

INJURY & VIOLENCE PREVENTION A VIEW OF THE FIELD

**Results from the 2024 Injury & Violence
Prevention Program Infrastructure &
Workforce Development Survey**



ACKNOWLEDGEMENTS

Safe States would like to extend a special thank you to the injury and violence prevention (IVP) professionals and state-designated representatives across the United States for participating in the survey. The data and insights collected will help inform the development and growth of future IVP efforts.

Safe States' 2024 Injury & Violence Prevention Program Infrastructure and Workforce Development survey was developed and conducted in 2024 by Kristen Lindemer, MPH, Safe States Program Manager. The analysis of the survey data and original graphics were done by Zoe M. Miller, LCSW, MPH. The *Injury and Violence Prevention: A View From the Field* report was authored by Kristen Lindemer, MPH, Safe States Program Manager, with editorial support from Sharon Gilmartin, MPH, Safe States Executive Director, Catherine Guerrero, MPH, Safe States Deputy Director, and Eva Bland, MA, Safe States Associate Director of Workforce Development. The report was designed by Julie Alonso, Safe States Associate Director of Programs and Communication.

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The Safe States Alliance is a national non-profit 501(c)(3) organization dedicated to serving as the national voice in support of injury and violence prevention professionals engaged in building a safer, healthier America. Founded in 1993, the Safe States Alliance is the only national non-profit organization comprised of public health injury and violence prevention professionals representing all states and territories in the United States. Learn more at safestates.org.

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INTRODUCTION

The Safe States Alliance is a national organization and professional association whose mission is to strengthen the practice of injury and violence prevention (IVP). It is the only association that represents state, territorial, local, and tribal IVP programs from all 50 states, including directors of state health department IVP programs.

Injury and violence create significant challenges to well-being and quality of life in the U.S, and multiple factors can contribute to injuries and violence. Safe States provides resources for practitioners and partners looking to strengthen the practice of injury and violence prevention, including [*Mapping Out Injury and Violence Prevention*](#), an interactive tool that provides a deeper understanding of how IVP is practiced.

The driving force behind the work of Safe States Alliance is the goal of advancing the field of IVP by strategically strengthening its diverse workforce and the capacity of its programs. Fundamental to this goal is maintaining a current understanding of the IVP workforce – its composition, needs, challenges – and the organizational environment and programmatic infrastructure in which these individuals work. While support for IVP programs has grown over the past three decades, IVP programs still face limited capacity and resources across the [*Core Components of IVP Programs*](#).

Data collected through the ***Safe States 2024 Injury & Violence Prevention Program Infrastructure and Workforce Development Survey*** provide a point-in-time snapshot among Safe States members and partners of the IVP workforce, its programmatic infrastructure and organizational environment, and the perspectives of individual IVP professionals on key issues. Survey findings enable Safe States and its prevention partners to:

- better understand existing and future needs of the IVP workforce and IVP programs;
- educate stakeholders and policy makers about the status, strengths and needs of the IVP field, infrastructure, and workforce; and
- guide the content and format of IVP training, technical assistance, and other professional development opportunities.

To provide further insight, a separate set of data was collected from the State Designated Representatives, a Safe States member group of appointed representatives of state IVP programs across the country, most of which are located within a state health department. These data provide additional status and perspective on current infrastructure across state IVP programs, including staffing, funding levels and types of funding, and partner collaboration.

DEFINITIONS & CONCEPTS

For the purposes of this report, it is important to acknowledge and understand the meaning of “upstream concepts” and associated terms referenced throughout the report. A full set of terms and definitions can be found in [Appendix A: Terms & Definitions](#).

Upstream Concepts

In this report, the term “upstream concepts” refers to Social Drivers of Health (SDOH) and Shared Risk and Protective Factor (SRPF) approaches as defined below.

Social Drivers of Health

The social drivers (also referred to as determinants) of health can be defined as conditions and contexts in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions can be social, economic, or physical, and they include policies, systems, and environments. They also encompass common risk and protective factors to extend far beyond individual factors. Social drivers of health can be attributed to larger factors that influence individual choices, and not individual choices alone.

(Adapted from: [U.S. Department of Health and Human Services, HealthyPeople.gov; Centers for Disease Control and Prevention; Jones, 2016](#))

Shared Risk and Protective Factor Approaches

These approaches can be defined as efforts to improve multiple population health and quality-of-life outcomes by aligning a variety of multisector interventions that positively impact the social drivers of health. 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.



