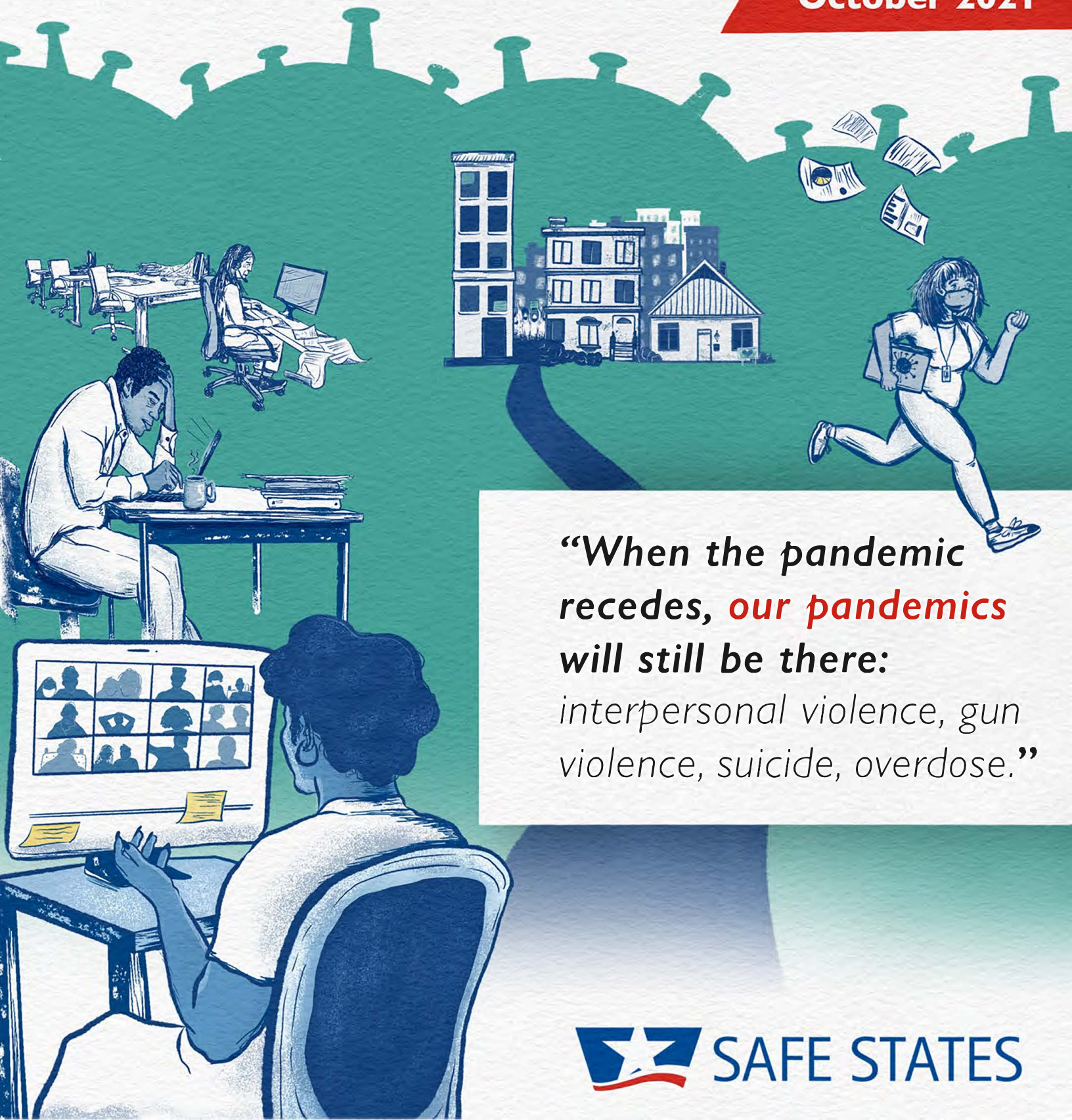
CRISIS AMIDST COVID-19:

The state of *injury and violence prevention* in health departments and hospitals

October 2021



"When the pandemic recedes, our pandemics will still be there: *interpersonal violence, gun violence, suicide, overdose."*

SAFE STATES

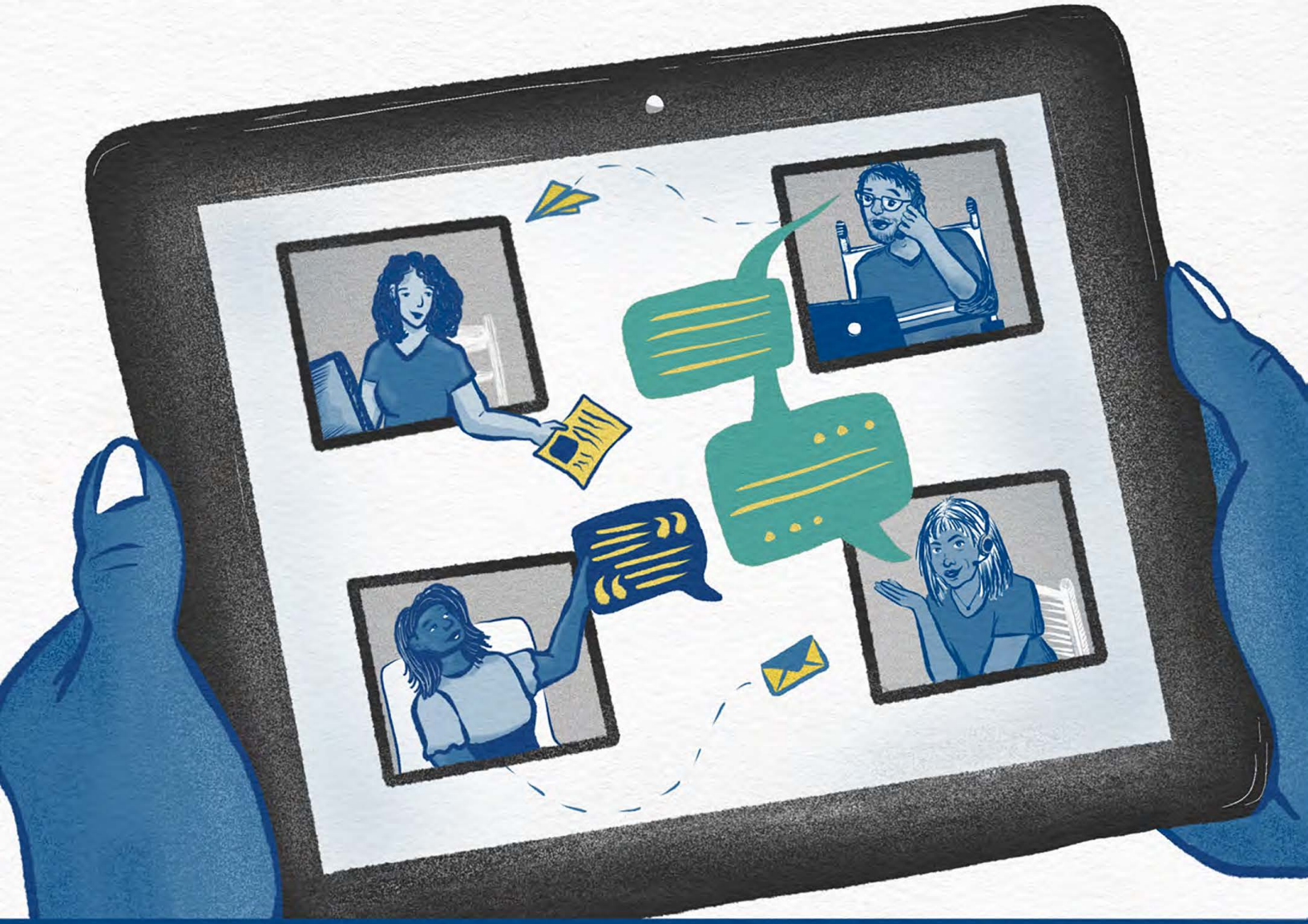
ACKNOWLEDGEMENTS

The following Insight for Action staff contributed to the production of this report: Katie Winters, PhD, Ronda Zakocs, PhD, Nidhi Pai, BS.

We are grateful to the Safe States team for their guidance and collaboration: Sharon Gilmartin, MPH, Shelli Stephens-Stidham, MPA, and Ina Robinson, MPH.

We also extend appreciation to Catherine Guerrero, MPA, Principal with HMA Community Strategies®. and Jamila Porter, DrPH, Senior Advisor for the deBeaumont Foundation, for contributing invaluable content expertise.

We are especially grateful to the Injury and Violence Prevention (IVP) professionals who contributed their experiences and recommendations by participating in the focus groups and surveys that formed the basis of this evaluation. Their wisdom was invaluable to this endeavor.



The development and publication of this document was supported by funding from the Centers for Disease Control and Prevention (CDC) under the Cooperative Agreement Number 5NU17CE924917. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

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EXECUTIVE SUMMARY

Background

Each day, one person dies from injury or violence every three minutes, totaling over 214,000 deaths annually.[1] Prior to the COVID-19 pandemic, these deaths already represented a tremendous public health burden on individuals, families, communities, and the healthcare system. Since the first case of COVID-19 was reported in the United States on January 21, 2020, national and localized responses to the outbreak have had considerable implications for injury and violence prevention (IVP). The pervasive community- and family-level stressors associated with the pandemic and response activities have led to anticipated and observed increases in injuries and violence.[2, 3, 4, 5, 6] At the same time, much of the IVP workforce is being called to pause their day-to-day IVP efforts to contribute to the COVID-19 response.

