SAFE STATES

STATE OF THE STATES

2015 REPORT

About the Safe States Alliance

The Safe States Alliance is a national non-profit organization and professional association whose mission is to strengthen the practice of injury and violence prevention.

To advance this mission, Safe States Alliance engages in activities that include:

- Increasing awareness of injury and violence throughout the lifespan as a public health problem;

- Enhancing the capacity of public health agencies and their partners to ensure effective injury and violence prevention programs by disseminating best practices, setting standards for surveillance, conducting program assessments, and facilitating peer-to-peer technical assistance;

- Providing educational opportunities, training, and professional development for those within the injury and violence prevention field;

- Collaborating with other national organizations and federal agencies to achieve shared goals;

- Advocating for public health policies designed to advance injury and violence prevention;

- Convening leaders and serving as the voice of injury and violence prevention programs within state health departments; and

- Representing the diverse professionals that make up the injury and violence prevention field.

For more information about the Safe States Alliance, contact the national office:

Safe States Alliance
2200 Century Parkway, Suite 700
Atlanta, Georgia 30345
770.690.9000
info@safestates.org
www.safestates.org

From the Safe States Alliance

The Safe States Alliance is proud to present the *State of the States: 2015 Report*, the only national assessment of capacity among state public health injury and violence prevention (IVP) programs in the United States. Now in its sixth iteration, State of the States provides the most up-to-date and comprehensive information about the structure, organization, people, resources, and work of state IVP programs.

This report provides:

- comprehensive national data on the status of state IVP programs;
- longitudinal views of changes that have occurred in state IVP programs over time; and
- a collection of stories illustrating achievements of state IVP programs in 2015.

Survey findings from the State of the State assessment are presented as a series of six issue briefs that align with the six "core components" of IVP, listed on page 8 of this report, and described in detail in our publication, *Building Safer States: 2013 Edition*. We have included examples of each of these core components "in action," highlighting the current successes and future potential of the critical work of state IVP programs.

We sincerely thank state IVP program staff for their commitment and effort to complete the extensive *State of the States* survey, and for their vital work in their states and communities. *State of the States* is made possible by the continued financial support of the National Center for Injury Prevention and Control (NCIPC) of the Centers for Disease Control and Prevention (CDC). Safe States would like to thank its members and partners for reviewing materials and providing indispensable input into this resource. The comprehensive report, individual issue briefs, and highlights from the report are available online at: http://www.safestates.org/SOTS.

We welcome your thoughts on how Safe States can continue to build this resource to serve the field of injury and violence prevention.

Sincerely,

Binnie LeHew
President

Amber N. Williams
Executive Director

Binnie LeHew, MSW
President, Safe States Alliance
Executive Officer, Office of Disability,
Injury & Violence Prevention
Iowa Department of Health

Amber N. Williams
Executive Director
Safe States Alliance

From the Centers for Disease Control & Prevention

Roderick McClure
*Director - Division of
Analysis, Research and
Practice Integration*

The National Center for Injury Prevention and Control (Injury Center) of the Centers for Disease Control and Prevention (CDC) is pleased to partner with Safe States Alliance in their production of the *State of the States: 2015 Report*.

Violence and injuries continue to be the leading causes of death for the first four decades of life. Working with state health departments and their injury and violence prevention (IVP) programs is a critical component of CDC's strategy to prevent injuries and save lives.

The *State of the States: 2015 Report* provides valuable up-to-date and comprehensive information that helps us understand the progress and needs of state IVP programs, as well as highlighting the life-saving work being conducted across the nation to prevent violence and injuries.

CDC's Injury Center congratulates Safe States Alliance and the state health departments who worked collaboratively on this important report. We are pleased to continue our support of this work and look forward to working alongside Safe States Alliance and state health departments to make progress in reducing violence and injury-related death and disability in each state and throughout the nation.

Sincerely,

Rod McClure, MBBS, PhD, FAFPHM, FAICD
Director, Division of Analysis, Research, and Practice Integration
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Acknowledgements

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Background

KEY INJURY AND VIOLENCE FACTS

Injuries and violence affect everyone – at every age, and in every community. Each year, thousands of Americans lose their lives to injuries or violence, succumbing to the consequences of falls, car and bicycle crashes, homicides, suicides, unintentional poisonings, fires, and drownings. Injuries are the leading cause of death for people ages 1-44 in the United States and the fourth leading cause of death for Americans overall.[1] Injuries and violence have a significant impact on the overall health of Americans including premature death, disability, and an increased burden placed on the health care system. Despite the existence of prevention strategies that have been proven effective, each year there are:

Over 26.9 Million	People treated in emergency departments for injuries[1]
Over 2.5 Million	Hospitalizations related to injury[1]
Nearly 199,800	Deaths related to injury - nearly 1 person every 3 minutes[1]
$671 Billion	Lifetime medical and work loss costs due to injury and violence[2,3]

THE CORE COMPONENTS OF STATE INJURY AND VIOLENCE PREVENTION PROGRAMS

In the United States, injury and violence prevention (IVP) efforts – particularly those at the community and societal levels – are most effectively led by state public health IVP programs. In order to successfully implement and evaluate these efforts, it is essential that states have sufficient organizational "capacity" – an ability to act effectively on a sustained basis in pursuit of their objectives.[4]

[1] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online] (2014) [accessed 2016 Oct 17]. Available from URL: http://www.cdc.gov/injury/wisqars.
[2] Florence C, Simon T, Haegerich T, et al. Estimated Lifetime Medical and Work-Loss Costs of Emergency Department–Treated Nonfatal Injuries — United States, 2013 [online] (2015) [accessed 2016 Oct 17]. Available from URL: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6438a5.htm?s_cid=mm6438a5_w"Estimated%20Lifetime%20Medical%20and%20Work%20Loss%20Costs%20of%20Emergency%20Department%20Treated%20Nonfatal%20Injuries,%20United%20States%202013
[3] Florence C, Simon T, Haegerich T, et al. Estimated Lifetime Medical and Work-Loss Costs of Fatal Injuries — United States, 2013. [online] (2015) [accessed 2016 Oct 17]. Available from URL: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6438a4.htm?s_cid=mm6438a4_w"Estimated%20Lifetime%20Medical%20and%20Work%20Loss%20Costs%20of%20Fatal%20Injury,%20United%20States%202013.
[4] Polidano C. Measuring public sector capacity. *World Dev*. 2000;28(5):805–822.

The Safe States Alliance has defined six "core components" that describe the capacity of IVP programs.[5] They are:

Build and sustain a
solid, stable
infrastructure

Collect, analyze, and disseminate
injury and violence data

Provide **training** and
**technical
assistance**

Select, implement,
and evaluate effective
**program and policy
strategies**

Effectively **communicate**
information to key
stakeholders

Engage
partners for
collaboration
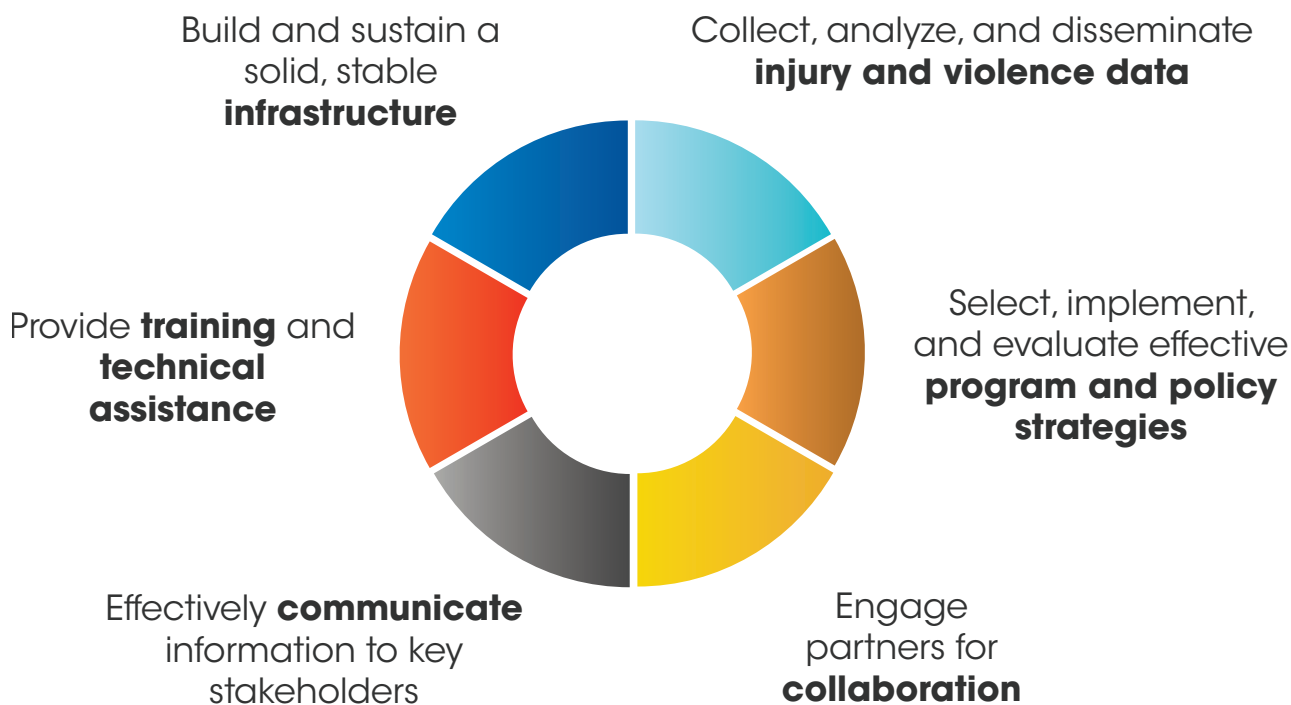
These components are essential, foundational elements that address data collection and analysis; identification of the populations and locations at greatest risk; identification of risk and protective factors; and development and utilization of evidence-based strategies and programs to address injuries and violence at the individual, family, community, and societal levels.

THE NEED FOR STATE PUBLIC HEALTH INJURY AND VIOLENCE PREVENTION PROGRAMS

A comprehensive and effective IVP program that is located within the state health department is key to providing focus and direction for prevention efforts. State health department IVP programs that are grounded in the public health approach and attuned to the six core components are best positioned to meet the challenges associated with coordinating many diverse prevention partners and making the best use of limited resources.

Robust, innovative, and adaptable state health department IVP programs are critical to ensuring that collective progress is made to reduce injuries and violence across the nation. Given the importance of building and maintaining comprehensive state programs to prevent and address injuries and violence, it is critical to conduct regular assessments of their capacity to understand how they are functioning and what elements are needed to strengthen and sustain their work.

[5] Building Safer States: Core Components of State Public Health Injury and Violence Prevention Programs. (2013). Atlanta (GA): Safe States Alliance. [accessed 2016 Oct 17]. Available from URL: https://c.ymcdn.com/sites/safestates.site-ym.com/resource/resmgr/Files/2013_BuildingSaferStates.pdf.

Significant, Timely, and Relevant Findings

2015 STATE OF THE STATES SURVEY

INFRASTRUCTURE

- Lifetime medical and work loss costs due to injury and violence in the United States are $671 billion, or $2116 per person. However, responding states spent an average of only $0.68 per person on critical prevention initiatives with funding levels ranging from as low as $0.02 per person up to $4.11 per person.

- In 2015, nearly $90 million from 28 funding sources was invested in state injury and violence prevention (IVP) programs among the 39 responding states - an average of $2.3 million per state (median of $1.6 million, ranging from $18,000 to $9.7 million).

- Five funding sources – CDC/NCIPC RPE, CDC PHHS Block Grant, HRSA/MCHB Title V Block, Dedicated State Funding Streams, and State General Revenue – accounted for 61 percent ($54.9 million) of the total funding received by responding state IVP programs and supported over half (56%) of the 328.9 FTE working across these programs in 2015.

DATA

- Since 2009, state IVP program access to data professionals (e.g., epidemiologist, statistician, etc.) has decreased. Twenty-one percent of states report no access to data professionals in 2015, compared to only four percent in 2009. States with Core VIPP funding had an average of 2.5 FTEs of data professionals compared to 0.86 FTEs among non-Core VIPP funded state IVP programs.

POLICY AND PROGRAMS

- States most commonly reported using programs to address fall injuries, unintentional poisoning/prescription drug overdose (PDO), sexual violence, child passenger safety, and suicide. Policy strategies were most commonly used for a different set of injury priorities: child passenger safety, teen driver safety, unintentional poisoning/PDO, and seat belts.

- Previously, state IVP programs reported informing policy through collaboration with partners more frequently than independently. However, in 2015, informing policy through collaboration with partners decreased as much as 32% from 2013 for all activities except inviting congressional delegates to meetings/events (5% increase).

COLLABORATION

- State IVP programs continue to partner with other state agencies, federal agencies, non-governmental organizations, and private entities for access to the latest research evidence, assistance with evaluation, topic-specific expertise, and more. Most notably, the proportion of state IVP programs that have a strong relationship with ICRCs has increased from 26% in 2009 to 50% in 2015.

COMMUNICATION

- State health departments are increasing communication efforts, with an emphasis on leveraging digital platforms to share their states' critical injury and violence-related information. Both website and social media usage have increased substantially over recent years, while more traditional digital sharing, such as newsletters or group listservs, have either stagnated or decreased in usage.

TRAINING

- While nearly every responding state provided some form of training or technical assistance (TA) to others engaged in prevention efforts in 2015, they were more frequently the recipient of TA and training than they were the provider. States most often *provided* TA around program strategies and interventions, and most often *received* TA on data analysis and evaluation.

About the Survey: Methodology & Results

The *State of the States: 2015 Report* presents results from the sixth administration of the State of the States survey. The Safe States Alliance conducts this data collection activity on a biennial basis to develop a comprehensive picture of the status of U.S. state health department injury and violence prevention (IVP) programs over time.

The 2015 State of the States survey was developed and reviewed by Safe States staff members and an evaluation consultant. Most questions have remained throughout iterations over the years; some questions were updated to improve clarity.

The 2015 State of the States survey was administered from November 2015 – May 2016, and collected data on the status of programs in Federal Fiscal Year (FFY) 2015 (October 1, 2014 – September 30, 2015). A total of 46 states participated in the 2015 State of the States Survey. However, not all states responded to all survey questions; therefore, the number of states responding to each question varies, as noted in figures, tables, and text throughout the document.

In most states, the state health officer appoints a staff person to serve as the state's designated Safe States Alliance representative. In these cases, the 2015 survey was sent to this state representative. In states without a designated Safe States Alliance representative, the state IVP program was contacted to identify the appropriate person to complete the survey. Safe States Alliance sent each state representative/survey respondent an email containing a link to the online survey. A copy of the survey was also included as an attachment to the email. Participating states completed the survey online or sent Safe States Alliance a completed hard copy. If a hard copy was submitted, Safe States Alliance staff entered the data into the survey database.

Special considerations regarding the data presented are as follows:

- Results within the report are organized around each of the six core components identified by Safe States Alliance as essential elements that describe the capacity of a comprehensive state public health IVP program.
- Some questions, such as those about IVP program staff, were asked at the individual level instead of the state level. For these questions, exact numbers are referenced in figures, tables, and document text.
- Motor vehicle injury as a grouped category was not reported by states in the primary focus areas in the 2015 survey.
- Totals on graphs and charts may not add up to 100% due to rounding and occurrences in which respondents could select more than one survey option (i.e., "check all that apply").
- Unless noted otherwise, all reported results reflect the status of state IVP programs in FFY 2015. All references to "2015 data" or the "2015 survey" are for the period of the 2015 FFY.
- While a majority of states participated in the survey, the data presented in this report are not national and only represent those states providing responses to survey questions.

The results presented in this report were analyzed using the statistical software: Statistical Package for the Social Sciences (SPSS) Version 23.0.