KEY FINDINGS & RECOMMENDATIONS



IVP WORKFORCE

Who We Are

Among the 393 respondents included in the survey analysis, individuals were predominately female and white, many had master's level degrees or higher, and a significant proportion have lived experience of injury and/or violence.

Recommendation

Continued efforts are needed to ensure a well-rounded IVP workforce that reflects the populations and communities that are most impacted by injury and violence.

Where We Work

Survey respondents conduct their IVP work in a variety of organizations and institutions – governmental, health, community, and academic – and serve people at state, local and tribal levels in both rural and urban/suburban areas.

Recommendation

IVP workforce development efforts should reflect and be relevant to the various settings in which IVP practitioners and researchers work.

What We Do

In their individual IVP jobs, respondents fulfill multiple functions beyond their primary role, address multiple areas of injury and violence, and consider cross-cutting factors related to upstream concepts, such as housing, adverse childhood experiences, smart growth/community design, and mental health. This work is done in multi-sector collaboration with partners from various professions and disciplines.

Recommendations

- Given that IVP staff are often stretched thinly across multiple roles, increased program capacity and use of cross-cutting approaches across IVP mechanisms and organizational silos could benefit IVP programs and the IVP workforce as a whole.
- IVP program supervisors, managers, and directors need opportunities to develop strong program and people management skills – for the managers to be effective, and to aid in staff retention.
- Given the multifaceted nature of IVP jobs, many in the IVP workforce need opportunities for developing skills to partner across multiple sectors, professions and disciplines, and to address root causes of IVP, including upstream concepts.

Growing & Retaining The IVP Workforce

About 45% of respondents were students and early career professionals (0-5 years), 40% mid-to-late career (6-20 years), and 14% end of career or near retirement (21+ years). Most had little to no knowledge about IVP before their first IVP job, and only 5% learned about IVP through an academic course.

Among all respondents, about 70% plan to stay for the foreseeable future, 16% plan to retire at some point in the next 10 years, and about 10% plan to leave in the next year (but not retire) – mostly due to a lack of career opportunities in their current job, wanting higher pay or better benefits, or experiencing burnout.

Over 60% reported having feelings of burnout within the past year, due in part to an increased workload. Three quarters (75%) of all respondents prefer a hybrid work environment, and 60% consider the option to work remotely a very important factor in future job choices.

Recommendations

- Continued partnership with academic institutions is needed to help grow the pipeline of IVP professionals, ensure expanded opportunities to learn about IVP in undergraduate and graduate programs, and connect students with practicum, internship and other practice-based experiences.
- Safe States and its partners should consider the unique needs of IVP professionals new to the field (e.g., onboarding, orientation to IVP and its core competencies, coaching/mentoring, skills development) and those who are established but in need of mid-career and management training and tools.
- To support and grow the IVP workforce, resources and tools are needed to (1) help managers and staff alike to navigate staffing changes and succession planning, and (2) respond to work environment concerns, such as the desire for hybrid/remote work options and the challenge of burnout.

Providing Relevant IVP Training & Technical Assistance

Most respondents indicated they are primarily motivated by a personal desire to learn (88%) – more than organizational or CEU requirements. They prefer virtual and on-demand formats, and want further training in topics such as violence prevention, upstream concepts, and cross-cutting public health skills. Much of the IVP workforce enters the field without support, as only half (53%) of respondents received a formal IVP orientation or a more comprehensive onboarding process. Only 15% of respondents reported they participate in a mentoring/coaching program via their organization or Safe States.

Respondent data reflects the need for ongoing training or technical assistance to enable the IVP workforce to develop and apply the essential knowledge and skills that are widely considered necessary to work in the field of IVP specifically, and public health more broadly, and to ensure conditions for optimal health for all people using the best available evidence.

Notable findings include:

- Slightly less than half of respondents indicated they could *apply* skills in the areas of evaluating programs, managing programs, or stimulating change.
- Among the **strategic public health skills**, only about a third (27-30%) reported they can *apply* skills in policy engagement, resource management, and change management, and less than half (39-48%) indicated they can *apply* skills in data analytics, persuasive communication, or systems thinking.
- Among **upstream concepts** on an individual level, about half of the respondents indicated they have knowledge of or can *apply* skills in the areas of social drivers of health (58%) and shared risk and protective factor approaches (48%), but fewer (44% and 35%, respectively) indicated they feel confident or very confident *applying* these knowledge or skills.

