APPLYING A SHARED RISK AND PROTECTIVE FACTOR FRAMEWORK TO INJURY AND VIOLENCE PREVENTION: A NATIONAL PERSPECTIVE

LESSONS LEARNED & READINESS MATRIX

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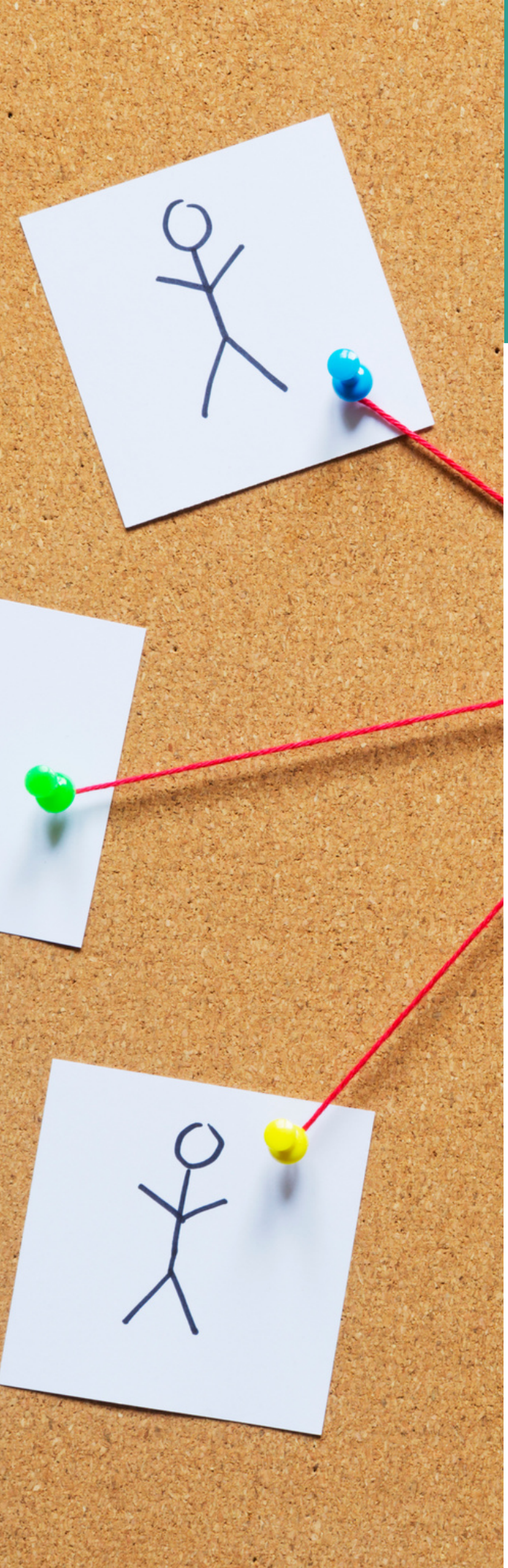
SAFE STATES



WHY SHARED RISK AND PROTECTIVE FACTORS (SRPF) APPROACHES?

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BACKGROUND

Across the country, public health professionals face the need to implement programs more effectively and efficiently, while still demonstrating meaningful outcomes. This need is especially urgent in injury and violence prevention (IVP) work, given the epidemics of suicide, interpersonal violence, and opioid abuse, among others.

In recent years, the fundamental questions at the root of public health have been shifting from addressing single, specific issues, to instead focusing on the system that supports wellbeing holistically. Many sectors contribute to our health and quality of life, including economics, housing, transportation, social services, and education. Although these sectors use different vocabularies and concepts, they all have core connections that unite them. Understanding the root causes of public health and expanding resources in a way that proactively prevents multiple issues at once improves the way people live, work, and play.

For IVP professionals, this shift upstream has been characterized by the increased focus on shared risk and protective factor (SRPF) approaches. A "shared risk and protective factor approach" – defined as efforts to improve multiple population health and quality-of-life outcomes by aligning diverse, multi-sector interventions that positively and equitably impact the social determinants of health (SDOH)[1], is relevant not only to IVP, but to public health and wellbeing more broadly. These approaches acknowledge that risk and protective factors are interconnected, occur at a range of levels from individual to societal, and influence many health and quality-of-life outcomes. Their impacts can be both universal and iterative, as risk and protective factors are influenced by the conditions in which we live, learn, work, grow, and age.