Build a Solid Infrastructure for Injury and Violence Prevention

UNDERSTANDING THE INFRASTRUCTURE OF STATE INJURY AND VIOLENCE PREVENTION PROGRAMS

Infrastructure refers to the basic physical and organizational "building blocks" that make it possible for a state injury and violence prevention (IVP) program to function.

Key characteristics of a state program's infrastructure may include: a state mandate, a stable and supportive organizational location (usually within a state health department), core staff and leadership, strategic plans, and stable funding. Each of these characteristics can impact how a state IVP program is structured, how it operates, and what it is capable of achieving.

ORGANIZATIONAL LOCATION

A centralized program is one in which the identified IVP program is primarily responsible for conducting all IVP activities. Centralized programs maximize coordination across IVP efforts and allow for a more comprehensive approach to IVP. In contrast, decentralized programs often experience challenges in securing funding due to a lack of dedicated staff time and competition among departments.

- In 2015, the majority of state IVP programs (89%) were located within state health departments.
- More than one-third of state programs (38%) were located in an organizational unit that addresses health promotion, disease prevention, community health, and/or behavioral health.
- Of the 44 states responding to the survey, 38 states reported having some type of formal IVP program in their state (Figure 1).
    - ❑ Twenty-three (23) states (52%) reported a centralized program in which the IVP program is primarily responsible for conducting all IVP activities for the state.
    - ❑ Fifteen (15) states (34%) reported a decentralized program in which IVP activities are conducted by multiple departments across the state health department.

Figure 1.
Centralization of IVP Activities Among States with IVP Programs, 2015, 2013, and 2011

Legend:
- No Formal State IVP Program
- IVP Activities in State are Decentralized
- IVP Activities in State are Centralized

2015 (N=44): 14%, 34%, 52%
2013 (N=41): 10%, 31%, 59%
2011 (N=47): 11%, 32%, 57%
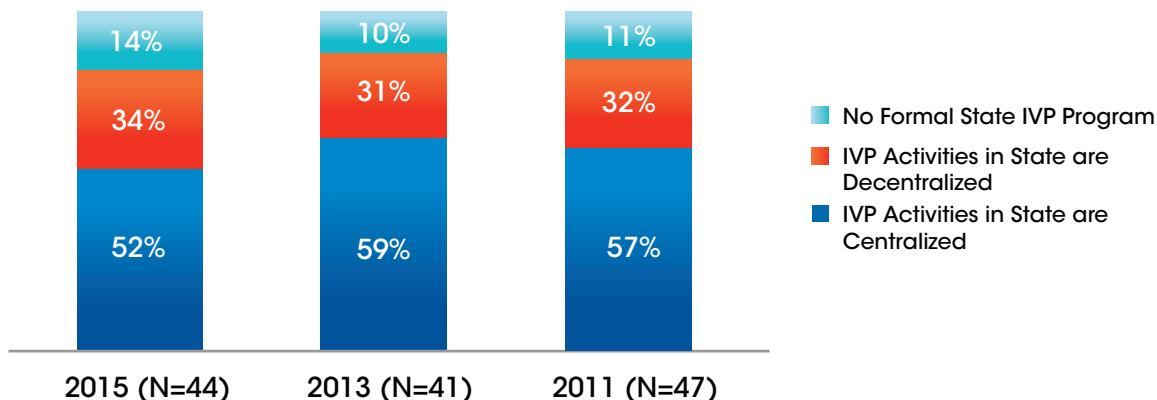
STRATEGIC PLANNING

States are increasingly using strategic plans to guide their IVP work to ensure that all activities are supporting their departmental and organizational missions.

- The majority of states reported that at least one type of statewide plan existed to guide IVP activities (Figure 2).
- Between 2009 and 2015, there have been notable increases in the presence of health department strategic plans (29% to 77%) and statewide health plans (18% to 61%). These plans address multiple health issues and extend beyond IVP.
- While the presence of IVP-specific strategic plans has also increased during that time, particularly for state IVP plans (29% to 59%), they continue to be less common than overall health-related strategic plans.

Figure 2.
States Reporting the Existence of State and/or Health Department Plans, 2009, 2011, 2013, and 2015

■ 2009 (N=49) ■ 2011 (N=47) ■ 2013 (N=41) ■ 2015 (N=44)

State Health Department Strategic Plan
- 77%
- 79%
- 47%
- 29%

State Injury and Violence Prevention Plan
- 59%
- 55%
- 53%
- 29%

State Health Department Injury and Violence Prevention Plan
- 32%
- 31%
- 43%
- 24%

Statewide Health Plan
- 61%
- 29%
- 23%
- 18%
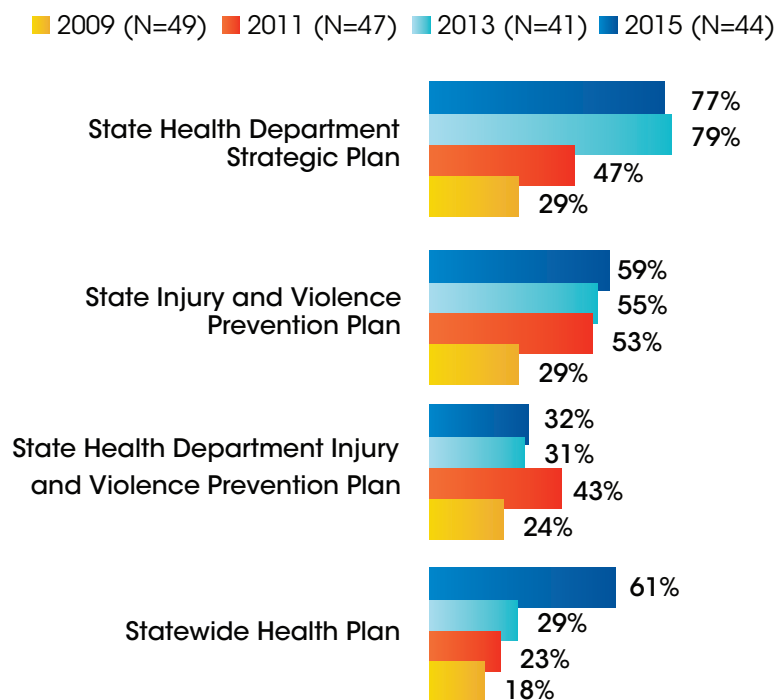
TYPES OF FUNDING SOURCES

In 2015, nearly $90 million was invested in state IVP programs among the 39 states that responded to this survey item.

- This is an average of $2.3 million per state program (median of $1.6 million, ranging from $18,000 to $9.7 million).
- Investments in state IVP programs come from a variety of funding sources, including federal agencies, state governments, non-profit organizations, and foundations.
- Sixty-seven percent of funding awarded to state IVP programs is from federal sources (Figure 3). Comparatively, in a 2014 report by ASTHO, 53 percent of overall state health department agency revenue was from federal sources.[1]

Figure 3.
Funding Source Types Awarded to State IVP Programs, 2015 (N=41)

$59.9M (67%)	Federal Funding: 39 states	• Of the 39 states receiving federal funding, three received federal funding **only** • Two states received **no** federal funding
$28.7M (32%)	State Funding: 39 states	• 36 of the 39 states receiving funding from their state also received funding from federal sources • Three states received state funding **only**
$1.3M (1%)	Other Funding: 14 states	• **All** states receiving funding from other sources also received funds from federal and state sources

STATE AND NATIONAL PER CAPITA COMPARISONS

One person dies in the US every three minutes from injury,[2] however millions of individuals experience injuries and survive. Lifetime medical and work loss costs due to injury and violence in the United States are $671 billion,[2,3] or $2116 per person.[4]

The lifetime costs of injury and violence are $2,116 per person living in the United States

Cost of Injury per person

Investment in IVP Programs per person

$2,116   68¢
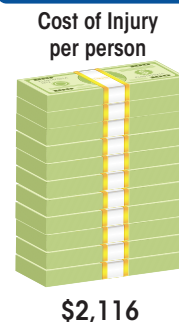
An average of **68¢ per person** is invested in state public health IVP Programs among responding states

[1] Association of State and Territorial Health Officials. ASTHO Profile of State Public Health, Volume Three. Washington, DC: Association of State and Territorial Health Officials. 2014. [accessed 2016 Oct 17]. Available from URL: http://www.astho.org/Profile/Volume-Three/Issue-Briefs/finance/.
[2] Florence C, Simon T, Haegerich T, et al. Estimated Lifetime Medical and Work-Loss Costs of Fatal Injuries — United States, 2013. [online] (2015) [accessed 2016 Oct 17]. Available from URL: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6438a4.htm?s_cid=mm6438a4_w"Estimated%20Lifetime%20Medical%20and%20Work%20Loss%20Costs%20of%20Fatal%20Injury,%20United%20States%202013.
[3] Florence C, Simon T, Haegerich T, et al. Estimated Lifetime Medical and Work-Loss Costs of Emergency Department–Treated Nonfatal Injuries — United States, 2013 [online] (2015) [accessed 2016 Oct 17]. Available frpm URL: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6438a5.htm?s_cid=mm6438a5_w"Estimated%20Lifetime%20Medical%20and%20Work%20Loss%20Costs%20of%20Emergency%20Department%20Treated%20Nonfatal%20Injuries,%20United%20States%202013
[4] United States Census Bureau. American Fact Finder [online] (2016) [accessed 2016 Oct 17]. Available from URL: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

Across respondents, states spent an average of only $0.68 per person with funding levels ranging from as low as $0.02 per person up to $4.11 per person. but still represent a small fraction of public health investments. Trust for America's Health estimated that state and federal governments invested $75.4 billion total in 2013 — or $239 per person.[5] Notably, nearly three-fourths (72%) of responding states were funded at less than the average of $0.68 per person (Figure 4).

Figure 4.
State Health Department IVP Funding per Capita, 2015

State IVP Funding per Capita

- Less than **15¢** per person
- **16¢ - 30¢** per person
- **31¢ - 44¢** per person
- **45¢ - 67¢** per person
- More than **68¢** per person
- No data available
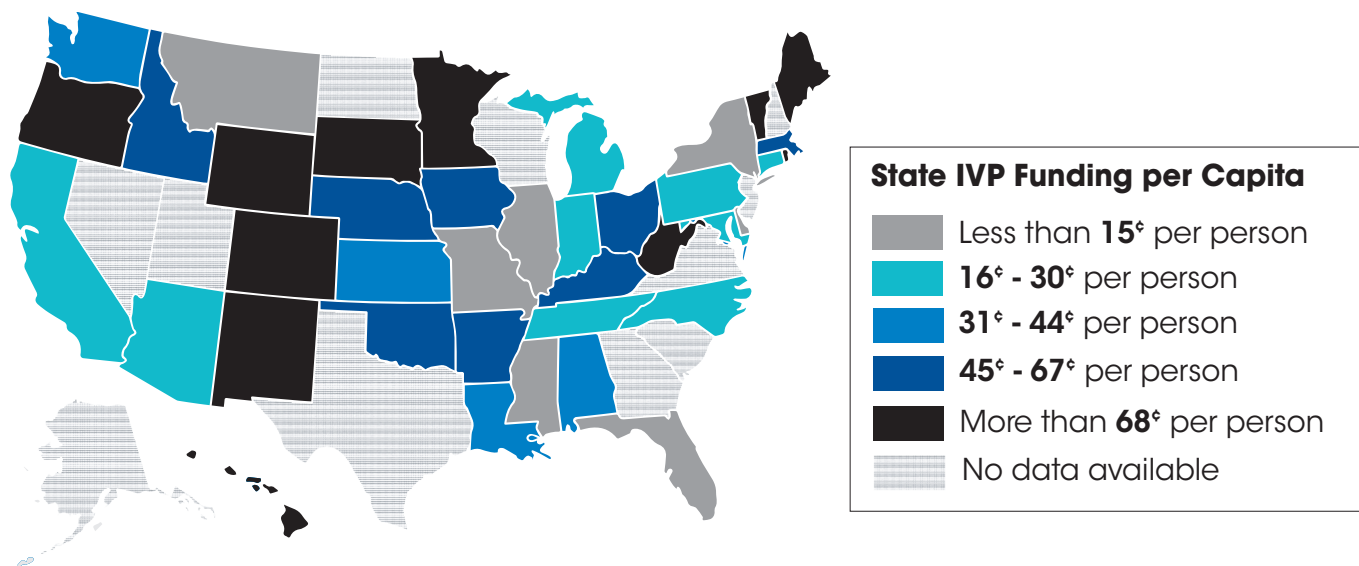
ALLOCATION OF FUNDING AND PROGRAMMATIC TOPIC AREAS SUPPORTED

To make the greatest possible impact on their communities, state IVP programs must strategically invest their resources (Figure 5).

- Public health practitioners are critical to the success of IVP programs, and this importance is reflected in the 2015 funding allocations, with personnel receiving the greatest proportion of funds across funding categories ($32.9 million, 37%).

- Funds to expand the reach of the IVP program beyond the walls of the state health department accounted for the next two largest categories of spending: grants, mini-grants, and contracts to support local programs ($21.2 million, 24%), and external contractors and consultants ($15.9 million, 18%).

[5] Trust for America's Health. Investing in America's Health: A State-by-State Look at Public Health Funding and Key Health Facts 2015. [accessed 2016 Oct 17]. Available from URL: http://healthyamericans.org/assets/files/TFAH-2015-InvestInAmericaRpt-FINAL.pdf.

Figure 5.
Allocation of State Health Department IVP Funding, 2015 (N=39)

$32.9 M
Personnel (Salary & Fringe)

$21.2 M
Grants/Mini-Grants/ Contracts

$15.9 M
Contractor/Consultant (Company or Individual)

$10.2 M
Other

$6.7 M
Overhead Expenses (Indirect Costs)

$3 M
Safety Equipment
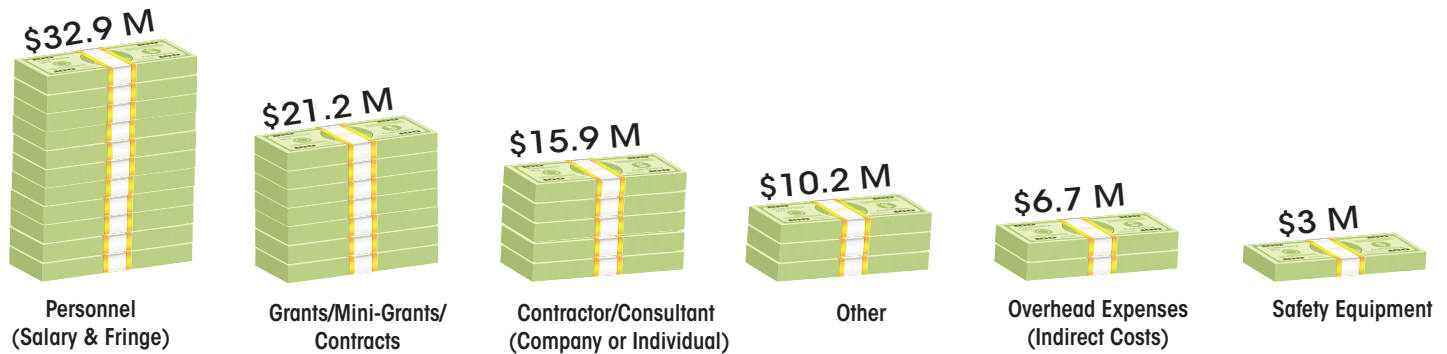
When state IVP programs receive funding from a federal or state source, the funds are frequently used to address multiple injury topics simultaneously. Similarly, states leverage multiple funding sources to address a given injury topic. Table 1 demonstrates the interwoven relationships among these entities.