To identify the professional challenges created by these circumstances and produce recommendations for needed infrastructure enhancements to best equip IVP programs in handling future unforeseen scenarios, the Safe States Alliance conducted an evaluation to gather information from state and local health departments and hospital-based IVP programs about the impact of the COVID-19 response on IVP infrastructure and activities, with particular emphasis on ensuing effects on equity.

Purpose

For this report, Safe States partnered with Insight for Action to evaluate the impacts of the COVID-19 pandemic on Injury and Violence Prevention (IVP) capacity to:

- Inform development of short-term supports to address IVP in the context of COVID-19; and
- Identify opportunities to build a more resilient, equitable system that can better prevent and respond to future public health emergencies.

Methods

The mixed-method evaluation consisted of **three data sources** (refer to Appendix for methodology details).

A scan of 36 websites, blog posts, webinars, and articles describing IVP and how the pandemic has impacted program capacity, funding, and infrastructure.

Eight focus groups with 52 Safe States Alliance members representing state health departments (n=27), local (i.e., city and county) health departments (n=10), and hospital-based IVP programs (n=15) across 31 states.

A national survey of Safe States Alliance members representing state health departments (n=30), local health departments (n=11), hospital-based IVP programs (n=30), and tribal organizations (n=1), across 27 states.[7]

Injury and violence professionals from three-fourths of states (37 out of 52) participated in the focus groups and/or the national survey.

Summary of Key Findings

IVP is grounded in the notion that injuries result from a predictable convergence of human factors with the surrounding environment.[8] Prevention is possible with solid, stable infrastructure.

Even before COVID-19, the IVP system was highly fragmented due to the decentralized approach to funding public health in the U.S. With the main burden delegated to state and local governments, **IVP perennially lacked adequate resources to achieve its aims before the pandemic began.**[9]

Family and community violence and injuries including domestic violence, (unreported) child maltreatment, Adverse Childhood Experiences (ACEs), suicide, overdoses, and gun violence have surged due to the stress and isolation of pandemic-related social distancing mandates and the economic fallout resulting from forced business closures.[2, 3, 4, 5, 6] Concurrently, the IVP workforce has been siphoned to non-IVP, pandemic-related efforts such as contact tracing or data management. **COVID-19 is negatively impacting *all* areas of IVP capacity at a time when unintended injury and violence are surging.**

IVP programs have been pivoting to virtual formats to maintain routine programs and services but **lack the resources and infrastructure necessary to effectively adapt and innovate** through this emergency. **The pandemic is also exacerbating workforce burnout;** many IVP professionals are leaving their posts.[10]

The pandemic has raised awareness of the harms of inequities among the public and those in positions of power.

This is a critical opportunity for IVP to amplify efforts to reduce systemic inequities.

IVP programs acknowledge the need to redirect strategy and resources toward upstream solutions but need additional resources and support to accomplish this worthy aim. **IVP practitioners are eager for technical assistance and more adequate, stable funding to navigate COVID-19, prepare for future emergencies, and address root causes of unintended injury and violence.**

Recommendations

Based on the key findings of the evaluation, the Safe States Alliance developed the following recommendations for national partners, health departments, and IVP programs to buoy IVP professionals as they continue to navigate the COVID-19 pandemic and ensure IVP is better-positioned to navigate future public health emergencies:

❶ **Develop** an IVP standard definition of equity and actionable guidance to promote upstream, collaborative solutions to address systemic health inequities.

❷ **Advocate** for adequate and consistent IVP funding so every state, territory, and corresponding local and tribal entities can build a coordinated, stable, and sustainable infrastructure.

❸ **Recruit** and retain a robust and diverse IVP workforce that can sustain core functions while responding to public health emergencies.

❹ **Support** the IVP system to adapt to changing conditions in the workplace and the communities it serves.

SUMMARY OF KEY FINDINGS

The following pages of this report present **six key findings** garnered from the inquiry. For each finding, a narrative description is accompanied by a graphic representation of the survey results and focus group quotes representative of the themes.

KEY FINDING 1

COVID-19 is negatively **impacting all areas of IVP capacity.**

KEY FINDING 2

COVID-19 is exacerbating **workforce burnout.**

KEY FINDING 3

IVP is adapting to COVID-19 by **shifting to a virtual environment.**

KEY FINDING 4

COVID-19 is **exposing and intensifying technology inequities,** reducing access to needed IVP programs and services.

KEY FINDING 5

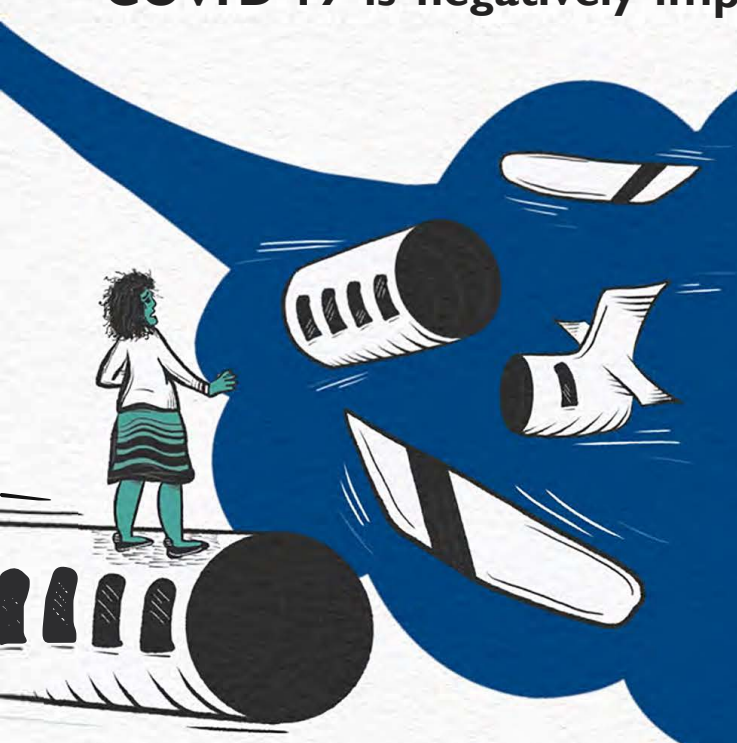
COVID-19 is **catalyzing interest in addressing inequities with upstream solutions;** however, there is a lack of clarity around the definition of equity, how to address it, and which strategies to prioritize.

KEY FINDING 6

IVP practitioners are **eager for support to navigate COVID-19, prepare for future emergencies, and address root causes** of unintended injury and violence.

KEY FINDING 1

COVID-19 is negatively impacting all areas of IVP capacity.



"We're in new territory related to programming and strategies. Nobody's done this before. We're having to build the plane as we're flying it."

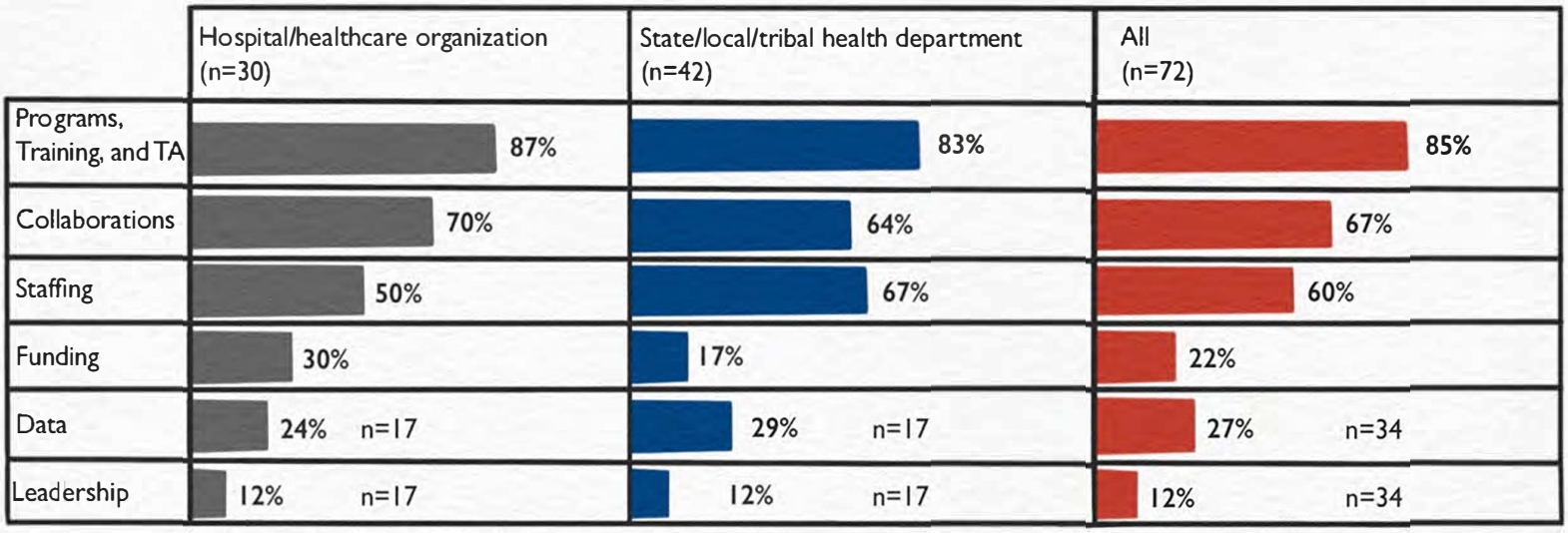
The Safe States Alliance has defined six "core components" that describe the capacity of state and local IVP programs: infrastructure, injury and violence data, program and policy strategies, collaboration, communications, training and technical assistance, and leadership.[11] Similarly, Level I and II trauma center injury and violence prevention programs also have their own core components: leadership, resources, data, effective interventions, and partnerships.[12] **Respondents were asked to identify which core components were negatively impacted by COVID-19. Programs, training and technical assistance, collaborations, and staffing were most often reported in the survey and described as significantly impacted during the focus groups.**

Safe States Alliance's **Six Core Components** describing the capacity of IVP programs:

1. Build and sustain a solid and stable **infrastructure**
2. Provide **training and technical assistance**
3. Effectively **communicate** to key stakeholders
4. Engage partners for **collaboration**
5. Select, implement, and evaluate effective **program and policy strategies**
6. Collect, analyze, and disseminate **injury and violence data**

Note: The remainder of this report is organized based on the components of IVP that surfaced during the focus groups, and which subsequently formed the basis of the survey. The categories differ somewhat from those developed by the Safe States Alliance.

