply because they may be difficult or controversial.

EAT RIGHT COALITION CASE STUDY (continued)

The director of the health department and school board chief decided to form an action plan committee that would consult with all current members of the coalition to officially set out the mission, goals, and objectives of the coalition's first intervention. Proposals already decided upon by ERC members would serve as a foundation. The committee would also conduct an initial analysis and form a prospective timeline for the planned activities. Several parents, teachers, principals, government officials, youth, and physicians volunteered for the committee. The committee was given 6 weeks to create a comprehensive action plan. To be officially accepted, the plan would need to gain majority approval at the next meeting.

The action plan committee first decided to develop the mission, goals, and objectives for the coalition's efforts. After numerous conversations with various coalition members, these guiding principles were drafted:

Mission: To decrease obesity in youth in order to lessen the risks of such conditions as heart disease and diabetes.

Goals: To reduce obesity in middle/high school students, increase their awareness of healthy eating practices, and promote such practices in their schools.

Selected Objectives**:**

- By the end of year 2, all area middle and high schools should have taken steps to create a supportive school food service environment.
- By the end of year 3, 85% of middle and high school students should demonstrate their understanding of core nutritional concepts.
- By the end of year 3, there should be a 15% increase in the number of middle and high school students who purchase healthy food items at school.
- By the end of year 4, obesity prevalence should have dropped to 20% among area high school and middle school students.

Once this basic outline had been created, it was necessary to look at each program component more intensively. Specifically, the action plan committee needed to look at each program component from the standpoint of who would carry out its duties, what the deadline would be for full implementation of program activities, what barriers and collaborators might be present, what resources would be required for the program, and what indicators would be necessary to evaluate the program.

Designing an Intervention

After the coalition writes goals and objectives, its next step is to construct a set of program components that will constitute the intervention. Program components should address the antecedent factors of the Critical Health Objectives being addressed as well as the health outcomes. As part of the needs-and-assets assessment, the coalition should have researched the antecedent factors associated with these Critical Health Objectives. Now is the time to revisit that information to determine the most logical and effective interventions for the goals and objectives developed by the coalition. The coalition should link each program component to the objectives and goals it has selected. Those planning the intervention should be sure to match the intervention to the population with which it is working and be as specific as possible about the content, level of exposure, and resources needed that are necessary to accomplish the coalition's goals.

Coalitions can take a variety of approaches to designing an intervention. For example, they may use a single strategy, such as launching a major health education campaign,

and implement it at each of the four levels of influence. An anti-tobacco project might raise awareness of the risks of smoking among individual teens and their family members; provide informational brochures to medical providers; implement a public education campaign using billboards, television, radio, and bus ads; and educate policy makers about the issue of teen smoking and the need for policy changes, such as restricting tobacco sales to youth and regulating tobacco companies' advertising at the local, state, and national levels. Alternatively, the coalition might implement different strategies at each level. For example, a teen smoking prevention project might consist of a health education program for middle and high school students, a family-based intervention to increase communication about smoking, and a youth advocacy program in which young people persuade business owners to limit sales to minors and lobby policy makers to support anti-tobacco legislation. Both approaches recognize that the complex health problems represented by the Critical Health Objectives require multilevel interventions.

As the collaborative begins to map out the selected program components, it might find that one strategy can be used to achieve several objectives. Linking program components with goals and objectives will help streamline activities and help the coalition determine how to make the most effective use of limited resources (see Worksheet 8).

Best Practices and Model Programs

When considering program components, the coalition should research "best practices" and model programs related to its selected Critical Health Objectives. Lessons learned from what has worked in the past can provide a valuable foundation for future work. Those strategies, activities, and approaches that research and evaluation have found to be effective in promoting public health are called "best practices." Programs and strategies that have some quantitative data showing positive outcomes for the behavior but do not have enough research or replication to support generalizable outcomes are called "promising practices." "Guiding principles" are recommendations on how to create effective prevention programs. When a community already has a prevention program or strategy in place, the guiding principles can be used to gauge the program's potential effectiveness. They can also be used to design an innovative program/strategy when none or only a few of the best practices are appropriate to the community's needs. In addition, many professional associations have published clinical guidelines and recommendations for providers (Park et al. 2001).

Reviewing model programs saves communities from "reinventing the wheel" and gives immediate direction to program planning. Using best practices in combination with program evaluation contributes to further testing of effective strategies. In addition, funders are more likely to fund programs that use strategies shown to be effective. Information about best practices and model programs can help the coalition determine how to proceed with the specifics of developing its interventions (e.g., whom to involve, which levels should be targeted first, sequence of events, and possible curricula). Existing research can provide a foundation for creating new interventions, or the coalition may decide to replicate an existing successful program or project.

Federal agencies and organizations such as the U.S. Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention and the National Campaign to Prevent Teen Pregnancy publish information about best practices for addressing various adolescent health issues (see Table 6-1: Guidelines and Best Practices).

The coalition can search Web sites that specialize in research on best practices and evaluation research:

- Best Practices Web Site Resource Guide: *http://www.asu.edu/aprc/Pages/Best_Practices/Website%20guide.htm*

- Center for Effective Collaboration and Practice: *http://www.air.org/cecp/*
- Center for Substance Abuse Prevention Model Programs: *http://www.samhsa.gov/centers/csap/modelprograms/programs.cfm*
- Center for Substance Abuse Prevention's Western Center for the Application of Prevention Technologies Best and Promising Practices: *http://casatweb.ed.unr.edu/cgi-bin/WebObjects/Step6.woa/wa/getList*
- Western Regional Center for the Application of Prevention Technologies Best Practice Resource Materials: *http://www.open.org/~westcapt/bpresrce.htm*

Coalitions can ask youth or family-serving organizations that focus on the selected Critical Health Objectives if they have more information on program planning and developing interventions.

Overview of Guidelines

Critical Health Objective	Guideline(s)
Nutrition and Physical Activity	Promoting Lifelong Healthy Eating (CDC) *http://www.cdc.gov/mmwr/preview/mmwrhtml/00042446.htm* Promoting Lifelong Physical Activity (CDC) *http://www.cdc.gov/mmwr/preview/mmwrhtml/00046823.htm*
Injury and Violence Prevention	Injury and Violence: Guidelines to Prevent Unintentional Injuries and Violence (CDC) *http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5022a1.htm* Blueprints for Violence Prevention *http://www.colorado.edu/cspv/blueprints/index.html*
Tobacco Use Prevention	Guidelines to Prevent Tobacco Use and Addiction (CDC) *http://www.cdc.gov/mmwr/preview/mmwrhtml/00026213.htm*
Substance Abuse Prevention	Center for Substance Abuse Prevention (CSAP) *http://www.samhsa.gov/centers/csap/modelprograms*
HIV/AIDS Prevention	Guidelines for Effective School Health Education to Prevent the Spread of AIDS (CDC) *http://wonder.cdc.gov/wonder/prevguid/p0000217/p0000217.asp*
Teen Pregnancy Prevention	Program Archive on Sexuality, Health and Adolescence (Sociometrics, *www.socio.com*) No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy, ETR Associates *http://www.teenpregnancy.org/resources/data/report_summaries/no_easy_answers/default.asp*
Suicide Prevention	National Institute of Mental Health (NIMH) *http://www.nimh.nih.gov/* Department of Health and Human Services (DHHS): National Strategy for Suicide Prevention *http://www.mentalhealth.org/suicideprevention/strategy.asp*

Questions to consider:

- What effective strategies have been identified for each of the four levels: individual/family, schools/peers, community, and policy/society?
- What strategies have been shown to be effective for the sociodemographic profile of our community?
- What critical components from evaluated programs can we commit ourselves to incorporating?