Table 1.
Top Three Funding Sources for Five Most Commonly-Supported IVP Topic Areas, 2015 (N=42)

Injury Topic Area	No. of Unique Funding Sources	CDC/NCIPC Core VIPP	CDC PHHS Block Grant	CDC/NCIPC National Violent Death Reporting System (NVDRS)	CDC/ NCIPC Rape Prevention and Education (RPE)	HRSA/MCHB Title V Block Grant	SAMHSA State and Tribal Youth Suicide Prevention Grants	State General Revenue
Child Passenger Safety	18		#1 (tied)			#1 (tied)		#3
Fall Injuries (e.g., older adults and children)	12	#1	#2					#3
Sexual Violence	11		#2		#1			#3
Suicide	10			#2			#3	#1
Unintentional Poisoning/ Prescription Drug Overdose	14	#1	#2			#3		

TOP FUNDING SOURCES

Of the 28 funding sources included in the 2015 State of the States Survey, five sources accounted for 61% ($54.9 million) of the total amount of funding utilized by state IVP programs in 2015. These sources included CDC/NCIPC RPE, CDC PHHS Block Grant, HRSA/MCHB Title V Block, Dedicated State Funding Streams, and State General Revenue. Of these five top funding sources, three were federal sources and two were state sources.

- CDC/NCIPC RPE contributed the most dollars to state IVP programs. In 2015, 28 states received a combined total of $17 million from CDC/NCIPC RPE. This is the only nationally funded injury and violence prevention program that all states receive through a block grant program.

- Although fewer states received Dedicated State Funding Stream dollars, this funding source contributed nearly $11 million to 12 state IVP programs in 2015.

Staff time that is dedicated to state IVP programs is measured in terms of full-time equivalents (FTEs) – a unit that allows for the comparison of hourly workloads in a standardized way relative to a traditional 40-hour work week.

- While over 30 funding sources were reported among 44 state health department IVP programs in 2015, over half of FTEs were supported by just five of those sources (Figure 6).

- Nearly 211 FTEs were supported by federal funds, followed by 113 by state funds and six by other funding sources.

Figure 6.
FTEs by Funding Sources, 2015

44%
144.7 FTEs

56%
184.2 FTEs

FTEs Supported by Top Funding Sources:

Dedicated State Funding
52.2 FTEs — **16%**

CDC/NCIPC Core VIPP
37.5 FTEs — **11%**

CDC/NCIPC NVDRS
34.9 FTEs — **11%**

CDC/NCIPC RPE
31.4 FTEs — **10%**

CDC PHHS Block Grant
28.2 FTEs — **9%**
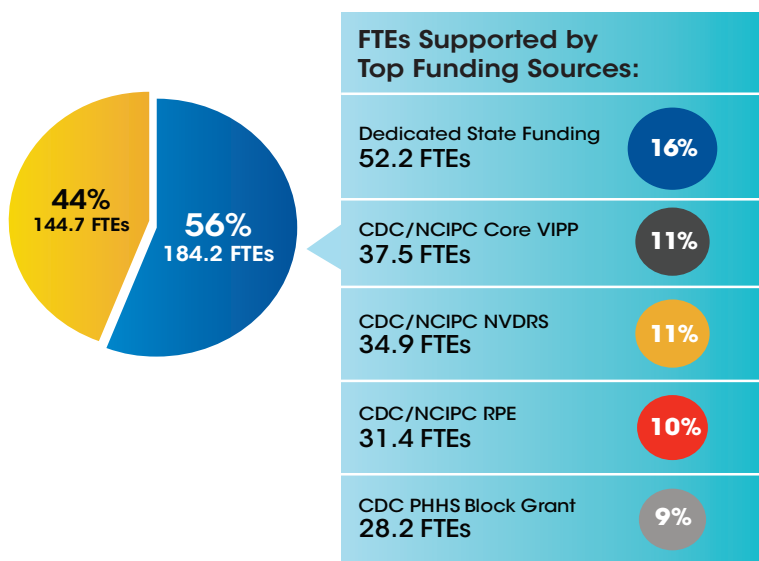
INDIVIDUAL EMPLOYEES AND FULL-TIME EQUIVALENTS (FTE)

- A total of 432 individuals worked in 39 state IVP programs in 2015.
  - Of these individuals, 329 (76%) were full-time or part-time paid staff, 55 (13%) were full-time or part-time contractors, and the remaining 48 (11%) worked in other capacities.

- State programs had a median of 6.0 FTEs and an average of 8.4 FTEs, with values ranging from 0.3 to 26.59 FTEs (Figure 7).
- Forty-one percent of states had 5.0 FTES or less in their IVP program, 35.9% had between 6.0 and 15.0 FTEs, and the remaining 23.1% had more than 16.0 FTEs.

Figure 7.
Distribution of Primary Roles for FTEs, 2015 (N=39 states, N=328.9 FTEs)

328.9
Full-Time Equivalents

Worked within State Injury and Violence Prevention Programs

- **29%** Intervention & Program Coordination
- **20%** Data Analysis & Collection
- **13%** Management
- **10%** Support Staff/Administrative
- **9%** Coalition Building & Coordination
- **9%** Technical Assistance & Training
- **3%** Evaluation
- **3%** Public Policy & Advocacy
- **3%** Communications
- **2%** Other
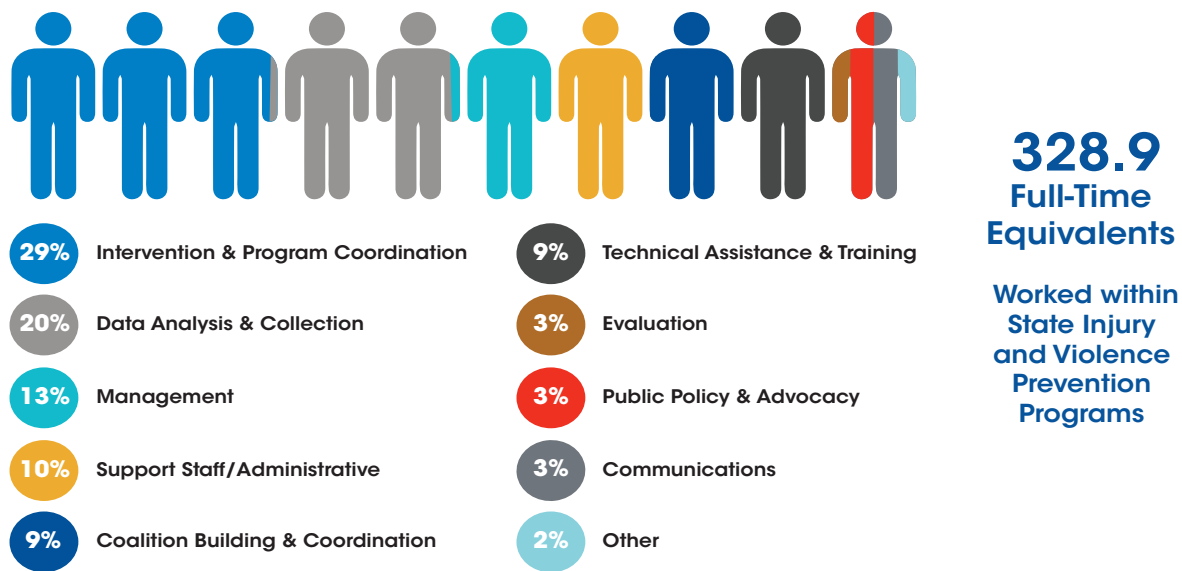
BUDGET CUTS

Seven states experienced budget cuts in 2015. Budget cuts adversely affect the activities and services provided by state IVP programs, reducing the potential impact of their efforts. (Figure 8).

Figure 8.
Anticipated Impacts of Budget Cuts, 2015 (N=7)

Impact	Percent
Reduction in support to partners	57%
Loss of staff through attrition	29%
Reduction in surveillance efforts	14%
Reduction in services	14%
Elimination of entire program(s)	14%
Reduction in support to local health departments	14%
Staff Layoffs	14%
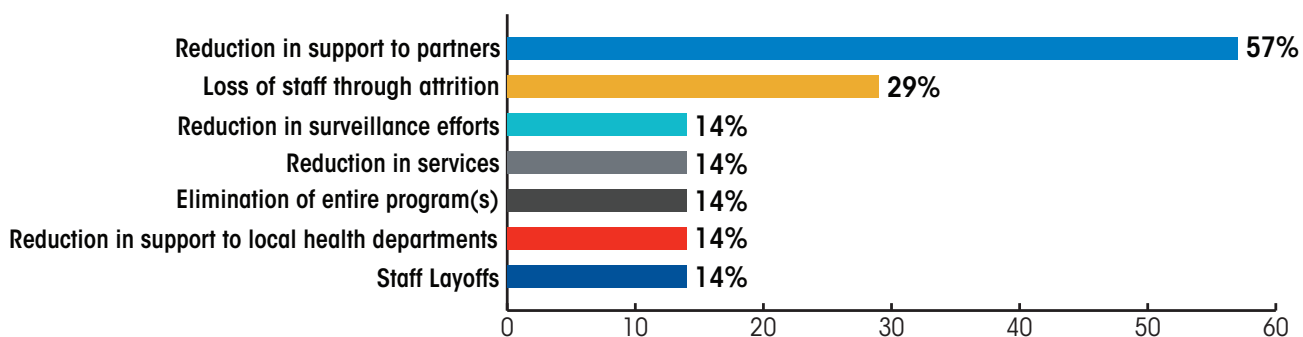
Infrastructure in Action

SHARING AND STRENGTHENING A PUBLIC HEALTH APPROACH TO RAPE PREVENTION EDUCATION ACROSS ILLINOIS

In Illinois, sexual violence programs have always focused their efforts on both sexual violence prevention and response to survivors. When the Violence Against Women Act (VAWA) was passed nearly 25 years ago in 1994, it established CDC's Rape Prevention and Education (RPE) grant program, which provides funding to all 50 states. Since then, public health approaches have influenced the field by **shifting interventions from those focused primarily on prevention education services to broader prevention strategies** aimed at the community and societal levels.

The public health approach calls for using data to define the problem, identifying specific risk and protective factors, matching an evidence-based program to the problem, and then implementing and evaluating the intervention. It sounds simple and straightforward, but in reality is often more complicated.
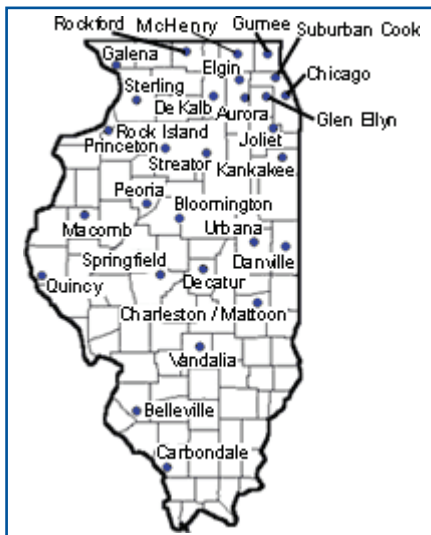
The Illinois Department of Public Health's IVP program (IDPH) and its partner, the Illinois Coalition Against Sexual Assault (ICASA), wanted to ensure that this powerful approach was fully understood and applied by the state's **29 local rape crisis centers**, which are overseen by ICASA and are not formal public health entities. To help spur greater understanding, adoption, and application of the public health approach, they turned to a **combination of training, coaching, and formal requirements** for the annual prevention plans the rape crisis centers are required to submit.

In 2015, rape crisis center directors and staff were encouraged to attend a **customized 2-day training on the public health approach and outcome evaluation**, led by trainers with expertise in both public health and sexual violence. The training topics were unique, but so was the format: directors and staff rarely attend training or other events together to receive the same message at the same time.

Next, ICASA and IDPH worked together to create **annual prevention plan guidance and templates consistent with the public health approach.** The prevention plan prompted rape crisis centers to **use data to identify sexual violence issues in their service area.** They also were asked to **identify risk and protective factors** relevant to the issue, selecting some on their own or from a list of common factors developed by CDC. The plans also called for **identifying the level of the socio-ecological model being addressed**, as well as **specific objectives, strategies, evaluation strategies, and actions.** These, in turn, formed the basis for a workplan that would be reassessed in subsequent years.

After the first wave of prevention plans was submitted in December 2015, ICASA staff carefully reviewed each one, providing extensive and constructive feedback. Rape crisis centers used this feedback to improve or strengthen their plans, and also began submitting **quarterly narrative progress reports** regarding the implementation of their plans. Now, ICASA staff report, "It feels like we've achieved a broad transformation." Indeed, the joint training and collective work on improving their prevention plans and progress reviews have yielded a sense of camaraderie across the 29 centers, **elevated the practice of prevention, extended the health department's reach,** and helped these vital front line practitioners perceive their work as **driven not only by compassion and caring, but also by research and best practice.**

Collect and Analyze Injury and Violence Data

UNDERSTANDING INJURY AND VIOLENCE DATA

To understand and monitor changes to health issues, state injury and violence prevention (IVP) programs must obtain accurate and consistent data. However, the wide range of circumstances under which injuries and violence occur means that there are many different types of injuries, risk factors, and degrees of severity on which to collect data. No single data source can provide all the information needed to accurately describe the burden of injuries and violence. As a result, programs must utilize data from a variety of sources, including vital records (death certificates), hospital discharge data systems, hospital emergency departments, crime reports, and many other sources in order to capture the full scope of an issue.

The Safe States Alliance publication, *Consensus Recommendations for Injury Surveillance in State Health Departments*[1] (ISW5), advises state IVP programs to identify their priorities by using 11 core data sets to analyze recommended injuries and injury risk factors. Such data enable state and local IVP programs to track incidences of injuries and violence, identify underlying causes, identify groups at highest risk, recommend prevention priorities, and measure the effectiveness of policies and programs.

ACCESS TO AND USE OF CORE DATA SETS

In 2015, state IVP programs' access to and use of core data sets varied among the 41 reporting states (Figure 9).

- As in previous survey years, most states reported having access to and using data from the Behavioral Risk Factor Surveillance System (BRFSS) (100%), vital records (98%), the Youth Risk Behavioral Surveillance System (YRBSS) (95%), hospital discharge data (HDD) (88%), and Web-based Injury Statistics Query and Reporting System (WISQARS) (88%).

- Most states who had access to data, used it. However, access to data sources varied by type. National Occupant Protection Use Survey (NOPUS) (78%), Uniform Crime Reporting System (UCR) (61%), and Medical Examiner (ME) (46%) were the least likely to be available for use by the reporting states.

In 2015, state IVP programs used the core data sets to identify topics or populations at risk (Figure 10).

- Sixty-four to 81 percent of states that reported having access to the top five data sources (vital records, BRFSS, YRBSS, HDD, and WISQARS) used the information to identify specific population groups that were affected by various injury or violence issues.

- HDD was the most common data set used to:
  - ❑ identify topic-specific injury and violence issues affecting the state (92%)
  - ❑ identify differences in injury or violence prevalence by specific population groups (81%)
  - ❑ identify geographic regions disproportionately affected by injury or violence issues (78%)

- YRBSS was the most common data set used to identify differences in risk and/or protective factors among populations (69%).