Recommendations

- Marketing of IVP professional development opportunities should reflect a personal desire to learn among the IVP workforce – more than organizational or CEU requirements – and include virtual and on-demand formats.
- To enhance IVP capacity, meet the needs and interests of the IVP workforce, and increase public health capacity to respond to ongoing and future public health emergencies, Safes States and other technical assistance providers should develop training, professional development, and peer-based support opportunities that:
 - Are offered in virtual and on-demand formats
 - Span the career continuum – from orientation and onboarding to mid-career leadership development and succession planning due to job change or retirement. This includes virtual opportunities to better prepare the IVP workforce as it enters the field and its various workplace settings, as well as a suite of orientation and onboarding tools and resources for IVP program managers who conduct these important processes.
 - Expand opportunities for coaching and mentoring.
 - Develop individual-level knowledge and skills *and the ability and confidence to apply these skills* in the Core Competencies for IVP, strategic and cross-cutting public health skills, and upstream concepts.

Advocacy & Policy

Policy and advocacy skills are essential for raising the visibility of IVP programs, communicating their impact, and building capacity for these programs and the IVP field. Less than half of respondents indicated they could apply the advocacy and policy-related skills of coordinating with stakeholders (40%), disseminating stories of success and challenges met (35%), or educating policymakers and stakeholders (27%).

Recommendation

- Provide tools and resources to help IVP practitioners understand how to educate and work with policymakers, and how to apply these skills at local, state, or national levels.

KEY FINDINGS & RECOMMENDATIONS



STATE IVP PROGRAM INFRASTRUCTURE

Overview

Effective prevention requires comprehensive and coordinated approaches based on the best available evidence to support programmatic, policy, communication, and evaluation activities at state, local, and community levels. State IVP programs, most often located in state health departments, typically serve as the central leaders for these coordinated approaches, so building their capacity to implement IVP interventions based on the best available evidence is foundational to successful IVP. Given the disproportionate burden of IVP compared to available national and state funding for state IVP programs – and the lack of consistent funding – it is particularly important to understand funding status.

Towards these goals, Safe States is home to the [State Designated Representative \(SDR\) Special Interest Group \(SIG\)](#), a member group of appointed representatives of state IVP programs who are currently active in 43 states. An additional set of survey questions was disseminated to these state IVP program leaders to capture essential state IVP program information and insight unique to the SDRs. Because each state IVP program looks different, SDRs provide critical information needed for a full picture of what IVP looks like across the U.S. Survey data reflect information about staffing levels and roles, succession planning, program priorities, IVP program funding, and key infrastructure challenges.

Organizational Home

Half (50%) of the 30 state IVP program leaders indicated their state IVP programs are centrally located within their respective state health departments, meaning there is a designated IVP program that is primarily responsible for conducting IVP activities for the state. A similar proportion (43%) of the 30 leaders indicated that IVP activities in their states are decentralized within the state health department, meaning IVP activities are conducted by multiple organizational units across the state health department. While some state IVP programs may be their own organizational unit (e.g., IVP section), many of the 30 centralized and decentralized state IVP programs are located in units such as community health, chronic disease, maternal and child health, or other departments.

Staffing & Roles

Staffing levels among the 30 state IVP prevention programs vary. About a third (30%) have only 1-5 full time employees, while overall, half (50%) have 1-10 full-time employees, and over a third (37%) of programs have 1-4 part-time employees. About 73% of state IVP program leaders indicated that their staff *somewhat* reflects the populations whom they serve. State IVP program staff typically fulfill multiple functions within their individual roles or positions.

Years in the IVP Field, Intent to Stay or Leave & Succession Planning

Half (50%) of state IVP leaders are mid-career professionals, meaning they have worked in the IVP field for 6-15 years. While over half (57%) of state IVP program leaders plan to stay in the IVP field for the foreseeable future, 43% plan to retire at some point in the next 10 years.

Almost half of the state IVP program leaders (47%) view their program and/or their organization (mostly state health departments) to be “moderately prepared” to conduct succession planning for leadership and staff, meaning the topic was discussed and some steps were taken. Only 30% selected “slightly prepared” meaning the topic was sometimes discussed, but no action had been taken.

