UNDERSTANDING THE INFRASTRUCTURE OF STATE INJURY AND VIOLENCE PREVENTION PROGRAMS

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

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

ORGANIZATIONAL LOCATION

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

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

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

<table>
<thead>
<tr>
<th>Year</th>
<th>No Formal State IVP Program</th>
<th>IVP Activities in State are Decentralized</th>
<th>IVP Activities in State are Centralized</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 (N=44)</td>
<td>14%</td>
<td>34%</td>
<td>52%</td>
</tr>
<tr>
<td>2013 (N=41)</td>
<td>10%</td>
<td>31%</td>
<td>59%</td>
</tr>
<tr>
<td>2011 (N=47)</td>
<td>11%</td>
<td>32%</td>
<td>57%</td>
</tr>
</tbody>
</table>
STRATEGIC PLANNING

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

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

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

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

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

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Funding: 39 states</td>
<td>$59.9M</td>
<td>67%</td>
</tr>
<tr>
<td>• Of the 39 states receiving federal funding, three received federal funding only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Two states received no federal funding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Funding: 39 states</td>
<td>$28.7M</td>
<td>32%</td>
</tr>
<tr>
<td>• 36 of the 39 states receiving funding from their state also received funding from federal sources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Three states received state funding only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Funding: 14 states</td>
<td>$1.3M</td>
<td>1%</td>
</tr>
<tr>
<td>• All states receiving funding from other sources also received funds from federal and state sources</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### STATE AND NATIONAL PER CAPITA COMPARISONS

One person dies in the US every three minutes from injury,² however millions of individuals experience injuries and survive. Lifetime medical and work loss costs due to injury and violence in the United States are $671 billion,²³ or $2116 per person.⁴

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

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

<table>
<thead>
<tr>
<th>State IVP Funding per Capita</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 15¢ per person</td>
<td></td>
</tr>
<tr>
<td>16¢ - 30¢ per person</td>
<td></td>
</tr>
<tr>
<td>31¢ - 44¢ per person</td>
<td></td>
</tr>
<tr>
<td>45¢ - 67¢ per person</td>
<td></td>
</tr>
<tr>
<td>More than 68¢ per person</td>
<td></td>
</tr>
<tr>
<td>No data available</td>
<td></td>
</tr>
</tbody>
</table>

**ALLOCATION OF FUNDING AND PROGRAMMATIC TOPIC AREAS SUPPORTED**

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

- Public health practitioners are critical to the success of IVP programs, and this importance is reflected in the 2015 funding allocations, with personnel receiving the greatest proportion of funds across funding categories ($32.9 million, 37%).
- Funds to expand the reach of the IVP program beyond the walls of the state health department accounted for the next two largest categories of spending: grants, mini-grants, and contracts to support local programs ($21.2 million, 24%), and external contractors and consultants ($15.9 million, 18%).

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

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

<table>
<thead>
<tr>
<th>Injury Topic Area</th>
<th>No. of Unique Funding Sources</th>
<th>CDC/NCIPC Core VIPP</th>
<th>CDC/NCIPC National Violent Death Reporting System (NVDRS)</th>
<th>CDC/NCIPC Rape Prevention and Education (RPE)</th>
<th>HRSA/MCHB Title V Block Grant</th>
<th>SAMHSA State and Tribal Youth Suicide Prevention Grants</th>
<th>State General Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Passenger Safety</td>
<td>18</td>
<td>#1 (tied)</td>
<td>#1 (tied)</td>
<td>#3</td>
<td>#3</td>
<td>#3</td>
<td>#3</td>
</tr>
<tr>
<td>Fall Injuries (e.g., older adults and children)</td>
<td>12</td>
<td>#1</td>
<td>#2</td>
<td>#3</td>
<td>18</td>
<td>#3</td>
<td>#3</td>
</tr>
<tr>
<td>Sexual Violence</td>
<td>11</td>
<td>#2</td>
<td>#1</td>
<td>#3</td>
<td>3</td>
<td>#3</td>
<td>#3</td>
</tr>
<tr>
<td>Suicide</td>
<td>10</td>
<td>#2</td>
<td>#2</td>
<td>#3</td>
<td>7</td>
<td>#3</td>
<td>#1</td>
</tr>
<tr>
<td>Unintentional Poisoning/ Prescription Drug Overdose</td>
<td>14</td>
<td>#1</td>
<td>#2</td>
<td>#3</td>
<td>2</td>
<td>#3</td>
<td>#3</td>
</tr>
</tbody>
</table>
TOP FUNDING SOURCES

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

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

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

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

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

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

![Figure 6. FTEs by Funding Sources, 2015](image_url)

INDIVIDUAL EMPLOYEES AND FULL-TIME EQUIVALENTS (FTE)

- A total of 432 individuals worked in 39 state IVP programs in 2015.

  - Of these individuals, 329 (76%) were full-time or part-time paid staff, 55 (13%) were full-time or part-time contractors, and the remaining 48 (11%) worked in other capacities.
State programs had a median of 6.0 FTEs and an average of 8.4 FTEs, with values ranging from 0.3 to 26.59 FTEs (Figure 7).

Forty-one percent of states had 5.0 FTEs or less in their IVP program, 35.9% had between 6.0 and 15.0 FTEs, and the remaining 23.1% had more than 16.0 FTEs.

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

328.9 Full-Time Equivalents

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

**BUDGET CUTS**

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

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

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

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

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

The public health approach calls for using data to define the problem, identifying specific risk and protective factors, matching an evidence-based program to the problem, and then implementing and evaluating the intervention. It sounds simple and straightforward, but in reality is often more complicated.

The Illinois Department of Public Health’s IVP program (IDPH) and its partner, the Illinois Coalition Against Sexual Assault (ICASA), wanted to ensure that this powerful approach was fully understood and applied by the state’s 29 local rape crisis centers, which are overseen by ICASA and are not formal public health entities. To help spur greater understanding, adoption, and application of the public health approach, they turned to a combination of training, coaching, and formal requirements for the annual prevention plans the rape crisis centers are required to submit.

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

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

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