[1] Injury Surveillance Workgroup 5, Consensus Recommendations for Injury Surveillance in State Health Departments. Atlanta (GA): State and Territorial Injury Prevention Directors Association, 2007. [accessed 2016 Oct 17]. Available from URL: http://c.ymcdn.com/sites/www.safestates.org/resource/resmgr/imported/ISW5%20Final%209.13.07%20(color).pdf

Figure 9.
Access to and Use of Core Data Sets, 2015 (N=41)

Legend: ■ Access and Used ■ Access and Didn't Use ■ No Access

Data Set	Access and Used	Access and Didn't Use	No Access
Behvioral Risk Factor Surveillance System (BRFSS)	100%		
Vital Records	98%	*	
Youth Risk Behavior Surveillance System (YRBSS)	95%		5%
Hospital Discharge Data (HDD)	88%	*	10%
Web-based Injury Statistics Query and Reporting (WISQARS)	88%	*	10%
Emergency Department (ED)	71%	5%	24%
Child Death Review (CDR)	66%	5%	29%
Emergency Medical Services (EMS)	61%	5%	34%
Fatality Analysis Reporting System (FARS)	54%	7%	39%
Medical Examiner (ME)	54%		46%
Uniform Crime Reporting (UCR)	37%	*	61%
National Occupant Protection Use Survey (NOPUS)	20%	*	78%

x-axis: 0, 20, 40, 60, 80, 100

* 2 percent or less

Figure 10.
Proportion of States Using the Top Five Accessible Data Sets to Identify IVP Topics or Populations, 2015

Legend:
■ Identify topic-specific injury and violence issues
■ Identify risk and/or protective factors
■ Identify specific population groups
■ Identify geographic regions

Behavioral Risk Factor Surveillance System (BRFSS) N=40: 73%, 66%, 66%, 39%

Vital Records N=37: 90%, 37%, 80%, 76%

Youth Risk Behavior Surveillance System (YRBSS) N=29: 74%, 69%, 64%, 38%

Hospital Discharge Data (HDD) N=34: 92%, 38%, 81%, 78%

Web-based Injury Surveillance Query & Reporting System (WISQARS) N=30: 81%, 24%, 76%, 49%

In addition to the 11 core data sets listed in the ISW5 report, states used multiple other data sets to inform the work of the state IVP program and partner efforts (i.e., motor vehicle traffic records, Pregnancy Risk Assessment Monitoring System, prescription drug monitoring, etc.). Across all data sets, states used information from specific data sets to:

- *Communicate key findings to partners and the public*: HDD (78%), ED (77%), and vital records (76%)
- *Respond to data requests*: HDD (78%), ED (77%), and vital records (76%)
- *Inform policy or program evaluations*: HDD (70%), vital records (66%), motor vehicle traffic records (64%), and medical examiners (64%)
- *Make programmatic decisions*: HDD (78%), ED (77%), and vital records (76%)
- *Create scientific reports or presentations*: ED (71%), HDD (70%), and vital records (68%)

In order to share key data findings with state and local partners, state IVP programs produced a variety of reports and print materials in 2015.

- Ninety-one percent (91%) of states indicated that they produced some type of report using injury and violence surveillance data.
- States most commonly produced fact sheets about injury in general or specific injury problems for the public and/or policy makers (80%).
- Others presented orally or via posters at conferences and workshops (72%), produced technical reports (37%), publications in print media (37%), and publications in peer-reviewed journals (37%).

USE OF DATA SOURCES TO ADDRESS SPECIFIC INJURY AND VIOLENCE TOPIC AREAS

In 2015, vital records, HDD, ED data, and WISQARS were the most the common data sets used to address specific injury and violence topic areas. Vital records were used as a data source for all of the top five priority areas (Table 2).

Table 2.
Most Common Data Sources for Top Five Injury and Violence Topic Areas, 2015

Injury and Violence Topic Areas	Data Source
Fall Injuries (N=30)	Vital Records (87%), Hospital Discharge Data (80%), Emergency Department (67%)
Unintentional Poisoning/Prescription Drug Overdose (PDO) (N=30)	Vital Records (93%), Hospital Discharge Data (77%), Emergency Department (73%)
Sexual Violence (N=25)	Behavioral Risk Factor Surveillance System (64%), National Intimate Partner & Sexual Violence Survey (56%), Vital Records (36%), Youth Risk Behavioral Surveillance System (36%)
Child Passenger Safety (N=24)	Motor Vehicle Traffic Records (71%), Vital Records (63%), Emergency Department (46%)
Suicide (N=22)	Vital Records (95%), Hospital Discharge Data (86%), Emergency Department (68%)

ACCESS TO DATA PROFESSIONALS

- Since 2009, state IVP programs access to data professionals (e.g., epidemiologist, statistician, etc.) has decreased. Twenty-one percent of states report no access to data professionals in 2015, compared to only four percent in 2009 (Figure 11). States with Core VIPP funding had an average of 2.5 FTEs of data professionals within the state IVP program compared to 0.86 FTEs among non-Core VIPP funded state IVP programs.

- Many states, however, had access to data professionals through multiple mechanisms such as the within the state health department, or through consultants or ICRCs.
  - ❏ Thirty-three percent of states reported having access to a data professional within the state IVP program – a substantial decrease from 2013 (76%).
  - ❏ Four percent reported access by consultant, seven percent by an external partner, and seven percent by an Academic Research Center.

Figure 11.
State IVP Program Access to an Epidemiologist, Statistician, or Other Data Professional, 2015, 2013, 2011, and 2009 by FTE

Legend:
- 0 FTE
- 0.01 - 0.50 FTE
- 0.51 - 0.99 FTE
- 1.0 FTE or more

2015 (N=39): 0 FTE 21%, 0.01-0.50 FTE 21%, 0.51-0.99 FTE 5%, 1.0 FTE or more 54%

2013 (N=41): 0 FTE 14%, 0.01-0.50 FTE 20%, 0.51-0.99 FTE 10%, 1.0 FTE or more 56%

2011 (N=47): 0 FTE 2%, 0.01-0.50 FTE 30%, 0.51-0.99 FTE 9%, 1.0 FTE or more 59%

2009 (N=49): 0 FTE 4%, 0.01-0.50 FTE 51%, 0.51-0.99 FTE 4%, 1.0 FTE or more 41%
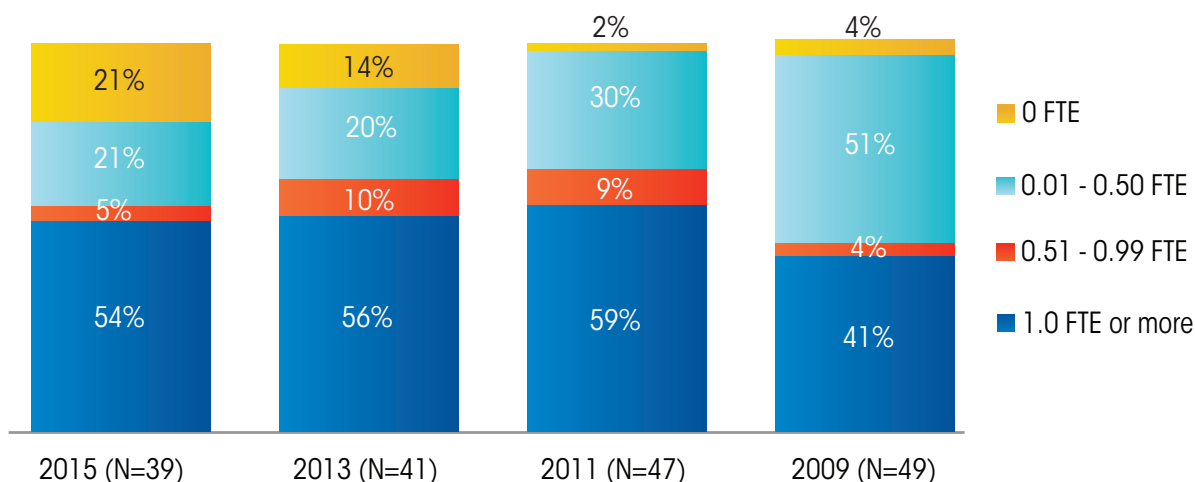
Data in Action

USING DATA TO EXPAND PERSPECTIVES ON CHILDHOOD ADVERSITY AND WELL-BEING IN CALIFORNIA

When the CDC/Kaiser Permanente Adverse Childhood Experiences (ACEs) study was first published in 1998, it changed our understanding of the prevalence of child abuse and neglect and the consequences for adult health. The results showed that two-thirds of an insured, employed population in Southern California had experienced at least one ACE,[2] and one in five had experienced three or more — greatly increasing their risk for adult health conditions such as alcoholism, depression, suicide attempts, and risk for sexual violence, among many others.

The findings were eye-opening, but raised a whole new set of questions. How could ACEs be prevented or mitigated in children before they damaged the health and well-being of adults? How could these findings move outside the clinical, one-on-one realm of doctor and patient to more community-wide, environmental prevention strategies?

In California, a **CDC Essentials for Childhood grant was part of the response**. The grant aligned well with a **Collective Impact approach** that brought early care and education partners together with a common agenda of preventing child maltreatment, conducting mutually reinforcing activities, and sharing data and outcomes. In late 2014, their efforts accelerated when the Center for Youth Wellness released a report — *A Hidden Crisis: Findings on Adverse Childhood Experiences in California*[3] — that included **county-specific AC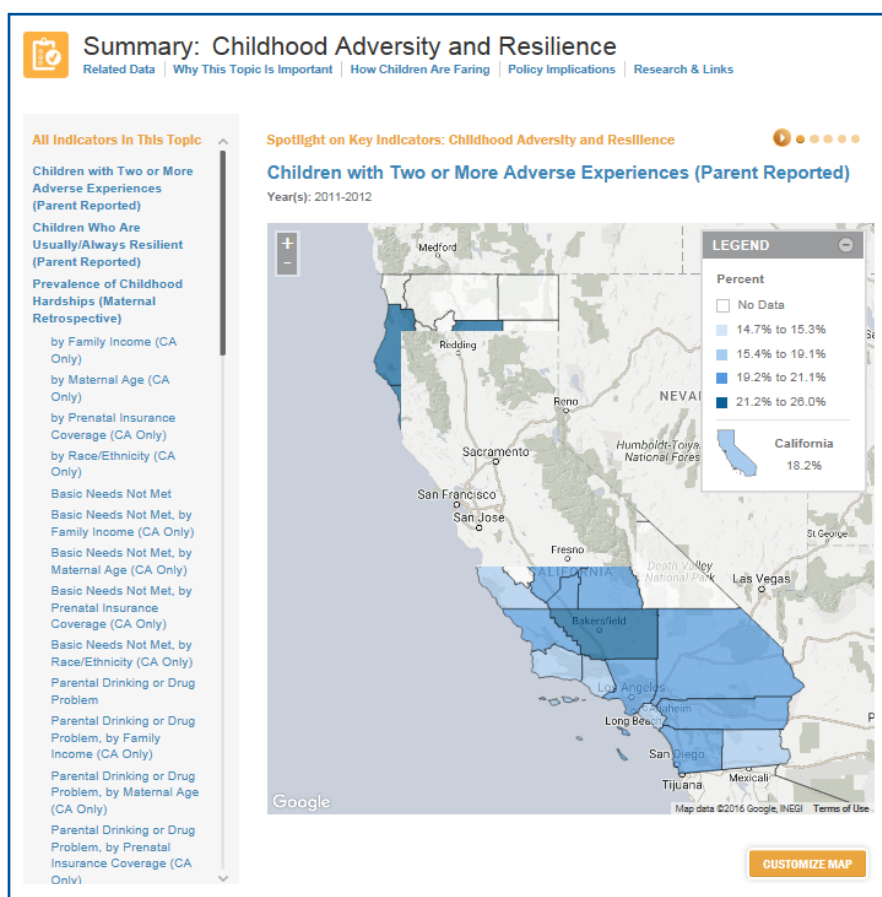Es data from a statewide survey** conducted by the California Department of Public Health (CDPH). CDPH and its partners considered how these data could be made more accessible and useful to the many partners interested in improving child health and well-being at the county level.

With support from the Lucile Packard Foundation for Children's Health, partners including the CDPH's Safe and Active Communities Branch, ACEs Connection, and First 5 California **collaborated** to make county-specific

Summary: Childhood Adversity and Resilience
Related Data | Why This Topic Is Important | How Children Are Faring | Policy Implications | Research & Links

All Indicators In This Topic

Children with Two or More Adverse Experiences (Parent Reported)
Children Who Are Usually/Always Resilient (Parent Reported)
Prevalence of Childhood Hardships (Maternal Retrospective)
by Family Income (CA Only)
by Maternal Age (CA Only)
by Prenatal Insurance Coverage (CA Only)
by Race/Ethnicity (CA Only)
Basic Needs Not Met
Basic Needs Not Met, by Family Income (CA Only)
Basic Needs Not Met, by Maternal Age (CA Only)
Basic Needs Not Met, by Prenatal Insurance Coverage (CA Only)
Basic Needs Not Met, by Race/Ethnicity (CA Only)
Parental Drinking or Drug Problem
Parental Drinking or Drug Problem, by Family Income (CA Only)
Parental Drinking or Drug Problem, by Maternal Age (CA Only)
Parental Drinking or Drug Problem, by Prenatal Insurance Coverage (CA Only)

Spotlight on Key Indicators: Childhood Adversity and Resilience

Children with Two or More Adverse Experiences (Parent Reported)
Year(s): 2011-2012

LEGEND
Percent
No Data
14.7% to 15.3%
15.4% to 19.1%
19.2% to 21.1%
21.2% to 26.0%
California
18.2%

CUSTOMIZE MAP

[2] Centers for Disease Control and Prevention, Division of Violence Prevention, "Adverse Childhood Experiences (ACEs)." [online] (2016) [accessed 2016 Oct 17]. Available from URL: https://www.cdc.gov/violenceprevention/acestudy/.

[3] *A Hidden Crisis: Findings on Adverse Childhood Experiences in California.* (2014). San Francisco (CA): Center for Youth Wellness. [online] (2014) [accessed 2016 Oct 17]. Available from URL: https://app.box.com/s/nf7lw36bjjr5kdfx4ct9.

ACEs data and Essentials for Childhood **indicators more accessible** through a data platform and dashboard.

The project is unfolding in several phases. In the **first phase**, currently underway, **three separate county-level measures of childhood adversity will be combined on www.kidsdata.org** (a statewide child health data website supported by the Packard Foundation). In addition to Behavioral Risk Factor Surveillance System (BRFSS) data on ACEs, these measures will include the Child and Adolescent Health Measurement Initiative (CAMI) National Survey of Children's Health, which asked parents of children aged 12 and under about their exposure to ACEs to measure exposure in real time, instead of waiting until these children are adults. Another measure is the Maternal and Infant Health Assessment (California's equivalent of PRAMS), which poses a series of questions about childhood adversity to post-partum women aged 18-34.

The **second phase** involves individuals selecting a short list of existing www.kidsdata.org indicators that are relevant to their Essentials common agenda and **developing county-specific data dashboards** to display these indicators. Future plans include **identifying data gaps** that could be filled with existing data and incorporating them into the www.kidsdata.org dashboards. For example, the child poverty measure does not currently take into account the effects of California's social safety net programs (e.g., California Work Opportunity and Responsibility to Kids; temporary cash aid; the earned income tax credit; or the California Supplemental Nutrition Assistance Program). Similarly, several surveys (e.g., California Healthy Kids and the National Child Health Survey) collect responses related to childhood resiliency, but these are not available in a way that would be useful and accessible to local advocates and planners. Ultimately, the group hopes to **stimulate broader discussions about childhood trauma and toxic stress** — conversations that move beyond parent-child interactions to address the powerful role of communities, policies, and social norms in preventing child maltreatment. **As data are transformed into more accessible and useful information, increased support can be generated from the public, legislators, and policy makers** for policies that prevent ACEs more effectively, on a societal and community level.

Select, Implement, and Evaluate Effective Policy and Program Strategies

UNDERSTANDING INJURY AND VIOLENCE PREVENTION POLICY AND PROGRAM STRATEGIES

To effectively change individual or group behaviors, public health professionals utilize two key types of interventions: policy-related and programmatic strategies. Policy strategies are those injury and violence prevention (IVP) efforts (administrative actions, incentives, resource allocations, etc.) that involve enacting, changing, or enforcing laws, regulations, procedures, or other voluntary practices of governments and other institutions.[1] According to the Institute of Medicine,[2,3] policy development is an essential public health function. Strategies that involve providing equipment, services, and/or information to individuals or communities for a defined amount of time and with a specific goal in mind are classified as "programs" or programmatic interventions. Programs have been an effective cornerstone of IVP efforts for decades, helping to raise awareness and change individual or group behaviors.[4]

Effective policy and program strategies that are implemented by state IVP programs address multiple forms of injury and violence that affect populations across the lifespan — from infancy to advanced age. Given their limited resources, state IVP programs are encouraged to prioritize strategies that are supported by the best available evidence and can reach those at the highest risk of injuries and violence. In addition, policy and program strategies should be evaluated regularly to ensure they are appropriately serving their populations and achieving their intended outcomes.