There has been an increased emphasis on SRPF approaches to IVP through both formal and informal mechanisms. Increasingly, funding opportunities for state health department IVP programs from federal partners, particularly the Centers for Disease Control and Prevention, have placed significant emphasis on incorporating a SRPF framework into state IVP efforts. In 2014, CDC released "Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence"[2] and has issued two five-year strategic visions for implementation. The most recent, published in 2020,[3] defined and established key concepts, and laid out a five-year vision for addressing the interconnectedness of multiple forms of violence. This type of analysis is now also being applied to unintentional injury, such as motor vehicle crashes[4]. Still, while internal and external stakeholders are generally supportive of this approach and there is a growing evidence base for it, many health departments are experiencing challenges translating the theoretical approach into practical activities for their networks to implement.

[1] Safe States Alliance. Connections Lab: Exploring Elements of Shared Risk and Protective Factor (SRPF) Approaches. 2020. (2/11/2021). https://www.safestates.org/general/custom.asp?page=ConnectionsLab

[2] Wilkins, N., Tsao, B., Hertz, M., Davis, R., Klevens, J. (2014). Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention Oakland, CA: Prevention Institute. Retrieved from: https://www.cdc.gov/violenceprevention/pdf/connecting_the_dots-a.pdf

[3] NCIPC Division of Violence Prevention 5 year Strategic Vision. Atlanta, GA: Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2020. Retrieved from https://www.cdc.gov/violenceprevention/pdf/dvpStrategicVision.pdf

[4] Safe States Alliance. (2019). Resource Document: Strategies to Address Shared Risk and Protective Factors for Driver Safety. Atlanta, GA: Safe States Alliance. Retrieved from: www.safestates.org/resource/resmgr/nhtsa_resource_document/NHTSA_BHWG_Recommendations_F.pdf

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ASSESSMENT HISTORY

To expand and better understand the types of SRPF approaches being implemented across the country, the Safe States Alliance (Safe States) and Health Management Associates (HMA) partnered to develop and deliver a comprehensive assessment and tailored training program to individual state IVP programs and regional networks of state programs. Since 2018, this assistance has provided IVP programs with a clear understanding of their strengths and areas of need related to taking on this type of shared programmatic approach.

By identifying strategies to address public health issues more effectively through an understanding of shared root causes and focusing program efforts on addressing these upstream conditions, HMA and Safe States aim to support IVP programs as they search for effective ways to reduce the burden of injuries and maximize financial and programmatic efficiency.

ASSESSMENTS TO DATE

To date, assessments have been conducted for eight state health department IVP programs and two Health and Human Services Regional Networks (comprising 17 states). Specific activities and overall scopes varied based on state needs and available funds within each state to support this work.

Assessing the readiness of state health department IVP programs in their attempt to adopt a SRPF framework to their IVP work has provided Safe States a unique view into the operationalization of the framework across the country. This national perspective has highlighted common themes – both items that facilitate the implementation of this framework and barriers that can hinder progress.

ASSESSMENT CONTENT

While SRPF assessments across states are customized to state-specific needs or concerns, they are generally similar in structure and purpose. Overall, the SRPF readiness assessment aims to answer the following questions for an IVP program:

1. How well do staff and external partners understand shared risk and protective factors?

2. What is needed to move forward with a shared risk and protective factor approach within the IVP program and externally with partners?

Assessment begins with a survey to gather key data points from internal and external stakeholders of the state IVP program. The customized survey is administered to relevant staff and partners of the IVP program to understand perceptions, understanding, concerns, and readiness about shifting to shared risk and protective factor approaches to IVP work.

To provide additional insight, Safe States conducts a series of key informant interviews with internal and external stakeholders. The interview tool is often developed and refined based on findings from the background materials and survey responses. There are several items that are examined in both the surveys and interviews. Examples include:

Attitudes and beliefs about upstream prevention and SRPF approaches

Knowledge of the theory behind SRPF approaches and the language used to discuss them

Understanding of related public health frameworks from both conceptual and operational perspectives

Organizational culture (i.e. innovation communication, partnerships, etc.)

Available resources and barriers (both current and potential)

The findings from the surveys and interviews are then developed into a summary report that is ultimately used to inform a custom training and/or technical service package to assist the organization in the utilization of shared risk and protective factor approaches based on the strengths and opportunities identified.

SUMMARY OF THEMES

LANGUAGE IS CONFUSING

Across states, one theme that continued to appear was terminology and language connected to SRPFs. Individuals often stated that understanding, explaining, and connecting terminology was confusing, yet an important piece to this work.