Which components of your IVP programs have been negatively impacted (i.e. stopped, slowed, reduced/hampered) **due to COVID-19 at all?**



Note: Total counts (n) for groups differ because Data and Leadership were added mid-implementation of the survey.

Programs, Training, and Technical Assistance

Programmatic offerings, including training and technical assistance, have been severely derailed during the pandemic. Among survey respondents, 85% reported that this aspect of their work had been negatively impacted by COVID-19. Focus group members commonly described their efforts as having "ground/ screeched to a halt" when in-person interactions were no longer at their disposal. They described retooling some methods to virtual formats, but this was a particularly heavy lift since staff capacity was reduced due to pandemic-related reassignments and in some cases required approval from developers who had designed evidence-based interventions to be delivered face-to-face. Focus group participants also reported that attendance in their programming had fallen.

"I haven't been able to focus on injury prevention or my position for a year now."

"The need to shift to a virtual platform, at least early on, was problematic, because the success of the violence and injury prevention model, the model that we use with intervention specialists and violently injured youth is 100% founded on that in-person trust, which is facilitated by that face-to-face and in-person."

Collaborations

IVP has learned to lean heavily on partnerships because its own resources and infrastructure have been historically inadequate to achieve its mission. During the pandemic, key partners such as schools, community-based organizations, and tribal reservations have been far less accessible due to social distancing, lack of technology infrastructure, and because they have been focused on responding to critical pandemic-related needs in their communities. Collaborations with other public health departments have also suffered. Among survey respondents, 67% reported that collaborations had been negatively impacted by COVID-19.

"Our counterparts in the department have also been redirected. Some of the partners that we have with Maternal Child Health or with our Office of Health Equity... have been redirected too, so it's slowed down our progress."

"Partnerships, which are the bread and butter and the foundation of the work that we do in the community, either were suspended, or faced significant challenges, because most if not all agencies, particularly nonprofits, either shut down, or everybody was at home and had trouble accessing their systems or their data."

"Especially some of our communities that were most impacted by COVID... areas that are really hit with health disparities and are some of our focus areas for a lot of our work, like our tribal partners on our reservations, almost all of our reservations completely shut down for months. Folks weren't doing any work. It was just really hard to get anything done."

Staffing

The IVP workforce is the driving force of all that IVP is and does. During COVID-19, IVP workers have been reassigned to pandemic response, forced to put their regular duties on hold, amplify their workload to maintain non-pandemic roles and responsibilities, and/or shift their work to others who were already working at full capacity.

This is occurring despite known increases in unintended injuries and violence such as drowning, unintentional shootings, and domestic violence.[13, 14, 15] Among survey respondents, 60% reported that staffing had been negatively impacted by COVID-19.

"When our injury prevention professionals were most needed to pivot their programs to address specific causes of violence that we saw spike during COVID... so many programs did not have the capacity to respond to that critical need because they were deployed or furloughed."

"It certainly was difficult to navigate because all of my epidemiologists and all my regular staff, myself, were pulled into COVID response. And I was the only one that was released back for a continuation of operations. All of sudden, I found myself running six grants by myself, which was a challenge to say the least"

"In those first several months of COVID, I would estimate about 25 to 30 percent of the injury prevention coordinators at those hospitals either left or were cut, and then every single one of them had some redeployment, lost effort, or some combination of that. There was not a single group that wasn't impacted, hugely in many cases."

Data

Among survey respondents, 27% indicated that data had been negatively impacted by COVID-19. During the focus groups, participants also discussed pandemic-related impacts to their data work, although to a lesser extent than the components of IVP presented in previous sections of this report. According to focus group participants, surveillance data collection has been interrupted due to pandemic-related staffing reassignments, particularly reassignment of epidemiologists. Collaborative partners, rightly focused on responding to urgent community needs, have ceased submitting data, compromising this and other essential components of IVP programs. Interpreting data collected during the pandemic or longitudinal trends spanning the COVID-19 timeframe are a foreseeable challenge.

Funding

According to the focus group participants, shifting staffing to COVID-19 response efforts has made it difficult to manage current grants or apply for new funding. Hospital-based programs have been subject to funding cuts during the pandemic. Some publicly funded IVP programs experienced a rapid influx of COVID-specific funding but struggled to efficiently utilize those resources or leverage them to achieve longer-term strategic solutions due to limitations on how the funds could be used, and because they were subject to aggressive spend-down timelines. Among survey respondents, 22% reported that funding had been negatively impacted by the pandemic.

*"Many of our data folks are working 70 hours a week on COVID-19 response so they're **just not available**."*

"...challenges in terms of dealing with massive influxes of funding really quickly that we have to spend really quickly. That's a huge burden. It's an amazing opportunity, but to be strategic with that, and thinking about sustainability. And the long-term effects rather than just sticking band aids on things, is really challenging."

"CDC said, 'Hey, here's some more money, you need to get this out to your partners.' Well, that takes a budget, and you have 90 days to do it. Moving money was one of our biggest challenges, because everything was all COVID all the time. And if we weren't spending money on COVID, we couldn't spend money."

"One of the fundamental issues that we keep bumping up against with hospital-based injury and violence prevention, is [...] everything that we do is soft money, or built into the hospital budget and does not generate revenue. So that is a challenging argument to have as administrators. And when times get tough, when you tighten your belt, the first thing to do is cut a program that does not generate revenue or allow for reimbursement. So, this is a much bigger and deeper systemic issue around national support for injury prevention."

Leadership

Like data and funding, leadership was discussed less often during the focus groups, although participants across the groups collectively elevated key challenges regarding leadership which have worsened during the pandemic. Prior to COVID-19, departments struggled to secure the attention of local, state, and national level decision-makers whose resource allocation decisions commonly conveyed that prevention and IVP efforts are a low priority. This has been especially pronounced since the pandemic began. Additionally, IVP leaders, spread thin prior to the pandemic, have been deployed to COVID-19 response efforts, further limiting their ability to build and sustain their departments and advocate for their programs. Among survey respondents, 12% reported that funding had been negatively impacted by the pandemic.

"As state General Assemblies moved to abbreviated sessions, it necessitated addressing only the most pressing policy issues. IVP legislation was so far out on the periphery of priorities, we effectively lost the 2020 session."

"...we're having to scrap and nickel and dime and beg and borrow and steal and find gift and soft money. And so that delegitimizes everything that we do with hospital administration - we're not a billable item, we're not earning our keep, we're not considered a valuable asset to the hospital system from the administrative perspective... we become like cannon fodder when it comes to the early rounds of cuts for these public health crises that come up."

KEY FINDING 2

COVID-19 is exacerbating workforce burnout.

*"We previously had **four full-time FTEs**, and two of those had already been cut. I was already covering basically three positions. My effort was cut, and my other colleague had effort cut, so that is **one part-time worker covering four FTEs.**"*