POLICY AND PROGRAM STRATEGIES: PRIMARY FOCUS AREAS

State IVP programs addressed multiple injury and violence areas through policy and program strategies in 2015. States were provided with a list of injury and violence-related topic areas, and were asked to indicate if the areas were a primary area of focus, secondary area of focus, minimal focus, or not a focus of the state IVP program in 2015. Each state could indicate more than one area of primary focus, and some topics were not mutually exclusive (e.g., distracted driving and teen driver safety).[5] Figure 12 shows the percentage of state IVP programs that identified the injury and violence topics that were their areas of primary programmatic focus in 2015, and the percentage that had funding allocated specifically to support evaluation efforts among these top nine primary programmatic focus areas.

- States most commonly reported using programs to address fall injuries, unintentional poisoning/prescription drug overdose (PDO), sexual violence, child passenger safety, and suicide.
- Thirty-four percent of states reported a primary focus on one or more motor vehicle injury areas (e.g., child passenger safety, teen driving, distracted driving, etc.).
- Similar to previous years, the topic areas that were generally not addressed by states in 2015 were elder abuse and rural/agricultural injury (no states reported addressing these focus areas).
- States have increased their focus on both falls and unintentional poisoning/prescription drug overdose prevention since 2005, whereas their consistent focus on suicide and motor vehicle-related injuries have remained high in that same time period.
- Compared to 2013, more states reported specifically allocating funding to support evaluation for the topic areas fall injuries (53%), sexual violence (48%), and unintentional poisoning/PDO (45%).

[1] Centers for Disease Control and Prevention, Office of the Associate Director for Policy, "Definition of Policy." [online] (2016) [accessed 2016 Oct 17].
  Available from URL: http://www.cdc.gov/policy/analysis/process/definition.html.
[2] Institute of Medicine (U.S.). *The Future of Public Health.* Washington, D.C.: National Academy Press; 1988.
[3] Institute of Medicine (U.S.). *The Future of the Public's Health in the 21st Century.* Washington, D.C.: National Academy Press; 2002.
[4] *Building Safer States: Core Components of State Public Health Injury and Violence Prevention Programs.* (2013). Atlanta (GA): Safe States Alliance. [accessed 2016 Oct 17]. Available from URL: https://c.ymcdn.com/sites/safestates.site-ym.com/resource/resmgr/Files/2013_BuildingSaferStates.pdf
[5] Motor vehicle injury as a grouped category was not reported by states in the primary focus areas in the 2015 survey.

Figure 12.
Top Nine Primary Programmatic Focus Areas Among State IVP Programs and Percentage of States with Funding Allocated to Support Evaluation for those Topic Areas, 2015
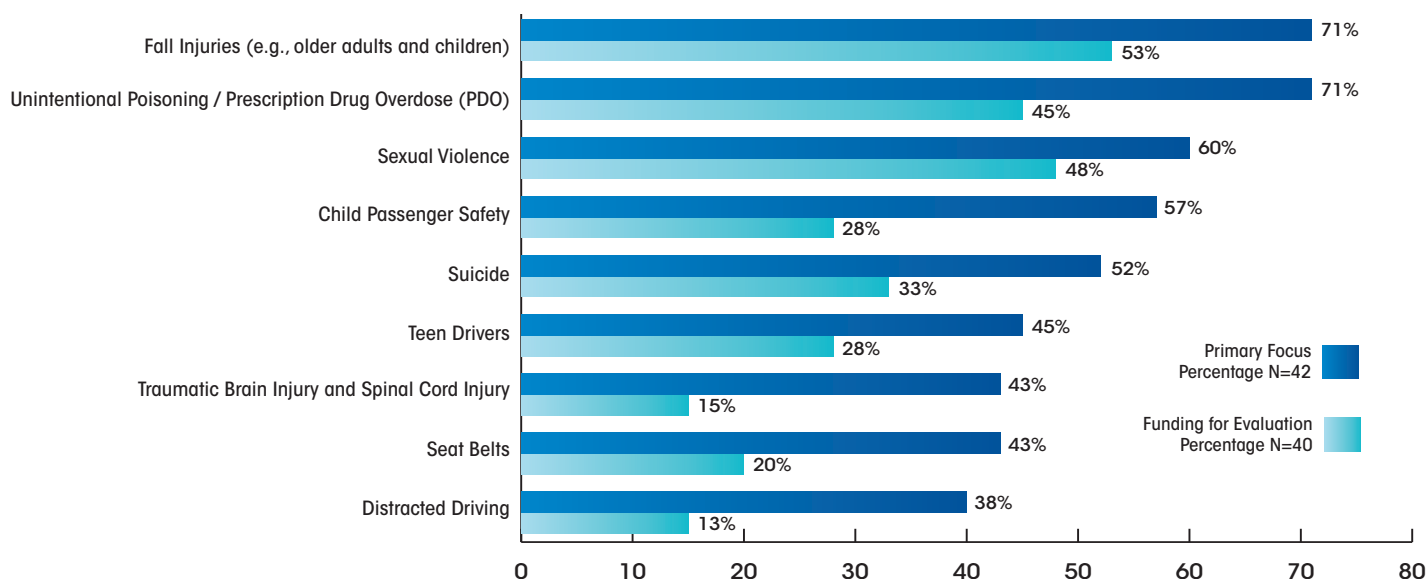
In the 2015 survey, states were asked to indicate how they selected their primary focus areas. Methods of determination included data, funding directives, needs assessments, political influence, state mandates, and other factors.

- Four of the five most common focus areas were determined by the information present in local, state, and national data. The exception was sexual violence prevention, for which funding directives were the primary method of determination (Figure 13).
- State mandates and political influences were the least commonly reported methods of determining primary focus areas. These factors were most frequently determinants for unintentional poisoning/PDO.

Figure 13.
Methods Used for Selecting the Top Five Injury and Violence Focus Areas, 2015

Focus Area	Data	Funding Directives	Needs Assessments	Political Influence	State Mandates
Fall Injuries (30 States)	93%	50%	33%	13%	0%
Unintentional Poisoning/PDO (30 States)	90%	57%	27%	47%	33%
Sexual Violence (25 States)	56%	100%	32%	16%	16%
Child Passenger Safety (24 States)	88%	58%	25%	4%	25%
Suicide (22 States)	95%	73%	27%	27%	27%

Legend
- Data
- Funding Directives
- Needs Assessments
- Political Influence
- State Mandates

POLICY AND PROGRAM STRATEGIES: IMPLEMENTATION AND EVALUATION

Implementation Plans

More than half of state IVP programs reported having an implementation plan to address the five most commonly reported primary focus areas. Table 3 shows the types of planning, evaluation, and reporting for the five most common injury and violence focus areas in 2015.

- Compared to the previous survey year, a larger percentage of states that addressed sexual violence reported having an implementation plan in 2015 (96%) than in 2013 (84%). States addressing this topic area had the highest reported prevalence of an implementation plan among the five most commonly reported primary topic areas.
- Fewer states that addressed fall injuries and unintentional poisoning/PDO had implementation plans in 2015 compared to 2013.
- Many states reported that the five most common injury and violence focus areas were addressed in their state strategic plan.

Evaluation Activities and Reporting

Strong public health programs require comprehensive evaluation planning in order to track and monitor program quality and effectiveness. Across the five most commonly reported focus areas for state IVP programs:

- Fewer than half of states reported having an evaluation plan for fall injuries, poisoning/PDO, child passenger safety, and/or suicide (Table 3).

- However, 84% of states that had a primary focus area of sexual violence prevention had an evaluation plan in place.

- Despite not having a formal evaluation plan, some states reported conducting evaluation activities (e.g., collecting process and/or outcome evaluation data) to update or change program or policy activities. The percentage of states that reported having outcome evaluation activities was highest for suicide (64%) among the five most commonly reported primary focus areas.

- On the decline in 2015, less than half of all states reported policy and program evaluation outcomes to stakeholders for all five of the most common primary focus areas (Table 3).

Table 3.
Reported Planning, Evaluation, and Dissemination of Findings for the Five Most Commonly Reported Focus Areas for State IVP Programs, 2015

		Fall Injuries (N=30)	Unintentional Poisoning/ PDO (N=30)	Sexual Violence (N=25)	Child Passenger Safety (N=24)	Suicide (N=22)
Implementation Plans	Implementation plan exists	67%	63%	96%	54%	77%
	Topic area is addressed in a state plan	83%	67%	44%	58%	68%
	No written formal implementation plan	3%	10%	0%	21%	9%
Evaluation Plans	Evaluation plan exists	47%	40%	84%	38%	45%
	Process evaluation data is collected to update or change program and/or policy activities	57%	43%	64%	50%	59%
	Outcome evaluation data is collected to update or change program and/or policy activities	53%	47%	56%	33%	64%
Dissemination of Findings	IVP program reports program and/or policy outcomes to stakeholders	43%	40%	36%	25%	45%

METHODS TO INFORM POLICY STRATEGIES

State IVP programs can play a vital role by informing policy decisions that may affect rates of injuries and violence. In 2015, states used multiple methods to inform public, regulatory, and/or organizational policies, both directly and through collaboration with partners (Table 4).

- Compared to 2013, states reported less frequent use of most of the direct methods available to inform policy in 2015. The only methods that increased were: working to encourage adoption of organizational policies for IVP; drafting and submitting potential policies to policymakers; and inviting congressional delegates to meetings/ events.

- The most common methods to inform policy that were used by state IVP programs in 2015 included:
  - ❑ Working to encourage adoption of original policies for IVP (61%)
  - ❑ Participating in boards and/or commissions (56%)
  - ❑ Working to increase public awareness of laws (56%)
  - ❑ Recommending health department positions on bills (54%)

Previously, state IVP programs reported using methods to inform policy through collaboration with partners more frequently than independently. However, in 2015, informing policy through collaboration with partners decreased as much as 32 percent from 2013 in all methods except inviting congressional delegates to meetings/events (5% increase).

Table 4.

Methods Used by State IVP Programs to Inform Public Policy, 2015 (N=41), 2013 (N=40)

Public Policy Method	Used Directly by the State IVP Program in 2015	Net Change in Method Used Directly by the State IVP Program since 2013	Used Through Collaboration with Partners in 2015	Net Change in Method Used Through Collaboration with Partners since 2013
Conducted cost benefit analyses of IVP policies	17%	↓ 7%	10%	↓ 12%
Drafted and submitted potential policies to policymakers	34%	↑ 18%	46%	↓ 8%
Evaluated/assessed/monitored the impact of laws	49%	↓ 10%	41%	↓ 22%
Invited congressional delegates to meetings/events	15%	↑ 4%	32%	↑ 5%
Invited state or local legislators to meetings/events	27%	No change	39%	↓ 17%
Met with policy makers	39%	↓ 3%	49%	↓ 7%
Participated in boards and/or commissions	56%	↓ 8%	44%	↓ 32%
Recommended health department positions on bills	54%	↓ 5%	27%	↓ 12%
Requested opportunities to review bills	41%	↓ 7%	27%	↓ 32%
Sent materials to policy makers	41%	↓ 4%	44%	↓ 29%
Testified at state and local hearings	24%	↓ 6%	32%	↓ 31%
Worked to develop/enforce regulations for IVP	41%	↑ 7%	34%	↓ 22%
Worked to encourage adoption of organizational policies for IVP	61%	↑ 8%	51%	↓ 12%
Worked to increase public awareness of laws	56%	↓ 8%	54%	↓ 22%

Seventy-eight percent (N=32) of state IVP programs that had a legislative session in 2015 (or during a similarly recent period) reported having mechanisms or protocols for communicating with policy makers. This represents a slight increase in the percentage of states that reported having mechanisms or protocols for communicating with policy makers in 2013 (73%), but a continued decrease since 2009 (89%).

IMPLEMENTATION OF POLICY STRATEGIES FOR INJURY AND VIOLENCE PREVENTION

- In 2015, the majority of state IVP programs (94%, N=36) implemented policy strategies, including those strategies implemented in collaboration with partners.
- Policy strategies were most commonly used to address the following IVP topic areas: child passenger safety (54%), teen drivers (46%), unintentional poisoning/PDO (46%), and seat belts (41%) (Figure 14).

Figure 14.
Policy Strategies Implemented by State IVP Programs, 2015

Topic area	Percent
Child passenger safety	54%
Teen drivers	46%
Unintentional poisoning/PDO	46%
Seat belts	41%
Suicide	34%
Pedestrian safety	34%
Distracted driving	34%
Impaired driving	34%
Traumatic brain/spinal cord injury	32%
Sexual violence	27%
Fall injuries (e.g., older/children)	27%
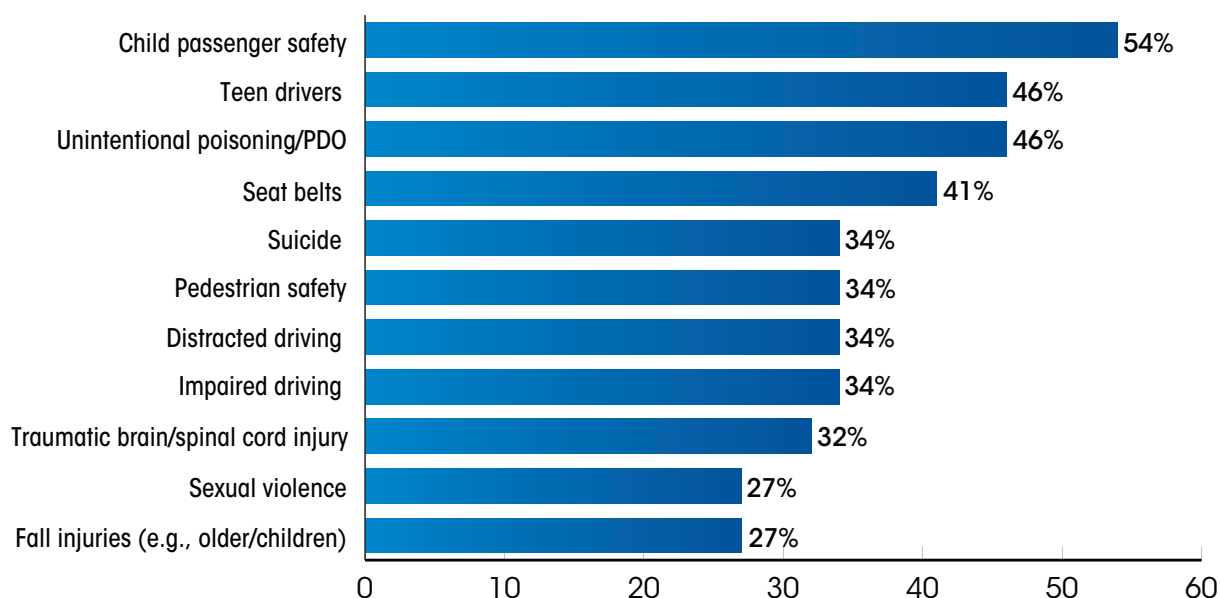
STATE PROGRAM FOCUS ON THE THREE MOST COMMONLY REPORTED IVP FOCUS AREAS

As noted in Figure 12, the top three most commonly reported IVP focus areas were fall injuries, unintentional poisoning/PDO, and sexual violence. The degree of focus (primary focus, secondary focus, or minimal/no focus/no data) within each state on these three topic areas are shown in Figure 15.