Assessment and interview responses continually noted “common language” as an important piece for SRPF work to expand; however, there was very little agreement as to what this “common language” looks like or that it currently exists.

Some states indicated that weaving upstream prevention and, specifically, SRPF language, into everyday work can provide clarity around “how” risk and protective factors connect to their work. Other states emphasized that building their own SRPF “vocabulary cross-walk” has helped in developing better collaboration with partners and internal staff addressing SRPFs.

There is a strong need among states to describe how their work on SRPFs relates to the social determinants of health (SDOH) and health equity using accurate language. States indicated the need for clear language so that they can easily connect their work to SRPFs and align it to larger goals connected to upstream prevention.

> *The number one barrier we're facing right now is terminology and what terms public health uses versus transportation versus public safety. When they talk about upstream, is that meaning the same thing as root causes? Is that meaning the same thing as risk and protective factors?*

Acknowledging SRPF approaches means understanding the systems of injustices that exist at different levels of the SEM. Out of those interviewed/surveyed across the states, many individuals noted how challenging this can be to translate in a way that resonates with partners and policymakers.

Others noted this type of approach/mindset is not new, but rather a different framing on work that is culturally rooted in their community. Different individuals noted that specific populations have historically approached prevention by addressing multiple factors at the same time. American Indian and Latinx communities have been working with these issues for decades, often focusing on community-level and multi-factor interventions to strengthen their collective health. Community health workers and grassroots workers have similarly routinely focused on holistic care, rather than piecemeal solutions. Despite using different terminology to describe how they are going about things, the underlying “why” which drives this type of work is often the same across programs and partners.

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TIME AND MONEY ARE SCARCE- FORCING A SHORT-TERM VIEW OF PREVENTION

Across states, two of the biggest barriers to moving towards SRPF approaches were cited as a lack of time and money. To embrace SRPF approaches, IVP professionals must be innovative, creative, and willing to challenge the status quo of how they approach their work. Applying this mindset can be done, but often in opposition to the deliverables and deadlines of their funding streams.

States and partners emphasized that the ability to maximize the impact of work was important and that a SRPF approach could help with this. There is a clear perception across practitioners that SRPF approaches drive long term efficiency. However, there is less understanding, around how this work can be operationalized and show impact in the short-term. States indicated the need for time to focus on upstream outcomes, while still being able to balance their current work.

Nearly every state noted also that their work is siloed and tied to specific funding streams. States indicated that there isn't enough time or funding to both meet the specific needs of their funders and operationalize SRPF approaches across the work (which don't often match the specific objectives of the grants).

States mentioned that because of these siloed areas of funding, overlapping prevention strategies (people unknowingly having similar workstreams) have developed. State IVP staffs indicated that it is not always clear how certain programs/area of focus connect or could connect. Adding to that issue, there is also the sentiment that some are not able or willing to focus on areas outside of their traditional areas of expertise and intervention. Seeing the larger picture of upstream prevention, aligning SRPFs, and developing an approach that connects the work requires equal parts understanding, funding, time, and willingness to collaborate.

COLLABORATION WITH PARTNERS CAN BE DIFFICULT TO MAINTAIN

This willingness to collaborate and understanding of how prevention work connects also impacts how state IVP programs and partners interact. Many states indicated that they are willing to engage or are already engaging with partners across disciplines and sectors. However, the engagement was often described as "difficult to maintain."

Again, the sentiment that some are not able or willing to focus on areas outside of their traditional areas of expertise and intervention was common with state partners. For internal staff, connecting the dots of their prevention work often requires time and money that state IVP programs don't have. Groups are willing to collaborate but there is insufficient time for them to do so intentionally. States identified the need for more strategic mechanisms to facilitate ongoing collaboration so that overlapping and siloed prevention strategies don't exist.

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SUMMARY OF THEMES

For states that had strong partnerships, the concentrated focus was put on timely communication and fostering a sharing culture. States emphasized the importance of being explicit in explaining the work they are doing and helping to connect it to their partners' work through SRPFs. Drawing connections together and asking questions about how and why work is being done has helped some state IVP programs have a broader reach of partners.

PEOPLE UNDERSTAND THE WHY - THEY JUST DON'T KNOW THE HOW

Across states, both partners and IVP programs understand the importance of a SRPF approach to IVP and are inspired by the impact such an approach could have on their work. However, IVP programs want to see applicable examples of SRPF approaches that make the concept less abstract. At the same time, partners want to see actionable steps in "what's next" with states attempting to implement SRPF approaches.