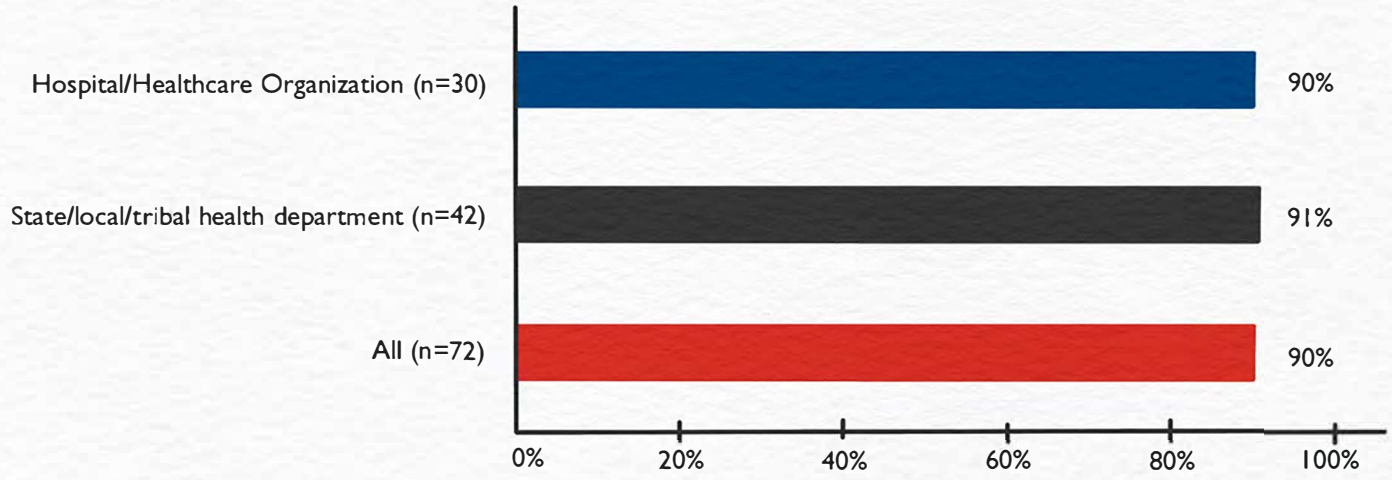
The IVP workforce drives all that IVP is and does. **Prior to the pandemic,** IVP was understaffed, with workers wearing "many hats" and programs experiencing furloughs and extended hiring freezes. As a largely grant-funded endeavor, IVP leaders are accustomed to adjusting roles and shifting full-time equivalents (FTEs) to maintain personnel, an inefficient staffing strategy. Among survey respondents, 90% agreed or strongly agreed that IVP workers are experiencing one or more dimensions of burnout, a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: (1) feelings of energy depletion or exhaustion; (2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; (3) reduced professional efficacy.

"We are cobbled together with a bunch of various grants from various funders. That's the biggest challenge in my branch. I have very few people who are funded by state general funds or some stable, year-to-year, non-threatened funding source. We are constantly looking for more grants and moving people from one grant to the next and it is so incredibly unstable for us... I'm mired down in deliverables from various grants to sustain our very existence."

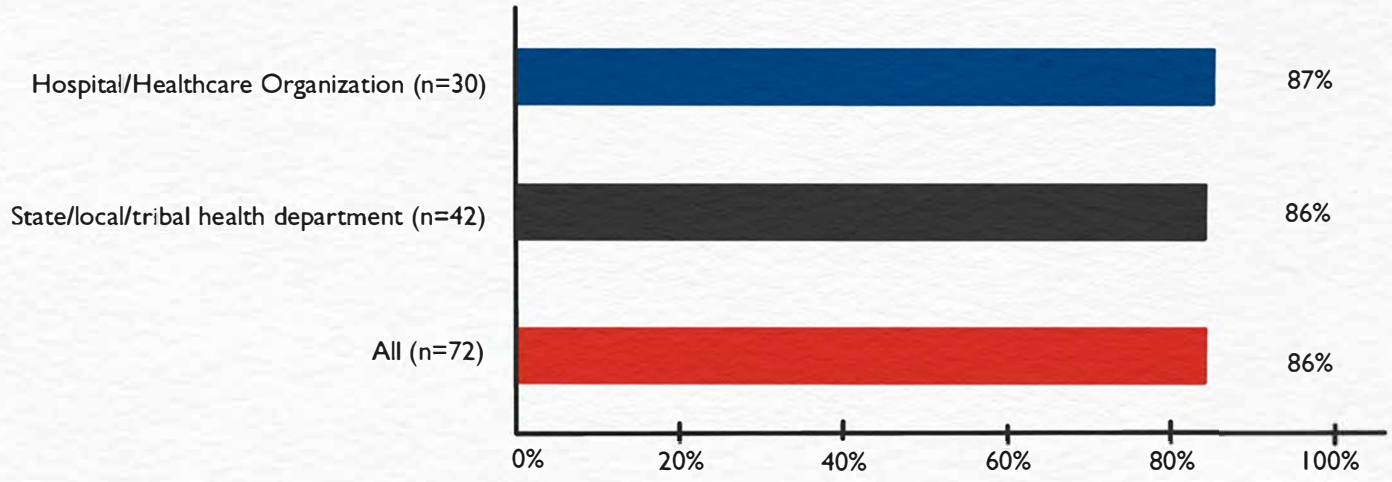
Since COVID-19, worker wellbeing has become a serious concern. Among survey respondents, 86% agreed or strongly agreed that burnout has increased among IVP workers during COVID-19, and 42% reported that one or more IVP workers in their organization have left the workforce since the pandemic began.

Focus group participants described IVP workers being harassed by community members for COVID-19-related mandates beyond their control and managers running interference to protect their staff from accusations and verbal assault. Managers also reported various tactics to bolster staff morale, although the general tone of the conversations was that they felt inadequate in this regard. Previously staffed at bare-bones levels, as workers take on additional pandemic-related responsibilities, they are experiencing burnout and leaving the field at accelerated rates.[16]

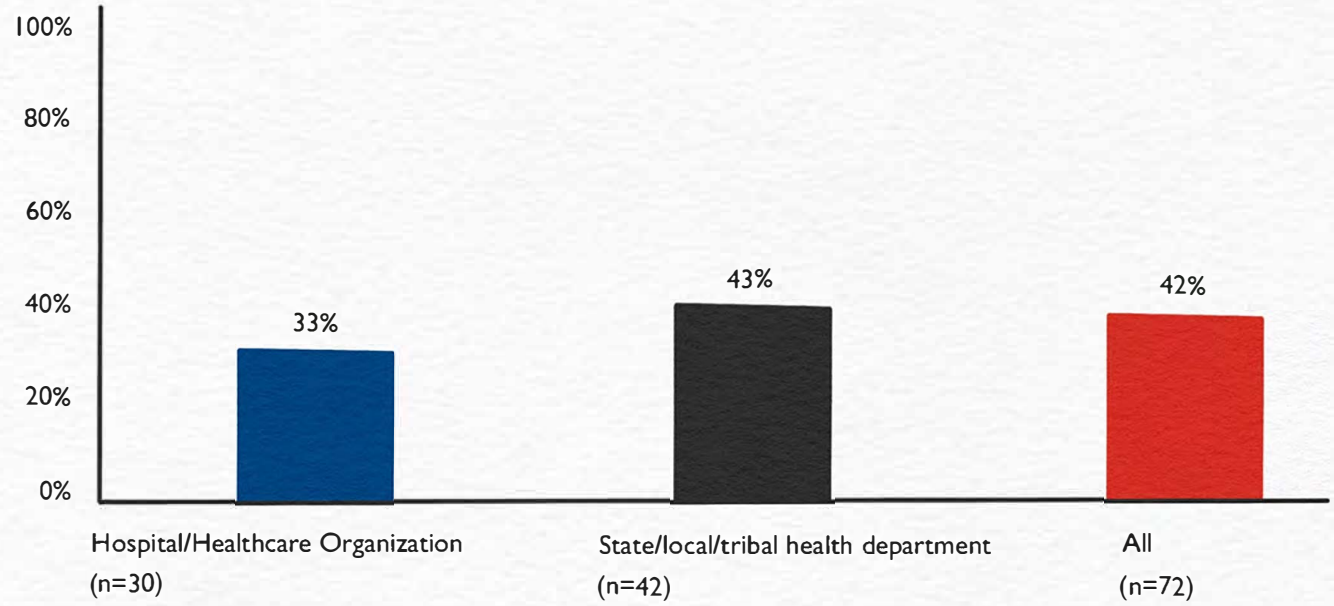
Most respondents **Agree or Strongly Agree** that IVP workers are experiencing one or more dimensions of burnout.



Most respondents **Agree or Strongly Agree** that one or more dimensions of burnout has/ have increased among IVP workers during COVID-19.



Respondents who reported that **one or more IVP workers in their organization have left** the workforce since the COVID-19 pandemic began.



KEY FINDING 3

IVP is adapting to COVID-19 by shifting to a virtual environment.

The pandemic has catalyzed a **system-wide transformation** from in-person to virtual formats, a process that has produced successful adaptations despite numerous challenges.

Challenges

The shift to remote work has posed numerous challenges for IVP programs. Many workers were ill-equipped, lacking the technology hardware, software, and knowledge to adapt. Among survey respondents, 43% reported that lack of access to or difficulty upgrading technology hardware has posed a barrier to shifting IVP work to a virtual environment. Areas with poor internet connectivity were especially challenged; 19% of survey respondents identified this as a barrier. In some cases, bureaucratic hurdles further hampered efforts to adjust. Organizational policies, or lack thereof, were identified as a barrier by 38% of survey respondents.