Figure 15.
Degree of Focus for Top Three Most Commonly Reported IVP Topic Areas by State, 2015

Fall Injuries

- Primary Focus
- Secondary Focus
- Tertiary or Minimal Focus
- Did Not Address in FFY 2015
- No Data Available

Unintentional Poisoning/ Prescription Drug Overdose

- Primary Focus
- Secondary Focus
- Tertiary or Minimal Focus
- Did Not Address in FFY 2015
- No Data Available

Sexual Violence

- Primary Focus
- Secondary Focus
- Tertiary or Minimal Focus
- Did Not Address in FFY 2015
- No Data Available

Top prevention strategies that were implemented for the most commonly reported IVP focus areas included:

Fall injuries

- Exercise-based fall prevention program (e.g., Tai Chi) (80%)
- Multi-faceted prevention program (e.g., Stepping On) (73%)
- Policy that establishes commissions, coalitions, and/or programs (50%)
- Clinical prevention interventions (50%)

Unintentional poisoning/prescription drug overdose (PDO)

- Prescription Drug Monitoring Program (83%)
- Other prescription drug-related policies (e.g., doctor shopping laws) (63%)

Sexual violence

- Conduct training to prevent sexual violence and promote protective social norms (96%)
- Teach healthy, safe dating and intimate relationships skills to adolescents (e.g., Safe Dates) (84%)
- Teach skills to prevent sexual violence (e.g., Second Step) (64%)
- Mobilize men and boys as allies (e.g., Men Can Stop Rape) (48%)

Policy Strategies in Action

STRANGE BEDFELLOWS: AN UNLIKELY PARTNERSHIP YIELDS CHILD SAFETY GAINS IN NORTH CAROLINA

North Carolina has a long history of preventing childhood poisoning. The nation's second poison control center was launched at Duke University in 1954. At the time, a quarter of all childhood poisonings were traced to flavored "candy aspirin." A Duke pediatrician, Dr. Jay Arena, worked with the company that made St. Joseph's aspirin to invent and market the first child safety cap.

Following this tradition, the **North Carolina Division of Public Health (NCDPH) recognized and addressed a new child poisoning hazard in 2015.** That's when North Carolina's legislature made it unlawful to sell e-liquid — the liquid that fills cartridges in refillable e-cigarettes — unless it was in a child-resistant container. E-liquids are packaged with images that are tempting to children. Sold in over 7,000 flavors, they

are sold in colorful containers that advertise tastes like "candy apple," just like the fruit-flavored "candy aspirin" of decades ago. In its concentrated form, liquid nicotine is extremely toxic, whether swallowed or ingested through the skin. As e-cigarettes became more popular in the preceding years, the **Carolinas Poison Center saw a 1,613% increase in calls about e-liquid exposure** over a 3-year period. No children have died of e-liquid poisoning in North Carolina, but a death has been reported nationally. With these increased levels of exposure, the risks of death, vomiting, and seizures were too great to ignore.
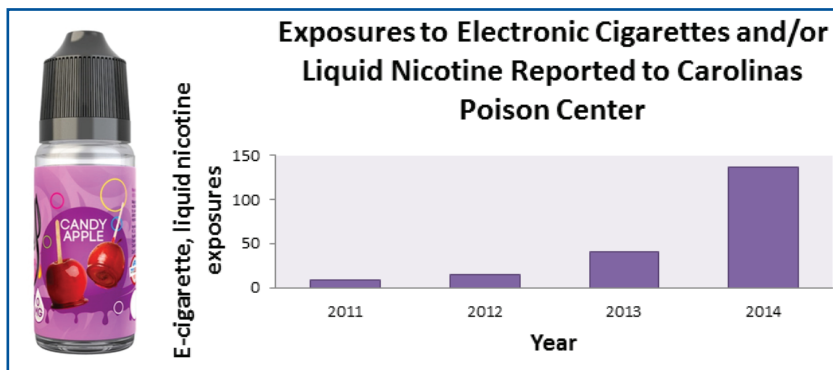
Requiring a child-resistant container seemed like an appropriate solution, but the lengthy federal regulatory process could expose children to a growing hazard for years to come. Instead, a **combination of internal and external partners worked together at the state level to make the sale of e-liquid in unsafe containers a Class A1 misdemeanor,** punishable by up to 60 days in jail, plus liability for potential damages as well. The approach followed a **policy change strategy: frame the data, identify an evidence-based solution, and then draft a policy solution that multiple partners can support.**

The state's Child Fatality Task Force was instrumental. The Task Force includes 35 members, ranging from Governor's Office appointees, Senate and House appointees, current legislators, and volunteers (including representatives from the Injury and Violence Prevention Branch at NCDPH). With an e-cigarette fact sheet in hand (so everyone would be working with the same facts), the Task Force members were able to raise the issue and make the case for introducing legislation. Other child-serving agencies lent their advocacy expertise to the effort.

Both Big Tobacco — an influential group in the tobacco-industry state — **and the vaping/e-cigarette industry were brought on board**, even though this collaboration was complicated by the fact that they are locked in competition for customers. Big Tobacco sees the vaping/e-cigarette industry as an unregulated competitor, so it was in favor of restrictions on e-liquid packaging. The vaping industry recognized the safety implications and did not want to be classified as a tobacco product and be subject to federal regulation. And **public health saw an opportunity, despite the uncomfortable alliance with Big Tobacco, to work together to achieve a safety improvement**. Each partner played a role in this policy change, and North Carolina's children are the beneficiaries.

Issue Brief No. 4

Engage Partners
for Collaboration

UNDERSTANDING THE IMPORTANCE OF ENGAGING PARTNERS AND COLLABORATORS

The scope of injury topics and prevention strategies are so broad that no program — no matter how large or well-established — can or should successfully address them alone. Partnerships bolster the overall capacity and effectiveness of state injury and violence prevention (IVP) programs and are essential for programs to achieve their desired outcomes and to amplify their work.

The many diverse partners at state and local levels may include (but are not limited to): traditional sectors within public health (e.g., chronic disease prevention, maternal and child health, mental health, etc.), aging, transportation, police, fire safety, emergency services, criminal justice, hospitals, schools, and academia.

In addition to serving as key partners, state IVP programs also serve as conveners – bringing multiple partners together to work on a range of injury and violence-related issues. The value of partnerships is not only in their ability to expand the reach and impact of IVP efforts, but also in the mutual benefit for all partners – such as the ability to share data, provide or receive training, reach key populations, and collaborate on program and policy efforts.

In the 2015 State of the States survey, respondents were asked to provide feedback on their partnerships with 61 different types of agencies and to describe the strength of their relationships with those partners. Additionally, respondents were asked to describe the activities through which the entities partner (i.e., sharing data, providing funding, etc.).

Overall, states varied greatly in the total number of reported "strong" partnerships. States had an average of:

- nine partnerships with other offices within the state health department (range from 3 to 15);
- five partnerships with other agencies within the state (range from 0 to 10);
- five partnerships with non-governmental organizations (range from 0 to 13); and
- three partnerships with governmental agencies (range from 0 to 7).

PARTNERSHIPS WITH STATE HEALTH DEPARTMENT OFFICES

Given both centralized and decentralized state IVP programs work across their state health agencies to pursue their IVP efforts, it is not surprising that states report strong relationships with many of their fellow state offices (Figure 16, Table 5).

- State IVP programs report their highest levels of partnership with the state offices of Epidemiology, Maternal and Child Health, Health Promotion/ Education/Community Health, and Vital Statistics, respectively.
- State IVP programs reported no relationship most commonly with the state offices of Adolescent Health.

Figure 16.
Top Five IVP Partnerships with State Health Department Offices by Strength, 2015

Legend: No Relationship | Needs Improvement | New and Developing | Strong

Maternal and Child Health (N=43)	* * 7% 88%
Vital Statistics (N=43)	* 5% 9% 84%
Health Promotion Education/ Community Health (N=40)	10% 5% 85%
Adolescent Health (N=38)	8% 5% 11% 76%
Epidemiology (N=37)	* * 92%

* Less than 5 percent
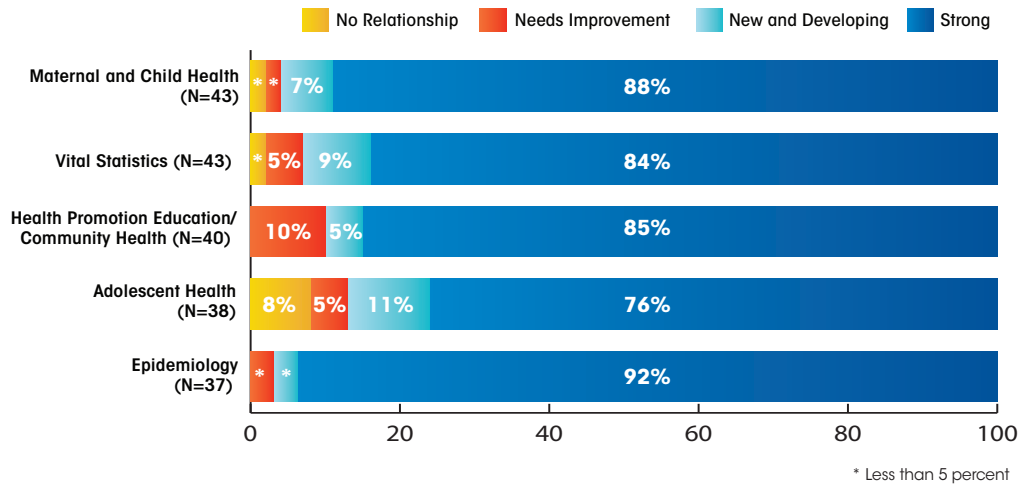
Table 5.
Ranking of IVP Partnerships by Specified Activities with State Health Department Offices, 2015

Activities		No. 1	No. 2	No. 3
Shared Data		Vital Statistics	Epidemiology	Maternal and Child Health
Actively involved in planning, programs, etc.		Maternal and Child Health	Health Promotion / Education / Community Health	Emergency Medical Services
Funding Exchanged:	IVP Program provided funding **TO:**	Epidemiology	Vital Statistics	Emergency Medical Services
	IVP Program received funding **FROM:**	Maternal and Child Health	Chronic disease	Health Promotion / Education / Community Health
Collaborated for:	Policy Activities	Maternal and Child Health	Health Promotion / Education / Community Health	Emergency Medical Services
	Evaluation Activities	Maternal and Child Health	Epidemiology	Health Promotion / Education / Community Health
	Communication Activities	Maternal and Child Health	Health Promotion / Education / Community Health	Adolescent Health
IVP Program Provided/Received Training/TA		Maternal and Child Health	Emergency Medical Services	Adolescent Health

PARTNERSHIPS WITH OTHER AGENCIES WITHIN THE STATE

Not only do state IVP programs partner with other programs within their state health departments, they also work across state agencies to extend their reach and enhance their prevention efforts (Figure 17, Table 6).

Figure 17.
Top Five IVP Partnerships with Other State Agencies and Offices by Strength, 2015

Legend: No Relationship | Needs Improvement | New and Developing | Strong

Agency	No Relationship	Needs Improvement	New and Developing	Strong
Criminal Justice/ Law Enforcement (N=43)	9%	28%	16%	47%
State Universities (N=42)	5%	12%	33%	50%
Highway Safety (N=41)	10%	10%	12%	68%
Department of Transportion (N=41)	5%	20%	10%	66%
Elder Affairs/Aging (N=41)	*	24%	24%	49%

* Less than 5 percent
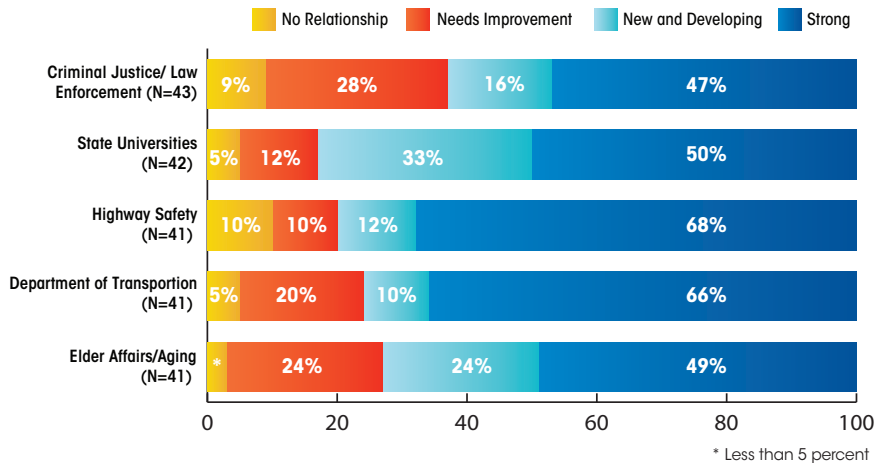
Table 6.
Ranking of IVP Partnerships by Specified Activities with Other State Agencies and Offices, 2015

Activities		No. 1	No. 2	No. 3
Legal Agreement or MOU		State Universities	Criminal Justice / Law Enforcement	Department of Transportation
				Highway Safety
Shared Data		Department of Transportation		Criminal Justice / Law Enforcement
		Highway Safety		
Actively involved in planning, programs, etc.		Highway Safety	Department of Transportation	
			Elder Affairs / Aging	
Funding Exchanged:	IVP Program provided funding **TO:**	State Universities	Criminal Justice / Law Enforcement	Education
				Elder Affairs / Aging
	IVP Program received funding **FROM:**	Highway Safety	Department of Transportation	Elder Affairs / Aging
Collaborated for:	Policy Activities	Department of Transportation		Criminal Justice / Law Enforcement
		Highway Safety		
	Evaluation Activities	State Universities	Highway Safety	Department of Transportation
	Communication Activities	State Universities		Department of Transportation
		Elder Affairs / Aging		Elder Affairs / Aging
IVP Program Provided/Received Training/TA		State Universities	Department of Transportation	Highway Safety

PARTNERSHIPS WITH NON-GOVERNMENTAL ORGANIZATIONS

In addition to state agencies, state IVP programs partner with a multitude of non-governmental and private organizations to enhance their effectiveness (Table 7). These organizations provide access to the latest research evidence, assistance with evaluation, topic-specific expertise, and more. Notably, the proportion of state IVP programs that have a strong relationship with ICRCs has increased from 26% in 2009 to 50% in 2015 (Figure 18).

Figure 18.
Top Five IVP Partnerships with Non-Governmental Organizations by Strength, 2015

Legend: No Relationship | Needs Improvement | New and Developing | Strong

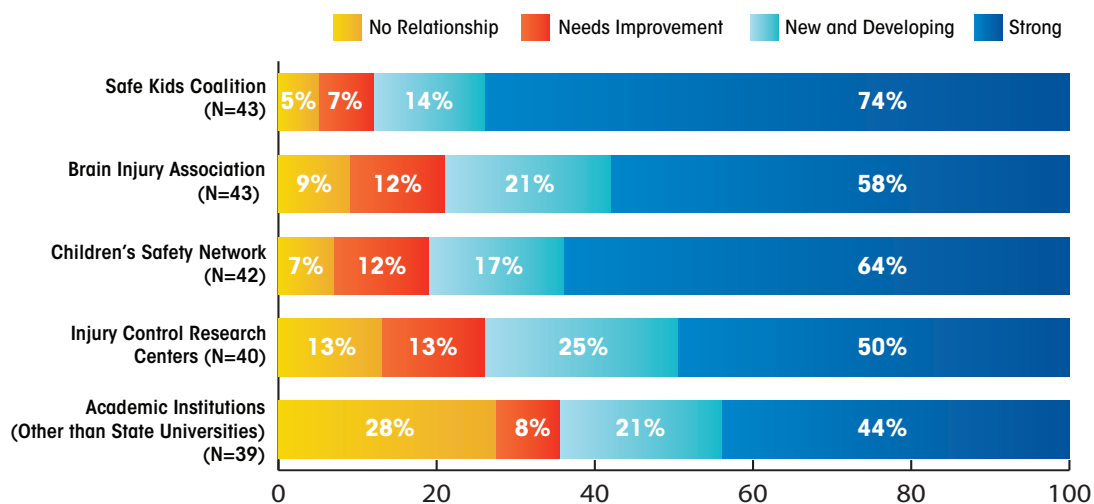| Organization	No Relationship	Needs Improvement	New and Developing	Strong
Safe Kids Coalition (N=43)	5%	7%	14%	74%
Brain Injury Association (N=43)	9%	12%	21%	58%
Children's Safety Network (N=42)	7%	12%	17%	64%
Injury Control Research Centers (N=40)	13%	13%	25%	50%
Academic Institutions (Other than State Universities) (N=39)	28%	8%	21%	44%

Table 7.
Ranking of IVP Partnerships by Specified Activities with Non-Governmental Organizations, 2015

Activities		No. 1	No. 2	No. 3
Legal Agreement or MOU		Safe Kids Coalition	Injury Control Research Centers	
			Brain Injury Association	
Shared Data		Brain Injury Association	Safe Kids Coalition	Healthcare Associations
				Injury Control Research Centers
Actively involved in planning, programs, etc.		Safe Kids Coalition	Brain Injury Association	Academic Institutions
				Healthcare Associations
Funding Exchanged:	IVP Program provided funding **TO:**	Safe Kids Coalition	Injury Control Research Centers	Academic Institutions
	IVP Program received funding **FROM:**	Safety Council		Safe Kids Coalition
		Businesses		Healthcare Associations
Collaborated for:	Policy Activities	Brain Injury Association	Safe Kids Coalition	Academic Institutions
				Injury Control Research Centers
				Mothers Against Drunk Driving
				Sports Associations
	Evaluation Activities	Injury Control Research Centers	Brain Injury Association	Academic Institutions
				Safe Kids Coalitions
	Communication Activities	Safe Kids Coalition	Brain Injury Association	Academic Institutions
				Children's Safety Network
				Injury Control Research Centers
IVP Program Provided/Received Training/TA		Children's Safety Network	Injury Control Research Centers	Safe Kids Coalition

PARTNERSHIPS WITH GOVERNMENTAL ORGANIZATIONS

Governmental partners provide additional perspectives beyond that of the state IVP program to inform and guide efforts (Figure 19, Table 8).

