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.

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From the Safe States Alliance

The Safe States Alliance is proud to present the State of the States: 2013 Report, the only national assessment of capacity among state public health injury and violence prevention programs in the United States. Now in its fifth iteration, State of the States provides the most up-to-date and comprehensive information about the structure, organization, people, resources, and work of state injury and violence prevention programs.

This report is intended to provide an update of comprehensive national data on the status of state injury and violence prevention programs; build on the information collected since 2005 to describe changes in state injury and violence prevention programs over time; and highlight achievements of injury and violence prevention programs. New in 2013, we’ve:

- Restructured the State of the States survey and report findings to align with the six “core components” of injury and violence prevention programs, which are described in our publication, Building Safer States: 2013 Edition;
- Added charts and graphs that reflect key findings from new, in-depth survey questions;
- Provided greater detail about the funding sources utilized by state injury and violence prevention programs to accomplish their work;
- Included qualitative data from key informant interviews with states that lacked a centralized injury and violence prevention program in 2013; and
- Made extensive comparisons between data across multiple survey years.

We sincerely thank state injury and violence prevention program staff for their commitment and effort in completing the extensive survey in a time when there are ever increasing demands and ever fewer resources. State of the States is made possible by the continued financial support of the Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control (NCIPC). We would also like to thank the members who contributed to the development of the survey and reviewed the report. We continually welcome comments on the comprehensive report, as well as on the online microsite which features highlights of the survey findings. The microsite is available at http://www.safestates.org/?page=SOTS.

Carol Thornton, MPA
President, Safe States Alliance
Violence and Injury Prevention Program
Section Chief, Pennsylvania
Department of Health

Amber N. Williams
Executive Director
Safe States Alliance
The Centers for Disease Control and Prevention’s (CDC) National Center of Injury Prevention and Control (Injury Center) is pleased to provide continued support for the Safe States Alliance State of the States: 2013 Report. Violence and injuries are the leading cause of death for the first four decades of life. In fact, in the first half of life, more Americans die from violence and injuries than from any other cause, including cancer, HIV, or the flu.

State health departments are on the front lines of violence and injury prevention. A comprehensive violence and injury prevention program at the state health department is critical for states to effectively identify, implement, and evaluate evidence-based injury and violence prevention strategies to save lives. The State of the States Report provides valuable up-to-date and comprehensive information that helps us understand the progress and needs of the state injury and violence prevention programs, as well as the life-saving work being conducted across the nation to prevent violence and injuries.

The CDC Injury Center applauds the Safe States Alliance and the state health departments that have joined forces to produce this valuable 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 deaths 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

The Safe States Alliance thanks the many individuals who contributed to the State of the States: 2013 Report.

This document would not have been possible without the participation of injury and violence prevention professionals from across the United States. Special thanks go to the state injury and violence prevention program staff members that completed the 2013 survey and provided invaluable data that will help inform the development and growth of future state injury and violence prevention efforts. Furthermore, the implementation of this survey would not have been successful without the contributions of the states that piloted the survey in advance of the official administration: Kansas, Michigan, New York, Rhode Island, and Washington. This report was developed with editorial support from Linda Scarpetta, MPH, Michigan Department of Community Health; Shelli Stephens Stidham, MPA, Injury Center of Greater Dallas; Michael Bauer, MS, New York Department of Health; Dolly Fernandes, MEd, Washington State Department of Health; Carol Thornton, MPA, Pennsylvania Department of Health; Carlene Pavlos, MTS, Massachusetts Department of Health; and Lori Haskett, Kansas Department of Health and Environment.

The analysis of the State of the States 2013 survey data (including comparisons to data from previous surveys) was conducted by Ms. Shenee Bryan, MPH, MPA, of Research and Evaluation Group, LLC. Ms. Bryan developed the State of the States: 2013 Report with writing and editorial support from the following Safe States staff members: Ms. Amber N. Williams, Executive Director; Ms. Jamila M. Porter, MPH, Director of Programs and Evaluation; Ms. Ashley M. Pruett, CAE, Director of Membership and Communications; Ms. Ina I. Allicott, MPH, Evaluation and Technical Assistance Coordinator; and Ms. Katie Arseniadis, Intern.
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Background

THE BURDEN OF INJURIES AND VIOLENCE IN THE UNITED STATES

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 third 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. However, despite the existence of prevention strategies that have been proven effective, each year there are:

- Over 32.4 million people treated in Emergency Departments for injury
- Over 2.8 million hospitalizations related to injury
- More than 187,000 deaths related to injury — nearly 1 person every 3 minutes
- $406 billion ultimately spent in a single year on medical costs and lost productivity due to injuries

Fortunately, injuries and violence are preventable. However, effective prevention efforts require a comprehensive and coordinated approach that addresses the many complex, underlying factors that contribute to injuries and violence. This is often referred to as the “public health approach.”

THE PUBLIC HEALTH APPROACH

According to the World Health Organization, the public health approach involves four iterative steps:

1. Defining the problem through the systematic collection and analysis of data to better understand the magnitude and scope of the problem, as well as the populations and locations at greatest risk;
2. Identifying risk and protective factors (factors that increase or decrease the risk of injuries and violence) and understanding what factors that can be modified through policy and program interventions;
3. Designing, implementing, and evaluating policy and program interventions to determine what works, when, and for whom; and
4. Disseminating effective and promising interventions widely, while continually evaluating their impact and cost-effectiveness.

The public health approach allows practitioners to implement injury and violence prevention policies or programs that are effective and impactful at the individual, family, community, and societal levels, and thus provide the maximum benefit for the largest number of people.

THE CORE COMPONENTS OF STATE INJURY AND VIOLENCE PREVENTION PROGRAMS

In the United States, injury and violence prevention efforts - particularly those specific to the community and societal levels - are most effectively led by state public health injury and violence prevention programs. However, 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.\(^4\) The Safe States Alliance has defined six “core components” that describe capacity of injury and violence prevention programs including:

- Build a solid infrastructure for injury and violence prevention;
- Collect and analyze injury and violence data;
- Select, implement, and evaluate effective policy and program strategies;
- Engage partners for collaboration;
- Effectively communicate information to key stakeholders; and
- Provide technical support and training.

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.

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THE NEED FOR STATE PUBLIC HEALTH INJURY AND VIOLENCE PREVENTION PROGRAMS

A comprehensive and effective injury and violence prevention program that is located within the state health department is key to providing focus and direction for prevention efforts. State health department injury and violence prevention program 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 injury and violence prevention 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.
About the Survey: Methodology & Results

The State of the States: 2013 Report presents results from the fifth 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 programs over time.

The 2013 State of the States Survey was developed and reviewed by Safe State staff members, an evaluation consultant, and a workgroup comprised of state injury and violence prevention program directors. Most questions have remained throughout iterations; however, some questions were updated to improve clarity. Additionally, several new questions were added to the 2013 administration to better align the survey with the six core components.

The 2013 State of the States Survey was administered from November 2013 – February 2014, and collected data on the status of programs in Federal Fiscal Year 2013 (October 1, 2012 – September 30, 2013). A total of 41 states participated in the 2013 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 2013 survey was sent to this state representative. In states without a designated Safe States Alliance representative, the state injury and violence prevention program was contacted to identify the appropriate person to complete the survey. The 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 the 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 the Safe States Alliance as essential elements that describe the capacity of a comprehensive state public health injury and violence prevention program.
- Some questions, such as those about injury and violence prevention 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.
- 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 injury and violence prevention programs in Federal Fiscal Year 2013 (FY 2013).

The results presented in this report were analyzed using the statistical software, Statistical Package for the Social Sciences (SPSS) Version 16.0, SAS Enterprise Guide 5.1, and ArcGIS 10.1.
## MAJOR FINDINGS FROM THE 2013 STATE OF THE STATES SURVEY

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<td><strong>Organizational Location</strong></td>
<td>In 2013, the majority of state injury and violence prevention programs (38 out of 41) were located within state health departments. More than half (55%) of these programs were located in an organizational unit that addresses health promotion, disease prevention, community health, and/or behavioral health.</td>
</tr>
<tr>
<td><strong>Program Decentralization</strong></td>
<td>Compared to 2009, more states reported having an identified injury and violence prevention program, while also decentralizing injury and violence prevention program activities throughout the health department. In 2013, 37 (90%) states reported that they had an identified injury and violence prevention program.</td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td>In 2013, $111.4 million was invested nationally in state public health injury and violence prevention programs. Of the 251 funded awards provided by 21 different sources, 68% were federal grants, 24% were from state sources, and 8% were other sources.</td>
</tr>
<tr>
<td><strong>Full-Time Equivalent (FTE) Employees</strong></td>
<td>A total of 431 individual employees worked in state health department injury and violence prevention programs, which equated to 341.69 full-time equivalents (FTEs).5</td>
</tr>
<tr>
<td><strong>Access to Data Professionals</strong></td>
<td>In 2013, 56% of state injury and violence prevention programs had access to one or more FTEs that served in a primary role described as “data collection and analysis.”</td>
</tr>
<tr>
<td><strong>Primary Focus Areas</strong></td>
<td>In 2013, the five most commonly reported primary focus areas of state injury and violence prevention programs were: motor vehicle injury (73%), fall injury (66%), poisoning/prescription drug overdose (66%), sexual assault/rape (63%), and child passenger safety (54%). With the exception of poisoning/prescription drug overdose, these focus areas have remained in the top five since 2011.</td>
</tr>
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| **Policy Strategies**           | The most common methods used by state injury and violence prevention programs in 2013 to inform policy included:  
  - Participating in boards and/or commissions (71%);  
  - Working to increase public awareness of laws (71%);  
  - Recommending health department positions on bills (63%);  
  - Working to encourage adoption of organizational policies (61%); and  
  - Evaluating/assessing/monitoring the impact of laws (61%). |
| **Evaluation**                  | High-level program implementation and evaluation involves reporting program and policy evaluation outcomes to stakeholders. More than half of all states that addressed the five most common primary focus areas also reported policy and program evaluation outcomes to stakeholders. In 2013, the most commonly reported injury or violence prevention topic areas that had funding allocated specifically to support evaluation were sexual assault/rape (55%) and fall injuries (45%). |
| **Communication to Key Stakeholders** | In 2013, the most commonly reported communication method used was a website (94%). This represented a change from earlier years, as participation in steering committees, community meetings, and professional association meetings were previously the most commonly used communications methods reported in the 2009 and 2011 surveys. |
| **Technical Assistance**        | Thirty-eight state IVP programs (93%) provided some form of training or technical support to partners, grantees, and others stakeholders engaged in injury and violence prevention efforts in 2013. The most common topics on which technical assistance and training were provided by the state injury and violence prevention program included: program strategies and interventions (e.g., child passenger safety technician training, etc.) (83%) and data collection, analysis, reporting, and quality improvement (73%). |

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5. Full-time equivalents (FTEs): the total number of hours worked by an individual employee divided by the total number of work hours in a full-time schedule (defined as 40 hours per week).
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 program to function. Key characteristics of a state program’s infrastructure may include (but are not limited to): a state mandate, a stable and supportive organizational location (usually within a state health department), core staff, leaders, strategic plans, and stable funding. Each of these characteristics can impact how a state injury and violence prevention program is structured, how it operates, and what it is capable of achieving.

STATE MANDATE

In general, a state mandate refers to a legal requirement that a state agency or subdivision engage in or increase the level of a specific activity or service. Mandates for state injury and violence prevention programs (and their related activities) may originate from a variety of sources including the state legislature, the state public health official, or another source. State mandates provide explicit legal authority to state injury and violence prevention programs, and may also address features such as the existence of the program, the program’s placement within the state system, the duties of the program, and program funding.

As reflected in past years, the majority of states reported that they did not have a state mandate for a comprehensive injury and/or violence prevention program (Figure 1). In 2013, only eight (19%) states reported that they had a state mandate, which represents a net decrease of four states since 2009. Of the eight states with a state mandate in 2013, only four states reported that the mandate was funded.

Figure 1.

<table>
<thead>
<tr>
<th>Year</th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
</tr>
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<tbody>
<tr>
<td>2013 (N=41)</td>
<td>19%</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>2011 (N=47)</td>
<td>17%</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>2009 (N=49)</td>
<td>25%</td>
<td>73%</td>
<td>2%</td>
</tr>
<tr>
<td>2007 (N=51)</td>
<td>16%</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>2005 (N=48)</td>
<td>28%</td>
<td>69%</td>
<td>6%</td>
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ORGANIZATIONAL LOCATION

In 2013, the majority of state injury and violence prevention programs (N=38) were located within state health departments. More than half of state programs (55%) were located in an organizational unit that addresses health promotion, disease prevention, community health, and/or behavioral health (Figure 2).

Figure 2. Location of Injury and Violence Prevention Programs in State Health Departments, 2005, 2007, 2009, 2011, and 2013

Differences in the program’s organizational location across years can result from reorganizations or changes in state health department leadership. From 2005 to 2013, nearly half of state injury and violence prevention programs changed locations within the health department at least one time. Four state programs changed their location three times, two programs changed their location twice, and 12 programs changed their location once during that period.

Respondents were asked if there was an identified injury and violence prevention program in their state and who was responsible for the injury and violence prevention activities conducted within the state health department. Compared to 2009, more states reported having an identified state injury and violence prevention program, while also decentralizing injury and violence prevention activities throughout the health department in 2013 (Figure 3). Sixty-three (90%) states reported that they had an identified injury and violence prevention program, but only 24 (59%) of these states reported that they were primarily or solely responsible for injury and violence prevention activities within the state health department.