Having real-life examples of SRPF approaches in action takes the concept from theoretical to operational and provides states with more actionable ideas to base their next steps. Both partners and state IVP professionals emphasized the need for these examples. Specifically, there was a need for examples of SRPF approaches addressing multiple levels across the social ecology. Prevention science research suggests that the most effective method for preventing violence and injury involves addressing both risk and protective factors at each level of the social-ecological model (SEM). However, out of those interviewed, most are more comfortable identifying SRPF approaches at the individual level and feel less clarity on how to develop and implement similar approaches at higher levels of the social ecology.

A disconnect also exists in how data-focused IVP professionals and those involved with programs understand SRPF approaches. Often, individuals working in data and surveillance indicated that SRPFs "did not impact them" or were not important to their work. Again, this shows a need for shared goals around SRPF approaches and clear connections across workstreams.

There is a hesitancy to take on SRPF approaches without additional guidance on how they can be operationalized in the short term. As discussed before, limited capacity in time and money plays a large role in the ability to operationalize a SRPF approach. States are looking for a way to apply a SRPF approach to IVP while also balancing their current workloads. Gaining buy-in from leadership and partners can create roadblocks for this type of work to succeed. Buy-in from partners that work in secondary and tertiary prevention can especially be difficult. Successful buy-in and understanding from these groups take time, which in turn takes money. However, gaining buy-in from these partners can significantly enhance a program's success in shifting their work towards an upstream focus addressing SRPFs.

SUMMARY OF THEMES

THERE IS A SPECTRUM OF WORK

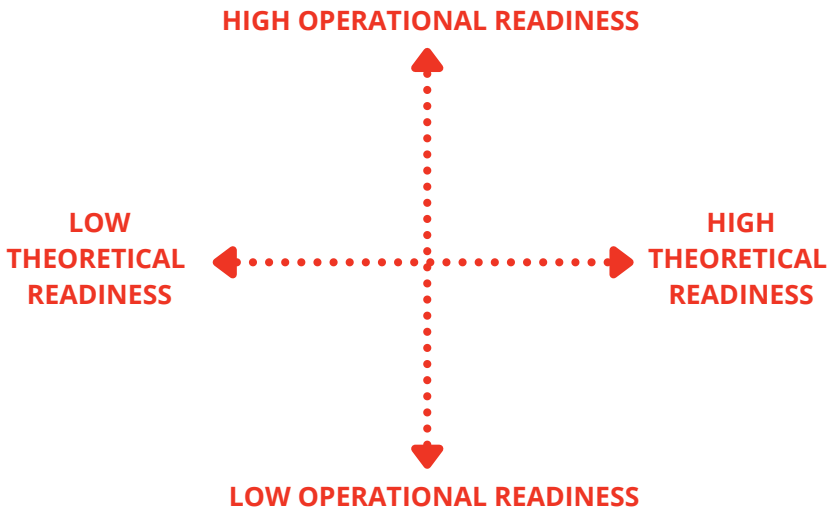
States are at different points with SRPF work. Some are just getting comfortable with the terminology and how it connects to their own work while others are developing and implementing a formal "Theory of Change" model.
Implementing SRPF approaches creates the potential to build partnerships that effectively break down issue-specific silos and enhance the sustainability of state IVP programs and partner initiatives. But this type of work requires aligning many pieces. Because of this, states are at very different places in this work.

As noted in the following sections, readiness to embrace a SRPF approach to IVP work is not binary. Perhaps the biggest take away from assessing SRPF work across states is that there is a broad spectrum of work across states, and no state is "right" in its approach. States vary in both their theoretical knowledge and understanding of SRPF approaches, as well as their ability to operationalize this type of work.

THE SRPF APPROACH READINESS MATRIX

CONTINUUM OF READINESS

Readiness to take on a SRPF approach to IVP work is not binary, as injury and violence prevention programs cannot simply be deemed “ready” or “not ready”. Readiness also does not fall on a linear scale. Rather, readiness is evaluated by assessing many qualities of IVP programs, both theoretical and operational in nature. To accurately capture the dynamic continuum of readiness, the Safe States Alliance created a matrix, characterized by a scale of theoretical readiness and a scale of operational readiness,.



Matrix quadrants include low theoretical readiness and low operational readiness (low-low), low theoretical readiness and high operational readiness (low-high), high theoretical readiness and high operational readiness (high-low), or high theoretical readiness and high operational readiness (high-high).