Figure 19.
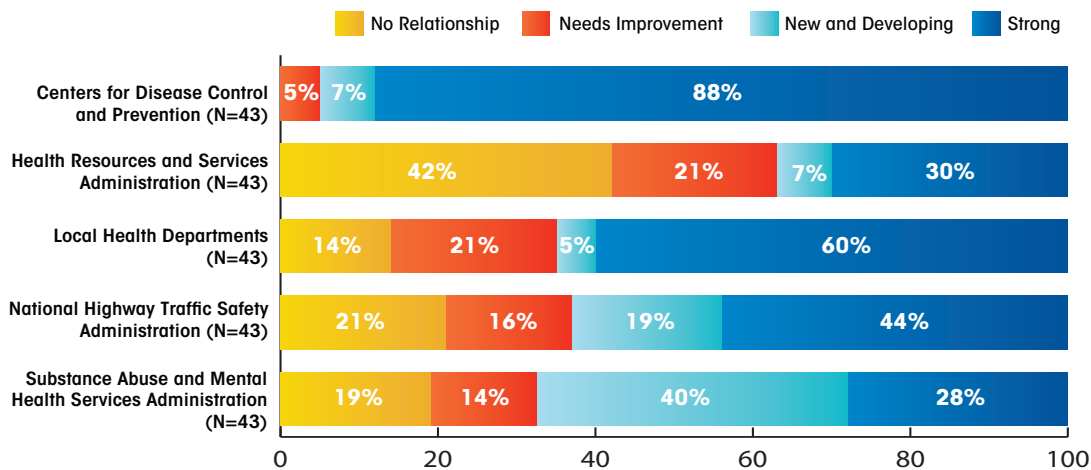**Top Five IVP Partnerships with Governmental Organizations by Strength, 2015**

Legend: No Relationship | Needs Improvement | New and Developing | Strong

Organization	No Relationship	Needs Improvement	New and Developing	Strong
Centers for Disease Control and Prevention (N=43)	5%		7%	88%
Health Resources and Services Administration (N=43)	42%	21%	7%	30%
Local Health Departments (N=43)	14%	21%	5%	60%
National Highway Traffic Safety Administration (N=43)	21%	16%	19%	44%
Substance Abuse and Mental Health Services Administration (N=43)	19%	14%	40%	28%

Table 8.
Ranking of IVP Partnerships by Specified Activities with Governmental Organizations, 2015

Activities		No. 1	No. 2	No. 3
Legal Agreement or MOU		CDC	Local Health Departments	HRSA / SAMHSA
Shared Data		CDC	Local Health Departments	NHTSA
Actively involved in planning, programs, etc.		CDC	Local Health Departments	SAMHSA
Funding Exchanged:	IVP Program provided funding **TO:**	Local Health Departments	CDC	SAMHSA
	IVP Program received funding **FROM:**	CDC	HRSA	SAMHSA
Collaborated for:	Policy Activities	CDC	Local Health Departments	NHTSA / SAMHSA
	Evaluation Activities	CDC	Local Health Departments	SAMHSA
	Communication Activities	CDC	Local Health Departments	SAMHSA
IVP Program Provided/Received Training/TA		CDC	Local Health Departments	NHTSA / SAMHSA

Partnership in Action

POOLING FUNDS TO FORM A RESEARCH-TO-PRACTICE LEARNING COMMUNITY IN THE MIDWEST

Like their counterparts directing CDC-funded Rape Prevention Education (RPE) programs in state and territorial health departments across the country, directors of RPE programs in Health and Human Services Regions 7 and 8 have been thinking about how best to **shift their work toward more comprehensive sexual violence prevention programming**. Moving beyond program strategies directed solely at individuals, they are seeking ways to **intervene more effectively at higher levels of the socio-ecological model, using a shared risk and protective factor approach.**

To help move strategically, they asked: *What can current research offer as guidance to practitioners? What strategies seem most promising in addressing risk and protective factors for sexual violence? Which specific strategies might be poised for testing and evaluation?*

To explore these questions with both researchers and practitioners in the room together, RPE directors from regions 7 and 8 — the upper midwest and mountain states — have **pooled funding from each of their CDC grants to create a research-to-practice learning collaborative**. The group, dubbed the **Cross-State Initiative (CSI)**, has convened four meetings so far, meeting in person twice a year (usually in conjunction with annual grantee meetings or other national conferences). They also frequently confer by phone and webinar and, sparked by these robust meetings and calls, share and explore ideas via e-mail and Google Drive.

The first CSI meeting was held in January 2015. Nine researchers were invited to share insights from their own research, suggest strategies particularly relevant to broader levels of the socio-ecological model, and identify research and interventions from other fields that might apply to sexual violence prevention. The meeting was designed to foster exchange and conversation: the group was kept relatively small, and the format built in plenty of time for conversation and networking, which helped to bridge research to practice. Topics included the relationships between bullying, sexual harassment, pornography, and sexual violence; insights from other fields (particularly alcohol and drug prevention and STD/HIV prevention); and the role of social norms.

Subsequent meetings followed a similar format, with further exploration of shared risk and protective factors, as well as more detailed consideration of potential evaluation measures. At its most recent meeting in August 2016, members of this unique learning collaborative agreed to continue a focus on collaborative learning opportunities, shared work across members, and continued exploration of opportunities to partner and collaborate across states.

Keys to success for the CSI include:

- each RPE program's willingness to contribute financially and to participate in meeting planning and logistics;
- Safe States Alliance's willingness to serve as fiscal agent for the pooled funds;
- CDC's participation among the researchers as well as supporting this use of funds; and
- the safe environment for questioning and learning created by the researchers and practitioners together.

CSI members feel they need not wait for additional research and interventions relevant to the higher levels of the socio-ecological model — there's plenty to work with already, from both the violence prevention field and others. With future calls and meetings in the works, a logic model, and an evaluation plan in place, t**hey are poised to become implementers and testers of interventions across states, contributing to the ongoing flow of research to practice for the entire field.**

Effectively Communicate Information to Key Stakeholders

UNDERSTANDING EFFECTIVE COMMUNICATION TO KEY STAKEHOLDERS

Translating the implications and nuances of injury and violence prevention (IVP) data into action can be a difficult task. Nevertheless, communication skills—from using infographics to conducting media advocacy—are essential to effectively reach key audiences, including policy makers, partners, and the public. To share their powerful and compelling stories, state IVP programs need strong communicators and effective communication channels within their programs to ensure that data, partnerships, and strategies garner the support they need to be sustained and successful.
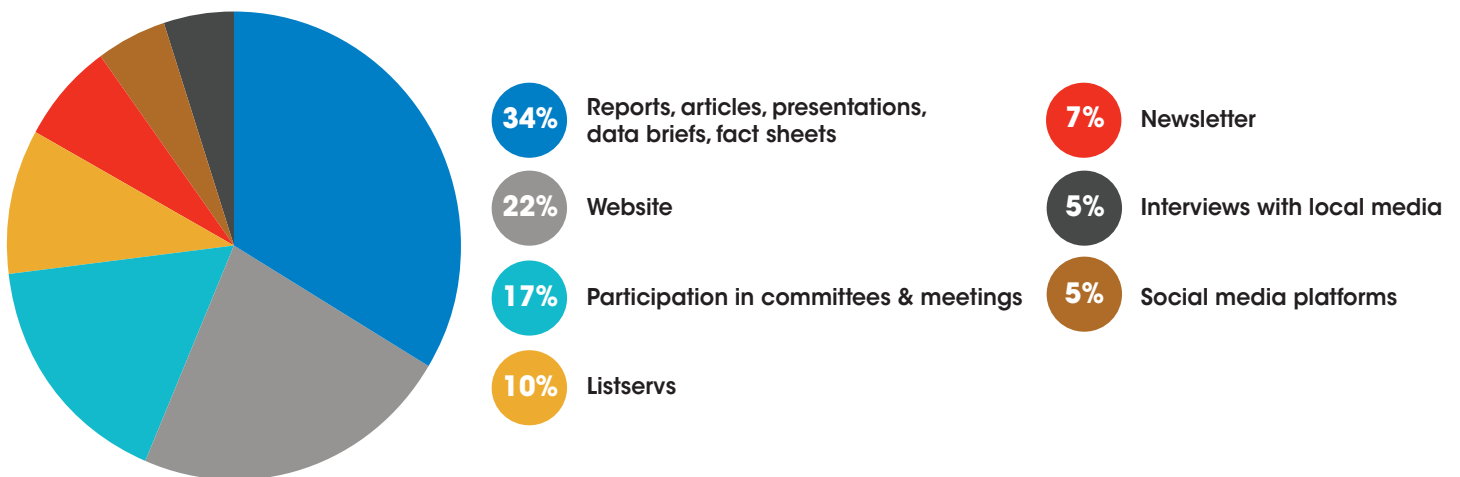
COMMUNICATION METHODS

■ Most of the 40 state IVP programs responding to the survey provided some form of communication to target populations, partners, local groups, or others engaged in IVP in 2015. However, only six states reported having an "official" communications plan.

■ Overall, state health departments are increasing communication efforts, with an emphasis on leveraging digital platforms to share their states' critical injury and violence-related information. Both website and social media usage have increased substantially over recent years (Table 9).

■ While online sharing has increased, more traditional digital sharing, such as newsletters or group listservs, have either stagnated or decreased in usage.

■ Formal communication tools (e.g., reports, fact sheets, issue briefs, etc.) are the primary method through which state IVP programs are sharing information with partners. More than one third of states indicate this is their primary method of communication.

■ Despite high usage of social media platforms for information sharing (78%), most IVP programs are using these platforms to support other communication efforts with only five percent of programs using social media as their primary method of communication (Figure 20).

Table 9.
Methods to Communicate Injury- and Violence-Related Information, 2015, 2013, and 2011

Communication Method	2015 (N=41)	2013 (N=40)	2011 (N=47)
Website	95%	92%	72%
Reports, articles, presentations, data briefs, fact sheets	90%	87%	93%
Participation in steering committees, community meetings, professional association meetings	83%	87%	93%
Social Media platforms (e.g., Twitter, Facebook, etc.)	78%	62%	n/a
Interviews with local media (TV, radio, etc.)	71%	72%	38%
Listservs	68%	75%	61%
Newsletter	51%	52%	27%
Advertisements/Public Service Announcements	39%	45%	n/a

Figure 20.
Primary Method to Communicate Injury and Violence-Related Information, 2015

34% Reports, articles, presentations, data briefs, fact sheets

22% Website

17% Participation in committees & meetings

10% Listservs

7% Newsletter

5% Interviews with local media
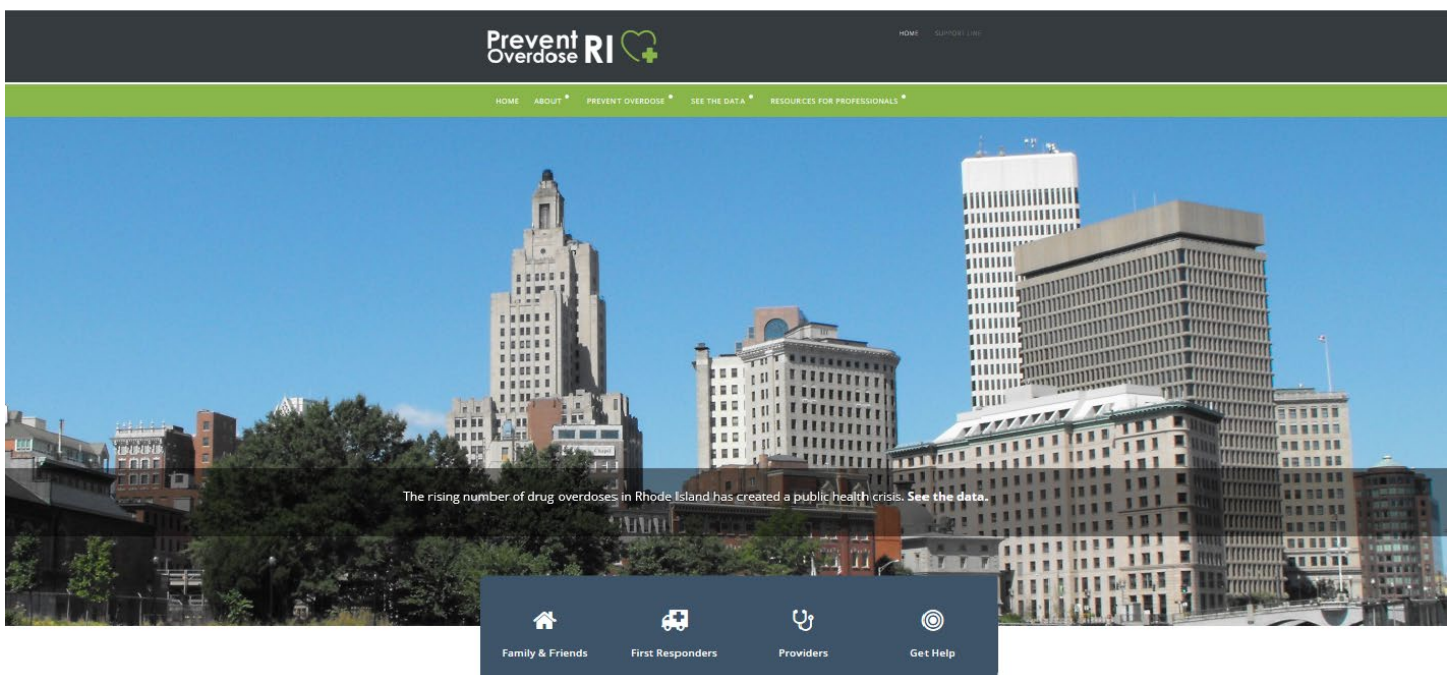
5% Social media platforms

Communication in Action

PREVENT OVERDOSE RHODE ISLAND - MAKING DATA MORE TIMELY, USEFUL, AND ACCESSIBLE IN RHODE ISLAND

Despite their communication's office best efforts, most public health websites are unlikely to win any design awards – and that's particularly true of those attempting to share public health data in various forms.