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6. Decentralized activities are defined as injury and violence prevention activities that are implemented by multiple programs and/or divisions throughout the state health department and that are beyond or outside the domain of the identified state injury and violence prevention program.
In comparison to previous years, more state injury and violence prevention programs reported that program activities were decentralized throughout various organizational units within the state health department in 2013. Sixty percent of state injury and violence prevention programs that were located in a division of Maternal and Child Health/Family Health in 2013 reported decentralizing their activities. However, only one-third (32%) of state programs that were primarily located in a division of Health Promotion/Disease Prevention/Community Health/Behavioral Health decentralized some of their program activities (Figure 4).

Figure 3. States with an Identified Injury and Violence Prevention Program & Centralization of Injury and Violence Prevention (IVP) Activities, 2009, 2011, and 2013

Figure 4. Centralization of Injury and Violence Prevention Activities by State Program Organizational Locations within State Health Departments, 2013
STRATEGIC PLANNING

The majority of states reported that at least one type of statewide strategic plan existed to guide injury and violence prevention activities. With the exception of health department injury and violence prevention plans, the percentage of strategic plans that addressed injury and violence prevention statewide or at the health department level increased compared to previous survey years. The number of states that reported the existence of health department injury and violence prevention plans decreased from 43% in 2011 to 31% in 2013 (Figure 5). The number of states that reported the existence of state plans produced by multiple agencies outside of the health department increased from 29% in 2009 to 55% in 2013. The existence of statewide health plans that addressed multiple health issues (in addition to injuries and violence) also increased compared to previous survey years. However, the number of statewide health plans in existence remained low in comparison to other types of strategic plans.

All 12 states that reported having a statewide health plan also reported having specific injury and violence prevention topics included in the plan. Similarly, 73% of states that reported having a health department strategic plan also reported that specific injury and violence prevention topics were included in the plan. The most common injury and violence prevention topics that were included in statewide health plans and health department strategic plans were: fall injury prevention (17 states), suicide prevention (13 states), motor vehicle injury prevention (9 states), and poisoning/prescription drug overdose (9 states).

TYPES OF FUNDING SOURCES

In 2013, $111.4 million was invested nationally in state public health injury and violence prevention programs. This is an average of $2.8 million per state program (median of $1.5 million, ranging from $54,933 to $22.8 million). Investments in state injury and violence prevention programs come from a variety of funding sources, including federal agencies, state governments, non-profit organizations, and foundations.

Of the 251 awards that state injury and violence prevention programs received from 21 different funding sources, 68% were federal grants, 24% were from state sources, and 8% were from other sources in 2013. Federal sources contributed $70.9 million (64%) of all funding through 170 funding awards to state injury and violence prevention programs nationwide (Figure 6). State funds contributed $39.3 million (35%) and other sources of funding (i.e., universities, private/corporate, non-profits, etc.) contributed $1.2 million (1%). A greater number of awards came from federal sources than from state and other sources combined.
While 36 states reported receiving federal funding, four (10%) of states reported receiving funding from federal sources only (Figure 7), and another four (10%) of states reported not receiving any federal funding. The majority of states (N=32, 78%) received funding from federal and state sources only. Only 10 states (25%) reported receiving funding from federal, state, and other sources.

State injury and violence prevention programs received funding from a median of five total funding sources (ranging from one to 14 funding sources). They received funding from a median of four federal sources (ranging from one to 10 sources), two state sources (ranging one to three sources), and two other sources (ranging from one to three sources).
STATE & NATIONAL PER CAPITA COMPARISONS

In a single year, injuries and violence will ultimately cost the United States $406 billion, which includes over $80 billion in medical costs and $326 billion in lost productivity. This is an annual cost of nearly $1,303 for every individual living in the U.S. In contrast, only about $111.4 million was invested nationally in state public health injury and violence prevention programs in 2013. This amount resulted in a national average investment of only $0.45 per person in the United States.

While five state injury and violence prevention programs were funded at amounts close to or equal to the national average of $0.45 per person, 21 state programs were funded at less than the national average (Figure 8). Five state programs received between $0.16 and $0.30 per person, while eleven state programs received funding that equated to less than $0.15 per person. At the other end of the spectrum, several state programs received funding amounts equal to or greater than the national average. Thirteen state programs received between $0.45 and $1.00 per person, while another four state programs received and invested more than $1.00 per person to support injury and violence prevention efforts.

Figure 8.
State Health Department Injury and Violence Prevention 2013 Funding per Capita: State Funding per Capita Compared to National Funding per Capita ($0.45 per capita)

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ALLOCATION OF FUNDING AND PROGRAMMATIC TOPIC AREAS SUPPORTED

In 2013, the majority of state injury and violence prevention program funding ($60.6 million, 54%) was allocated to grants, mini-grants, and contracts that supported programmatic efforts (Figure 9). The next highest allocation of funding ($29.0 million, 26%) went to support personnel. Overhead expenses, safety equipment, and other spending categories made up the remaining 20% of all expenses incurred by state injury and violence prevention programs in 2013.9

States were asked to list the injury and violence topic areas addressed by each funding source. Almost all funding sources were used to address multiple topics. The five most common injury and violence-related topics that were supported by all funding sources were:

1. Motor vehicle injury prevention
2. Fall injury prevention
3. Sexual assault/rape prevention
4. Suicide/self-inflicted injury prevention
5. Poisoning/prescription drug overdose prevention

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9. Overhead expenses include indirect cost. Safety equipment may include items like child booster seats, smoke alarms, helmets, etc. Other expenses travel, meetings, educational material, surveillance systems, etc.
As shown in Table 1, state injury and violence prevention programs used a variety of funding sources to address the five most common injury and violence topic areas in 2013. Eighteen (18) sources and 80 awards were used to address motor vehicle injury prevention efforts nationally. The most commonly reported funding sources used to support motor vehicle injury prevention were CDC/NCIPC Core VIPP, State Highway Safety Office, State General Revenue, and HRSA/MCHB Title V Block Grant. Fall injury prevention efforts were supported by a total of 13 funding sources and 56 awards nationwide. The most commonly reported funding sources for fall injury prevention were CDC/NCIPC Core VIPP, the CDC Preventive Health and Health Services (PHHS) Block Grant, and the HRSA/MCHB Title V Block Grant. Sexual assault/rape prevention efforts were supported by a total of 12 funding sources and 55 awards nationwide. The most commonly reported funding sources for sexual assault/rape prevention were CDC/NCIPC Rape Prevention and Education, CDC PHHS Block Grant, and State General Revenue.

### Table 1.
**Five Most Common Injury and Violence Topic Areas and Supporting Funding Sources, 2013**

<table>
<thead>
<tr>
<th>Rank</th>
<th>IVP Topic Area</th>
<th>No. of Funding Sources</th>
<th>Most Commonly Reported Sources Funding Sources Used to Support IVP Topic Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Motor vehicle injury prevention</td>
<td>18 (80)</td>
<td>CDC/NCIPC Core VIPP; State Highway Safety Office; State General Revenue; HRSA/MCHB Title V Block Grant</td>
</tr>
<tr>
<td>2</td>
<td>Fall injury prevention</td>
<td>13 (56)</td>
<td>CDC/NCIPC Core VIPP; CDC PHHS Block Grant; State General Revenue; HRSA/MCHB Title V Block Grant</td>
</tr>
<tr>
<td>3</td>
<td>Sexual assault/rape prevention</td>
<td>12 (55)</td>
<td>CDC/NCIPC Rape Prevention and Education (RPE); CDC PHHS Block Grant; State General Revenue</td>
</tr>
<tr>
<td>4</td>
<td>Suicide/self-inflicted injury prevention</td>
<td>17 (55)</td>
<td>CDC/NCIPC NVDRS; State General Revenue; HRSA/MCHB Title V Block Grant</td>
</tr>
<tr>
<td>5</td>
<td>Poisoning/prescription drug overdose prevention</td>
<td>13 (51)</td>
<td>Core VIPP; CDC PHHS Block Grant; State General Revenue; HRSA/MCHB Title V Block Grant</td>
</tr>
</tbody>
</table>

### INDIVIDUAL EMPLOYEES AND FULL-TIME EQUIVALENTS (FTE)

A total of $60.6 million from 21 different funding sources supported 431 individual employees working in state health department injury and violence prevention programs. Of these individuals, 341 (79%) were full-time or part-time paid staff, 49 (11%) were full-time or part-time contractors, and the remaining 41 (10%) worked in other capacities.

Staff time that is dedicated to state injury and violence prevention programs is measured in terms of full-time equivalents (FTEs). The 431 individual employees working in state injury and violence prevention programs in 2013 equated to a total of 341.69 FTEs. State programs had a median of 7.50 FTEs and an average of 8.54 FTEs, with values ranging from 0.55 to 26.00 FTEs. A quarter of states had less than 3.00 FTEs in their injury and violence prevention program, 50% had between 3.50 and 12.83 FTEs, and the remaining 25% had more than 12.84 FTEs.

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10. Full-time equivalents (FTEs): the total number of hours worked by an individual employee divided by the total number of work hours in a full-time schedule (defined as 40 hours per week).
FTEs contributed to injury and violence prevention efforts through a variety of primary roles, including intervention/program coordination (32%), data collection and analysis (15%), and management (13%) (Figure 10). The majority of states did not have any FTEs with primary roles in public policy (75%), evaluation (63%), or technical assistance and training (55%). Only three states had staff with time dedicated to all of the nine primary staff roles depicted in Figure 10.

Figure 10. Distribution of FTE Primary Staff Roles from All Funding Sources, 2013

Of the 21 funding sources included in the 2013 State of the States (SOTS) Finance and Personnel Survey, six sources accounted for 84% ($93.5 million) of the total amount of funding utilized by state injury and violence prevention programs in 2013. These sources included State General Revenue, HRSA/MCHB Title V Block, CDC/NCIPC RPE, Dedicated State Funding Stream, CDC/NCIPC Core VIPP, and CDC PHHS Block Grant (Figure 11). Of these six top funding sources, four were federal sources and two were state sources. State General Revenue contributed the most dollars to state injury and violence prevention programs. In 2013, 21 states received a combined total of $26.8 million (24% of state program funding nationally) from State General Revenue. In contrast, the CDC PHHS Block Grant provided less total funding to state injury and violence prevention programs ($7.9 million or 7% of state program funding nationally), but provided funding to more states (N=25). Additionally, although fewer states received Dedicated State Funding Stream dollars, this funding source contributed slightly more funding to state injury and violence prevention programs than CDC/NCIPC Core VIPP or the CDC PHHS Block Grant.

TOP FUNDING SOURCES

Of the 21 funding sources included in the 2013 State of the States (SOTS) Finance and Personnel Survey, six sources accounted for 84% ($93.5 million) of the total amount of funding utilized by state injury and violence prevention programs in 2013. These sources included State General Revenue, HRSA/MCHB Title V Block, CDC/NCIPC RPE, Dedicated State Funding Stream, CDC/NCIPC Core VIPP, and CDC PHHS Block Grant (Figure 11). Of these six top funding sources, four were federal sources and two were state sources. State General Revenue contributed the most dollars to state injury and violence prevention programs. In 2013, 21 states received a combined total of $26.8 million (24% of state program funding nationally) from State General Revenue. In contrast, the CDC PHHS Block Grant provided less total funding to state injury and violence prevention programs ($7.9 million or 7% of state program funding nationally), but provided funding to more states (N=25). Additionally, although fewer states received Dedicated State Funding Stream dollars, this funding source contributed slightly more funding to state injury and violence prevention programs than CDC/NCIPC Core VIPP or the CDC PHHS Block Grant.
Figure 11.
Number of States that Reported Receiving the Funding Sources vs. Total Provided by Each Funding Source, 2013

A. Substance Abuse and Mental Health Services Administration (SAMHSA) Campus Suicide Prevention Grants
B. CDC/NCIPC Residential Fire-related Injury Prevention Program
C. Federal Emergency Management Agency (FEMA)
D. National Highway Traffic Safety Administration (NHTSA) Other
E. Corporate/Private
F. Foundation
G. U.S. Department of Justice
H. HRSA/MCHB – Emergency Medical Services for Children (EMSC)
I. NHTSA CODES
J. Nonprofit Organizations
K. Universities
L. SAMHSA State and Tribal Youth Suicide Prevention Grants
M. Other Funding Sources
N. Consumer Product Safety Commission (CPSC)
O. Other State Funding Sources
P. CDC/NCIPC National Violent Death Reporting System (NVDRS)
Q. State Highway Safety Office
R. Other Federal Funding Sources
The six top sources supported 233.13 FTEs, or 70% of all staff of state health department injury and violence prevention programs (Figure 12). Although State General Revenue contributed the largest dollar amount to support FTEs, CDC/NCIPC Core VIPP funding supported the highest number of FTEs (59.48).

**BUDGET CUTS**

Sixty percent (60%) of states (N=25) experienced budget cuts in 2013. These budget cuts impacted numerous funding sources and, in turn, adversely affected the activities and services provided by state health department injury and violence prevention programs. The most commonly reported consequences of budget cuts were reductions in support to partners (68%), services (64%), and surveillance efforts (44%), as well as the loss of staff through attrition (36%) (Figure 13).