States’ readiness scores are calculated by identifying the number of attributes a state has as a percentage out of the total number of attributes being assessed. The percentage is then converted into a number on a 1-10 scale. For instance, if a state is being assessed for 20 attributes of theoretical readiness and only successfully exhibits 10 of them, they will have 50% of the attributes, which will translate to a 5 on the scale.

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THE SRPF APPROACH READINESS MATRIX

THEORETICAL READINESS ATTRIBUTES EXAMINED

- Familiarity with upstream prevention approaches
- Understanding of how one's role contributes to upstream prevention
- Confidence in SDOH, ACES, SEM, Health Equity, and connections with SRPF approaches
- Perception of SRPF approaches as important and efficient
- Open communication about primary prevention/SRPF approaches with partners, staff, and leadership
- Understanding of the activities that need to be prioritized to focus on upstream prevention
- Belief that a SRPF approach is in line with vision and goals of IVP program
- Support of IVP program's goal of using SRPF approach in planning and implementation

OPERATIONAL READINESS ATTRIBUTES EXAMINED

- Received training around SRPF approaches
- Shared language across primary prevention/SRPF work
- Open communication across partners and collaborative internal culture
- Work across partners, sectors, and coalitions
- Support for innovative approaches
- Internal champions with vision and strategy
- Availability of: research on effective strategies, reliable data, funding, personnel, examples of SRPF approaches within the state, connections to organizational networks and communities of practice/coalitions, high-quality resources, policy support
- Absence of barriers, such as: limited capacity, discomfort changing programs, lack of statewide political will, administrative issues

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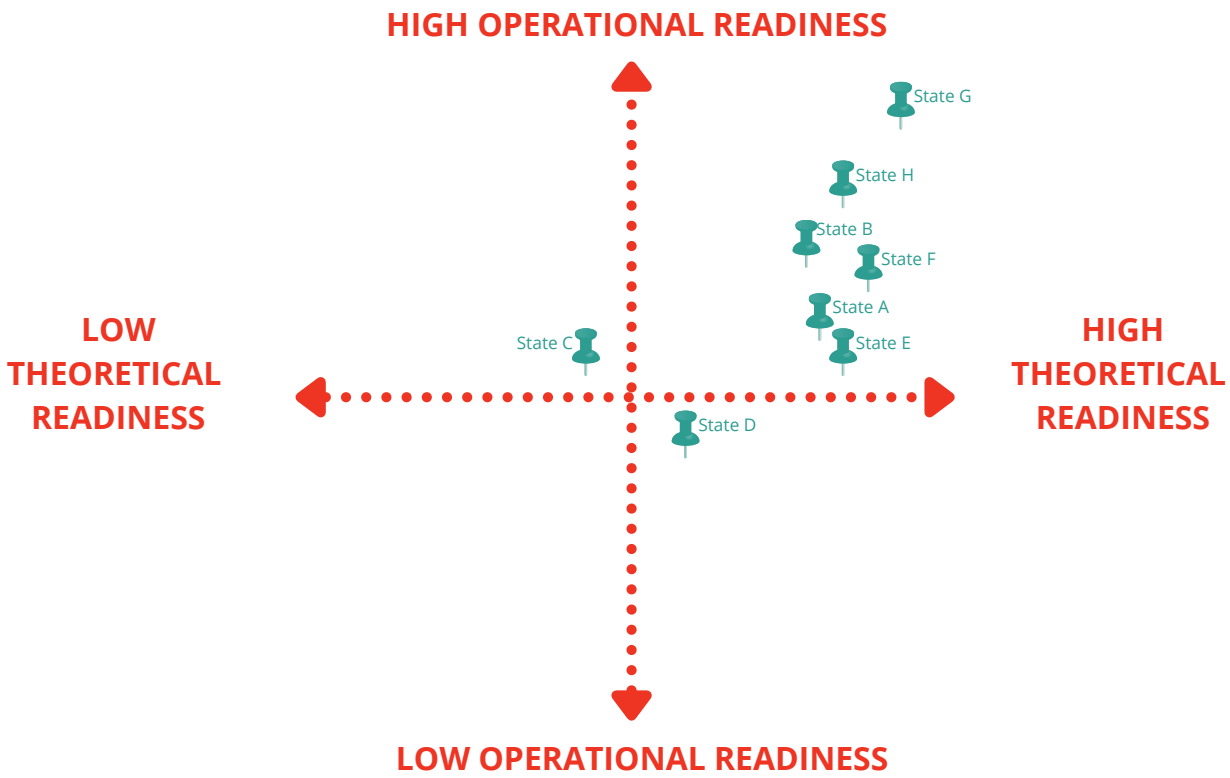
THE SRPF APPROACH READINESS MATRIX

WHAT THE MATRIX LOOKS LIKE ACROSS STATES

While there is a spectrum of work happening across states, assessments have highlighted a trend that many states are falling into a space of high theoretical readiness and mid-to-high-level operational readiness, as depicted by States H, B, F, A, and E.