- What financial resources does the coalition have right now? Do we need to focus on fundraising efforts at this stage?
- What resources can be redeployed to support the implementation of best practices and strategies within existing programs? For example, what staff training and resources may be necessary to incorporate a well-tested curriculum in existing school health education programs?

CASE STUDY

Communities searching for best practices to address an adolescent health issue have many possible avenues. Consulting literature reviews, government and private documents, speaking with experts in the field, and studying the success of similar communities can all yield valuable information on the creation and implementation of a particular intervention and its associated strategies.

The Department of Children, Families, and Learning, the Minnesota Coordinated School Health and States Incentive Grants, the Department of Public Safety's Office of Drug Policy and Violence Prevention, and the University of Minnesota's Konopka Institute for Best Practices in Adolescent Health have worked together to produce an adolescent health document entitled "Growing Absolutely Fantastic Youth: A Guide to Best Practices in Healthy Youth Development" (*http://allaboutkids.umn.edu/kdwbvfc/Fantastic%20Youth%20Book.pdf*). The document, released in spring 2000, highlights the latest research and theories behind youth development, risk factors, protective factors, and resiliency. It showcases the various roles that schools, families, and communities can play in promoting healthy adolescent development. The document also contains numerous examples of successful youth programs within Minnesota. Most importantly, the document dispels various myths about adolescent health and adolescent health programs so that persons interested in creating their own youth interventions are guided by research rather than negative, stereotypical images. Lastly, the document places its information about seven problem areas (alcohol/tobacco/other drugs, motor vehicle crashes, violence, suicide, risky sexual behavior, nutrition, and physical activity), in the context of a community youth development framework so that communities can see how many research principles apply to community youth problems. The document serves as a valuable resource to Minnesota parents, policy makers, youth, grantees, and service providers for improving the health and well-being of youth.

Challenges: When Models Are Not Available

Throughout this document, the importance of addressing the Critical Health Objectives from a multilevel approach has been emphasized. In addition, we strongly recommend applying evidence-based research and best practices when developing a plan of action. Still, there are gaps in our knowledge about what is effective. Few evidence-based programs address critical health issues at the four levels discussed in this document. Communities may find there is much more knowledge about what works at the individual level, because it is generally harder to measure the impact of interventions designed to produce changes in the environment, such as policy-level interventions. Because interventions operating at multiple levels are more likely to be successful, however, as in the case of "designated drivers," communities should not forgo interventions at the school, community, and policy levels.

Some health issues addressed by the 21 Critical Health Objectives, such as teenage pregnancy, have more available research on best practices and effective programs than others, such as mental health. Where there is less research, communities need to examine best practices and evidence-based research for other health issues addressed by the 21 Critical Health Objectives to review whether parallel findings in those content areas

have implications for their own efforts. No matter what health issue is being addressed, adolescents need specific knowledge regarding the issue; a specific set of skills that enable them to adapt and apply that knowledge to their own behavior; a family, school, and community environment in which the requisite knowledge and skills can be used and supported; and a policy environment that provides sufficient resources and political commitment to support improved adolescent health and changes in social norms.

Communities may also find that existing program evaluations and research have been conducted with certain ethnic groups but not with those in their own communities. Much of the existing research has been conducted on non-Latino white and African American youth; less research has involved Latinos, Asians/Pacific Islanders, Native Americans or adolescents representing multi-ethnic groups. For the latter populations, the coalition will need to consider what cultural adaptations, if any, are necessary. A coalition might, for example, aim to reduce teen pregnancy among Latino youth and decide to tailor an existing program to work with this group. It may help to research the types of general interventions that have been effective in reaching Latino communities, especially Latino youth. It is also advisable for a subcommittee to work with parents, youth, and teachers to consider what cultural adaptations are needed. When incorporating interventions with demonstrated effectiveness, the coalition should keep the tailored program as true as possible to the original model with respect to factors such as classroom hours and learning objectives.

Choosing Program Components

After reviewing best practices about its selected health issue, the coalition may have difficulty deciding which components to incorporate. It should take the time to research and consider a variety of options, paying attention to what has worked and what has not. A common pitfall is combining interesting elements from several model programs. For example, a teen drug prevention coalition might mix components from three such programs, but this is a "hybrid" intervention, which changes the core of the program and essentially defeats the purpose of using evaluated programs. Coalitions are better off staying true to one model's core evaluated curriculum, adding components only after the core program has been fully implemented. Mixing and matching components from model programs makes evaluation more difficult and may prevent the coalition from using previously developed evaluation measures.

The following principles can guide planners in selecting, replicating, and adapting model programs:

- **Select and adapt programs based on the unique needs of youth participants:** Choose programs that serve similar populations. Once a program is selected, consider how it may be applied more effectively to the background and experience of youth in the community. If possible, conduct focus groups to test the acceptability and relevance of the model.
- **Plan for evaluation of the program from the outset:** Keeping evaluation in mind during program planning will help guide implementation efforts.
- **Seek outside assistance:** Establish contact with people who have used the program to find out about potential challenges or pitfalls and to learn from their experiences. Consult a researcher or statistician on the best way to evaluate the program.
- **Consider resources and training:** Ensure that there are adequate resources (e.g., staffing, training) to implement the program model.

- **Replicate evaluation criteria:** Replicate evaluation procedures used in the model program so that the effectiveness of your program can be compared among different sites and populations. Use programs with goals and objectives that are similar to those of the coalition.
- **Adhere to the model:** When adapting an already tested program, do not let changes compromise the goals or objectives of the original. If necessary, supplement evaluated materials to tailor the program to a specific audience, but these supplemental materials must not change the core elements of the original materials.

(Adapted from Brindis and Davis 1998).

Creating an Action Plan

Now that the coalition has decided on the program components of the intervention, it is time to plan how it will be put into action (see Worksheet 10). Creating an action plan includes determining the steps involved in implementing each program component, assigning responsibility for them, determining what resources are necessary, and creating a timeline.

An action plan should incorporate:

- *Actions that must take place to accomplish the objectives.* For example, if a coalition chooses to create a peer education program as a component of an intervention to prevent drunk driving, its action steps might include hiring a program coordinator, securing or developing a training curriculum, recruiting young people, and training the peer educators.
- *Groups and individuals who will perform these actions.* These people should understand what the goals are; be given tasks that match their capabilities, available time, and spheres of influence; and be provided with relevant training and resources.
- *Anticipated time for implementing the action and the sequence in which the actions will be implemented.* Make sure to incorporate enough time to accomplish the goals. Be sure to consider trainings that need to be given, staff that need to be hired, and funds that need to be raised.
- *Requisite resources to carry out these changes.* Whether through funding or redeployment, those carrying out the plan need to have access to proper resources.
- *Potential barriers to completing program activities.* Identifying potential barriers in advance will help the coalition be prepared to deal with roadblocks as they arise.
- *Agencies and individuals that can be collaborative partners.* Working in collaboration with others to implement program strategies that maximize resources can help forge important relationships between organizations and can increase the likelihood of a program's sustainability.

EAT RIGHT COALITION (ERC) CASE STUDY (continued)

Program Component #1: Offer comprehensive middle/high school nutrition and cooking classes that will increase individual understanding of core nutritional concepts.