**Figure 12. Comparison of FTEs in Top Six Funding Sources to All Other Sources**

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>FTEs Supported</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDC/NCIPC Core VIPP</td>
<td>59.48 FTEs</td>
<td>18%</td>
</tr>
<tr>
<td>State General Revenue</td>
<td>59.27 FTEs</td>
<td>18%</td>
</tr>
<tr>
<td>HRSA/MCHB Title V Block</td>
<td>36.23 FTEs</td>
<td>11%</td>
</tr>
<tr>
<td>CDC/NCIPC RPE</td>
<td>36.10 FTEs</td>
<td>11%</td>
</tr>
<tr>
<td>CDC PHHS Block Grant</td>
<td>26.05 FTEs</td>
<td>8%</td>
</tr>
<tr>
<td>Dedicated State Funding</td>
<td>16.00 FTEs</td>
<td>5%</td>
</tr>
</tbody>
</table>

**Figure 13. Anticipated Impacts of Budget Cuts, 2013**

- Reduction in support to partners: 68%
- Reduction in services: 64%
- Reduction in surveillance efforts: 44%
- Loss of staff through attrition: 36%
- Elimination of entire program(s): 24%
- Reduction in support to local health departments: 24%
- Staff layoffs: 24%
- Staff furloughs: 12%
- Staff layoffs: 8%
STATES LACKING A CENTRALIZED INJURY AND VIOLENCE PREVENTION PROGRAM

During the data collection process, a total of five states (out of 41) reported that they did not have an identified state injury and violence prevention program and injury and violence prevention activities were decentralized throughout the state health department in 2013. To better understand decentralized injury and violence prevention activities in states, key informant interviews were conducted with health department staff from these states. Specific questions were asked to learn more about their infrastructure, prevention activities, and partnerships, as well as their perceived value of potentially having a centralized program.

Infrastructure

States that lacked a centralized IVP program in 2013 reported that they had limited staff who served in multiple roles within the health department, “wearing two or three hats” to implement injury and violence prevention activities. In some states, the political environment was a key factor that prevented the department from hiring staff to lead injury and violence prevention activities; as a result, state staff members were often forced to rely on outside contractors or consultants to implement program activities. As one interviewee said, “As long as they don’t have to hire somebody to do it, as long as they can put that hat on somebody who already exists and has a job…they’re not going to hire.” At least one state reported that it was in the process of hiring new staff to address injury and violence prevention activities and expressed a need for new staff who could manage data-related activities.

States were also asked about the availability of funding to support their existing infrastructure in 2013. In general, state staff indicated that the lack of a centralized program (and therefore lack of dedicated staff) created a significant barrier to competing for new funding or to implementing programs if funding was ultimately secured. Given the decentralized activities taking place in the state, applying for funding also had the potential to create tension between different divisions or agencies working on similar initiatives. For example, one interviewee said, “If we were to decide, well we’re going to take on the prescription drug monitoring program or we’re going to apply for this grant and kind of do it on our own without telling them, we would be stepping on toes through departments all throughout the state and it would just be politically bad as well as just strategically dumb.” Nevertheless, state staff indicated an awareness of various injury and violence-related funding opportunities and expressed a desire to pursue them if they would be eligible to do so. The staff member from the state in the process of hiring new staff said, “We’re very interested in knowing ahead of time when funding opportunities come around. I do think that we really try to keep an ear to the ground as to what’s coming down the pike and we just hope we have an opportunity to apply.” They also mentioned the value of federal funding, stating, “Well if we were funded through CDC, it would really give us a basis for the basic capacity that you would develop in injury prevention and the state, such as the program manager and an epidemiologist.”
Prevention Activities

With regard to activities, states that lacked a centralized program reported that there was a limited number of injury and violence prevention activities that could be implemented by health department staff in 2013. This was generally due to both a lack of dedicated staff and dedicated funding. One interviewee explained, “So it’s not that we’re missing completely off injuries because we still kind of are in it, but we’re not receiving the funding for injury to do it. So we do some things but...it’s not what I would call a concerted effort to it.” As a result, partnerships were essential to conducting many prevention activities. As another interviewee said, “We do have some activities going on with some of our sister agencies and some partners that we collaborate with...but in our injury program there is no activities going on.” The majority of state-level prevention activities that were implemented related to surveillance work or coordination with state and local agencies. Prevention activities were generally spread across various state and local agencies, and the lack of a centralized program adversely impacted staff knowledge about activities that were currently being implemented or which staff person (in any agency) was primarily responsible for specific activities. As one interviewee mentioned, “It’s sort of scattered here and there” and “We’re not communicating and I think you need that single synergy source that is going to pull all the partners together and right now we don’t have that.”

Value of a Centralized Injury and Violence Prevention Program

During the interviews, state staff members were asked to describe how they perceived the potential value of having a centralized program, as well as the potential challenges associated with establishing one. Most interviewees believed that having a centralized program would allow for a greater expansion of resources, provide more focus on injury and violence prevention at the state level, and result in less duplication of injury and violence prevention activities across both the state health department and other state and local agencies. One interviewee said that a centralized program would “allow us to take a more comprehensive approach to injury” and another mentioned that it would allow for a “consistent knowledge base.” However, interviewees identified two primary barriers to establishing a centralized program:

- The political environment was identified as a significant barrier. According to interviewees, state leaders may not acknowledge injury and violence prevention as a priority, nor did legislative mandates exist. Interviewees also indicated that there may be injury and violence-related state laws in place, such as trauma data reporting, but enforcement of these laws was not well executed.
- Agency silos – at both the state and local levels – were also identified as key barriers to the establishment of a centralized program. Interviewees acknowledged that the existence of these isolated silos made communication and collaboration difficult to achieve, and therefore adversely impacted the ability of various agencies to work together effectively on injury and violence prevention efforts.
Collect and Analyze Injury and Violence Data

UNDERSTANDING INJURY AND VIOLENCE DATA

To track health problems, state injury and violence prevention 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, including special systems such as spinal cord and traumatic brain injury registries.

The Safe States Alliance publication titled, Consensus Recommendations for Injury Surveillance in State Health Departments, advises state injury and violence prevention programs to identify their priorities by using 11 core datasets to analyze recommended conditions (Appendix A). Such data enable state and local injury and violence prevention 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 DATASETS

In 2013, state injury and violence prevention programs’ access to and use of core datasets varied (Table 2). As in previous survey years, most states reported having access to data from vital records (95%), the Behavioral Risk Factor Surveillance System (BRFSS) (90%), Hospital Discharge Data (HDD) (90%), and the Youth Risk Behavioral Surveillance System (YRBSS) (83%). Although a smaller percentage of states reported having access to all 11 core datasets compared to previous survey years, more states reported greater use of the data in 2013 compared to 2011. All states (100%) that reported having access to vital records, HDD, and emergency department (ED) data also utilized the information provided by these datasets in 2013.
In 2013, state injury and violence prevention programs used the core datasets to identify topics or populations at risk (Figure 14). At least 64% of states that reported having access to vital records, BRFSS, HDD, YRBSS, and child death review (CDR) data used the information to identify population groups that were affected by specific injury or violence issues. In 2013, HDD was the most common dataset used to identify topic-specific injury and violence issues affecting the state (95%). Vital records was the most common dataset used to identify specific population groups affected by injury and violence issues (95%), as well as to identify geographic regions where an injury or violence issue were occurring in the state (90%). Finally, CDR was the most common dataset used to identify risk and/or protective factors among populations (79%).

Table 2.
Access to and Use of Core Datasets, 2013 (N=41), 2011 (N=47), and 2009 (N=49)

<table>
<thead>
<tr>
<th>Dataset</th>
<th>2013</th>
<th>2011</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital Records</td>
<td>39 (100%)</td>
<td>47 (91%)</td>
<td>45 (96%)</td>
</tr>
<tr>
<td>Behavioral Risk Factor Surveillance System (BRFSS)</td>
<td>37 (97%)</td>
<td>46 (88%)</td>
<td>46 (85%)</td>
</tr>
<tr>
<td>Hospital Discharge Data (HDD)</td>
<td>37 (100%)</td>
<td>43 (88%)</td>
<td>43 (91%)</td>
</tr>
<tr>
<td>Youth Risk Behavior Surveillance System (YRBSS)</td>
<td>34 (94%)</td>
<td>42 (76%)</td>
<td>44 (77%)</td>
</tr>
<tr>
<td>Child Death Review (CDR)</td>
<td>28 (92%)</td>
<td>33 (67%)</td>
<td>42 (71%)</td>
</tr>
<tr>
<td>Emergency Department (ED)</td>
<td>26 (100%)</td>
<td>33 (79%)</td>
<td>28 (100%)</td>
</tr>
<tr>
<td>Fatality Analysis Reporting System (FARS)</td>
<td>24 (87%)</td>
<td>33 (61%)</td>
<td>42 (69%)</td>
</tr>
<tr>
<td>Emergency Medical Services (EMS)</td>
<td>22 (95%)</td>
<td>31 (58%)</td>
<td>38 (50%)</td>
</tr>
<tr>
<td>Medical Examiner</td>
<td>22 (90%)</td>
<td>32 (75%)</td>
<td>27 (78%)</td>
</tr>
<tr>
<td>Uniform Crime Reporting System (UCR)</td>
<td>21 (95%)</td>
<td>30 (63%)</td>
<td>35 (77%)</td>
</tr>
<tr>
<td>National Occupant Protection Use Survey (NOPUS)</td>
<td>20 (95%)</td>
<td>19 (74%)</td>
<td>23 (48%)</td>
</tr>
</tbody>
</table>
ACCESS TO AND USES OF INJURY AND VIOLENCE DATA

Across all datasets (including the 11 core datasets listed in Appendix A), the most commonly used datasets in 2013 were vital records (95%), BRFSS (90%), HDD (90%), and the Web-based Injury Statistics Query and Reporting System (WISQARS) (85%).

The use of injury and violence data by state injury and violence prevention programs in 2013 varied by dataset (Table 3). Many state programs used data and information from specific datasets to communicate key findings to partners and the public, to respond to data requests, to inform policy or program evaluations, to make programmatic decisions, and to create scientific reports or presentations.

More than half of the states that have reported access to injury and violence datasets also reported using the datasets to communicate key findings to partners and the public.
<table>
<thead>
<tr>
<th>Dataset</th>
<th>Access to Dataset (N)</th>
<th>Communicate key findings to partners and the public N (%)</th>
<th>Respond to data requests N (%)</th>
<th>To inform policy or program evaluations N (%)</th>
<th>Make programmatic decisions N (%)</th>
<th>Create scientific reports or presentations N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital Records</td>
<td>39</td>
<td>32 (82%)</td>
<td>35 (89%)</td>
<td>30 (76%)</td>
<td>28 (71%)</td>
<td>33 (84%)</td>
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<tr>
<td>Behavioral Risk Factor Surveillance System (BRFSS)</td>
<td>37</td>
<td>28 (75%)</td>
<td>24 (64%)</td>
<td>20 (54%)</td>
<td>17 (45%)</td>
<td>17 (45%)</td>
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<tr>
<td>Hospital Discharge Data (HDD)</td>
<td>37</td>
<td>31 (83%)</td>
<td>33 (89%)</td>
<td>29 (78%)</td>
<td>25 (67%)</td>
<td>31 (83%)</td>
</tr>
<tr>
<td>Web-based Injury Statistics Query and Reporting System (WISQARS)</td>
<td>35</td>
<td>26 (74%)</td>
<td>25 (71%)</td>
<td>19 (54%)</td>
<td>15 (42%)</td>
<td>21 (60%)</td>
</tr>
<tr>
<td>Youth Risk Behavior Surveillance System (YRBSS)</td>
<td>34</td>
<td>26 (76%)</td>
<td>24 (70%)</td>
<td>19 (55%)</td>
<td>18 (52%)</td>
<td>16 (47%)</td>
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<tr>
<td>Child Death Review (CDR)</td>
<td>28</td>
<td>20 (71%)</td>
<td>9 (32%)</td>
<td>17 (60%)</td>
<td>18 (64%)</td>
<td>13 (46%)</td>
</tr>
<tr>
<td>Motor Vehicle Traffic Records</td>
<td>28</td>
<td>20 (71%)</td>
<td>17 (60%)</td>
<td>21 (75%)</td>
<td>19 (67%)</td>
<td>17 (60%)</td>
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<td>Emergency Department (ED) data</td>
<td>26</td>
<td>22 (84%)</td>
<td>24 (92%)</td>
<td>21 (80%)</td>
<td>18 (69%)</td>
<td>20 (76%)</td>
</tr>
<tr>
<td>Fatality Analysis Reporting System (FARS)</td>
<td>24</td>
<td>12 (50%)</td>
<td>11 (45%)</td>
<td>16 (66%)</td>
<td>10 (41%)</td>
<td>9 (37%)</td>
</tr>
<tr>
<td>National Intimate Partner and Sexual Violence Survey (NISVS)</td>
<td>23</td>
<td>14 (60%)</td>
<td>7 (30%)</td>
<td>11 (47%)</td>
<td>8 (34%)</td>
<td>6 (26%)</td>
</tr>
<tr>
<td>Emergency Medical Services EMS data</td>
<td>22</td>
<td>15 (68%)</td>
<td>13 (59%)</td>
<td>11 (50%)</td>
<td>12 (54%)</td>
<td>12 (54%)</td>
</tr>
<tr>
<td>Medical Examiner</td>
<td>22</td>
<td>14 (63%)</td>
<td>14 (63%)</td>
<td>13 (59%)</td>
<td>14 (63%)</td>
<td>13 (59%)</td>
</tr>
<tr>
<td>Uniform Crime Reporting System (UCR)</td>
<td>21</td>
<td>13 (61%)</td>
<td>7 (33%)</td>
<td>9 (42%)</td>
<td>10 (47%)</td>
<td>7 (33%)</td>
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<tr>
<td>National Violent Death Reporting System (NVDRS)</td>
<td>20</td>
<td>17 (85%)</td>
<td>16 (80%)</td>
<td>15 (75%)</td>
<td>13 (65%)</td>
<td>16 (80%)</td>
</tr>
<tr>
<td>Pregnancy Risk Assessment Monitoring System (PRAMS)</td>
<td>19</td>
<td>10 (52%)</td>
<td>6 (31%)</td>
<td>9 (47%)</td>
<td>12 (63%)</td>
<td>5 (26%)</td>
</tr>
<tr>
<td>Prescription Drug Monitoring Program (PDMP)</td>
<td>11</td>
<td>10 (90%)</td>
<td>6 (54%)</td>
<td>8 (72%)</td>
<td>6 (54%)</td>
<td>7 (63%)</td>
</tr>
</tbody>
</table>
USE OF DATASETS TO ADDRESS INJURY AND VIOLENCE TOPIC AREAS

In 2013, vital records, HDD, ED data, and WISQARS were most the common datasets used to address specific injury and violence topic areas. Specifically among the state injury and violence prevention programs that indicated that motor vehicle injury was one of their primary focus areas (N=30), 86% used vital records to inform their efforts, while 73% used HDD, 73% used ED data, and 63% used WISQARS (Table 4). Other common data sources that were used to address motor vehicle injury prevention included traffic records (73%), the Fatality Analysis Reporting System (FARS) (43%), and YRBSS (40%). For other injury and violence topics, such as sexual assault/rape, state injury and violence prevention programs relied on other datasets to inform their efforts. Among the 26 state programs that addressed sexual assault/rape, 65% used BRFSS, Uniform Crime Reporting Systems (UCR), and the National Intimate Partner and Sexual Violence Survey (NISVS) respectively.