State IVP Programs - Needs & Challenges

Input from state IVP program leaders on infrastructure challenges, resources needed, and threats to and opportunities for the IVP field mostly centered on three key areas – **funding** (need for sustained, reliable program funding), **workforce** (staffing/hiring challenges, yet also opportunities to expand workforce) and **policy/advocacy** (challenges seeing IVP as a leading public health issue, yet opportunities to mainstream IVP issues and leverage cross-discipline partnerships).

State IVP programs implement and receive federal funding for *a variety of essential programs and activities* – from core program functions to suicide prevention and opioid and other drug overdose surveillance systems. Funding for IVP programs is often disproportionate given the burden of injury and violence.

Recommendations

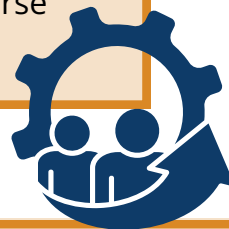
- Support and expand capacity of state IVP programs to play an essential coordinating role across IVP topics areas, settings and disciplines. State IVP programs can serve as central leaders to convene prevention partners and coordinate IVP approaches. Foundational to successful IVP is building the capacity of state IVP programs – and that of their local, territorial, tribal, and regional affiliates and partners – to implement interventions based on the best available evidence.
- Resources and tools are needed to help IVP programs and their managers prepare for the future retirements of IVP program leaders and conduct succession planning to minimize programmatic loss of institutional knowledge.
- Enhance and communicate understanding of how IVP intersects with other areas of public health and upstream concepts. Demonstrating how IVP topics intersect with other public health priorities and upstream concepts – including through shared risk and protective factor approaches – can help IVP programs play a more prominent role in strategic prevention planning and implementation.
- Support and advocacy for reliable, sustained funding for state IVP programs remains a priority need; federal funding has been essential to maintaining and building additional state IVP program capacity thus far.



ROLE OF SAFE STATES

As a membership organization comprising over 800 public health injury and violence prevention (IVP) professionals representing all US states and territories, the Safe States Alliance (Safe States) has over 35 years of experience in strengthening the practice of IVP and building IVP capacity in state and local health departments, hospitals and healthcare organizations, community-based groups, and other settings. Safe States promotes comprehensive, coordinated approaches to IVP that are grounded in evidence to support programmatic, policy, communication, training/technical assistance, and evaluation activities at state, local, tribal, regional, and community levels.

The driving force behind the work of Safe States Alliance is the goal of advancing the field of injury and violence prevention (IVP) by strategically strengthening its diverse workforce and the capacity of its programs.



Safe States regularly gathers this essential information through its strong membership and stakeholder communications, and input from its broad, inclusive national and regional partner networks. The association also conducts periodic, timely assessments – including comprehensive surveys of the IVP workforce. The collective insight gained from its members, partners and assessments enables Safe States to provide informed and relevant opportunities for training, technical assistance, leadership development, advocacy and overall capacity building at individual, programmatic and organizational levels.

Fundamental to this goal is maintaining a current understanding the IVP workforce – its composition, needs, challenges – and the organizational environment and programmatic infrastructure in which these individuals work.

BACKGROUND



SURVEY PURPOSE

Data collected through the **Safe States 2024 Injury & Violence Prevention Program Infrastructure and Workforce Development survey** provides a point-in-time snapshot among Safe States members and partners of the IVP workforce and its programmatic infrastructure and organizational environment.

Workforce survey data can help to:

- Understand the demographic characteristics of the IVP workforce
- Identify IVP workforce strengths and opportunities for improvement
- Identify IVP workforce development interests and needs
- Inform recommendations for IVP program succession planning and retention efforts
- Inform strategic plans for IVP workforce development

Infrastructure survey data can help to:

- Identify IVP program infrastructure strengths and opportunities for improvement
- Describe IVP program infrastructure needs
- Inform recommendations for strengthening IVP program infrastructure

The survey also provides an opportunity to collect data that builds on other Safe States scans and assessments. See [Appendix B: Overview of Safe States' Surveys, Assessments, Scans & Reports](#) for more information.