This coalition activity required several considerations. Would existing teachers be used or would new teachers need to be hired? Which model nutrition curriculum would be chosen, and would it be adapted to meet the local community's needs? From where would funding for the teacher training/curriculum come? Would parent and student

associations help to choose a curriculum and consider any possible modifications? How would possible conflicts between principals and teachers be resolved? What indicators would be necessary to monitor how well students learn nutritional concepts?

The committees responsible for carrying out the action steps would focus more specifically on these issues. In preparation, however, the action planning committee deliberated on some of these issues to create an action plan template.

Action Step	Persons Responsible	Resources Required	Potential Collaborators	Indicator(s)	Potential Barriers	Potential Solutions
To implement a comprehensive nutrition and cooking class in all area middle and high schools at the beginning of year 2.	Teachers; principals to guide implementation process	Model curriculum; classroom/time availability in schools; funding for teacher salaries/overtime and school supplies	PTA; student associations; teachers unions; school board/ principals; local physicians; mayor	Percentage area middle and high school students understanding core nutritional concepts (Percentage may come from base-line survey accompanying curriculum)	Principals/school board worried about time constraints on teachers; lack of interest shown by students; lack of funding; inability to recruit existing teachers for program	Work closely with school officials Engage youth in coalition work; take their input seriously Provide incentives for teachers to engage them in the project

Program Component #2: Create a supportive food service environment in area middle/high schools by offering more healthy, appetizing options on school menus and conducting healthy-eating campaigns.

This program component had a myriad of questions to be considered. What food options would be chosen for the school menus? How much would they cost and for what price would they be sold? How would their use be tracked? Who would lead healthy-eating campaigns in school cafeterias?

Action Step	Persons Responsible	Resources Required	Potential Collaborators	Indicator(s)	Potential Barriers	Potential Solutions
Create a supportive food service environment in area middle/high schools by offering more healthy, appetizing options on school menus and designing healthy-eating campaigns by the end of year 2.	Principals to guide implementation process (purchase food); food service staff to prepare/ publicize healthy food options, conduct healthy-eating campaigns, and coordinate school nutrition activities	Healthy, appetizing foods; school supplies (flyers, table settings, etc.) for campaigns; improved cooking equipment; time for campaign activities; increased funding for food service staff	PTA, student associations, school board/ principals, area food businesses	Number of area middle/ high schools that have added three healthy, appetizing items to each school meal; number of area schools conducting healthy-eating campaigns	Principals opposed to expense of adding healthier foods to school menus; food service staff inexperienced in preparing/ publicizing healthy food options and conducting healthy-eating campaigns; student apathy; tracking student use of healthy foods; making time for campaign activities	Work closely with school officials to engage their support Work with local food businesses and restaurants for the mutual benefit all parties Have recommendation box for student menu suggestions and use them

The deliberations that went into creating these templates helped the action planning committee form a hypothetical timeline for the ERC's activities. These timelines would necessarily undergo future revisions, especially by the individual committees handling the implementation of various program components, but they provided a useful benchmark to gauge the pace and success of the coalition's efforts. Here is an example of the timeline used for **Program Component #1:**

Partial ERC Timeline: Program Component 1, Year 1

	Jan	Feb	March	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Research and select appropriate curriculum.	X	X										
Secure grant money for instructor salaries and purchase of curriculum/school supplies.	X	X	X	X								
Create official curriculum proposal to be approved by school board.			X	X	X	X	X					
Work with area schools to find instructors for curriculum.			X	X	X	X	X	X				
Train teachers with curriculum (use paid/ free consultant for this).					X	X	X	X	X			
Adjust school schedules, and class teaching schedules to incorporate more nutrition information.						X	X	X				
Urge all area middle and high schools to introduce class.								X	X	X	X	X
Publicize the program in the community and provide necessary information to school staff.								X	X	X	X	X

Time Sequencing

Some objectives need to be met before others are put into place, while others can be met concurrently. It is essential to consider the relationships between activities when creating the action plan. A timeline allows for the organization and efficient use of resources and serves as a guide for gauging progress and realistic goal setting. Some questions to consider when creating a timeline are:

- What is the necessary sequence for introducing different activities? What critical tasks need to be accomplished first, second, third, etc? What activities can occur concurrently?
- What are the critical dates (e.g., when do the tasks have to be accomplished to meet the projected implementation deadlines)?
- What other interim tasks have to be accomplished for the community-wide plan to be implemented?
- What concrete benchmarks will indicate progress made toward meeting the goals and objectives?
- When should the project be completed?

It may be helpful to designate a subgroup of persons to write the plan, which should be written in clear, accessible language that makes sense to the community and the people who will be carrying it out. Once the plan is developed, with the responsibilities of each partner clearly defined, it can be distributed by the coalition to the partners. Realistic timelines are needed to ensure timely progress. It is wise to build in a cushion of time while maintaining a set of clearly defined benchmarks to measure timely completion of tasks.

Evaluating Community Resources: Revisiting the Needs-and-Assets Assessment

An understanding of community resources is instrumental in deciding which strategies to pursue at this time and how to pursue them. Although additional funds will probably be necessary to support some of the plan's components, there are numerous ways to be creative with available resources.

Based on the needs-and assets assessment, consider what resources exist:

- What resources does the community (and the coalition) already have in place? For example, who or which groups/agencies are working on the issue, what facilities exist; what activities are already in place?
- How can other community sectors be best incorporated and involved?
- What resources are lacking? How can these be secured?
- What skills need to be developed? Who can help develop them?
- How can all the existing resources be coordinated and better aligned so that simultaneous efforts are under way at each major level of effort (i.e., from the individual/family to school/peers to community to policy/society)?

One of the most important outcomes of a needs-and-assets assessment is gaining an understanding of which existing resources and groups are related to the Critical Health Objectives. Restructuring staff and resources or using money in creative ways can be as useful as seeking new funds. Many resources can be redeployed without using additional funds. For example, two schools in a community that want to reduce the number

of adolescents injured or killed in car crashes involving alcohol might provide free weekend transportation to teens. The two schools can pool their resources (e.g., developing joint grant applications, purchasing of vans, and asking members of Parents and Students Against Destructive Decisions to drive on weekends).

Once completed, assess your action plan:

- Is it based on the needs-and-assets assessment?
- Does it have activities geared to specific individuals, agencies, and community-wide efforts?
- Does it set up specific steps?
- Does it include age-appropriate activities for adolescents?
- Does it include multiple strategies that operate at multiple levels?
- If it involves a coalition, does it coordinate program activities and encourage joint planning among partners?
- Does it incorporate support from multiple funding sources?
- Is it based on best practices?
- Does it clearly delineate who will be involved and responsible for carrying out different components?

(Adapted from Brindis 1999b).

Developing a Logic Model

Using a Logic Model Approach

A logic model is a visual representation that illustrates how an intervention will achieve its intended outcomes by clarifying the links among the needs and the target populations, the goals and objectives, and the intervention strategies. The logic model establishes measurements that will be used for the evaluation and can also be used to facilitate program planning and implementation. The logic model synthesizes all the planning steps presented in this document.

Although a logic model may sound intimidating, it is just another tool for describing how an intervention is intended to work. Laying out intervention components visually can clarify the links among the target population, program activities, and the desired outcomes, and can help communicate the concepts and assumptions supporting the coalition's belief that its intervention will work.