<table>
<thead>
<tr>
<th>Injury and Violence Topic Areas</th>
<th>Vital Records</th>
<th>Hospital Discharge Data N (%)</th>
<th>Emergency Department N (%)</th>
<th>WISQARS N (%)</th>
<th>Other Common Data Sources (N, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor Vehicle Injury (N=30)</td>
<td>26 (86%)</td>
<td>22 (73%)</td>
<td>22 (73%)</td>
<td>19 (63%)</td>
<td>Traffic Records (22, 73%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>FARS (13, 43%)</td>
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<td></td>
<td></td>
<td></td>
<td>YRBSS (12, 40%)</td>
</tr>
<tr>
<td>Poisoning/Prescription Drug Overdose (N=27)</td>
<td>26 (96%)</td>
<td>23 (85%)</td>
<td>18 (66%)</td>
<td>17 (62%)</td>
<td>Medical Examiner (10, 37%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Addiction and Mental Health Surveys (10, 37%)</td>
</tr>
<tr>
<td>Fall Injuries (N=27)</td>
<td>25 (92%)</td>
<td>23 (85%)</td>
<td>22 (81%)</td>
<td>19 (70%)</td>
<td>BRFSS (16, 59%)</td>
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<tr>
<td>Suicide/Self-inflicted Injury (N=20)</td>
<td>20 (100%)</td>
<td>13 (65%)</td>
<td>15 (75%)</td>
<td>10 (50%)</td>
<td>Medical Examiner (14, 70%)</td>
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<tr>
<td>Child Passenger Safety (N=22)</td>
<td>15 (68%)</td>
<td>14 (63%)</td>
<td>9 (40%)</td>
<td>11 (50%)</td>
<td>Traffic Records (16, 73%)</td>
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<tr>
<td>Sexual Assault/Rape (N=26)</td>
<td>3 (11%)</td>
<td>9 (34%)</td>
<td>6 (23%)</td>
<td>7 (26%)</td>
<td>BRFSS (17, 65%)</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>UCR (17, 65%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NISVS (17, 65%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YRBSS (14, 54%)</td>
</tr>
<tr>
<td>Traumatic Brain Injury (N=21)</td>
<td>18 (85%)</td>
<td>17 (80%)</td>
<td>7 (33%)</td>
<td>14 (66%)</td>
<td>Medical Examiner (5, 24%)</td>
</tr>
<tr>
<td>Suicide Attempts (N=15)</td>
<td>5 (33%)</td>
<td>13 (86%)</td>
<td>5 (33%)</td>
<td>11 (73%)</td>
<td>YRBSS (14, 93%)</td>
</tr>
<tr>
<td>Domestic/Intimate Partner Violence (N=11)</td>
<td>4 (36%)</td>
<td>2 (18%)</td>
<td>2 (18%)</td>
<td>2 (18%)</td>
<td>BRFSS (9, 82%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YRBSS (7, 64%)</td>
</tr>
<tr>
<td>Youth Violence (N=13)</td>
<td>3 (23%)</td>
<td>4 (30%)</td>
<td>4 (30%)</td>
<td>2 (15%)</td>
<td>YRBSS (11, 85%)</td>
</tr>
</tbody>
</table>

BRFSS = Behavioral Risk Factor Surveillance System; FARS = Fatality Analysis Reporting System; NISVS = National Intimate Partner and Sexual Violence Survey; UCR = Uniform Crime Reporting System; WISQARS = Web-based Injury Statistics Query and Reporting System; YRBSS = Youth Risk Behavior Surveillance System
Compared to 2009 and 2011, state injury and violence prevention programs reported having less access to data professionals. In 2013, only 86% of state programs reported access to an epidemiologist, statistician, or other data professional to analyze data for the state program, compared to 96% in 2009 and 98% in 2011. Many states, however, had access to more than one type of data professional. Seventy-six percent (76%) of states reported having access to a data professional within the state injury and violence prevention program, 29% reported having access within the State Health Department, 7% reported access by consultant, and 2% reported access by an Injury Control Research Center. In 2013, 56% of state injury and violence prevention programs had access to one or more full-time equivalents (FTEs) whose primary role was data analysis and collection (Figure 15). This was a 15% net increase compared to 2009 and a 3% net decrease compared to 2011. The decrease in access to data professionals can be attributed to budget cuts in 2013.

**Figure 15.**
Access to State Injury and Violence Prevention Programs Have Access to an Epidemiologist, Statistician, or other Data Professional, 2009, 2011, and 2013
In 2013, state injury and violence prevention programs produced a variety of reports. Ninety-five percent (95%) of states indicated that they produced some type or report using injury and violence surveillance data (Figure 16). Most states produced presentations or posters at conferences and workshops (83%). Others produces fact sheets about general or specific injury problems (78%), technical reports (51%), publications in print media (49%), and publications in peer-reviewed journals (27%).

Of those states that produced injury and violence surveillance reports of some kind, most disseminated these report to other agencies within their state (71%) and to members of their Injury Community Planning Group (ICPG) (66%). The injury and violence prevention programs also disseminated these data reports to other groups, including non-governmental agencies (66%), local health departments (61%), other state health department divisions (54%), and federal agencies (51%). Of the states that disseminated reports, approximately half (48%) reported that next steps or action items were identified as a result of sharing the reports. Some of the next steps/action items included recommendations for programmatic/policy implementation of injury and violence prevention efforts and promotion of best practices and evidence-based prevention strategies. The dissemination also helped to inform the prioritization of funding across various competing topic areas.

Figure 16.
Types of Reports Produced by State Injury and Violence Prevention Programs, 2013 (N=41)
Select, Implement, and Evaluate Effective Policy and Program Strategies

UNDERSTANDING INJURY AND VIOLENCE PREVENTION POLICY AND PROGRAM STRATEGIES

Injury and violence prevention strategies that involve enacting, changing, or enforcing laws, regulations, procedures, administrative actions, incentives, resource allocations or other voluntary practices of governments and other institutions are referred to as policy strategies or interventions. According to the Institute of Medicine, policy development is an essential public health function. Furthermore, policy is integrated into three of the 10 Essential Public Health Services.

In keeping, 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 injury and violence prevention efforts for decades, helping to raise awareness and change individual or group behaviors.

Policy and program strategies that are implemented by state injury and violence prevention programs should address multiple forms of injury and violence that affect populations across the lifespan – from infancy to advanced age. Given their limited resources, state injury and violence prevention programs should 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 injury and violence prevention programs addressed multiple injury and violence areas through policy and program strategies in 2013. 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 injury and violence prevention program in FFY 2013. Each state could indicate more than one area of primary focus, and some topics were not mutually exclusive (i.e., motor vehicle injury and child passenger safety). Table 5 provides the most common primary focus areas for the last five survey years.

Table 5.

<table>
<thead>
<tr>
<th>Top Primary Focus Areas</th>
<th>2013</th>
<th>2011</th>
<th>2009</th>
<th>2007</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Motor vehicle injury</td>
<td>Motor vehicle injury</td>
<td>Motor vehicle injury</td>
<td>Suicide attempts</td>
<td>Suicide attempts</td>
</tr>
<tr>
<td>2</td>
<td>Fall injury</td>
<td>Fall injury</td>
<td>Child passenger safety</td>
<td>Child passenger safety</td>
<td>Sexual assault/rape</td>
</tr>
<tr>
<td>3</td>
<td>Poisoning/Prescription Drug</td>
<td>Sexual assault/rape</td>
<td>Fall injury</td>
<td>Motor vehicle safety</td>
<td>Child passenger safety</td>
</tr>
<tr>
<td></td>
<td>Overdose</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Sexual assault/rape</td>
<td>Injuries to children</td>
<td>Injuries to children</td>
<td>Sexual assault/rape</td>
<td>Traumatic brain injury</td>
</tr>
<tr>
<td>5</td>
<td>Child passenger safety</td>
<td>Child passenger safety</td>
<td>Sexual assault/rape</td>
<td>Injuries to children</td>
<td>Injuries to children</td>
</tr>
<tr>
<td>6</td>
<td>Traumatic brain injury</td>
<td>Poisoning/Prescription Drug</td>
<td>Suicide/self-inflicted injury</td>
<td>Traumatic brain injury</td>
<td>Fall injury</td>
</tr>
<tr>
<td></td>
<td>Overdose</td>
<td>Overdose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Suicide/self-inflicted injury</td>
<td>Suicide/self-inflicted injury</td>
<td>Suicide attempts</td>
<td>Fall injury</td>
<td>Fire and burn injury</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Suicide attempts</td>
<td>Injuries to adolescents</td>
<td>Traumatic brain injury</td>
<td>Domestic violence/intimate</td>
<td>Homicide</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>partner violence</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Youth Violence</td>
<td>Traumatic brain injury</td>
<td>Injuries to the elderly</td>
<td>Poisoning/Prescription Drug</td>
<td>Motor vehicle injury</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Overdose</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Domestic violence/intimate</td>
<td>Suicide attempts</td>
<td>Injuries to adolescents</td>
<td>Fire and burn injury</td>
<td>Injuries to the elderly</td>
</tr>
<tr>
<td></td>
<td>partner violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In 2013, the most commonly reported primary focus areas were motor vehicle injury (73% of states), fall injuries (66%), poisoning/PDO (66%), sexual assault/rape (63%), and child passenger safety (54%). The topic areas that were generally not addressed by states in 2013 were elder abuse and rural/agricultural injury (no states reported addressing these focus areas). Figure 17 shows the percentage of state injury and violence prevention programs that identified selected injury and violence topics as areas of primary programmatic focus in 2013.
In the 2013 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. As seen in Figure 18, data was the most common method used to determine four of the five most common focus areas. The exception was sexual assault/rape prevention, in which funding directives were the primary method of determination. State mandates and political influences were the least commonly reported methods of determining primary focus areas. Political influence was highest in establishing poisoning/PDO as a primary focus area for state injury and violence prevention programs (26%), and state mandates were highest in determining child passenger safety as a primary focus area (18%).

**Figure 18. Methods Used for Selecting Top Five Injury and Violence Focus Areas, 2013**

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Data</th>
<th>Funding Directives</th>
<th>Needs Assessments</th>
<th>Political Influence</th>
<th>State Mandates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor Vehicle Injury Prevention</td>
<td>97%</td>
<td>47%</td>
<td>37%</td>
<td>10%</td>
<td>3%</td>
</tr>
<tr>
<td>30 States</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall Injury Prevention</td>
<td>100%</td>
<td>37%</td>
<td>48%</td>
<td>19%</td>
<td>11%</td>
</tr>
<tr>
<td>27 States</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poisoning/Prescription Drug Overdose</td>
<td>100%</td>
<td>30%</td>
<td>37%</td>
<td>26%</td>
<td>0%</td>
</tr>
<tr>
<td>27 States</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Assault/Rape Prevention</td>
<td>73%</td>
<td>92%</td>
<td>46%</td>
<td>23%</td>
<td>8%</td>
</tr>
<tr>
<td>26 States</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Passenger Safety</td>
<td>82%</td>
<td>68%</td>
<td>27%</td>
<td>9%</td>
<td>18%</td>
</tr>
<tr>
<td>22 States</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
IMPLEMENTATION AND EVALUATION OF POLICY AND PROGRAM STRATEGIES

Implementation Plans

More than half of state injury and violence prevention programs reported having an implementation or strategic plan to address their primary focus areas. Table 6 shows the injury and violence prevention program levels of planning for the five most common injury and violence focus areas in 2013. Compared to previous survey years, a large percentage of states that addressed motor vehicle or fall injuries reported having an implementation plan in 2013. In 2011, only 18 (53%) of states that addressed motor vehicle injuries reported having an implementation plan compared to 21 (70%) in 2013. Similarly, only 20 (69%) of states that addressed fall injuries reporting having an implementation plan in 2011 compared to 23 (85%) in 2013. Many states reported that motor vehicle injuries and fall injuries were addressed in their state strategic plan. However, across all of the five most commonly reported focus areas, no more than three states reported not having a formal, written implementation plan.

Evaluation Activities & Reporting

Compared to previous survey years, a greater number of state injury and violence prevention programs reported having an evaluation plan for their primary focus areas. More than half of states reported having an evaluation plan for motor vehicle injuries, fall injuries, poisoning/prescription drug overdose, and/or sexual/assault rape prevention (Table 6). However, only seven states (31%) that primarily focused on child passenger safety had an evaluation plan in place. Many states reported that they did not have formal evaluation plans across all of their focus areas. 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 fall injuries (70%) among the five most commonly reported primary focus areas.