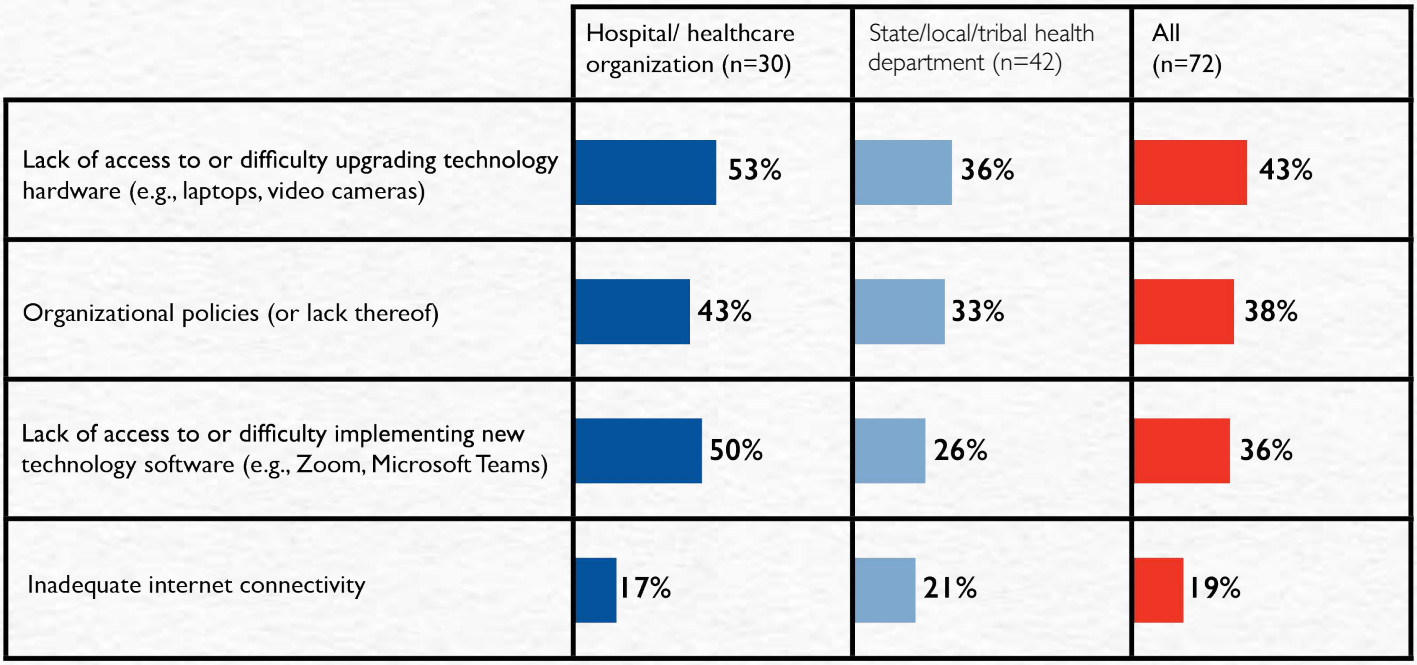
"We've run into a lot of union issues when people started teleworking because there were issues around personal computers or state computers. It took me four months to get a laptop because I was never allowed to have one. I still don't have VPN access from home. As the state's migrating everything to OneDrive and Teams, the security has been a big issue. We had to get the free Zoom accounts. We have 45 minutes and only a couple of people to try and hurry up and meet together."

The learning curve was steep as departments developed new staffing structures and workflow pathways, which contributed to programs slowing or halting completely. Without the impromptu face-to-face

exchanges that occurred organically prior to COVID, many informal, unstructured communications have been lost. Creative processes such as brainstorming sessions have also occurred less often.

"We didn't even have laptops at the beginning of the pandemic... My team just got laptops, as of November... in that shift we've also gone from Windows 10, which is laughable that we're still working on Windows 10, to Office 365. So, we 're learning Teams, we 're learning new Outlook systems, everything has shifted, and it's a major learning curve for folks who are on very antiquated systems."

Barriers to shifting IVP work to a virtual environment:



Prior to COVID-19, most programs were developed and tested in face-to-face formats. Subject to social distancing mandates, evidence-based programs could not be administered virtually without gaining approval from developers. Adaptations were largely focused on retooling pre-existing programs and services and upgrading antiquated technology to maintain basic workflows.

"We didn't even have policies in place that allowed us to do virtual activities. It was having to go through and change those policies and look at the programs too and suspend activities until we could get that going."

Successful Adaptations

Despite these challenges, numerous virtual, hybrid, and non-virtual adaptions were discussed, many of which were successful. As a result of COVID-19, some programs were able to get telehealth services up and running quickly, a service which was not previously available in many locations. Moving programs and services online and developing innovative non-virtual mechanisms to disseminate information has also increased access for some users.

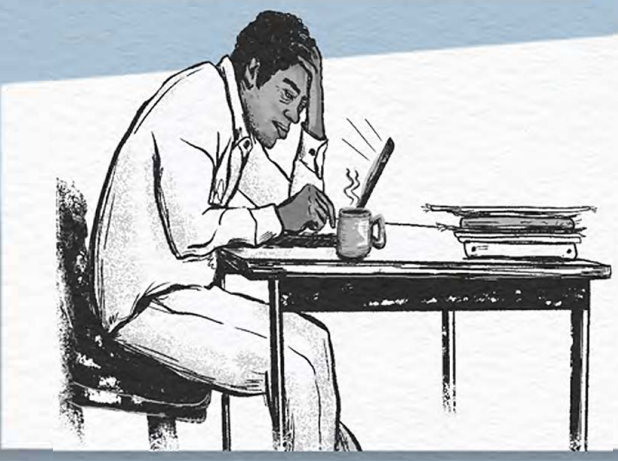
Another benefit of the virtual shift, some focus group participants described professional roles that are better suited to remote work such as epidemiology which requires long stretches of focus to conduct analysis, and call center positions in which workers need privacy to recover from fielding difficult-to-hear violence cases. Communicating through Zoom has also enabled more efficient and better-attended meetings, both within programs and with collaborative partners.

"For some of our staff, it's just way more efficient [to work remotely]. Our epidemiology teams, surveillance informatics, you know, a lot of them will probably continue doing it."

"My group is the violent death reporting system abstractors. They have found it to be really great to be at home. That work is really difficult to do, generally speaking. To be able to be at home and take breaks and have maybe their animals around them has really, really helped with their mental health."

KEY FINDING 4

COVID-19 is exposing and intensifying technology inequities, reducing access to needed IVP programs and services.



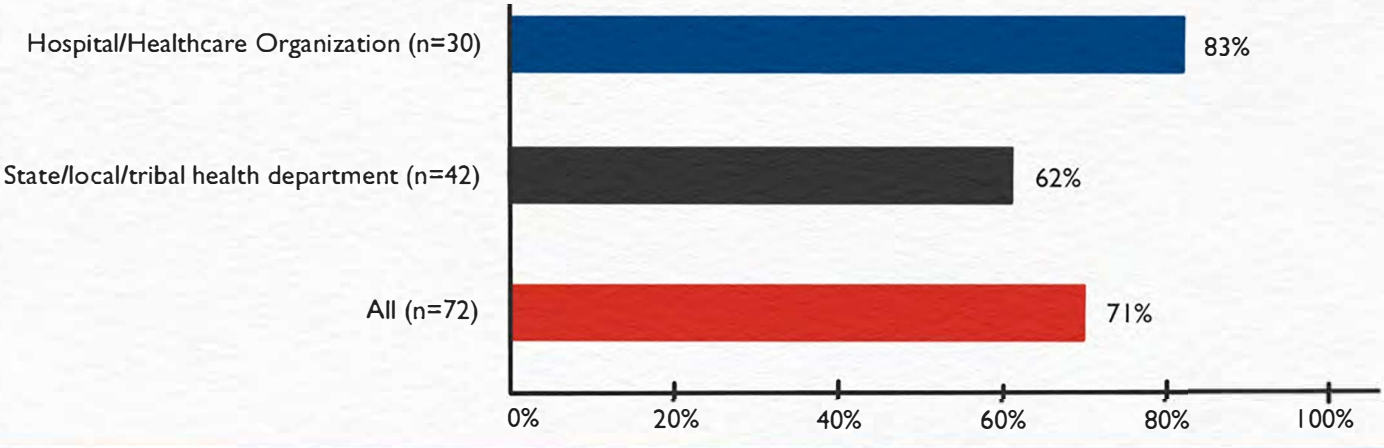
The pandemic has laid bare inequities, especially regarding **technology.**

The "digital divide" - the gulf between those who have ready access to computers and the internet, and those who do not - was discussed regularly during the focus groups, both amongst the IVP workforce and their constituents. Older adults, people living in rural communities including Native American reservations, people living with disabilities, and people with low incomes commonly lack adequate access to technology infrastructure and sometimes lack the skill to use it. During COVID-19, these populations have systematically lost access to programs and services to protect them from unintended injury and violence.

"There are some counties that continue to struggle because the technology is just not there. Specifically [on the Native American reservations], technology is just not something that people have used..."