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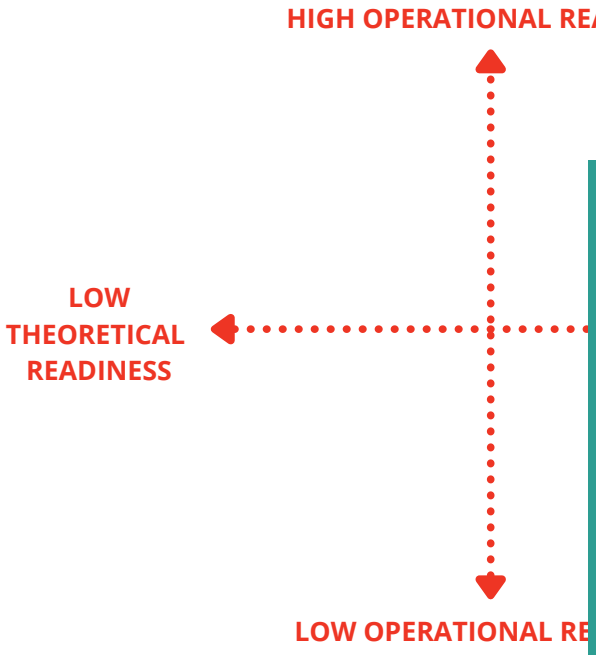
COMPARING INDIVIDUAL STATE ATTRIBUTES TO THE MATRIX

Let's take a closer look at one of our state's and how they scored.



State H Attributes

THEORETICAL READINESS SCORE 8.9

- Internal staff and partners are very familiar with primary prevention and SRPF approaches to IVP & how their work contributes to these approaches.
- Internal staff and partners believe SRPF approaches are important and efficient in the long term & know which activities they need to prioritize
- IVP program has strong and open communication internally & with partners
- There is widespread support for IVP goal to use a SRPF approach

OPERATIONAL READINESS SCORE 7.4

- Strong partnerships & coalitions that engage collectively on goal-setting
- IVP program and partners working across disciplines and sectors
- Strong connections to organizational networks, communities of practice/coalitions, & dedicated personnel.
- Champions within the state with a vision and strategy for adopting a SRPF approach.

WHY THE MATRIX IS IMPORTANT

The matrix portion of the assessment can help states as they look to expand their work using a SRPF approach. The matrix provides a visual representation of how states perform comparatively and on which areas they should continue to work to move further into the upper right quadrant, characterized by a high-high readiness score. It should also be noted that states can move along the continuum in both directions; as personnel or other internal changes occur, states may see shifts in their theoretical or operational readiness. Recognizing that readiness is not a static measure should reassure states that shifting to new strategies is an ongoing process comprised of continual learning and growth – there is no “start” or “finish.”

As the national momentum for SRPF approaches has gradually increased over recent years, this clustering of states transitioning from theoretical to operational readiness is not surprising. It provides a clear opportunity for peer-to-peer learning and broader technical assistance to support states as they shift their approach to IVP and move towards this type of strategic work.

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WHERE ARE WE GOING FROM HERE?

Taking a SRPF approach to IVP work is a clear national priority, as state health departments work to move their programs to focus on upstream prevention to maximize funding and impact.

To date, SRPF approaches have been largely focused on intentional injury (violence). While there is work being done to advance SRPF approaches with motor vehicle safety and other unintentional injury topics, more focus must be placed on this to ensure that the same functionality and efficiency can drive benefit across a variety of health outcomes.

While a SRPF approach may be referred to by a variety of different names, state IVP programs need to be able to embrace and operationalize this kind of cross-cutting approach to make themselves effective and sustainable in their prevention efforts. By bolstering states' abilities to weave funding streams and focusing on relationships between outcomes, the approach supports sustainability of prevention programs to be maintained over funding cycles and as funding streams start and stop. Ultimately, the functionality and efficiency of taking a SRPF approach to IVP provides a strong rationale for the continuation of this work across all states. Prevention partners wanting to implement this type of approach within their respective programs should engage with colleagues across the country to share their experiences, learn from others, and collectively advance the field.

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