High-level program implementation and evaluation requires reporting program and policy evaluation outcomes to stakeholders. At least half of all states reported policy and program evaluation outcomes to stakeholders for all five of the most common primary focus areas, with the exception of poisoning/prescription drug overdose (Table 6). Dissemination of evaluation findings was most commonly reported for states primarily addressing fall injuries, with 59% reporting that they shared outcomes with stakeholders.
Table 6. Reported Levels of Planning, Evaluation, and Reporting for the Five Most Commonly Reported Focus Areas for State Injury and Violence Prevention Programs, 2013

<table>
<thead>
<tr>
<th></th>
<th>Motor vehicle injury (N=30)</th>
<th>Fall injuries (N=27)</th>
<th>Poisoning/Prescription Drug Overdose (N=27)</th>
<th>Sexual assault/rape (N=26)</th>
<th>Child passenger safety (N=22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation Plans</td>
<td>Implementation plan exists</td>
<td>21 (70%)</td>
<td>23 (85%)</td>
<td>21 (77%)</td>
<td>22 (84%)</td>
</tr>
<tr>
<td>Topic area is addressed in a state plan</td>
<td>21 (70%)</td>
<td>21 (77%)</td>
<td>20 (74%)</td>
<td>19 (73%)</td>
<td>13 (59%)</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Evaluation plan exists</td>
<td>17 (56%)</td>
<td>17 (62%)</td>
<td>14 (51%)</td>
<td>16 (61%)</td>
</tr>
<tr>
<td>Process evaluation data is collected to update or change program and/or policy activities</td>
<td>18 (60%)</td>
<td>19 (70%)</td>
<td>13 (48%)</td>
<td>18 (69%)</td>
<td>16 (72%)</td>
</tr>
<tr>
<td>Outcome evaluation data is collected to update or change program and/or policy activities</td>
<td>19 (63%)</td>
<td>19 (70%)</td>
<td>17 (62%)</td>
<td>14 (53%)</td>
<td>13 (59%)</td>
</tr>
<tr>
<td>Dissemination of Findings</td>
<td>Injury and violence prevention program reports program and/or policy outcomes to stakeholders</td>
<td>16 (53%)</td>
<td>16 (59%)</td>
<td>12 (44%)</td>
<td>13 (50%)</td>
</tr>
</tbody>
</table>
In 2013, the most commonly reported injury or violence prevention topic areas that had funding allocated specifically to support evaluation were sexual assault/rape (55%) and fall injuries (45%). Figure 19 shows the percentage of state injury and violence prevention programs that had funding allocated specifically to support evaluation for each topic area in 2013. Although no states reported addressing rural/agricultural injury as a primary topic area in 2013, one state (2%) had funding to support evaluation of a program (or strategy) in this area.

![Figure 19. Injury and Violence Prevention Topic Areas with Funding Allocated to Support Evaluation, 2013 (N=41)](image-url)

- Sexual assault/rape: 55%
- Fall injuries: 45%
- Motor vehicle injury: 40%
- Poisoning/Prescription Drug Overdose: 40%
- Suicide/self-inflicted: 31%
- Child passenger safety: 24%
- Suicide attempts: 21%
- Child abuse/neglect: 19%
- Traumatic brain injury: 19%
- Teen Dating Violence: 14%
- Spinal cord injury: 12%
- Submersion injuries/drowning: 12%
- Domestic/intimate partner violence: 10%
- Fire and burns injury: 7%
- Homicide: 7%
- Occupational injury: 7%
- Pedestrian injury: 7%
- All Terrain Vehicle injury: 5%
- Motorcycle/motorized scooter injury: 5%
- School-based injury: 5%
- Rural/agricultural injury: 2%
METHODS TO INFORM POLICY STRATEGIES

It is important for state injury and violence prevention programs to have established methods of informing policy decisions that may impact rates of injuries and violence. In 2013, states used multiple methods to inform public, regulatory, and/or organizational policies, both directly and through collaboration with partners (Table 7).

Compared to 2011, more states reported direct uses of most methods to inform policy in 2013. The most common methods to inform policy that were used by state injury and violence prevention programs in 2013 included:

- Participating in boards and/or commissions (71%);
- Working to increase public awareness of laws (71%);
- Recommending health department positions on bills (63%);
- Working to encourage adoption of organizational policies (61%); and
- Evaluating/assessing/monitoring the impact of laws (61%).

However, as shown in Table 7, there was a decrease in the direct use of four methods: working to encourage adoption of organizational policies (net 3% decrease), working to develop/enforce regulations (net 7% decrease), conducting cost-benefit analyses (net 2% decrease), and inviting congressional delegates to meetings/event (net 9% decrease). Only 2% of state injury and violence prevention programs invited congressional delegates to meetings and events in 2013 compared to 11% in 2011.

Overall, state injury and violence prevention programs reported using methods to inform policy through collaboration with partners more frequently than using methods directly. The most common methods used through collaboration with partners were:

- Participating in boards and/or commission (76%);
- Working to increase public awareness of laws (76%);
- Sending materials to policy makers (73%);
- Evaluating/assessing/monitoring the impact of laws (63%); and
- Working to develop/enforce regulations for injury and violence prevention (63%).

Between 2011 and 2013, the greatest net increases in use of methods through collaboration with partners included requesting an opportunity to review bills (net 20% increase) and evaluating/assessing/monitoring the impact of laws (net 14% increase). The methods used through collaboration that were associated with the greatest net decreases in use were inviting congressional delegates to meetings/events (net 14% decrease) and working to develop/enforce regulations for injury and violence prevention (net 12% decrease).
### Table 7.
**Methods Used by State Injury and Violence Prevention Programs to Inform Public Policy: 2013 (N=40), 2011 (N=47)**

<table>
<thead>
<tr>
<th>Public Policy Method</th>
<th>Used Directly by the State IVP Program in 2011</th>
<th>Used Through Collaboration with Partners in 2013</th>
<th>Net Change in Method Used Directly by the State IVP Program since 2011</th>
<th>Net Change in Method Used Through Collaboration with Partners since 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participated in boards and or commissions</td>
<td>64%</td>
<td>76%</td>
<td>▲ 12%</td>
<td>▲ 5%</td>
</tr>
<tr>
<td>Worked to increase public awareness of laws</td>
<td>64%</td>
<td>76%</td>
<td>▲ 7%</td>
<td>▼ 1%</td>
</tr>
<tr>
<td>Recommended health department positions on bills</td>
<td>59%</td>
<td>39%</td>
<td>▲ 4%</td>
<td>▲ 3%</td>
</tr>
<tr>
<td>Evaluated/assessed/monitored the impact of laws</td>
<td>59%</td>
<td>63%</td>
<td>▲ 16%</td>
<td>▲ 14%</td>
</tr>
<tr>
<td>Worked to encourage adoption of organizational policies for IVP</td>
<td>53%</td>
<td>63%</td>
<td>▼ 3%</td>
<td>▲ 6%</td>
</tr>
<tr>
<td>Requested opportunity to review bills</td>
<td>48%</td>
<td>59%</td>
<td>▲ 3%</td>
<td>▲ 20%</td>
</tr>
<tr>
<td>Sent materials to policymakers</td>
<td>45%</td>
<td>73%</td>
<td>▲ 7%</td>
<td>▲ 3%</td>
</tr>
<tr>
<td>Met with policymakers</td>
<td>42%</td>
<td>56%</td>
<td>▲ 10%</td>
<td>▼ 3%</td>
</tr>
<tr>
<td>Worked to develop/enforce regulations for IVP</td>
<td>34%</td>
<td>56%</td>
<td>▼ 7%</td>
<td>▼ 12%</td>
</tr>
<tr>
<td>Testified at state and local hearings</td>
<td>30%</td>
<td>63%</td>
<td>▲ 7%</td>
<td>▲ 8%</td>
</tr>
<tr>
<td>Invited state or local legislators to meetings/events</td>
<td>27%</td>
<td>56%</td>
<td>▼ 2%</td>
<td>▼ 1%</td>
</tr>
<tr>
<td>Conducted cost-benefit analyses of IVP policies</td>
<td>24%</td>
<td>22%</td>
<td>▼ 2%</td>
<td>▼ 1%</td>
</tr>
<tr>
<td>Drafted and submitted potential policies to policymakers</td>
<td>16%</td>
<td>54%</td>
<td>▲ 4%</td>
<td>▼ 2%</td>
</tr>
<tr>
<td>Invited congressional delegates to meetings/events</td>
<td>11%</td>
<td>27%</td>
<td>▼ 9%</td>
<td>▼ 14%</td>
</tr>
</tbody>
</table>

IVP = injury and violence prevention
Seventy-three percent (N=29) of state injury and violence prevention programs that had a legislative session in 2013 (or during a similarly recent period) reported having mechanisms or protocols for communicating with policy makers (Figure 20). This represents a decrease in the percentage of states that reported having mechanisms or protocols for communicating with policy makers from 2011, 2009, 2007, and 2005 (74%, 89%, 82%, and 81%, respectively). These results indicate a 16% net decrease between 2009 and 2013.

Figure 20.

On the other hand, 68% of state injury and violence prevention programs indicated that they maintained a record of existing injury and violence-related state policies (e.g., laws, regulations, etc.) in 2013. This represents a significant increase compared to previous years (47% in 2011, 38% in 2009, and 43% in 2007).
IMPLEMENTATION OF POLICY STRATEGIES FOR INJURY AND VIOLENCE PREVENTION

The majority of state injury and violence prevention programs (95%, N=38) implemented policy strategies in 2013. As shown in Figure 21, policy strategies were most commonly used to address the following injury and violence prevention topic areas: motor vehicle injury prevention (66%), poisoning/prescription drug overdose (66%), and child passenger safety (60%).

Figure 21.
Policy Strategies Implemented by State Injury and Violence Prevention Programs, 2013

- Motor vehicle injury: 66%
- Poisoning: 66%
- Child passenger safety: 60%
- Fall injuries: 49%
- Traumatic brain injury: 46%
- Sexual assault/rape: 43%
- Childhood injury: 34%
- Domestic/intimate partner violence: 31%
- Suicide/self-inflicted: 31%
- Teen Dating Violence: 29%
HIGHLIGHTS OF THE THREE MOST COMMONLY REPORTED INJURY AND VIOLENCE PREVENTION FOCUS AREAS: FUNDING, FTES, AND STRATEGIES

Motor Vehicle Injury Prevention

Figure 22 illustrates which states identified motor vehicle injury prevention as a primary focus area, secondary focus area, tertiary focus area, or did not address the topic in 2013.

Figure 22.
State Program Focus: Motor Vehicle Injury Prevention, 2013

30 states identified motor vehicle injury prevention as a primary focus area

Nationally, state injury and violence prevention programs invested $141.4 million in motor vehicle injury prevention efforts which contributed to 124 FTEs
Figure 23 illustrates the most common motor vehicle injury prevention policy and program strategies that were implemented by state injury and violence prevention programs in 2013. The most common motor vehicle injury prevention strategies that were implemented included: child restraint/booster seat policies (76%), teen driving/graduated drivers licensing (76%), and child safety seat distribution programs (74%).
Fall Injury Prevention

Figure 24 illustrates which states identified fall injury prevention as a primary focus area, secondary focus area, tertiary focus area, or did not address the topic in 2013.

Figure 24.
State Program Focus: Fall Injury Prevention, 2013

27 states identified fall injury prevention as a primary focus area

Nationally, state injury and violence prevention programs invested

$28.1 million in fall injury prevention efforts which contributed to

89 FTEs

Figure 25 illustrates the most common fall injury prevention policy and program strategies that were implemented by state injury and violence prevention programs in 2013. The most common fall injury prevention strategies that were implemented included: exercise-based fall prevention programs (e.g., Tai Chi Otago Exercise Program) (74%), multi-faceted fall prevention programs (e.g., Stepping On) (59%), and policies that established commissions, coalitions, and programs for fall prevention (59%). Twenty-six percent (26%) of states that focused on fall prevention in 2013 also implemented home modification programs like the Falls-Home Integration Team program.

Figure 25.
Most Common Fall Injury Prevention Programs, 2013 (N=27)

Exercise-based fall prevention programs 74%
Multi-faceted fall prevention program 59%
Policy that establishes commissions, coalitions, and programs for fall prevention 59%
Home modification program 26%
Poisoning and Prescription Drug Overdose Prevention

Figure 26 illustrates which states identified poisoning and prescription drug overdose prevention as a primary focus area, secondary focus area, tertiary focus area, or did not address the topic in 2013.

Figure 26. State Program Focus: Poisoning & Prescription Drug Overdose Prevention, 2013

27 states identified Poisoning & Prescription Drug Overdose prevention as a primary focus area

Nationally, state injury and violence prevention programs invested

$142.1 million

in Poisoning & Prescription Drug Overdose prevention efforts which contributed to

116 FTEs

Figure 27 illustrates the most common poisoning and prescription drug overdose prevention policy and program strategies that were implemented in 2013 were Prescription Drug Monitoring Programs (PDMP) (78%) and other prescription drug-related policies (e.g., doctor shopping laws, pain management clinic oversight, etc.) (52%). Eighteen (18) out of the 27 states that worked on poisoning and prescription drug overdose prevention as their primary focus area also continued to support the implementation of their state’s PDMP from previous years, while three states just started supporting the implementation of these policies in 2013.