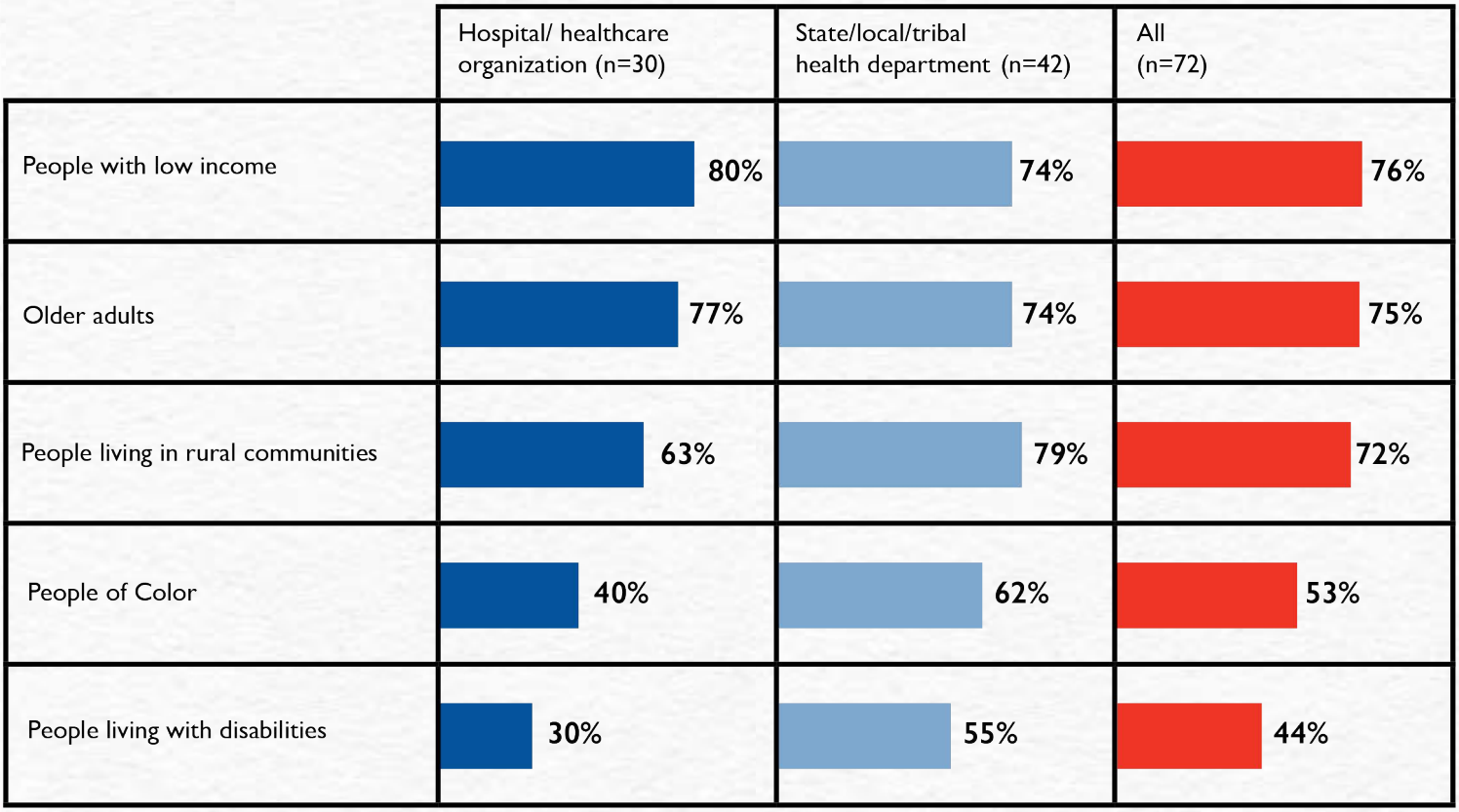
Among survey respondents, 71% agreed or strongly agreed that shifting programs/services to virtual formats has exacerbated inequities for IVP participants/recipients.

Most respondents **Agree or Strongly Agree** that shifting programs/services to virtual formats has exacerbated inequities for IVP participants/recipients.



Survey respondents indicated that people from a variety of vulnerable and marginalized groups, including people with low income, older adults, and people living in rural communities, have experienced greater IVP program service inequities due to shifting to a virtual environment. An important consideration in relation to these data is the nature of intersectionality. Many people experience multiple overlapping social identities within interdependent systems of discrimination and disadvantage. An example of this intersectionality is that an older, low-income person of color living in a rural community is apt to face multiple systemic barriers to accessing essential IVP services, a reality which is likely to have worsened during the pandemic.

Which of the following groups have experienced **greater IVP program service inequities** due to shifting to a virtual environment?



"When we think about how COVID has really changed the way we interact with, not just internally, but within our communities in terms of the technology, there seems to be a great digital divide, because some communities don't have the resources to access some of that technology that we are requiring them to use to engage in some of the work."

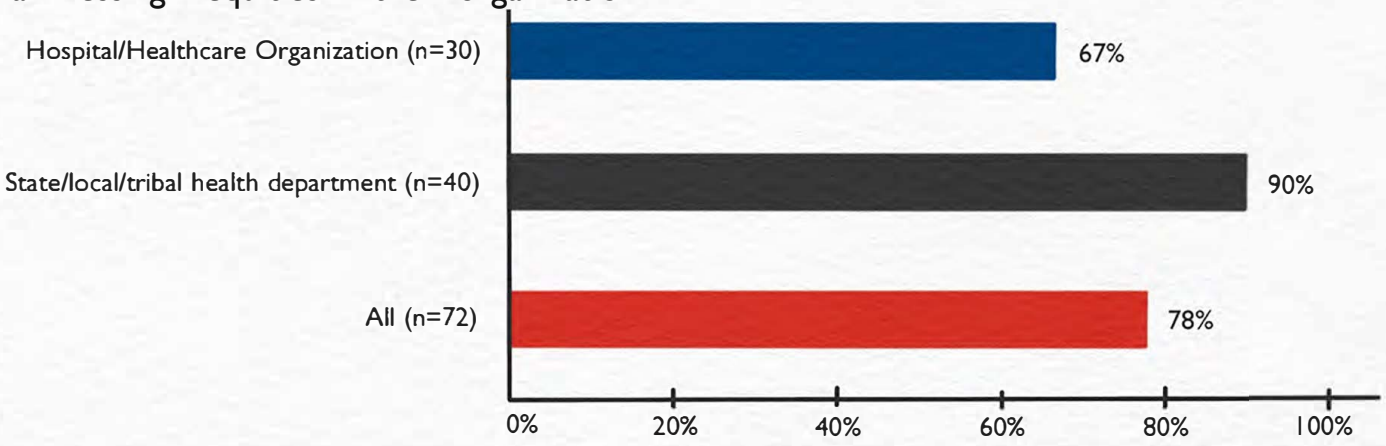
"We've also lost participation from the disabled community members we had, and I suspect it's because of the challenges with participating online. So, we've kind of lost that voice in some of our programs as well."

KEY FINDING 5

COVID-19 is catalyzing interest in addressing inequities with upstream solutions; however, there is a lack of clarity around the definition of equity, how to address it, and which strategies to prioritize.

IVP is making a more concerted effort to redirect strategy and resources toward upstream solutions to address the social determinants of health, as well as learning how to better partner with communities and organizations providing culturally specific services. Among survey respondents, 78% agreed or strongly agreed that COVID-19 has increased interest in addressing inequities in their organizations. Focus group participants echoed this sentiment.

Most respondents **Agree or Strongly Agree** that COVID-19 has increased interest in addressing inequities in their organization.



"This is an opportunity that the governor has embraced, it's been an eye opener in a lot of ways. As horrible as COVID is, it's been a boon for health equity, to really show people what health equity means and how social determinants really affect your health and how all of these areas that we've talked about for years now make a huge difference. And so the governor has started to put money where their mouth is, and actually expand the internet capacity within those areas that don't have it now. It's going to take years to actually make a real difference to build that infrastructure up, but it's happening."

"Another thing that's been laid bare, you'll hear this in the media all the time, too, is the focus on inequities in our data. Our program was already doing some really nice work on equity, but it's so much easier to get people to buy into it now. People are focusing on it. People understand it better. It's a priority in a way that we haven't seen in the past... it's a relief, we can actually do the good work that needs to be done."

When asked to offer examples of their equity-focused work during the focus groups, responses included hiring a health equity policy analyst, hiring a COVID-19 tribal liaison, conducting outreach specific to rural and lower-income communities, staff discussions about the characteristics of white supremacy, disseminating the work of subject matter experts on racial equity and social justice during townhall meetings, and creating culturally specific resources for patient navigation. One participant specifically mentioned Calricaraq, indigenous Yup'ik wellbeing, an indigenous method to address historical trauma, suicide prevention/ postvention, and domestic violence. Others described redistributing money and power to grassroots partner organizations.

"Next week, we're having a vaccine clinic sponsored by the NAACP, our local branch, and they have done all the communicating. We started out with the concern for vaccine hesitancy, and the reasons in that community. And they took the lead in this... it really comes down to who you want to hear the message. I could say it all day long, but coming from me [a white man], it is not going to be received as well as it is coming from them. And so we as a health department locally have had to really hand a lot of stuff over... and we're just in a support role. And even though we're the ones with the vaccines, it's been their baby. And that's worked real well."

While a variety of examples of equity-related work were offered during the focus groups, these examples were more challenging to elicit and were rarely connected to specific outcomes. Participants commonly requested technical assistance to draw connections between their work and equity issues. This highlighted a need for clear communication around what is meant by addressing inequities, as well as guidance around effective interventions and evaluation strategies.

"This whole tension around law enforcement, public health, racism, and policing... we need to examine that whole system. Where does a balance exist, to do the things we need to reduce violence and injury but to not have the racist outcomes that we've witnessed?"

"We're going through, essentially, a paradigm shift and how we are approaching what we do with health education, not only in injury, but in other areas... it's been going on for years, but it's so new still... we're all still exploring and moving forward... how do we change our way of thinking and move more upstream to that ultimate primary prevention, looking at things like homelessness and affordable housing and low pay and equality for women, all those things that we know impact domestic violence and impact rape and impact [adverse childhood experiences]. How do we start moving more towards that and communicating within our agency? Because as we start to pull out of COVID, this is our next big thing. So that weighs heavy for me."

"It's really hard to figure out what we should be doing... until the state action planning team really dug into the motor vehicle crashes work it was hard to see that we're supposed to change the programs, we're supposed to work together, we're supposed to work at this higher level. But what does that mean?... Putting together examples of, 'here's what your hiring policies look like,' or 'here's what a program that works with these three departments could look like.' I think that would be really important, whether we adopt those policies wholeheartedly or just see where we could go together."