Groups often do not want to create a logic model because they do not see its value and believe it differs little from narrative descriptions of the intervention. Some may not think it necessary to map out what seems obvious. However, there are many ways in which a logic model will ultimately improve the implementation and evaluation of an intervention. A logic model:

- Helps build understanding about what the program is, what it expects to do, and what measures of success it will use.
- Helps monitor progress and track changes during implementation so that successes can be replicated and mistakes can be avoided in the future.

- Serves as an evaluation framework by clarifying evaluation questions and the data needed to answer them.
- Helps reveal assumptions that need validating.
- Provides a clear mechanism to communicate information about the intervention, it's goals, and expected outcomes.

Logic models are typically developed by workgroups of program planners, evaluators, and other stakeholders who are knowledgeable about both the issue and the community. Using such a workgroup promotes stakeholder involvement, greater commitment, and a shared vision of the project.

There are many ways to construct a logic model. The coalition can use the template described here or research other logic model templates (Worksheet 10 provides a template for the method used in this guide). With the exceptions of identifying indicators and data sources as well as constructing a theory of change, the coalition should have defined most of the logic model's components during the action-planning phase. The group will simply need to insert the goals, objectives, antecedent factors being addressed, and program components into the logic model format. Although other logic models may label the components differently, it is important not to be deterred by different terminology. What is important is considering how each component fits in a logical progression of steps toward the goal.

A logic model has the following components:

- **Antecedent Factors:** These factors, which are based on research, either place people at risk for, or protect them from, the health issue being addressed. The antecedent factors should have been identified by the needs-and-assets assessment as relevant to the community.
- **Theory of Change:** This theory explains the underlying assumptions and constructs for why the chosen strategies are expected to create positive change.
- **Program Components:** This set of strategies constitutes the intervention. Individually, strategies may operate on different levels; together they create a comprehensive, multifaceted approach to the problem. Curricula, public education campaigns, drafts of recommendations for policy changes, and service coordination are examples of components that together form a strategy set.
- **Process Indicators:** These measures determine whether the program is being implemented as planned (e.g., training conducted, educational materials handed out, number and types of people reached).
- **Short- and Long-Term Outcomes (From Goals and Objectives):** These outcomes, which are short- and long-term changes expected to result from program activities and components, flow directly from the goals and objectives of the intervention. They can be at the level of individual/family, school/peers, community, or policy/society. Examples include changes in knowledge, skills, attitude, behavior, policies, and programs. Outcomes can be related to such areas as building the capacity of individuals or organizations, reducing underlying risk factors, increasing protective factors, or decreasing risk behaviors.
- **Outcome Indicators:** These measures determine the degree to which an outcome objective has been met. They are usually expressed as increases or decreases in the numbers or percentages of something. One example is an increase in the percentage of persons who, after participating in a program on injury prevention, have increased their knowledge of the subject.

- **Data Sources:** Sources of the data, which can either be readily available from existing sources, or can be collected to measure the process and outcome indicators, can range from state statistics to medical records reviews to surveys of program participants (Western Regional Center for the Application of Prevention Technologies 2003).

Developing a Theory of Change

A very common problem in prevention programs is that program strategies and activities do not lead to the desired outcomes. Thinking through assumptions about why a program should work will help to increase the likelihood that the program will be effective and resources will be put to good use. One approach is to create a series of "if…then" statements.

Example: Theory of Change

If a program invests time and money to develop a directory of drug-free summer activities, then youth will be more informed about what is available in the community. If youth know what is available, then they will be more likely to participate in these programs. If youth participate in alternative activities, then they will be more likely to develop friendships with non-drug-using peers and less likely to use alcohol, tobacco, and other drugs.

In this series of if…then statements, several assumptions are being made about the problem being addressed and what the program can achieve.

- Youth do not currently know what is available.
- The collaborative will have the time, money, expertise, and other resources needed to create the directory.
- Once the directory has been developed, people will receive and use it.
- The people who use the directory will be from the target population.
- Knowing about available activities will lead youth to participate in them.
- The activities will support the development of positive peer relationships.

Taking the time to understand assumptions will help the coalition clarify the logic behind its intervention, highlight assumptions that may be incorrect, and identify additional steps to be taken. In the example shown in the box, the coalition might discover the need to develop a strategy for publicizing the directory in a way that ensures that the target population will be reached. The coalition might also realize that it needs to create a referral system for increasing the likelihood that young people who need the programs will actually enroll.

Developing a theory of change is another tool for ensuring that resources are used wisely and that an intervention is based on sound logic. It will also help the coalition communicate about the program more effectively to colleagues, community members, and potential funders.

Developing Indicators

Indicators can be thought of as markers toward achieving its goal that help the collaborative know whether it is on the right path. They are essential for evaluating a program's effectiveness. Many of the health issues addressed by the 2010 Critical Health Objectives are caused by an array of complex, multifaceted factors, and thus programs addressing the Critical Health Objectives may take several years to produce results. Identifying realistic indicators, which can be assessed at periodic intervals, will help the collaborative and its funders know if the intervention is making progress.

Indicators help measure progress in quantifiable ways. For example, the percentage of adolescents who exercise 3 to 5 times per week for 30 minutes or more serves as an indicator for the goal "teens are physically active." The percentage of adolescents who wear seat belts is a possible indicator for "teens are safe." The coalition needs to consider, in both its action plan and the logic model, the indicators that will help determine whether it is meeting its goals. Coalitions should make sure that their indicator set includes measures at the four levels of action: individual/family-, schools/peer-, community, and policy/society-.

Indicators can be used to gauge progress only if they are compared to baseline measures. Once collaborative members have decided on their indicators, they must collect data to determine the community's current status as measured by them. Data from the needs-and-assets assessment or from state or national sources can serve as a baseline. Data will be collected again at intervals throughout implementation and after program completion to measure the impact of the intervention. The Evaluation section of this document provides further discussion.

Example: Outcome Indicator Inventory Tool: UNHEALTHY DIETARY BEHAVIOR

Type of Indicator	Indicator	Method and Source	Availability (City, County, State, National, or Not Available)
Risk factor	Poor body image	Minnesota Student Survey	City, county, and state
Protective factor	Parental nutrition behavior	CDC Behavioral Risk Factor Surveillance System	State
Youth risk behavior	Fast or skip meals to lose or control weight	Minnesota Student Survey	City, county, and state
Youth risk behavior	Few or no servings of fruits, fruit juices, and vegetables yesterday	Minnesota Student Survey	City, county, and state
Consequence of youth risk behavior	Overweight	Minnesota Health Profile	County and state
Consequences of youth risk behavior	Type 2 Diabetes	Minnesota Health Profile	County and state
Capacity building	Policies regarding nutritional content of school meals	School district records	County and state

(Source: Minnesota Youth Risk Behavior Endowment 2003).

As program accountability becomes increasingly important to potential funders, greater emphasis is placed on measuring the "results" of an intervention, which makes the need for program indicators clear. In addition, with the relatively new emphasis on youth development and asset building as prevention strategies, it is important that programs measure asset- or resiliency-based indicators. Although measures of resiliency are still in development, there is already a strong body of evidence supporting this new approach. See Chapter 4 for more information on measuring assets and possible indicators of this concept.

Once the coalition has created a logic model, the members should check their logic: is each element of the model causally linked to the next? Are causal linkages realistic? Are both outcomes and activities clear and measurable? The time invested in developing the logic model is well spent, as it enables the group to address potentially troublesome issues in advance so that less time is diverted during implementation to

working on such problems. It is important to schedule sufficient time to develop the logic model; working through assumptions and reaching consensus will ultimately benefit the resulting intervention.