Figure 27. Most Common Poisoning & Prescription Drug Overdose Prevention Programs, 2013 (N=27)

Prescription Drug Monitoring Program (PDMP) 78%
Other prescription drug-related policies 52%
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 programs. Collaborating with both internal and external partners is essential for state injury and violence prevention programs to achieve their 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 injury and violence prevention programs also serve as conveners, bringing multiple partners together to work on a range of injury and violence-related issues and in a variety of roles. The value of partnerships is not only in their ability to expand the reach and impact of injury and violence prevention efforts, but also in the mutual benefits can occur for all partners – such as the ability to share data, provide or receive training, reach key populations, and collaborate on policy efforts.

OVERVIEW OF PARTNERSHIPS

In the State of the States survey, respondents were asked to provide feedback on their potential partnerships with 61 different types of agencies and entities, including:

- 18 offices within the state health department;
- 12 other agencies within the state;
- 19 non-governmental organizations; and
- 12 federal agencies.

If respondents confirmed that a specific agency or entity existed within the state, they were asked to describe the strength of their relationship with the partner using the following options: “strong,” “new and developing,” “needs improvement,” or “no relationship.” Additionally, respondents were asked to describe the nature of the partnership between the state injury and violence prevention program and the agency or entity using eight distinct activities that included:

1. Sharing data with the partner;
2. Actively involving the partner in programs, planning, etc.;
3. Providing funding to the partner;
4. Receiving funding from the partner;
5. Collaborating on policy with the partner;¹⁶
6. Collaborating on evaluation activities with the partner;
7. Collaborating on communication activities with the partner; and/or
8. Providing or receiving training/technical assistance from the partner.

¹⁶ The activity, “collaborating on policy” explicitly excludes lobbying, which is prohibited by state and federal agencies.”
Overall, states varied greatly in the total number of reported partnerships. States had an average of 12 partnerships with other offices within the state health department (range from 6 to 18), eight partnerships with other agencies within the state (range from 0 to 11), 11 partnerships with non-governmental organizations (range from 3 to 18), and five partnerships with federal agencies (range from 2 to 9).

PARTNERSHIPS WITH STATE HEALTH DEPARTMENT OFFICES

Strength of Partnerships with State Health Department Offices

In 2013, state injury and violence prevention programs were asked to describe the strength of their partnerships with other offices within the state health department. The five most common partnerships within the state health department were with Vital Statistics, Epidemiology, Maternal and Child Health, Emergency Medical Services EMS or EMS for Children, and Health Promotion Education/Community Health (Figure 28). Since 2009, state injury and violence prevention programs reported the strongest relationships and partnerships with Vital Statistics, Epidemiology, Maternal and Child Health, and Emergency Medical Services EMS or EMS for Children. Although all states reported having a partnership with Vital Statistics and Maternal and Child Health in 2013, some states perceived that their partnerships with those offices needed improvement (5% and 12%, respectively). More states reported having a strong relationship with Vital Statistics (88%) than with any other office within the health department.

Figure 28.
Top Five Injury and Violence Prevention Partnerships with State Health Department Offices Ranked by Strength, 2013

<table>
<thead>
<tr>
<th></th>
<th>Strong</th>
<th>New and Developing</th>
<th>Needs Improvement</th>
<th>No Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital Statistics</td>
<td>88%</td>
<td>7%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Epidemiology</td>
<td>78%</td>
<td>11%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Maternal Child Health</td>
<td>69%</td>
<td>19%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Emergency Medical Services EMS or EMS for Children</td>
<td>55%</td>
<td>10%</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>Health Promotion Education / Community Health</td>
<td>50%</td>
<td>25%</td>
<td>19%</td>
<td></td>
</tr>
</tbody>
</table>

17. Respondents that indicated an agency “did not exist” are excluded from values (N and percent) in Figure 28 and discussion in Table 8.
Integration with State Health Department Offices

“Integration” is the process whereby formal units jointly pursue a shared objective in order to improve the health of the populations.18 Agencies achieve integration through joint decision-making, sharing responsibility for program development/improvement, having mutual accountability of results, and sharing the risk and rewards of the program.19,20 Of all the partnerships that existed within the state health department in 2013, the majority of state injury and violence prevention programs were “integrated” with Maternal and Child Health (86%), Vital Statistics (85%), and Epidemiology (89%) (Figure 29).

Figure 29. Integration of Injury and Violence Prevention Partnerships with the State Health Department, 2013

11% 14% 14%
47% 36% 45%
42% 50% 40%

Epidemiology (N=37) Maternal and Child Health (N=42) Vital Statistics (N=42)

Partnerships Activities: State Health Department Offices

State injury and violence prevention programs most commonly reported engaging in more partnership activities with Maternal and Child Health than with any other state health department office in 2013. Maternal and Child Health ranked first out of 18 health department offices in being actively involved in planning and programs, collaborating on policy, collaborating on communications activities, providing funding to the state injury and violence prevention program, and providing/receiving training and technical assistance (Table 8). Maternal and Child Health also ranked second in collaborating on evaluation activities, third in sharing data, and fifth in receiving funding from the state injury and violence prevention program. Similarly, the Emergency Medical Services (EMS) or EMS for Children ranked in the top five for all partnership activities; however, 33% of state programs reported their partnership with EMS needed improvement, was new and developing, or did not exist.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Shared Data</th>
<th>Actively Involved in Planning, Programs, Etc</th>
<th>Funding Exchanged</th>
<th>Collaborated on Policy</th>
<th>Collaborated on Evaluation Activities</th>
<th>Collaborated on IVP Program</th>
<th>IVP Program Provided/Received Training/TA</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Epidemiology</td>
<td>Emergency Medical Services (EMS) or EMS for Children</td>
<td>Emergency Medical Services (EMS) or EMS for Children</td>
<td>Chronic Disease</td>
<td>Health Promotion Education Community Health</td>
<td>Maternal &amp; Child Health</td>
<td>Adolescent Health</td>
</tr>
<tr>
<td>3</td>
<td>Maternal &amp; Child Health</td>
<td>Health Promotion Education Community Health</td>
<td>Vital Statistics</td>
<td>Aging</td>
<td>Emergency Medical Services (EMS) or EMS for Children</td>
<td>Health Promotion Education Community Health</td>
<td>Epidemiology</td>
</tr>
<tr>
<td>4</td>
<td>Emergency Medical Services (EMS) or EMS for Children</td>
<td>Sexual Health</td>
<td>Adolescent Health</td>
<td>Emergency Medical Services (EMS) or EMS for Children</td>
<td>Epidemiology</td>
<td>Emergency Medical Services (EMS) or EMS for Children</td>
<td>Health Promotion Education Community Health</td>
</tr>
<tr>
<td>5</td>
<td>Chronic Disease</td>
<td>Adolescent Health</td>
<td>Maternal &amp; Child Health</td>
<td>Occupational Health</td>
<td>Chronic Disease</td>
<td>Vital Statistics</td>
<td>Emergency Medical Services (EMS) or EMS for Children</td>
</tr>
</tbody>
</table>

IVP = injury and violence prevention
PARTNERSHIPS WITH OTHER AGENCIES WITHIN THE STATE

Strength of Partnerships with Other Agencies within the State

State injury and violence prevention programs were asked to describe the strength of their partnerships with other agencies within the state. The five most common partnerships with other state agencies were with Highway Safety, Department of Transportation, Local Health Departments, State Universities, and Criminal Justice/Law Enforcement (Figure 30). Although most states reported having a partnership with Department of Transportation and Local Health Departments, some states perceived that their partnerships with those state agencies needed improvement (12% and 21%, respectively). More states reported having a strong relationship with Highway Safety (70%) than with any other state agency. Within the most commonly reported partnerships, several states reported not having a relationship/partnership with Local Health Departments (12%), State Universities (10%), or Criminal Justice/Law Enforcement (10%).

Figure 30.
Top Five Injury and Violence Prevention Partnerships with Other Agencies within the State Ranked by Strength, 2013

- **Highway Safety (N=40)**: 70% Strong, 13% New and Developing, 10% Needs Improvement, 8% Relationship does not exist
- **Department of Transportation (N=41)**: 61% Strong, 20% New and Developing, 12% Needs Improvement, 7% Relationship does not exist
- **Local Health Departments (N=41)**: 55% Strong, 12% New and Developing, 21% Needs Improvement, 12% Relationship does not exist
- **State Universities (N=40)**: 55% Strong, 18% New and Developing, 18% Needs Improvement, 10% Relationship does not exist
- **Criminal Justice / Law Enforcement (N=40)**: 50% Strong, 15% New and Developing, 25% Needs Improvement, 10% Relationship does not exist

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21. Respondents that indicated an agency “did not exist” are excluded from values (N and percent) in Figure 30 and discussion in Table 9.
Partnership Activities: Other Agencies with the State

State injury and violence prevention programs reported engaging in more partnership activities with Highway Safety, Local Health Departments, and Departments of Transportation compared to all other agencies within the state in 2013 (Table 9). Partnerships with Highway Safety ranked first out of 12 other agencies within the state for sharing data, being actively involved in planning, programs, etc., receiving funding from the state injury and violence prevention program, collaborating on policy activities, and collaborating on communication activities. Highway Safety ranked second for sharing data and evaluation activities.

### Table 9.
Ranking of Injury and Violence Prevention Partnerships with the Top Five Agencies within the State that Engaged in Specified Partnership Activities, 2013

<table>
<thead>
<tr>
<th>Rank</th>
<th>Legal Agreement or MOU</th>
<th>Shared Data</th>
<th>Actively Involved in Planning, Programs, Etc.</th>
<th>Funding Exchanged</th>
<th>Collaborated for Policy</th>
<th>Collaborated on Evaluation Activities</th>
<th>Collaborated on Communication Activities</th>
<th>IVP Program Provided/Received Training/TA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>State Universities</td>
<td>Local Health Departments</td>
<td>Highway Safety</td>
<td>Local Health Departments</td>
<td>Highway Safety</td>
<td>Highway Safety</td>
<td>State Universities</td>
<td>Highway Safety</td>
</tr>
<tr>
<td>2</td>
<td>Local Health Departments</td>
<td>Highway Safety</td>
<td>Department of Transportation</td>
<td>State Universities</td>
<td>Department of Transportation</td>
<td>Department of Highway Safety</td>
<td>Local Health Departments</td>
<td>State Universities</td>
</tr>
<tr>
<td>3</td>
<td>Criminal Justice Law Enforcement</td>
<td>Department of Transportation</td>
<td>Criminal Justice Law Enforcement</td>
<td>Criminal Justice Law Enforcement</td>
<td>Criminal Justice Law Enforcement</td>
<td>Department of Criminal Justice Law Enforcement</td>
<td>Department of Education</td>
<td>Department of Education</td>
</tr>
<tr>
<td>4</td>
<td>Department of State Universities</td>
<td>Elder Affairs/Aging</td>
<td>State Universities</td>
<td>Elder Affairs/Aging</td>
<td>State Universities</td>
<td>Attorney General’s Office</td>
<td>Mental Health</td>
<td>Elder Affairs/Aging</td>
</tr>
<tr>
<td>5</td>
<td>Highway Safety</td>
<td>Criminal Justice Law Enforcement</td>
<td>Department of Education</td>
<td>Department of Education</td>
<td>Elder Affairs/Aging</td>
<td>Child Welfare Agencies</td>
<td>Local Health Departments</td>
<td>Department of Transportation</td>
</tr>
</tbody>
</table>

IVP = injury and violence prevention
PARTNERSHIPS WITH NON-GOVERNMENTAL ORGANIZATIONS

Strength of Partnerships with Non-Governmental Organizations

State injury and violence prevention programs were asked to describe the strength of their partnerships with non-governmental organizations in their state. The five most common partnerships with non-governmental organizations were with state and/or local Safe Kids Coalitions, Children’s Safety Network, the Brain Injury Association, Academic Institutions, and Healthcare Associations (Figure 31). Since 2009, state injury and violence prevention programs reported the strongest relationships and partnerships state and/or local Safe Kids Coalitions, Children’s Safety Network, and the Brain Injury Association. In 2013, the majority of the states reported having a strong partnership with Safe Kids Coalitions (state and/or local) (78%).

**Figure 31. Top Five Injury and Violence Prevention Partnerships with Non-Governmental Organizations Ranked by Strength, 2013**

<table>
<thead>
<tr>
<th>Partnership</th>
<th>Strong</th>
<th>New and Developing</th>
<th>Needs Improvement</th>
<th>Relationship does not exist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Kids Coalitions (N=32)</td>
<td>78%</td>
<td>6%</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>Children’s Safety Network (N=32)</td>
<td>72%</td>
<td>21%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Brain Injury Association (N=29)</td>
<td>55%</td>
<td>16%</td>
<td>19%</td>
<td>10%</td>
</tr>
<tr>
<td>Academic Institutions (N=31)</td>
<td>53%</td>
<td>16%</td>
<td>22%</td>
<td>9%</td>
</tr>
<tr>
<td>Healthcare Associations (N=31)</td>
<td>42%</td>
<td>29%</td>
<td>13%</td>
<td>16%</td>
</tr>
</tbody>
</table>

---

22. Respondents that indicated an agency “did not exist” are excluded from values (N and percent) in Figure 31 and discussion in Table 10.

23. Academic Institutions include all universities/institutions that are not Injury Control Research Centers (ICRCs).
Partnership Activities: Non-Governmental Agencies

State injury and violence prevention programs reported engaging in more partnership activities with Safe Kids Coalitions than any other non-governmental organization in 2013 (Table 10). Partnerships with Safe Kids Coalitions ranked first out of 19 non-governmental organizations for sharing data, being actively involved in planning, programs, etc., providing funding to and receiving funding from the state injury and violence prevention program, and collaborating on communication activities. Safe Kids Coalitions ranked second for collaborating on policy and evaluation activities.