"Social determinants of health and [adverse childhood experiences' are the long game. And if we direct all of our resources into the long game, then what happens about the short game, like what happens with the immediate needs? We need to be able to balance both of them, and there's not enough funding for either side, so balancing that is really hard."

"So much of the work that we do is funded, not all of it exclusively, but especially at the federal level, is really sort of pigeon-holed into an evidence-based strategy or an evidence-based approach. And not that that's a bad thing. But I don't think that we spend enough time talking about who's defining the evidence and what communities is that evidence based off of. There's what data is used, but also what data is missing? What are some of the limitations of that? Sometimes we miss community voice and the ability to really include community and decision making around our prevention strategies. Because that may not necessarily fit into the evidence base box, or quite frankly, a federal timeline for application of funding. We need to think about those things within an equity framework."

"Somebody had mentioned our indigenous people's trust, building the trust, and being able to do the training and do the work in those communities. I know I personally still struggle with some of that, particularly in this environment where you can't build that personal connection very easily."

KEY FINDING 6

IVP practitioners are eager for support to navigate COVID-19, prepare for future emergencies, and address root causes of unintended injury and violence.

Specifically, IVP practitioners requested that Safe States and other national partners provide solutions to address pressing challenges, better address equity, and policy changes to prepare for future emergencies.

For decades, IVP has been underfunded, creating a largely reactive system. The IVP workforce has been accustomed to shuffling scarce resources and putting out fires. Many technical assistance requests were reflective of this reality, requesting technical solutions to pressing challenges and to mitigate workforce burnout.

General technical assistance requests included:

- Guidance to manage teams and workloads, cross train staff, and triage worker reassignment during emergencies
- Support to access and use workplace technology
- Assistance to transition evidence-based programs to virtual and hybrid formats along with dissemination of successful adaptations
- Support application for COVID-specific grants by providing evidence that ties topic-specific programs and trainings such as traumatic brain injury and drowning to the pandemic
- Support for programs to interpret and contextualize surveillance data trends vis-a-vis COVID-19
- Easily digestible resources to assist managers to connect interpersonally and build resilience in their teams and support workers to engage in self-care
- Examples of trauma-informed organizational policies
- Live networking opportunities such as meetings and peer-to-peer learning opportunities so the workforce can stay connected and learn from colleagues in real time

While IVP professionals are well-aware that equity issues must be addressed, they are learning how to transform their work in service to a more just society. They sometimes struggle to communicate this in a manner that is understandable and compelling to external audiences.

Equity-related technical assistance requests included:

- Develop a policy and position statement on equity.
- Provide training and examples to assist programs to pivot from interventions designed to convey information to individuals to an approach focused on addressing the social determinants of health.
- Provide guidance about how to access and analyze data on the social determinants of health/inequities and communication tools to justify these efforts.
- Assist states to access statewide data, such as community needs assessment data, on perceptions of local needs (e.g. food, housing).
- Disseminate examples of evidence-based/promising programs tailored to/developed by specific communities (e.g., culturally specific/tribal, rural).

- Support programs to balance expectations to implement evidence-based programs with locally tailored interventions that may not be evidence-based.
- Support programs to retool efforts grounded in the dominant culture for non-dominant communities, including translation and cultural adaptation.
- Provide technical assistance to conduct social marketing campaigns that are culturally tailored.
- Provide guidance about how to build relationships with marginalized and historically oppressed communities.
- Provide guidance about how to funnel money/resources to community partners/culturally-specific organizations
- Provide guidance about how to recruit, interview, and successfully hire people of color, bilingual people, and people with lived experience, such as people in recovery. Support programs to hire diverse staff in the face of resistant unions/HR departments.

IVP is often perceived as a reactive system that responds to emergencies as they surface, which can cause resources/effort to be applied inconsistently and damage the credibility of IVP among the communities it is intended to serve. Focus group participants conveyed their awareness that policy changes are needed to fortify IVP to achieve its aims and prepare for future public health emergencies. Many encouraged Safe States and national IVP partners to advocate for increased and more flexible funding with less cumbersome grant reporting requirements.

Policy and advocacy recommendations included:

- Support all states to receive Core SIPP grants, make funds more flexible, and reduce/streamline reporting requirements.
- Partner with other public health partners to amplify communications to policymakers about the importance of IVP.
- Communicate to leaders and decision-makers about the importance of IVP and that IVP professionals cannot put their work aside in the face of an emergency.
- Advocate with leaders (e.g., Health Resources & Services Administration, Maternal Child Health) and legislators nationally to build a better-funded, integrated, more robust system by helping those groups to understand the connection between the social determinants of health and IVP.
- For COVID-specific grants, advocate for application brevity and flexible use of funds.

"Only 23 states or something like that actually get core funding. And it's literally the smallest grant I have, but it's the one that has the most work. It's the infrastructure for everything... it does seem odd that it's not offered to all the states, that it's not like the preventive block grant where all the states can get that. Core is limited, you're talking about less than half of the states and territories can get this, but at least for us it frames the structure for IVP."

RECOMMENDATIONS

Based on the key findings of the evaluation, the Safe States Alliance developed the following recommendations for national partners, health departments, and IVP programs to buoy IVP professionals as they continue to navigate the COVID-19 pandemic and ensure IVP is better-positioned to navigate future public health emergencies.

1 Develop an IVP standard definition of equity and actionable guidance to promote upstream, collaborative solutions to address systemic health inequities

Actions for National Partners (Safe States, CDC, and Policymakers)

- Collaborate multi-sector partners to develop an IVP standard definition of equity and actionable guidance to address inequities
- Integrate health and racial equity into all federally-funded programs that support IVP (e.g., Core State Violence Program, Rape Prevention and Education Program, National Violent Death Reporting System, Essentials for Childhood, Overdose Action, etc.)
- Develop and advocate for policies that provide funds or mandate reimbursement for efforts to address inequities
- Infuse health equity as a foundation for ongoing and planned activities across organizational portfolios
- Provide technical assistance on how to make equity a foundational component, including prioritizing lived experiences and community voices for planned activities across organizations

Actions for State/Local Health Departments and Community Partners (Hospital-based IVP and Community-based Organizations)

- Implement guidance as appropriate given local contextual conditions
- Share guidance across regional, state, and local stakeholders to maximize buy-in and coordination
- Infuse health equity as a foundation for ongoing and planned activities across organizational activities

2 Advocate for adequate and consistent IVP funding so every state, territory, and corresponding local and tribal entities can build a coordinated, stable, and sustainable infrastructure.

Actions for National Partners (Safe States, CDC, and Policymakers)

- Strategically and proactively advocate for adequate and consistent funding for IVP in every state and territory
- Deliver funding in manner that allows states and territories of different capacities to start, build upon, and enhance public health actions necessary to prevent injuries and violence in their unique contexts
- Develop a plan to dedicate financial and human resources to driving strategic communication focused on the role, potential impact, and value of IVP infrastructure in addressing ongoing and emerging public health threats.

Actions for State/Local Health Departments and Community Partners (Hospital-based IVP and Community-based Organizations)

- Educate policymakers and national stakeholders on the scope of IVP efforts, needs, and uses for expanded support
- Disseminate stories of success and challenges met throughout the spectrum of IVP service delivery to highlight critical need for ongoing and sustained expansion
- Coordinate with stakeholders across regional, state, and local jurisdictions to align efforts as they grow
- Develop policies and practices to ensure funding is distributed equitably and sustainably from state to local entities

3 Recruit and retain a robust and diverse IVP workforce that can sustain core functions while responding to public health emergencies

Actions for National Partners (Safe States, CDC, and Policymakers)

- Develop and advocate for policies that facilitate the maintenance of a well-resourced and diverse workforce

Actions for State/Local Health Departments and Community Partners (Hospital-based IVP and Community-based Organizations)

- Ensure staff roles and skills enable states and territories to lead and support community-based injury and viole
- Prioritize prevention, particularly at the community level, rather than trauma mitigation or clinical cost reduction
- Facilitate availability, access, and delivery of professional development for IVP workers
- Cultivate positive workplace culture that prioritizes worker safety and self-care
- Identify the causes of short- and long-term impacts of burnout and implement strategies to ameliorate them.

4 Support the IVP system to adapt to changing conditions in the workplace and the communities it serves.

Actions for National Partners (Safe States, CDC, and Policymakers)

- Develop mechanisms to rapidly facilitate uptake of effective adaptations in workplace environments and community programs.
- Fund evaluation of adaptations so states and territories can learn how to apply them efficiently and effectively
- Expeditiously deliver guidance and support to navigate public health emergencies

Actions for State/Local Health Departments and Community Partners (Hospital-based IVP and Community-based Organizations)

- Increase state and local/regional coordination across IVP programs to facilitate dissemination of locally developed adaptations.
- Support workers to function in, and transition seamlessly between, face-to-face and virtual formats.
- Ensure organizational policies give staff the tools, resources, and flexibility to succeed across changing conditions.
- Provide continuous professional development and resources to increase IVP staff capacity to understand the root causes of inequities and implement upstream solutions.

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APPENDIX 1: DETAILED METHODS

The mixed-method evaluation included a scan of resources, eight focus groups, and a national survey of Safe States members.

The scan included 36 websites, blog posts, webinars, and peer-reviewed and news articles describing IVP and how the pandemic has impacted program capacity, funding, and infrastructure.