SURVEY METHODS

The survey was implemented during a six-week period in 2024. Over 3,000 Safe States members and partners were sent an email with a brief overview of the survey and its purpose, plus a shareable survey link. Survey recipients reflected various disciplines, roles, work settings, training, and experience. Respondents who are one of Safe States' current 43 State Designated Representatives were asked an additional, separate set of questions focusing on state IVP program capacity. The State Designated Representatives are Safe States members who are leaders of IVP in their states. See [Appendix C: Survey Methods & Analysis](#) for more information.

SURVEY RESPONSE

A total of 393 respondents were included in the full survey analysis. In addition, 30 of the current 43 State Designated Representatives completed the additional set of questions about state IVP program capacity. Results of these questions were analyzed separately and are presented in the [State IVP Program Infrastructure section](#) of this report.



IVP WORKFORCE: SURVEY RESULTS SECTION

The IVP professionals who completed the survey reflect various disciplines, roles, work settings, training, and years of experience. Survey results about the IVP workforce are organized around the 10 topics listed below.

- **Who We Are**
- **Where We Work**
- **What We Do**
- **Years in IVP & Paths to the Field**
- **Work Environment**
- **Threats & Opportunities**
- **Training & Professional Development**
- **IVP Core Competencies and Public Health Strategic & Cross-Cutting Skills**
- **Upstream Concepts**
- **Advocacy & Policy**



SURVEY RESULTS

IVP WORKFORCE

SURVEY RESULTS: IVP WORKFORCE



WHO WE ARE

Among survey respondents, individuals were predominately female and white, many had master's level degrees or higher, and a significant proportion have lived experience of injury and/or violence.



KEY FINDINGS

Total Respondents

393 respondents reflecting all 50 US states were included in the survey analysis.

Race & Gender

Respondents were **mostly female (82%) and white/Caucasian (76%)**, with 10% Black and 8% Hispanic/Latino.

Education

Respondents have **diverse educational backgrounds**. Almost half (46%) of the degrees reported by respondents were master's level or higher; 10% (n=40) of all respondents were currently enrolled in an academic program.

Lived Experience

Many respondents (41%) identified as **individuals with lived experiences of injury and/or violence**.



WHY IT MATTERS

Similarities to National Public Health Workforce

The high percentage of female survey respondents (82%) is similar to the composition of the Safe States membership (about 80% female) and respondents to the [2021 PH WINS Survey](#) (79% female).

Challenge to Better Reflect Populations Served

Survey respondents were 76% white/Caucasian, compared to Safe States members (70% white/Caucasian among those who shared this information in membership data) and 2021 PH WINS Survey respondents (54% white). A well-rounded IVP workforce can reflect the populations and communities that are most impacted by injury and violence.

Insight from Lived Experience

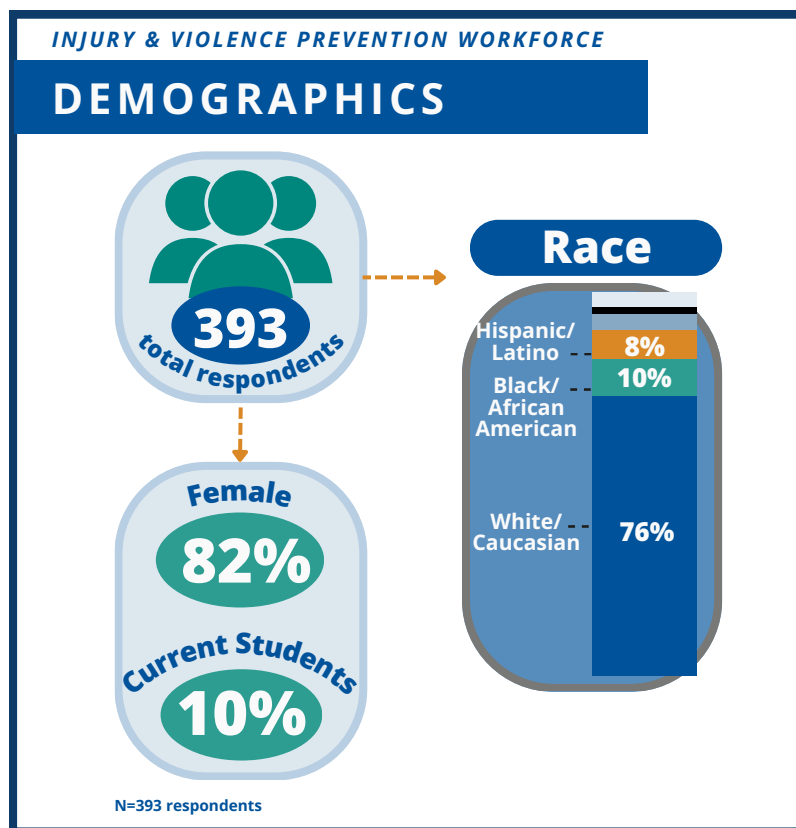
An IVP workforce with lived experiences of injury and/or violence brings unique and valuable insight to IVP prevention and policy efforts.