Table 10.
Ranking of Injury and Violence Prevention Partnerships with the Top Five Non-Governmental Organizations that Engaged in Specified Partnership Activities, 2013

<table>
<thead>
<tr>
<th>Rank</th>
<th>Shared Data</th>
<th>Actively Involved in Planning, Programs, Etc.</th>
<th>Funding Exchanged</th>
<th>Collaborated for Policy</th>
<th>Collaborated on Evaluation Activities</th>
<th>Collaborated on Evaluation Activities</th>
<th>IVP Program Provided/Received Training/Technical Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Academic Institutions</td>
<td>Safe Kids Coalitions</td>
<td>Safe Kids Coalitions</td>
<td>Safe Kids Coalitions</td>
<td>Brain Injury Association</td>
<td>Academic Institutions</td>
<td>Safe Kids Coalitions</td>
</tr>
<tr>
<td>2</td>
<td>Brain Injury Association</td>
<td>Academic Institutions</td>
<td>Academic Institutions</td>
<td>Consumer groups</td>
<td>Safe Kids Coalitions</td>
<td>Safe Kids Coalitions</td>
<td>Brain Injury Association</td>
</tr>
<tr>
<td>3</td>
<td>Safe Kids Coalitions</td>
<td>Brain Injury Association</td>
<td>Injury Control Research Centers (ICRCs)</td>
<td>Healthcare Associations</td>
<td>Injury Control Research Centers (ICRCs)</td>
<td>Brain Injury Association</td>
<td>Businesses</td>
</tr>
<tr>
<td>4</td>
<td>Injury Control Research Centers (ICRCs)</td>
<td>Healthcare Associations</td>
<td>Brain Injury Association</td>
<td>Injury Control Research Centers (ICRCs)</td>
<td>Academic Institutions</td>
<td>Injury Control Research Centers (ICRCs)</td>
<td>Healthcare Associations</td>
</tr>
<tr>
<td>5</td>
<td>Children's Safety Network</td>
<td>Injury Control Research Centers (ICRCs)</td>
<td>Healthcare Associations</td>
<td>---</td>
<td>Healthcare Associations</td>
<td>Healthcare Associations</td>
<td>Injury Control Research Centers (ICRCs)</td>
</tr>
</tbody>
</table>

IVP = injury and violence prevention; Academic Institutions include all universities/institutions that are not Injury Control Research Centers (ICRCs).

Partnerships with Federal Agencies

Strength of Partnerships with Federal Agencies

State injury and violence prevention programs were asked to describe the strength of their partnerships with federal agencies. All state injury and violence prevention programs reported having a relationship with the Centers for Disease Control and Prevention (CDC); 81% reported the relationship as strong, while 12% reported that the relationship needed improvement (Figure 32). Several states reported that there was not a relationship with Health Resources and Services Administration (HRSA) (31%), National Highway Traffic Safety Administration (NHTSA) (31%), Substance Abuse and Mental Health Services Administration (SAMHSA) (43%), or Federal Highway Administration (FHA) (55%).
Partnership Activities: Federal Agencies

State injury and violence prevention programs reported engaging in more partnership activities with CDC than with any other federal agency in 2013. CDC ranked first in the following activities: legal agreement/MOU sharing data, planning programs, providing funding to the state injury and violence prevention program, collaborating on policy, evaluation activities, communication activities, and providing training/technical assistance to the state injury and violence prevention program (Table 11).

![Figure 32.
Top Five Injury and Violence Prevention Partnerships with Federal Agencies Ranked by Strength, 2013](image)

**Table 11.**
**Ranking of Injury and Violence Prevention Partnerships with the Top Five Federal Agencies that Engaged in Specified Partnership Activities, 2013**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Legal Agreement or MOU</th>
<th>Shared Data</th>
<th>Actively Involved in Planning, Programs, Etc.</th>
<th>Funding Exchanged</th>
<th>Collaborated for Policy</th>
<th>Collaborated on Evaluation Activities</th>
<th>Collaborated on Evaluation Activities</th>
<th>IVP Program Provided/Received Training/Technical Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CDC</td>
<td>CDC</td>
<td>CDC</td>
<td>--</td>
<td>CDC</td>
<td>CDC</td>
<td>CDC</td>
<td>CDC</td>
</tr>
<tr>
<td>2</td>
<td>HRSA</td>
<td>NHTSA</td>
<td>SAMHSA</td>
<td>--</td>
<td>HRSA</td>
<td>NHTSA</td>
<td>SAMHSA</td>
<td>NHTSA</td>
</tr>
<tr>
<td>3</td>
<td>SAMHSA</td>
<td>HRSA</td>
<td>HRSA</td>
<td>--</td>
<td>SAMHSA</td>
<td>SAMHSA</td>
<td>NHTSA</td>
<td>SAMHSA</td>
</tr>
<tr>
<td>4</td>
<td>IHS</td>
<td>SAMHSA</td>
<td>NHTSA</td>
<td>--</td>
<td>NHTSA</td>
<td>HRSA</td>
<td>FHA</td>
<td>NHTSA</td>
</tr>
<tr>
<td>5</td>
<td>--</td>
<td>FHA</td>
<td>IHS</td>
<td>--</td>
<td>--</td>
<td>FHA</td>
<td>IHS</td>
<td>Administratino on Aging</td>
</tr>
</tbody>
</table>

CDC = Centers for Disease Control and Prevention; FHA = Federal Highway Administration; HRSA = Health Resources and Services Administration; IHS = Indian Health Service; IVP = injury and violence prevention; NHTSA = National Highway Traffic Safety Administration; and SAMHSA = Substance Abuse and Mental Health Services Administration
Effectively Communicate Information to Key Stakeholders

UNDERSTANDING EFFECTIVE COMMUNICATION OF INJURY AND VIOLENCE PREVENTION INFORMATION TO KEY STAKEHOLDERS

Translating the implications and nuances of injury and violence prevention 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.

State injury and violence prevention programs have powerful and compelling stories to tell. The ability to regularly and effectively communicate with partners, decision makers, the media, the public, and those affected by injuries and violence is paramount. State injury and violence prevention 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.

All (100%) of the 41 state injury and violence prevention programs surveyed provided some form of communication to target populations, partners, local groups, or others engaged in injury and violence prevention in 2013. However, when states were asked if their injury and violence prevention program had an “official” communications plan, only four states (9%) reported that such a plan existed. Of the four states that reported having an official communications plan in 2013, all four reported that the plan contained communication goals and descriptions of communication channels to be utilized (e.g., listservs, social media, in-person meetings, etc.). Three out of the four states with communications plans reported they included descriptions of communication materials (e.g., press releases, PSAs, etc.) in their communication plans. Furthermore, three states also reported that they used specific messaging tactics such as storytelling, infographics, and social math in their communication materials.

24. Storytelling is communication method that uses the telling of personalized stories to capture an audience’s attention, engage them emotionally, and motivate them to act.
25. Infographics are visual representations of information, data or knowledge that are generally-designed to translate complex data into simple visual concepts.
COMMUNICATION METHODS

In 2013, state injury and violence prevention programs used multiple methods to communicate injury and violence-related information (Table 12). In 2013, the most common method of communication was through a website (94%). This represented a change from earlier survey years, as participation in steering committees, community meetings, and professional association meetings were the most commonly used communications methods reported in the 2009 and 2011 surveys (93% for both years). To communicate information in 2013, state injury and violence prevention programs also used interviews with local media (TV, radio, newspaper, etc.) (72%), social media platforms (e.g., Twitter, Facebook, etc.) (62%), newsletters (52%), and advertisements/public service announcements (45%). In 2013, vital records and hospital discharge data were the most common datasets that were used to communicate key findings to partners and the public (82% and 83%, respectively).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Method</td>
<td>2013 (N=40)</td>
<td>2011 (N=47)</td>
<td>2009 (N=49)</td>
</tr>
<tr>
<td>Website</td>
<td>37 (92%)</td>
<td>34 (72%)</td>
<td>40 (88%)</td>
</tr>
<tr>
<td>Participation in steering committees, community meetings, professional association meetings</td>
<td>35 (87%)</td>
<td>44 (93%)</td>
<td>42 (93%)</td>
</tr>
<tr>
<td>Reports, articles, presentations, data briefs, fact sheets</td>
<td>35 (87%)</td>
<td>44 (93%)</td>
<td>&lt;no data available&gt;</td>
</tr>
<tr>
<td>Listservs</td>
<td>30 (75%)</td>
<td>29 (61%)</td>
<td>22 (48%)</td>
</tr>
<tr>
<td>Interviews with local media (TV, radio, newspaper, etc.)</td>
<td>29 (72%)</td>
<td>18 (38%)</td>
<td>21 (46%)</td>
</tr>
<tr>
<td>Social media platforms (e.g., Twitter, Facebook, etc.)</td>
<td>25 (62%)</td>
<td>&lt;no data available&gt;</td>
<td>&lt;no data available&gt;</td>
</tr>
<tr>
<td>Newsletter</td>
<td>21 (52%)</td>
<td>13 (27%)</td>
<td>9 (20%)</td>
</tr>
<tr>
<td>Advertisements/Public Service Announcements</td>
<td>18 (45%)</td>
<td>&lt;no data available&gt;</td>
<td>&lt;no data available&gt;</td>
</tr>
</tbody>
</table>
PLEASE DON'T TEXT AND DRIVE
Provide Technical Support and Training

UNDERSTANDING INJURY AND VIOLENCE PREVENTION TECHNICAL ASSISTANCE AND TRAINING

Knowledgeable staff members are essential for a state injury and violence prevention program to function effectively and sustainably. Staff members of state injury and violence prevention programs should keep their own skills and knowledge current, while also providing practical training and technical support to 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 injury and violence prevention activities. Developed by the National Training Initiative (NTI), the Core Competencies for Injury and Violence Prevention27 are an essential resource that provides guidance for training initiatives.

TECHNICAL SUPPORT AND TRAINING METHODS

Thirty-eight (38) state injury and violence prevention programs (93%) provided some form of training or technical support to partners, grantees, and others engaged in prevention efforts in 2013. State programs used a variety of methods to deliver technical support and training to program partners (Figure 33). The two most commonly reported methods were responding to requests for technical assistance (88%) and conducting in-person trainings (85%). These were also the most commonly reported methods in 2011 and 2009. In 2013, 44% of states offered practical experiences for students – an increase compared to both 2011 and 2009. However, only 22% of states offered courses for academic credit or continuing education units (CEUs) in 2013 - a decrease compared to 2011 and 2009 (33% and 37%, respectively).

In the 2013 survey, state injury and violence prevention programs were also asked questions regarding their awareness and use of the NTI Core Competencies for Injury and Violence Prevention. Ninety-five percent (95%, N=39) of state programs reported that they were aware of the NTI Core Competencies. However, only 62% of states that were aware of the NTI Core Competencies reported that they explicitly and consciously incorporated the Core Competencies into their trainings. In 2013, several states reported other uses of the NTI Core Competencies, including: informing staff performance plans (38%), conducting trainings or workshops for local partners (e.g., local health departments, local organizations, etc.) (33%), developing job descriptions (28%), and conducting training or workshops for state injury and violence prevention program staff (26%).
National Training Initiative (NTI) Core Competencies

More information about the Core Competencies can be found at www.safestates.org/?page=NTICoreCompetencies.

- 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 divers 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.

Compared to 2009 and 2011, fewer state injury and violence prevention programs reported using various technical assistance resources available to their programs in 2013, with the exception of resource centers such as Children’s Safety Network and the Suicide Prevention Resource Center (SPRC) (Table 13). The most commonly reported resources for technical assistance used by state injury and violence prevention programs in 2013 were: federal agencies (82%), the Safe States Alliance (80%), and the Internet (80%). In 2011, Regional Networks were funded through the Centers for Disease Control and Prevention’s Core Violence and Injury Prevention Program (Core VIPP) grant as an expanded component. As a result, there was an increase from 2009 (42%, N=21) to 2011 (64%, N=31) in the number of states that reported using Regional Networks as a technical assistance resource. However, this number decreased in 2013, as only 24 states (58%) reported using the Regional Network as a technical assistance resource.
Table 13.
Top Technical Assistance Resources Used by State Injury and Violence Prevention Programs, 2013, 2011 and 2009

<table>
<thead>
<tr>
<th>Resource Type</th>
<th>2013 (N=41)</th>
<th>2011 (N=47)</th>
<th>2009 (N=49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Agencies (such as CDC, HRSA, NHTSA, SAMHSA)</td>
<td>34 (82%)</td>
<td>41 (87%)</td>
<td>45 (90%)</td>
</tr>
<tr>
<td>Safe States Alliance</td>
<td>33 (80%)</td>
<td>40 (83%)</td>
<td>45 (90%)</td>
</tr>
<tr>
<td>Internet</td>
<td>33 (80%)</td>
<td>38 (79%)</td>
<td>41 (82%)</td>
</tr>
<tr>
<td>Resource Centers (such as CSN, SPRC, or CDR)</td>
<td>30 (73%)</td>
<td>34 (72%)</td>
<td>35 (71%)</td>
</tr>
<tr>
<td>Peer to Peer</td>
<td>26 (63%)</td>
<td>32 (68%)</td>
<td>37 (74%)</td>
</tr>
<tr>
<td>Regional Networks</td>
<td>24 (58%)</td>
<td>31 (64%)</td>
<td>21 (42%)</td>
</tr>
<tr>
<td>Other National Organizations</td>
<td>22 (53%)</td>
<td>25 (53%)</td>
<td>29 (59%)</td>
</tr>
<tr>
<td>University/Academic Institutions (Other than ICRCs)</td>
<td>21 (51%)</td>
<td>24 (51%)</td>
<td>27 (55%)</td>
</tr>
<tr>
<td>Injury Control Research Centers (ICRCs)</td>
<td>21 (51%)</td>
<td>23 (47%)</td>
<td>27 (55%)</td>
</tr>
</tbody>
</table>

In 2013, state injury and violence prevention programs were asked to describe the topics that were associated with technical assistance and trainings that were either provided or received by their program (Figure 34). Frequently reported topics for technical assistance and training provided by the state injury and violence prevention program were related to program strategies and interventions (e.g., child passenger safety technician training, etc.) (83%) and data collection, analysis, reporting, and quality improvement (73%). State injury and violence prevention programs largely received technical assistance and training in the areas of program strategies and interventions (76%) and evaluation methods and processes (71%). Other areas of technical assistance and training that were commonly received by state injury and violence prevention programs included: policy and legislation (68%); data collection, analysis, reporting, and quality improvement (68%); and communication (e.g., storytelling, media interviews, framing techniques, etc.) (66%).
Figure 34.
Topics for Technical Assistance and Training Provided and Received by the State Injury and Violence Prevention Programs, 2013

- Program strategies and interventions: 83% provided, 76% received
- Data collection, analysis, reporting and quality improvement: 73% provided, 68% received
- Coalition building and collaboration: 54% provided, 32% received
- Policy and legislation: 68% provided, 49% received
- Evaluation methods and processes: 71% provided, 46% received
- Communication: 66% provided, 41% received
- Social determinants of health: 27% provided, 12% received
- Management and leadership strategies: 29% provided, 10% received

IVP Provided TA Topic | IVP Received TA Topic
Appendix A: Glossary of Terms

AN OVERVIEW OF INJURY AND VIOLENCE TERMINOLOGY

Injury and violence prevention is a diverse and growing field, and so is some of its terminology. This is especially true for violence-related terms, which can vary in their meaning and use from program to program and state to state. To provide some consistency in the terms used in this document, the Safe States Alliance has developed a list of working definitions for common injury and violence prevention terms.