Celebrate a job well done. To keep partners motivated and inspired, it is a good idea to plan informal get-togethers (e.g., on a semi annual basis) to celebrate group accomplishments, however "small." Do not wait until the broader goals are attained, as they are harder to meet. Instead, celebrate the attainment of immediate objectives, which will show appreciation to partners and also draw attention to the progress being made.

EAT RIGHT COALITION SAMPLE LOGIC MODEL

Antecedent Factor	Theory of Change	Program Component	Process Indicator	Outcome(s)	Indicator(s)	Method/Data Source
Knowledge about nutrition and physical activity. Eating habits established by parents and/or at home (e.g., sit-down dinners, parent/child cooking). Access to fast food vs. healthier selections at school. School funding (uses funds generated by calorie-dense competitive foods to fund lunch service program, sports, etc.).	What youth eat in school affects their eating habits outside of school. Some youth will change their eating habits if given healthier, appetizing, inexpensive options. Publicizing changes in menu along with information on eating healthfully will encourage students to eat healthier if given options.	Offer comprehensive middle/high school nutrition and cooking classes that will increase individual understanding of core nutritional concepts. Create a supportive food service environment in area middle/high schools by offering more healthy, appetizing options in school menus and conducting healthy-eating campaigns.	Increase in number of healthier food options on menu. Increase in number of healthier foods, items sold. Decrease in number of fast-food items sold.	Short-term: Selling healthier food options will be sustainable for school cafeteria. Schools/school board will adopt policies that promote healthier eating through school cafeterias. Improved dietary lifestyle of teens (at school and at home). Long-term: Reduction in the proportion of teens who are overweight or obese.	Improved availability of healthy food choices and increased use by students. Strong policies in place that promote healthy food choices. Increased numbers of youth eating more fresh fruits and vegetables and fewer calorie-dense foods. Decreased proportion of teens who are overweight or obese.	Review of school and district policies. Survey data of youth and cafeteria workers. Medical records of youth.

*** Sources consulted for Best Practices and Guidelines include:*
American Academy of Family Physicians, American Academy of Pediatrics, American Dietetic Association, Centers for Disease Control and Prevention, National Hispanic Association, National Medical Association, Office of the Surgeon General, U.S. Department of Agriculture, U.S. Department of Health and Human Services.

Implementing an Action Plan

Implementation of Previously Evaluated Programs

When following an intervention program that has been previously evaluated, it is advantageous to implement as many of the components as possible. Maintaining the integrity of the approach will maximize the potential for achieving results similar to the original, although adaptation may be necessary to make the intervention relevant and meaningful to new communities.

For any prevention or intervention program at the individual level to be successful, the targeted youth must find the activities interesting and want to participate in them.

As the coalition plans to implement its model, it must consider the adaptations necessary to match the needs and demographics of the selected populations. However, it is vital to adhere to the model program (the concept of "fidelity") while making necessary adaptations based on such differences as culture and age of target population.

Adhering to the model entails maintaining the standards of previously evaluated programs. Compare the original community (from the evaluated model) and its resources to the target populations or community and available resources. Consider how the coalition can expand or modify the evaluated model for the population of interest (e.g., group with a different culture, youth with special needs). The coalition should take care, however, not to change the components that make an intervention successful. In brief, it is acceptable to add elements, but unadvisable to dilute critical aspects of any model or promising program. The Center for Substance Abuse Prevention provides instructions or tools for achieving program fidelity when applying model programs.

Communication Within the Collaboration and the Community

As the program gets under way, it is important for the coalition to keep relevant partners and community members informed about its progress. The coalition should communicate to partners how their input was incorporated and check in regularly with the persons carrying out the action. It is important to be accessible to partners and open to their concerns on what is needed to fulfill goals. Collaborative members could be asked to report on how they are accomplishing their tasks and be given an opportunity to communicate any questions, concerns, or suggestions that they may. Communication strategies could include in-person meetings, conference calls, e-mail or fax. Regular updates, such as a quarterly newsletter or a monthly group e-mail, are useful for synthesizing and celebrating the implementation efforts under way.

More formal partners, such as project funders, should receive a semi-annual or annual report covering the progress of the coalition. It is critically important to be accountable to those connected to the coalition's work. It is also important to get the word out to the community about the coalition's accomplishments and progress. It is also helpful to maintain relationships with the media, send them press releases, and invite them to community events. These efforts will also raise awareness about the issue and build support in the community.

Community Involvement and Staying Consistent With the Action Plan

Community members and youth need to be actively involved throughout the implementation of the action plan; there are several ways to achieve this aim. The highest degree of community involvement means that young people, community residents, coalition members, and partner organizations are actively involved in carrying out components of the action plan. For example, young people and parents might be trained as peer educators or members of a speakers' bureau. A partner organization might expand its existing mentoring program to serve a new group of young people recruited through the coalition's new intervention. An example of a less-involved form of inclusion is asking community members to serve on an advisory board of young people, parents, teachers, health care providers, and other relevant stakeholders. Such a group might meet monthly or quarterly to hear updates about the intervention, help troubleshoot challenges to the implementation, and plan additional activities.

The action plan is a work in progress, and the coalition should be open to suggestions for making it stronger and more complete. Although an advisory board can make helpful recommendations and bring to light some ways the intervention could be modified to better meet the needs of the community, there are serious risks to modifying the intervention partway through implementation. As outlined previously, changing or

eliminating components of a model program can weaken its effects. In addition, groups often miscalculate the time and resources necessary to implement a program, and activities can take longer than expected to get off the ground. The coalition also might find that certain organizations or institutions previously identified as collaborating partners are now unwilling to work with it. In reality, timelines and strategies will need to be continually reassessed, and the coalition will need to troubleshoot a variety of issues throughout the implementation process.

EAT RIGHT COALITION (ERC) CASE STUDY (continued)

Now that the action planning committee had formed an initial plan, it sent out flyers to all ERC members and posted them around the town. The flyers publicized the plans for the next meeting to adopt the action plans formulated by the action planning committee and work committees, etc. Approximately 100 persons attended the meeting, and they overwhelmingly approved the action plans. There was some disagreement about whether the timelines could be met, with many attendees believing there was not enough time for such activities as recruiting instructors for nutrition classes, but most attendees felt the timelines represented a good starting point.

The director of the health department and the school board chief decided to form two committees to oversee implementation of the agreed-upon program components. A moderate number of parents, principals, teachers, health care professionals, clergy, and youth volunteered, but there were not enough to truly implement coalition activities. Also, the volunteers did not possess sufficient expertise to manage the program components effectively. Thus, the audience members, especially educators and influential persons in the community, were urged to use the next month to actively recruit other principals, teachers, lawmakers, and parents into the coalition so that ERC's efforts would have more community support, expertise, and a better likelihood of success. A follow-up meeting was planned for the next month.

The next meeting had approximately 50 attendees, which included influential local citizens, such as prominent lawmakers, school board members, clergy, physicians, and principals, teachers, as well as some parents. These persons had been recruited by previous ERC members and offered general support for what the ERC was trying to achieve. Again, volunteers for the two program component committees (PCCs) came forward, and several additional persons volunteered to serve. This group appeared to have significantly more influence in the community and direct knowledge of what was being attempted. To supplement the volunteers, the health department director assigned several departmental employees to the various committees. It was unclear, however, how many of the new recruits would consistently participate in the coalition's efforts. The director of the health department stated that even though no formal governing structure had been adopted by the ERC, there should be a structure for managing funds, keeping track of progress, addressing needs, and so forth. The attendees decided that the director and the school board chief should remain the informal heads of the coalition, and two volunteers agreed to act as treasurer and secretary. Each PCC was asked to form its own governing structure and was required to send a progress report every month to the action planning committee. The various committees were expected to start meeting within a month. An advisory board of several volunteers was formed to help the PCCs troubleshoot problems.