Focus groups were administered to gain in-depth, rich information from injury and violence prevention professionals. Eight focus groups were held with a total of 52 participants from 27 states. The semi-structured, virtual discussions were conducted over Zoom with Safe States members recruited from state health departments (n=4 focus groups; n=27 participants), local (i.e., city and county) health departments (n=2 focus groups; n=10 participants), and hospital-based IVP programs (n=2 focus groups; n=15 participants). Local health department and hospital-based programs were a mix of rural and urban sites. The conversations focused on the core components/indicators/standards of IVP programs and equity, subsuming dialogue about COVID-19 impacts and technical assistance requests to Safe States within them. The conversations were audio recorded in Zoom and transcribed with Otter.ai. After each focus group, the facilitators completed reflective memos to document emerging themes, notable learnings, identify areas to probe more deeply in subsequent focus groups, and refine the protocol for increased clarity to support robust participant engagement. The transcripts were coded inductively with a coding scheme developed to capture impacts and adaptations related to each IVP core component, as well as text units associated with equity and technical assistance/training opportunities. The coders worked through several rounds of independently coding the transcripts and then reviewing codes together until 85% intercoder reliability was achieved. Then each transcript was coded electronically in Dedoose.

Synthesis of the data into themes was executed in an iterative manner through the following five-step process:

Step 1. Review memos and create an outline of draft key findings based on themes elevated through the memoing process.

Step 2. Identify codes relevant to each key theme.

Step 3. Extract all text units for the relevant codes for each theme from Dedoose into individual spreadsheets.

Step 4. For each theme, review the text unit spreadsheet, highlighting exemplary quotes with potential for inclusion in the report. Concurrently, craft a synthesis paragraph for the theme that builds from the memos, adding detail about noteworthy subthemes and takeaways drawn from the text units.

Step 5. Once this process is completed for all themes, review collectively and adjust as appropriate to tighten up key themes and synthesis paragraphs. Copy over exemplary quotes into a bulleted list beneath each key theme synthesis paragraph.

Table 1. Focus Group Participants by State

# = State Health Department	# = Local Health Department *R= Rural* *T= Tribal* *U= Urban*	# = Hospital-based IVP *R= Rural* *U= Urban*

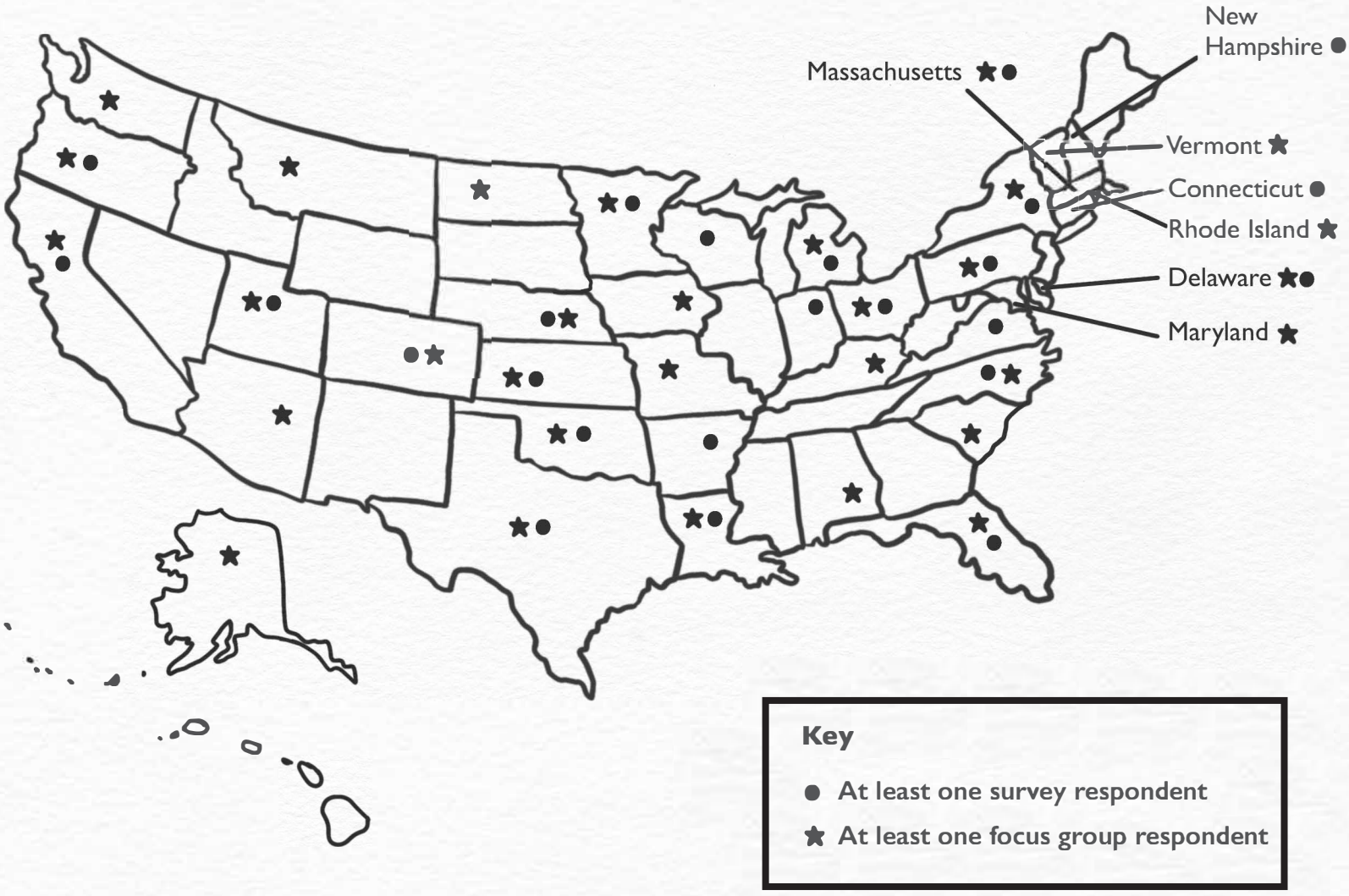
State	Program Type		
Alabama	1		
Alaska		1 *T*	
Arizona	1		1 *R*
Arkansas			
California	1		2 *R,U*
Colorado	1	1 *R*	2 *R,U*
Connecticut			
D. C.			
Delaware	1		1 *R*
Florida			1 *R*
Georgia			
Hawaii			
Idaho			
Illinois			
Indiana			
Iowa	1		
Kansas	1		
Kentucky	1		
Louisiana	1		
Maine			
Maryland		1 *R*	
Massachusetts	1		1 *U*
Michigan	1		1 *U*
Minnesota	1		
Mississippi			
Missouri	1		

State	Program Type		
Montana	1		
Nebraska	1		
Nevada			
New Hampshire			
New Jersey			
New Mexico			
New York	1		2 *R*
North Carolina	1		
North Dakota	1		
Ohio	1	2 *R,U*	
Oklahoma	1		
Oregon	1		
Pennsylvania	1	1 *U*	1 *R*
Rhode Island	1		
South Carolina	1		1 *R*
South Dakota			
Tennessee			
Texas	1	1 *U*	1 *U*
Utah		2 *R*	
Vermont	1		
Virginia			
Washington	1	1 *U*	1 *U*
West Virginia			
Wisconsin			
Wyoming			
Total	27	10	15

Table 2. Survey Response Rate

Respondent Group	Safe States Members Count	Number of Responses	Response Rate
State Health Departments *includes tribal entities/organizations	324	31	9.6%
Local Health Departments	62	11	17.7%
Hospital-based IVP	76	30	39.5%
Total	462	72	15.6%

Figure 1. States with at least one survey and/or focus group respondent



Limitations

The evaluation was subject to the following limitations:

- The Safe States Alliance membership is heavily comprised of IVP professionals who work at the state level. Far fewer members represent local health departments and hospital-based IVP programs. While state-level IVP workers were well-represented nationally among the focus group and survey samples, representation was far less nationally representative for local and hospital-based IVP professionals for both the focus groups and the survey. The survey respondents from local health departments and hospital-based programs from a small number of states were over-represented among respondents. Among local health department survey respondents, Pennsylvania (n=3) and Texas (n=3) comprised over half of respondents. Among hospital-based survey respondents, Pennsylvania (n=7) and Texas (n=11) are also over-represented, comprising nearly half of respondents.

- Despite a four-week multi-modal recruitment strategy, the overall response rate for the survey was low (15.6%). Given this, it is possible that the results are not representative of the total population of Safe States members. The survey data were strongly triangulated with the results of the scan and the focus groups, however.

- For one "select all that apply" item in the survey, response options were added mid-implementation, and so the response rate was lower for those options. These differences in sample size are reported for the bar chart for the item below and should be interpreted with caution:
  - Which components of your IVP programs have been negatively impacted (i.e., stopped, slowed, reduced/hampered) due to COVID-19 at all? (Response Options: Data and Leadership)

Table 3. Response Rate by Respondent Type and Data Collection Method

	Respondent Group by Data Source	Total Number of Respondents	Number of States Represented *duplicates across methods/ groups	Total Number of States Represented
Survey	State/Tribal health department	31	20 (includes 1 Tribal)	27
Survey	Local health department	11	7	
Survey	Hospital-based	30	11 (n=1 from Canada)	
Focus Groups	State health department	27	27	31
Focus Groups	Local department	10	8	
Focus Groups	Hospital-based	15	12	