It is important to note that all definitions provided in this glossary are for the purposes of this document only. The definitions for these terms can vary among federal, state and local laws. Legal definitions may be different than the definitions provided in this glossary. The glossary definitions below are not meant to change or be substituted for law.

DESCRIPTIONS OF RECOMMENDED DATA SETS

In 2007, the Safe States Alliance publication, Consensus Recommendations for Injury Surveillance in State Health Departments28 provided an update to the 1999 version of the recommendations report29 and reaffirmed the 11 core data sets for injury surveillance previously identified to support injury and violence prevention programs and policies. The 1999 recommendation report also provided data set definitions, which are presented below. If available, updated information was included in these definitions. The National Violent Death Reporting System (NVDRS) also included in these definitions. The National Violent Death Reporting System (NVDRS) also included in these definitions.

1. Vital records include birth certificates and death certificates. Death certificates classify injuries by external cause of death (E-codes). All fatal injuries with E-code classifications can be monitored with death certificate data. The residence of the deceased is recorded on the death certificate, so that population-based injury cause-of-death data can be generated from this data set for large or small geopolitical units. Death certificate data capture the most severe injuries, and therefore are important for creating and evaluating programs and policies, but they do not capture less serious and more common injuries. Risk factor information is not generally recorded on death certificates.

2. Hospital discharge data are generated from uniform hospital billing forms used in many states to bill for hospital services. This form has a dedicated field for recording an E-code. According to a recent MMWR,30 as of 2007:

- 46 (90%) of the 50 states and the District of Columbia had a statewide hospital discharge data system (HDDS) in place;
- 41 (89%) of the 46 states and the District of Columbia had a statewide HDDS routinely collect some level of E-codes in their statewide HDDS; and
- 26 (63%) of the 41 states and the District of Columbia that routinely collect some level of E-codes had mandated E-coding in their statewide HDDS.

Statewide hospital discharge data sets, like vital records, provide population-based injury data. Like vital records, these data can be stratified by county and city. Hospital discharge data may be more useful than vital records for surveillance in less-populated areas where some causes of injury death occur infrequently. Risk factor information is not recorded on hospital billing forms. Incidence rates may sometimes be inaccurate because of measurement problems in the hospital discharge data system. For example, if an injured person is treated at more than one hospital, the injury may be counted more than once, or if a person has multiple concurrent injuries some of them may not be counted. Also, hospital discharge data are affected by changes in the health care system that influences hospital admissions and coding practices. These changes may compromise the utility of these data for monitoring trends in injury morbidity.

3. **Fatality Analysis Reporting System (FARS)** data describe in detail all fatal motor vehicle injuries occurring on public roads. This data set contains a wealth of risk factor information on drivers, passengers, vehicles, and driving conditions at the time of the crash. FARS is population-based at state, county, and city levels. Some states also have centralized crash report data sets for non-fatal motor vehicle injuries. A few states have linked crash data to other data sets, including emergency medical services data, emergency department data, hospital discharge data, medical examiner and coroner data, and vital records. These linked data systems are known as Crash Outcome Data Evaluation Systems (CODES). CODES can be used to assess the effects of multiple risk factors such as seat belt and safety seat use on motor vehicle injury outcomes.

4. **Behavioral Risk Factor Surveillance System (BRFSS)** data are obtained by household telephone surveys. Specific questions on the surveys address the use of seat belts, safety seats, bicycle helmets, and smoke alarms, as well as risky behaviors such as drinking and driving. BRFSS data are representative of the population of the state that collects the data, but the data cannot be stratified by county or city without modifications of the survey sampling strategy. Survey respondents are limited to adults in households with telephones.

5. **Youth Risk Behavior Surveillance System data** are obtained from school-based surveys conducted every two years to monitor risk behaviors for students in grades 9-12. Specific questions address seat belt use, suicide attempts, fighting, weapon carrying, and riding with a drunk driver. These data are representative of the national population of students in grades 9-12, which excludes only about five percent of adolescents in this age group (who do not attend school).

6. **Emergency department data** are available in some states through a statewide hospital emergency department data system (HEDDS). According to a recent MMWR\(^{31}\) as of 2007:

- 27 (54%) of the 50 states and the District of Columbia had a statewide HEDDS;
- 25 (93%) of the 27 states and the District of Columbia that had a statewide HEDDS routinely collected some level of E-codes in their statewide HEDDS; and
- 18 (72%) of the 25 states and the District of Columbia that routinely collect some level of E-codes had mandated E-coding of their statewide HEDDS.

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Injuries treated in emergency departments that are not severe enough to require hospital admission are more common than injury hospitalizations. Therefore emergency department data are superior to hospital discharge data for tracking injuries that are common but not severe. Because injuries requiring emergency treatment but not hospitalization are common, emergency department data may be useful for assessing injury and violence prevention priorities in sparsely populated areas where injury deaths and hospitalizations may occur too infrequently to be useful. Moreover, emergency department visits are less likely than overnight hospital admissions to be affected by changes in the health care system. Therefore emergency department data systems, if they are population-based, may be superior to hospital discharge data systems for injury morbidity surveillance. Unfortunately, risk factor data such as the circumstances of injury and the use of safety devices are not often captured on emergency department records or hospital discharge records.

7. **Medical examiner systems** existed in 21 states and the District of Columbia in 2001, while 10 states had coroner-based systems and 19 states had a mixed medical examiner and coroner system. A medical examiner is usually a licensed physician, but a coroner does not have to be a physician and may have little or no formal medical training. For surveillance purposes, the ideal medical examiner system is statewide, population-based, and has standardized systems of death certification and data management. Since 1987, the national Medical Examiner and Coroner Information Sharing Program has been working to improve the quality of data on death certificates and to increase the availability of these data for injury and violence prevention. Medical examiner and coroner reports are medico-legal documents, and therefore the circumstances of intentional injuries are often well described. Information is often available on the use of alcohol and other drugs. The Institute of Medicine has recently recommended expanding medical examiner and coroner systems to create a fatal intentional injury surveillance system for all homicides and suicides, modeled after the Fatality Analysis Reporting System (FARS). Currently, state medical examiner and coroner systems do not capture all deaths, although a few capture all injury deaths.

8. **Child death review data** are gathered and analyzed by child death review teams to explore the circumstances surrounding the deaths of children for the purpose of preventing future deaths. All states have state and/or local child death review teams. Many child death reviews focus on the prevention of child abuse deaths, but child death review teams have also applied their findings to the prevention of motor vehicle injuries, suicides, firearm injuries, traumatic brain injuries, fall injuries, fire and burn injuries, and poisonings.

9. **National Occupant Protection Use Survey (NOPUS)** data are obtained from direct observations of passenger vehicle occupants to evaluate shoulder-belt use, motorcycle helmet use, and child safety seat use. These data are used primarily to monitor compliance with safety standards for the purpose of awarding federal funds to states. The data are assumed to be representative of the state where they were collected, but cannot be further stratified by county or city.

10. **Uniform Crime Reporting (UCR) System** data are based on voluntary reports from law enforcement agencies. The Supplementary Homicide Report to the UCR System collects information on homicide incidents, although detailed information on the homicide weapon is not available.

11. **Emergency medical services (EMS)** data are collected from ambulance run reports for injuries and other medical emergencies. The data are most useful for assessing EMS transport times and the medical condition of the injured person upon EMS arrival and during subsequent transport to definitive care. EMS data may provide useful information for submersion injuries, such as the location of the submersion incident, duration of the submersion and neurologic status of the submersion victim.

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12. **The National Violent Death Reporting System** (NVDRS) is an active, state-based surveillance system that collects information on homicides, suicides, deaths of undetermined intent (i.e., those for which available information is insufficient to enable a medical or legal authority to make a distinction among unintentional injury, self-harm, or assault), deaths from legal intervention (e.g., involving a person killed by an on-duty police officer), and unintentional firearm deaths. As of 2014, CDC funded 32 states to implement NVDRS. They are Alaska, Arizona, Colorado, Connecticut, Georgia, Hawaii, Iowa, Illinois, Indiana, Kansas, Kentucky, Massachusetts, Maryland, Maine, Michigan, Minnesota, North Carolina, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Utah, Virginia, Vermont, Washington, and Wisconsin. NVDRS uses a multi-source approach (i.e., death certificates, coroner/medical examiner reports, law enforcement records, and crime laboratory data) for analysis of violent deaths. Using information from all of these sources, data abstractors in each state assign a manner of death (i.e., suicide, homicide, unintentional firearm deaths, legal interventions, and undetermined deaths) to each case. NVDRS also collects the International Classification of Diseases, 10th Revision (ICD-10) code for underlying cause of death (UCOD), circumstances contributing to the death, and characteristics of the death, including victim-suspect relationship and victim toxicology results. The UCOD is categorized as suicide or homicide using standard definitions from the National Vital Statistics System (NVSS).33

All of the injuries recommended for core surveillance can be monitored successfully with access to just two core data sets: vital records and hospital discharge data. All states have vital records data, and as of 2007, 41 states routinely collected some level of E-codes in their statewide HDDS. Therefore state injury and violence prevention programs that are building state injury surveillance systems should begin by accessing death certificate data as well as E-coded hospital discharge data, if available. The remaining core data sets can then be added to strengthen these injury surveillance systems.

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DEFINITIONS OF KEY TERMS

Evaluation Plan

An evaluation plan is designed to inform and provide evidence to stakeholders about progress being made within the program and its activities. The evaluation plan is carried out through the use of surveillance systems and routine monitoring, measurement, and assessment of interventions and activities that support the strategic plan.

Injury

Injury is the physical damage that results when a human body is suddenly subjected to energy in amounts that exceed its threshold of tolerance (e.g., burns) or it can be the result of the lack of one or more vital elements (e.g., drowning). Injuries traditionally have been regarded as random, unavoidable “accidents.” In the last few decades, a better understanding of the nature of injuries has led to the view that injuries – both unintentional and intentional – are largely preventable events. Injuries are defined by intent:

- **Unintentional injuries** include motor vehicle crashes, poisoning, drowning, falls, fires, and burns/scalds.
- **Intentional injuries** are those caused by violence and include homicide, suicide, sexual violence, child maltreatment, and elder violence.

Integration

Integration is the process whereby formal units jointly pursue a shared objective in order to improve the health of the population. They do this through joint:

- Decision-making, priority-setting, planning
- Responsibility for program development, co-investment, resource sharing & development, implementation, evaluation, program improvement
- Mutual accountability for results & stewardship
- Sharing of risks and rewards

Guiding principles for integrating programs include:

- Do no harm to categorical program integrity.
- Clearly identify and state mutual benefits and opportunities.
- Be guided by efficiency-oriented processes.
- Be focused on health outcomes.
- Evaluate integration outputs and health outcomes.
- Engage stakeholders.
- Mobilize leaders.

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Strategic Plan
A strategic plan is a written document that outlines activities taking place and how they relate to programmatic goals and objectives. An implementation plan includes a timeline of activities, collaborating partners for each activity, logic models, and in some cases a budget for each activity. There are four types of strategic plans captured in the 2011 State of the States Survey:

• **Statewide Health Plan** - A statewide plan produced by multiple state agencies; this plan includes multiple health issues that may include chronic diseases, infectious disease, injury, violence, and more.

• **State Injury and Violence Prevention Plan** - A statewide plan produced by multiple agencies that only includes health issues surrounding injuries and violence.

• **Health Department Health Plan** - A health department strategic plan produced by multiple departments and units within the health department; this plan includes multiple health issues that may include chronic diseases, infectious disease, injury, violence, and more.

• **Health Department Injury and Violence Prevention Plan** - A health department strategic plan produced by the identified injury and violence prevention program that only includes health issues surrounding injuries and violence.