Implementation

While the director of the health department concentrated on securing stable funding, the PCCs tried to follow the directives of the action planning committee and set tasks for individual members. Tasks included deciding upon and purchasing materials (e.g., the nutrition curriculum); deciding how to find and use

necessary labor; advocating in front of school board members, policy makers, and principals; and tracking project indicators.

The PCC in charge of implementing the school nutrition and cooking class worked with area principals and the school board to find a curriculum that would suit the needs of the community. Initially, it found many curricula that were either geared toward urban communities or were not particularly useful for racially diverse communities (this town had large African- American and Hispanic populations). When the committee discovered a curriculum that appeared responsive to the town's needs, the price was prohibitively high. Finally, using input from local PTA groups, youth, and teachers, the committee settled on a curriculum that had served rural communities. Even though it was not as comprehensive as desired, the curriculum had been used in similar towns around the country with good results. It taught basic nutrition education and incorporated physical activity education, which was useful for schools desiring to form a coordinated "nutrition web" among physical education, nutrition, health, and food service staffs. The school board approved the curriculum.

The committee's biggest obstacle was achieving consolidated support for the program among the teachers and principals of area high schools and middle schools. Although schools were not responsible for purchasing the curriculum or paying the teachers extra for their additional efforts (this would be accomplished with grant funds), they still had to adjust student schedules, implement evaluation and tracking measures, and make sure the curriculum was integrated with the changes being requested by the other PCCs. To achieve this goal, the PCC charged with implementing the nutrition and cooking class worked with the school board and a popular health class teacher to create a detailed presentation that spelled out the important points of the curriculum intervention, its successful implementation elsewhere, how in other school districts health teachers participated, and where funding would be obtained. This presentation was given to area educators at a school board meeting. Concurrently, sympathetic influential parents, teachers, and youth activists lobbied for the curriculum at area schools, and youth activism was employed. The PCC then worked with school principals and teachers to create a class schedule and course content that would minimally disrupt the existing school environment; it also scheduled time for pretraining teachers in the curriculum. Subsequently, a final curriculum proposal incorporating all salient points was presented to the school board and received majority approval. The proposal's open support from the school board had significant impact not just on its passage but also on its acceptance by area middle/high schools; the school board's participation and involvement in the intervention had been central to the PCCs' success. Although the school district was careful not to dilute the curriculum, it did make additions felt to be relevant to the local community (e.g., it emphasized food enjoyed by its African-American members). Interestingly, the curriculum had been developed to be part of an existing health course, but some PCC members and other educators thought it merited a separate class. To maintain fidelity to the curriculum's intended use as well as to conserve funds, however, it was kept as part of a larger school health course.

The PCC charged with creating a more supportive school food service environment faced several difficult tasks. First, it needed to work with food service staff members, dieticians, and youth to come up with a list of foods that would meet three criteria: healthy, low cost, and appetizing. After the list was compiled, the PCC worked with principals, youth, and food service staff to develop ideas for healthy-eating campaigns that promoted the new foods. This task required speaking to other communities that had implemented similar programs and working with the other PCCs to ensure that their activities were properly coordinated. Such coordination involved offering the same foods cafeteria that were discussed in nutrition classes, allowing nutrition classes to meet in cafeterias to learn how to prepare healthy meals, and posting the nutritional contents of various school meals. Constant reinforcement of principles of healthy nutrition was a central aim.

As in other PCCs, youth activism played a prominent role in shaping these efforts. As part of its efforts, the PCC concerned with a supportive food service environment gave a detailed presentation to the school board and area educators about this program component; it specified what foods could be purchased, how coalition money would be used to purchase these foods as well as improved cooking equipment for needy schools. It also gave a preview of the planned healthy-food campaigns. The proposal received majority approval by the board. Two principals were not convinced, however, that they were not already providing healthy foods. They adopted a wait-and-see approach to see how successful other schools were with the program; they committed to joining the program the following year if there were noticeable results.

Youth Involvement

Youth had helped administer the needs-and-assets assessment and had voted in the prioritization process, but they had not taken an active role in the action planning committees. One concern was that the high school youth who had been specifically invited to the initial meeting made up the majority of those participating. Few middle school youth were participating, and few new high school students had been recruited. To address this problem, both PCCs elicited ideas from youth members on new ways to recruit other youth. The youth already involved were asked to take one month to focus solely on recruiting other youth. Specific attention was focused on having high school youth recruit middle school youth; recruiting more peer leaders; and letting youth know they would be valued active members of the coalition. The start of PCC activities was delayed until the process was finished. The process took longer than expected, but 15 more youth were recruited. Six youth were assigned to each PCC. The other youth chose to participate by helping out with administrative duties, including preparing progress reports and recording minutes at coalition meetings. The youth received modest stipends for their work.

The youth involved in the PCCs were quite active in planning the coalition's activities. The youth in the nutrition curriculum committee helped to select the final curriculum, interviewed officials from other towns to see how similar programs had been implemented, conducted literature searches on making health and nutrition materials engaging for youth, interviewed youth to find out what things they wanted in a nutrition class, added to the curriculum to meet students' desires, and worked with health teachers during the pretraining period to make nutrition classes engaging and interesting. Very importantly, these youth worked with principals and school board members to convince them of the necessity of nutrition and cooking classes. These youth were not only a prominent voice in the curriculum PCC, they were oftentimes the *dominant* voice in this PCC. They effectively represented the concerns of the curriculum's intended target population.

The youth working in the PCC concerned with making healthy additions to school menus and conducting healthy-eating campaigns in cafeterias were also heavily involved. Their input led to decisions to reject or accept certain healthy foods: They interviewed officials in other communities who implemented similar measures; they worked with educators and food service staff to create exciting, relevant healthy-eating campaigns; and they took inventories of the food equipment needs of area high and middle schools. These students were integral to the PCC's operation.

Despite the efforts of these 15 students, it was still unclear whether their enthusiasm would catch on with all the students. Many who had been interviewed for recruitment seemed skeptical of the program in spite of peer involvement. In fact, three students dropped out of the coalition because they felt 'it was a waste of time" and because "no kids wanted it." The coalition appreciated that it would need to work harder if it were going to improve general student support for its activities.

APPENDIX 6-1: Force Field Analysis

This appendix outlines the basic process of a **Force Field Analysis**. Consider how the information gathered through the needs-and assets-assessment can be used to fill in the steps of a Force Field Analysis.

1. State the goal(s) you want to accomplish.
2. List all **supporting forces** (i.e., positive forces currently in place that can help reach Critical Health Objective goals).
3. List the **blocking forces** (i.e., conditions currently in place that may prevent you from reaching your goal).
4. Examine the lists of supporting and blocking forces. Assess the strength of each force with respect to fulfilling or limiting your goals.
    - **Significance**: First, rate each supporting and blocking force (on a scale of 1- 3) in terms of its degree of significance. The number "1" represents a factor that is vitally important; the number "3" signifies the least significant force, either in a positive or negative sense. (Significance rankings are listed under the letter "S" in the table.)
    - **Changeability**: Next, rate each force (on a scale of 1- 3) to reflect the difficulty or ease of changing that force, either to increase supportive forces or decrease blocking forces. The number 1 represents a force that is relatively easy to change; the number 3 represents a major barrier that is difficult to overcome. (The ease of changing forces is listed under the letter "C" in the table.)

