Summary of Key Findings

IVP is grounded in the notion that injuries result from a predictable convergence of human factors with the surrounding environment. 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.

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. 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.

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.

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.

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.

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

4 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.