However, in Rhode Island, a **data workgroup that emerged from the Drug Overdose Prevention and Rescue Coalition**, convened under CDC Core Violence and Injury Prevention Program (VIPP) funding to address the state's escalating opioid overdose problem, decided to try something different. The idea became a reality with new CDC PDO Prevention for States funding in September 2015 and high-level support from the newly formed Governor's Task Force on Overdose Prevention and Intervention. A collaboration between the Rhode Island Department of Health and Brown University's School of Public Health led to the development of a **unique data dashboard – accessible in real time to researchers, legislators, clinicians, the media, and many other audiences**.

A crisp, modern design houses layers of useful surveillance data, compiled in visually appealing and accessible **infographics, interactive maps, videos, charts and other formats to encourage real-time, real-life use**. Clinicians may download flyers for their patients or **identify clusters of overdoses or "hot spots"** within their practice areas. **Practitioners can target interventions** to where they are most urgently needed. Researchers may u**se the data to explore the effectiveness of different interventions or combinations of interventions**. First responders can **watch a naloxone training video or schedule a training** for their group. Prescription drug users and their families can find **maps of local services,** download current **information about overdoses and how to prevent them,** or link directly to a warm line staffed by counselors who can listen and care, and also provide **information about services and referrals**. Everyone gets a message that echoes and reinforces the broader **Task Force's theme:** *addiction is a disease, and recovery is possible.*

The rising number of drug overdoses in Rhode Island has created a public health crisis. **See the data.**

The site reflects Rhode Island's unique tight-knit, inclusive, local feel, with a blend of state-wide data and strategies added to locally-relevant information. **High-level support from the Governor's office** for the entire initiative has helped make this possible, along with **data use agreements that balance the protection and sharing of data and allow the site to be housed outside the health department.** Future plans include a stronger social media presence and continued responsiveness to the feedback that led to current version of the dashboard. Check out the team's work by visiting www.preventoverdoseri.org.

A Plan to **End Rhode Island's Overdose Crisis**

The rising number of drug overdose deaths has created a public health crisis in Rhode Island.

In the past 5 years — We've lost **more than 1,000 people** to drug overdoses.

2011–2015 — The number of deaths from drug overdoses almost **doubled**.

In 2014 — More people died from drug overdoses than from **guns and cars combined**.

Rhode Island's overdose crisis has touched every community in the state.

Enter the Governor's Overdose Prevention Action Plan

With this plan, Rhode Island will **reduce overdose deaths by 1/3 in 3 years** — that means saving hundreds of lives.

We have one goal:
to save lives.

Here's how we plan to do it:

Prevention

Help doctors protect their patients by using safe prescribing practices.

Fact | It's time to change how we treat pain — opioids don't need to be the first line of defense.

Rescue

Make sure everyone has access to naloxone.

Fact | Nearly every opioid overdose death is preventable with naloxone.

Treatment

Make sure everyone who needs it can get medication-assisted treatment (MAT), like methadone or buprenorphine.

Fact | MAT lowers the risk of both relapse and death.

Recovery

Expand peer recovery services and treatment options that help people start recovery.

Fact | We're making sure that all patients treated for addiction have a long-term recovery plan.

To save lives, we need to educate everyone about the dangers of overdose and **end the stigma of addiction**.

We all have a role to play in ending Rhode Island's overdose crisis.
What's yours?

Find out at PreventOverdose.RI.gov
Data Source: Rhode Island Department of Health

Prevent Overdose RI

Issue Brief No. 6

Providing Technical Assistance and Training

UNDERSTANDING INJURY AND VIOLENCE PREVENTION TECHNICAL ASSISTANCE AND TRAINING

Knowledgeable staff members are essential for a state injury and violence prevention (IVP) program to function effectively and sustainably. State IVP staff must keep their own skills and knowledge current, while also providing practical training and technical assistance to other professionals, students, and the general public. Trainings — whether conducted on the job, virtually, or in classroom settings — should address both foundational and advanced skill-building in the principles, practices, and competencies necessary to successfully conduct IVP activities.

NATIONAL TRAINING INITIATIVE (NTI) CORE COMPETENCIES FOR INJURY AND VIOLENCE PREVENTION

In 2015, of the 37 states responding to the State of the States survey, 20 reported using the NTI Core Competencies. Of those using these Core Competencies for IVP, state IVP programs specifically reported the following uses:

- Developing job descriptions (55%)
- Informing staff performance plans (50%)
- Conducting trainings or workshops for state IVP program staff (45%)
- Conducting trainings or workshops for local partners (e.g., local health departments, local organizations, etc.) (45%)

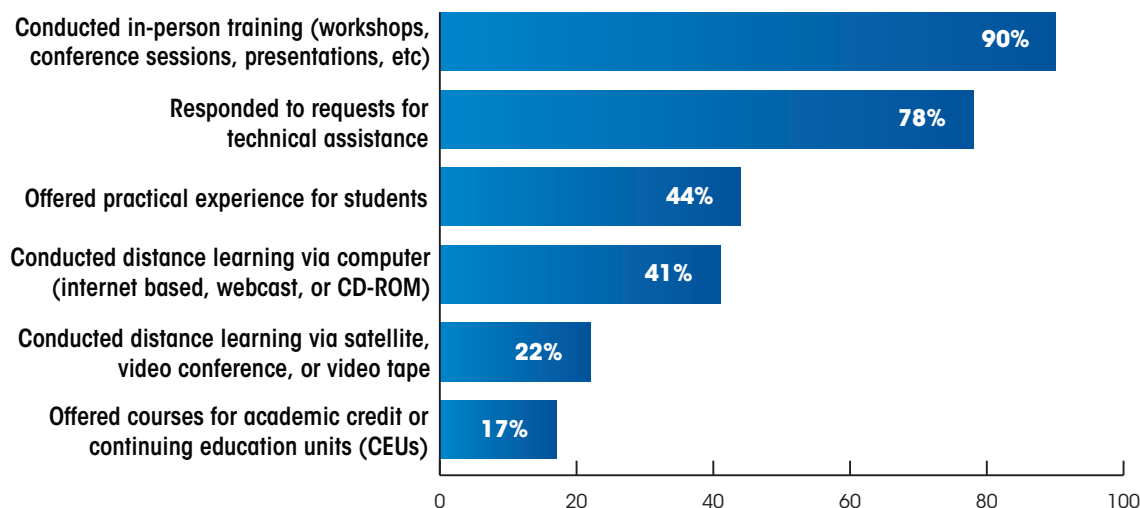### Core Competencies for Injury and Violence Prevention[1]

- Ability to describe and explain injury and/or violence as a major social and health problem;
- Ability to access, interpret, use and present injury and/or violence data;
- Ability to design and implement injury and/or violence prevention activities;
- Ability to evaluate injury and/or violence prevention activities;
- Ability to build and manage an injury and/or violence prevention program;
- Ability to disseminate information related to injury and/or violence prevention to the community, other professionals, key policy makers and leaders through diverse communications networks;
- Ability to stimulate change related to injury and/or violence prevention through policy, enforcement, advocacy and education;
- Ability to maintain and further develop competency as an injury and/or violence prevention professional; and
- Demonstrate the knowledge, skills and best practices necessary to address at least one specific injury and/or violence topic and be ability to serve as a resource regarding that area.

TECHNICAL ASSISTANCE AND TRAINING METHODS

- Forty state IVP programs (98%) provided some form of training or technical assistance to partners, grantees, and others engaged in prevention efforts in 2015.
- State IVP programs used a variety of methods to deliver technical assistance and training to program partners (Figure 21) – most commonly conducting in-person trainings (90%) and responding to requests for technical assistance (78%).
- State IVP programs offering courses for academic credit or continuing education units (CEUs) has decreased from 37% to 17% since 2009.

[1] A Core Competencies for Injury and Violence Prevention. Developed by the National Training Initiative for Injury and Violence Prevention (NTI), a joint project of the Safe States Alliance and the Society for the Advancement of Violence and Injury Research (SAVIR). May 2005. [accessed 2016 Oct 17]. Available from URL: www.safestates.org/?page=NTICoreCompetencies.

Figure 21.
Methods Used by State IVP Programs to Provide Technical Assistance and Training, 2015 (N=41)

Method	Percentage
Conducted in-person training (workshops, conference sessions, presentations, etc)	90%
Responded to requests for technical assistance	78%
Offered practical experience for students	44%
Conducted distance learning via computer (internet based, webcast, or CD-ROM)	41%
Conducted distance learning via satellite, video conference, or video tape	22%
Offered courses for academic credit or continuing education units (CEUs)	17%

TECHNICAL ASSISTANCE RESOURCES AVAILABLE TO STATES

In 2015, state IVP programs were asked to describe the technical assistance (TA) and trainings that were either provided or received by their program (Figure 22), as well as providers for obtaining their training (Table 10).

- Overall, state IVP programs were more frequently the recipient of TA and training than they were the provider. The topic for which states received TA (73%) more often than provided (46%) was on evaluation methods and processes.

- The topics for which states were most often *providing* TA include program strategies and interventions (76%) and data collection, analysis, reporting, and quality improvement (63%).

- The topics for which states were most often *receiving* TA include data collection, analysis, reporting, and quality improvement (76%) and evaluation methods and processes (73%).

- The Safe States Alliance (88%) and federal agencies (85%) were by far the most common technical assistance resources used by the state IVP programs (Table 10).

Figure 22.
Topics for Technical Assistance and Training Provided by and Received by the State IVP Programs, 2015 (N=41)
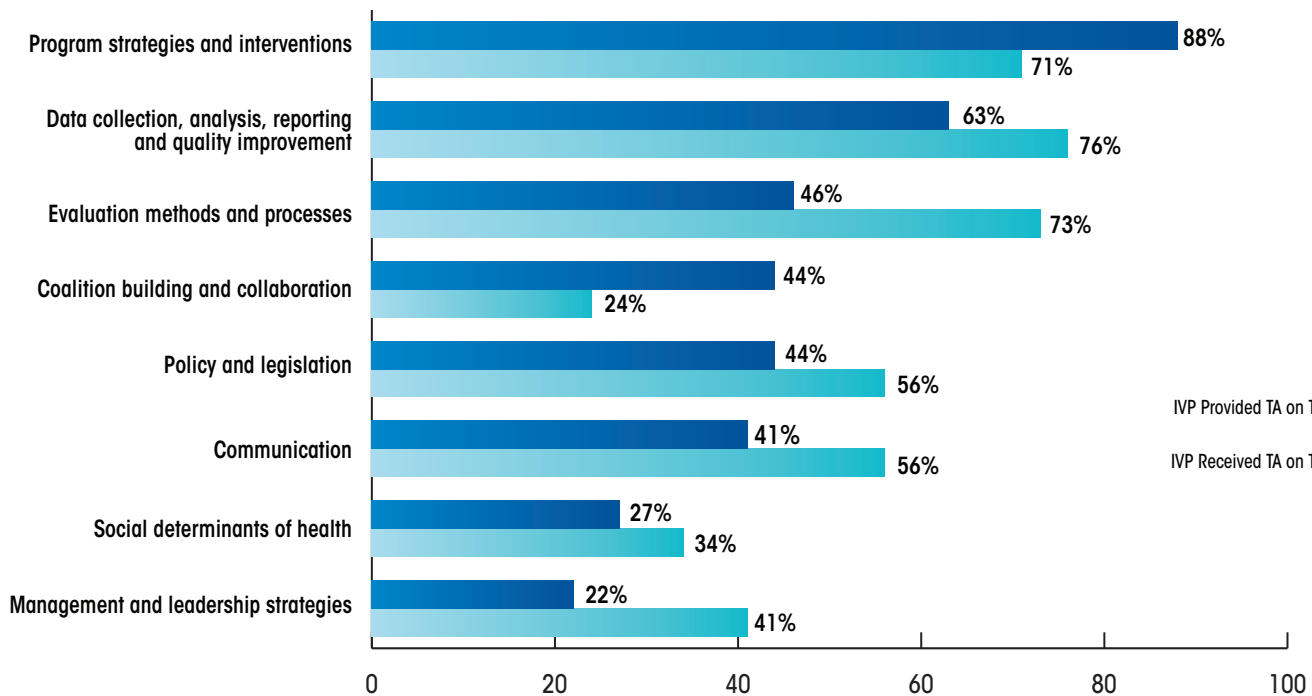

Topic	IVP Provided TA on Topic	IVP Received TA on Topic
Program strategies and interventions	88%	71%
Data collection, analysis, reporting and quality improvement	63%	76%
Evaluation methods and processes	46%	73%
Coalition building and collaboration	44%	24%
Policy and legislation	44%	56%
Communication	41%	56%
Social determinants of health	27%	34%
Management and leadership strategies	22%	41%

Table 10.
Top Five Technical Assistance Providers Used by State IVP Programs, 2015 (N=41)

Top Five Technical Assistance Providers Used by State IVP Programs, 2015 (N=41)	Percentage
Safe States Alliance	88%
Federal agencies (e.g., CDC, HRSA, NHTSA, SAMHSA)	85%
National resource centers (e.g., CSN, SPRC or CDR)	66%
Regional networks	63%
Other national organizations (e.g., Safe Kids Network, Prevention Institute)	59%

Training & TA in Action

A REGIONAL SUMMIT TO TRANSFORM INJURY AND VIOLENCE PREVENTION IN WASHINGTON STATE

The **Transforming Injury and Violence Prevention Summit**, held in November 2015 near the Seattle airport, enticed attendees with three tracks and a tag line: *innovations in policy, practice, and partnerships.* The Summit itself was an example of all three tracks. It was **made possible by a new partnership between the Washington State Department of Health's Injury and Violence Prevention (IVP) program and the Northwest Center for Public Health Practice (NWCPHP).** NWCPHP is one of 10 regional Public Health Training Centers funded by the Health Resources and Services Administration (HRSA). Together, they form a national Public Health Learning Network whose mission is to strengthen the technical, scientific, managerial, and leadership competence of the public health workforce.

Through their partnership, the Department of Health's IVP Program and the NWCPHP discovered a **shared need for a regional summit to address primary prevention.** NWCPHP had resources, technical expertise, and networks beyond the usual IVP crowd; the IVP Program had a wealth of content expertise, connections throughout the region, and access to research and best practices across the IVP spectrum. **Neither partner could have supported a Summit of this scale on its own, but together they quickly filled 100 seats with eager attendees.**

2015 Injury and Violence Prevention Summit

In addition to the three tracks on innovations in policy, practice, and partnerships, summit plenary speakers also addressed issues beyond IVP – particularly health care reform and health equity. These turned out to be among the most memorable and appreciated by summit participants. **As a result of the unique partnership, the summit also drew a diverse crowd**: researchers, practitioners, EMS and health care professionals, prosecutors, workers' compensation experts, and many others. A concrete **outcome of the summit was a set of new, cross-cutting networks, spanning not only topic areas and roles but also state borders.**

The IVP Program highly recommends reaching out to a regional Public Health Training Center to explore similar win-win opportunities to provide ongoing training and technical assistance. Beyond the summit itself, the partners have **collaborated on webinars and training calls, and plan to hold future summits** as well.

To find the closest Public Health Training Center, visit http://bhpr.hrsa.gov/grants/publichealth/phtc.html. For a webinar on the Public Health Learning Network (comprised of all 10 Public Health Training Centers), visit http://www.dialogue4health.org/web-forums/detail/the-new-era-of-public-health-training. And to for more details about the summit itself, see:

- Summit schedule and speaker list: http://www.nwcphp.org/documents/about/2015-ivp-summit/2015IVPSummitSchedule.pdf
- Links to summit presentations: http://www.nwcphp.org/about/funding/phtc/injury-and-violence-prevention-summit/slides-and-resources
- Summit resource guide that compiles the latest research and best practices across IVP topics: http://www.nwcphp.org/documents/about/2015-ivp-summit/ivp-resource-guide

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www.safestates.org

Safe States Alliance
2200 Century Parkway, Suite 700
Atlanta, Georgia 30345
770.690.9000
info@safestates.org