Sample Force Field Analysis Worksheet

Supporting Forces (+)	S*	C**	Blocking Forces (-)	S	C	Goals
Individual/Family			**Individual/Family**			**Individual/Family**
Teens responded that if offered a wider range of food options that were healthier, they would choose those.	1		Fast food is cheap and teens like it.	1	3	Offer nutrition education for students and parents that teaches how to prepare delicious, low-fat meals that are just as tasty as fast food and can be prepared quickly.
60% of teens would like to increase their level of physical activity.	1		Bag lunches are neither convenient nor cool to students.	1	2	
School/Peers			Teens may not buy healthier foods, such as quality fruits and vegetables, because they may cost more than fast food.	1	2	**School/Peers**
Teens believe there are few healthy fast food options.	1					Offer more affordable low-fat and low-calorie options in the school cafeteria.
More than 50% of high schools surveyed offer healthier food options (e.g., fruit, packaged salad, yogurt, bagels.)[1]	1		**School/Peers** 85% of school districts that sell fast food as a la carte items use profits from these sales to support food service operations.[3]	1	3	**Community** In partnership with the local youth organization that has funding for chronic disease prevention, form a youth development program. Activities may include engaging young people to advocate that local
Some schools that sell only healthy competitive food modify them to be healthier and sell them under the school name.[2]	1		Some school districts also use these profits to	1	3	

Supporting Forces (+)	S*	C**	Blocking Forces (-)	S	C	Goals
Community Several sports and recreation programs are available through the schools, the city's Parks and Recreation Department, and community based organizations.	1		fund other functions, e.g., athletics, education programs, and extracurricular activities.[4]			restaurants add low-fat options to their menus. The program can also help enroll young people in existing sports and recreation programs.
A local youth organization recently received a grant for chronic disease prevention activities.	1		At least 72% of responding school districts allow fast food and beverage advertising (e.g., posters, advertisements on scoreboards, other signage).[5]	1	3	**Policy/Society** With the participation of young people, develop a public education campaign about healthy eating to counteract the impact of advertising and the media.
Policy/Society CDC guideline: Increase availability of and accessibility to healthy foods to reinforce better eating.	1		**Community** There are an abundance of fast food restaurants in the community, especially near the schools.	1	3	
The Surgeon General's Call to Action: Include new foods and foods prepared in new ways and sufficient choices to better meet the taste preferences of a diverse student population.	1		**Policy/Society** Adolescents are exposed to hundreds of advertisements for fast foods and other unhealthy foods that make poor dietary behaviors seem attractive.	1	3	
CDC guideline: Implement a change in eating habits in schools because it is an opportunity to reinforce healthy eating.	1					

*S = Significance of force (1= most important; 2 = moderately important; 3 = least important)
**C = Ability to change the force (1 = easy for change; 2 = moderate effort required for change; 3 = challenging for change)

[1] Public Health Institute, "California High School Fast Food Survey: Findings and Recommendations." (2000) Author: Berkeley, California.
[2] Ibid
[3] Ibid
[4] Ibid
[5] Ibid

Force Field Analysis Blank Worksheet

Supporting Forces (+)	S*	C**	Blocking Forces (-)	S	C	Goals
1. Individual/Family			1. Individual/Family			1. Individual/Family
2. School/Peers			2. School/Peers			2. School/Peers
3. Community			3. Community			3. Community
4. Policy/Society			4. Policy/Society			4. Policy/Society

*S = Significance of force (1= most important; 2 = moderately important; 3 = least important)
**C = Ability to change the force (1 = easy for change; 2 = moderate effort required for change; 3 = challenging for change)

After rating the strength of each supporting and blocking force, the following steps will help determine the most appropriate strategies.

1. **Brainstorm strategies to diminish or remove the strongest blocking force(s)**. List what the group can do to weaken or eliminate blocking forces. In the example provided, schools are very resistant to giving up contracts with fast food and soda vendors as profits from their sales support school programs. However, students indicate that there are few healthy food options in the school cafeteria and the options that are available are more expensive than fast food. Offering a wider variety of healthy foods at affordable prices may diminish the appeal of fast food.

2. **Brainstorm strategies to strengthen the strongest supporting force(s).** List what the community can do to strengthen these forces, combining strong positives if possible. For example, 60% of the teens surveyed would like to increase their levels of physical activity and there are several already existing after school sports programs. Perhaps the coalition can identify ways to involve teens in these sports programs or expand or enhance the programs.

3. **Try to reverse a strong blocking force into a strong supporting force**. This requires ingenuity and creativity! For instance, the media is a powerful influence on young people. Advertising sends a strong message to young people that eating unhealthy foods is positive and cool. However, the coalition can decide to use the media to their advantage by creating counter-messages that show healthy eating and exercise as the more positive option.

4. **Research best practices to help identify promising strategies**.
   If the coalition has done some research on best practices for the health issue they are addressing, they can plug in the strategies that seem most appropriate based on the specific characteristics of their community that have been identified in the Force Field Analysis.

Addressing the strongest blocking forces generally has the greatest impact. However, sometimes the energy and resources required to change these forces may be too big a strain on existing resources. Instead, choose to work on a factor that is easier to change. Starting small and succeeding creates a sense of success and lends credibility to the coalition. It is much easier to build on smaller successes than to reach too high and fail, especially if resources are limited. For example, in the Force Field Analysis, extending the health education curricula on dietary and exercise habits in high schools appears to be extremely challenging, often due to the constraints schools face such as academic accountability and limited funding. It may be more realistic to try to limit teens' access to foods high in fat and sugar, by, for instance, regulating vending machines and advocating that school cafeterias offer low-fat snacks and fruit. This is not to say that the easiest strategy is always the best, especially if it has little potential to make an impact. The coalition should weigh each strategy and employ the one that seems both feasible and effective.

Keep in mind the four levels of influence when brainstorming strategies, so that the group can work toward a multi-level approach. Using the Force Field Analysis model should facilitate the prioritization process by helping the group choose where they want to focus next steps and which levels they would like to focus on first.

Selected Forces for Change

Diminish/Remove Strongest Blocking Force(s)		Who can help with this strategy?	Other available resources:	Implementation priority:	Action Steps
	Potential Strategies				
Individual/Family					
School/Peers					
Community					
Policy/Society					
Strengthen Strongest Blocking Force(s)					
	Potential Strategies				
Individual/Family					
School/Peers					
Community					
Policy/Society					

Worksheet 6: Prioritization

On a scale of 1-5, please indicate the degree to which you think each proposed strategy will be effective and supported by the community. All answers will be averaged and used to help prioritize strategies for the community action plan.

Proposed Strategy	Community Support					Effectiveness				
	Weak		Strong			Low		High		
	1	2	3	4	5	1	2	3	4	5
	1	2	3	4	5	1	2	3	4	5
	1	2	3	4	5	1	2	3	4	5
	1	2	3	4	5	1	2	3	4	5
	1	2	3	4	5	1	2	3	4	5
	1	2	3	4	5	1	2	3	4	5
	1	2	3	4	5	1	2	3	4	5

Source: Adapted from: Wadud, E. (2002). Rating community goals. In *Community Toolbox: Part J, Chapter 38, Section 3*. Retrieved September 29, 2002, from *http://crb.lsi.ukans.edu/tools/en/sub_section_main_1365.htm*

Instructions for Using the Prioritization Survey

- Use this survey with a group that offers broad representation of community stakeholders and viewpoints.
- Results may be used to prioritize strategies, or they may indicate a need to revise strategies and survey the group again.

1. Distribute the survey and describe to respondents what is meant by community support and effectiveness:
    - Community Support—Will the community find this strategy controversial, culturally appropriate, or a necessary expense? Will it consider the strategy a priority? These are examples of what respondents should consider when ranking each strategy for community support.
    - Effectiveness—Respondents should consider whether each strategy is based on best practices, whether the strategy will target young people most at risk, and whether the community has the resources to implement it.
2. Review survey responses: Someone will need to average the ratings for community support and effectiveness for each strategy. The results can be summerized in a table similar to this one:

Strategy	Community Support	Effectiveness
1. Change school lunch menus	3.7	4.5
2. Do away with candy machines on school grounds	1.8	3.9

3. The coalition will need to decide what strategies constitute higher and low priority for community members based on these ratings. One way to use this information to prioritize strategies is to create a ranking system similar to this one:

High Priority = high community support, high effectiveness
Priority = low community support, high effectiveness
Low Priority = high community support, low effectiveness
Last Resort = low community support, low effectiveness

Worksheet 7: Writing Goals and Objectives

Use this worksheet to create goals and objectives for your intervention. Copy extra sheets as needed.

Goals are *long-term outcomes* of an intervention that a community hopes to achieve over a significant period of time. A typical intervention has only one or two major goals, which may be pursued through multiple objectives.

Objectives are *short-term outcomes* and should be thought of as pathways to goals. They can be measured at the completion of a program or several months afterward.

When developing goals and objectives for an action plan, it is important to:

- Clearly **link** each objective to a goal.
- Be sure that both goals and objectives are **measurable**.
- Be specific about the **geographic area**, **target population**, and **time frame** of each goal and objective.

Goals	Objectives
By 2006, motor vehicle injuries among teenagers living in the state aged 16–19 will decrease by 20%.	By 2003, there will be a 25% decrease in the number of adolescents aged 16–19 who have ridden in a car with someone who has been drinking.
	By 2004, 75% of adolescents will be able to identify at least four strategies for preventing motor vehicle injuries.
	By 2005, the number of adolescents aged 16–19 who wear a seatbelt will increase by 25%.

Source: Card, J., Brindis, C.D., Peterson, J., & Niego, S. (2001). *Guidebook: Evaluating teen pregnancy prevention programs* (2nd ed, Chapter 4). Los Altos, CA: Sociometrics.

Worksheet 8: Linking Program Components with Goals and Objectives

Once goals and objectives have been identified, use this worksheet to link them with program components or activities. If matching a particular component to your goals and objectives seems difficult, you may need to abandon this approach and find a more appropriate strategy. Completing this worksheet will help the coalition focus its efforts. Complete the table from right to left by first filling in the Goals and Objectives columns, then filling in the program components that relate to them. It may help to draw arrows between program components and the goals and objectives to which they correspond, as some components will address more than one goal and objective.

Level	Program Component	Objectives	Goals
Individual/Family			
School/Peers			
Community			
Policy/Society			

Source: Card, J., Brindis, C.D., Peterson, J., & Niego, S. (2001). *Guidebook: Evaluating teen pregnancy prevention programs* (2nd ed, Chapter 4). Los Altos, CA: Sociometrics.

Worksheet 9: Action Plan Worksheet

Use this worksheet to create an action plan, or work plan, that will guide implementation efforts. A separate sheet can be completed for each program component. Make copies as needed.

Program Component:

Action Step	Person(s) Responsible	Data to be Completed	Resources Required	Potential Barriers or Resistance	Collaborations
Example Recruit, train, retain, and supervise a youth advisory board to assist in the development of a campaign.	Adult leaders, college mentors, Emilio, Cathy.	April 30, 2007.	Transportation, handouts, easel, paper, food, supervision, stipend.	Transportation, inability to recruit interested youth, parents concerned about their children participating.	Principal, PTA, student council, minority student union, business leaders (to pay stipends).

Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health; Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health; National Adolescent Health Information Center, University of California, San Francisco. *Improving the Health of Adolescents & Young Adults: A Guide for States and Communities.* Atlanta, GA: 2004.

Worksheet 10: Creating a Logic Model

This worksheet will help you create a logic model, which clarifies the links among the antecedent factors of the health issue, the intervention's goals and objectives, and the intervention strategies. Complete the worksheet from left to right, listing the following: 1) Antecedent Factors identified in your assessment process, 2) your theory of change (explaining why program components will bring about change), 3) program components, 4) indicators that will help monitor whether program components are being implemented as planned, 5) short- and long-term outcomes that the intervention is expected to bring about (short-term outcomes should correspond to objectives and long-term outcomes to program goals), 6) indicators that will serve as benchmarks of progress toward outcomes, and 7) sources of existing data or methods for collecting data to measure indicators.

Example: Sample logic model to reduce overweight and obesity rates among youth in the community.

Antecedent Factors	Theory of Change	Program Components	Process Indicators	Outcomes	Outcome & Impact Indicators	Methods/Data Source
Knowledge levels about nutrition. Eating habits established by parents and/or at home (e.g., sit-down dinners, parent/child cooking). Access to fast food vs. healthier selections at school. School funding (uses funds generated by sales of fast foods to fund lunch service program, sports, etc.).	What youth eat in schools affects their eating habits outside of school. Some youth will change their eating habits if given healthier, appetizing, inexpensive options. Publicizing changes in menu along with information on eating healthy will encourage students to eat healthier.	Provide nutrition and cooking classes for students and parents. Offer more healthy food options on school lunch menu and in school vending machines.	No. of nutrition and cooking classes offered. No. of people attending cooking classes. No. of healthier food options on menu. No. of healthier food options in vending machines. No. of parents involved in cooking meals with their teens.	**Short-term** Students and parents have increased knowledge of good nutrition practices and how to cook nutritious foods. Schools/ school board will adopt policies that promote healthier eating through nutrition classes, school cafeteria, and vending machines. No. of healthier foods, items sold increases. Decrease in No. of foods sold with high-fat, calorie, and sodium contents. Increase in number of students who eat recommended daily amounts of fruits and vegetables. Decrease in students' daily intake of foods with high-fat, calorie, and sodium contents.	**Outcome** Increased knowledge of good nutrition practices and how to cook nutritious foods. Policies regarding nutritional content of school meals. Cafeteria and vending machine sales. Servings of fruits, fruit juices, and vegetables yesterday. Servings of foods high in fat, sugar, and sodium. No. of times a student ate a meal at a restaurant. No. of meals from fast food restaurant.	Pre- and post-tests administered to nutrition/cooking class participants. School district records. School food service sales receipts. Student food logs.

Source: Western Regional Center for the Application of Prevention Technologies. (2003). *Building a successful prevention program: Step 7, Evaluation*. Retrieved May 23, 2003, from *http://www.unr.edu/westcapt/bestpractices/eval.htm.*

Antecedent Factors	Theory of Change	Program Components	Process Indicators	Outcomes	Outcome & Impact Indicators	Methods/Data Source
				Long-term Reduce the proportion of teens who are overweight or obese.	Impact % Overweight.	