TOTAL RESPONDENTS

A total of 393 respondents, representing all 50 U.S. states, were included in the survey analysis. While 414 individuals started the survey, 21 respondents were excluded from analyses because they only filled out the first question.

RESPONDENT DEMOGRAPHICS

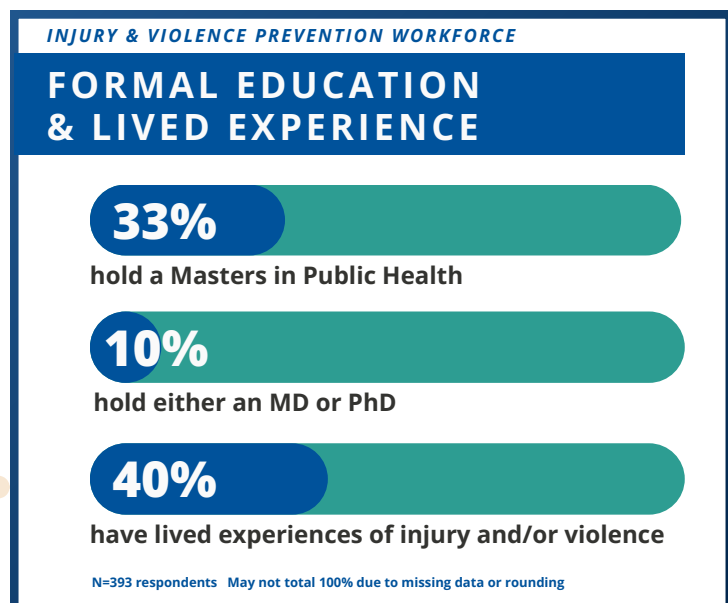
Key demographic characteristics show that the 393 survey respondents were from all 50 states, and most self-identified as female (82%) and white/Caucasian (76%). Others identified as Black/African American (10%), Hispanic/Latino (8%), Asian (4%), American Indian/Alaskan Native or Native Hawaiian/Other Pacific Islander (2%), and other (2%). Almost half (49%) of reported degrees were master's level or higher, and 10% of all respondents indicated that they were currently enrolled in an academic program. Many (41%) identified as persons with lived experiences of injury and/or violence. Lived experience is considered knowledge based on someone's perspective, personal identities, or history, beyond their professional or educational experience.



EDUCATION & CERTIFICATIONS

Education

Of the 667 degrees reported (from high school to a type of PhD), 310 (46%) of the degrees were master's degrees or higher. Due to limitations in how this question was asked (select all that apply, so a respondent could select multiple master's degrees, or a bachelor's, master's and PhD, for example), presenting percentages of all the answer choice questions is not helpful. However, the data show that respondents as IVP professionals have various educational backgrounds.



Certifications

Most respondents (44%) reported they did not have a professional certification. Among those that do, the most common types were Registered Nurse (17%), Child Passenger Safety Technician (13%), and other (21%). Respondents could select all that apply.

SURVEY RESULTS: IVP WORKFORCE



WHERE WE WORK

The IVP workforce conducts its work in various types of organizations and institutions – governmental, health, community, and academic – and serves people at state, local, and tribal levels in both rural and urban/suburban areas.



KEY FINDINGS

Organization Type

Among all respondents, **nearly half (44%) work in the government sector** (includes federal, state, local, and tribal agencies/organizations), **one fourth (25%) work in the healthcare sector**, and **13% work in an academic institution**.

Geographic & Population Focus

Almost half (49%) of respondents **work at the state level** (25% at the county level), and 60% work with **both rural and urban/suburban areas**.



WHY IT MATTERS

Reach & Breadth

Because IVP professionals are integrated into – and an integral part of – a variety of organizations and institutions at national, state, tribal, and local levels, they can reach numerous and various populations with IVP prevention from multiple perspectives and points of service in rural, urban and suburban areas.

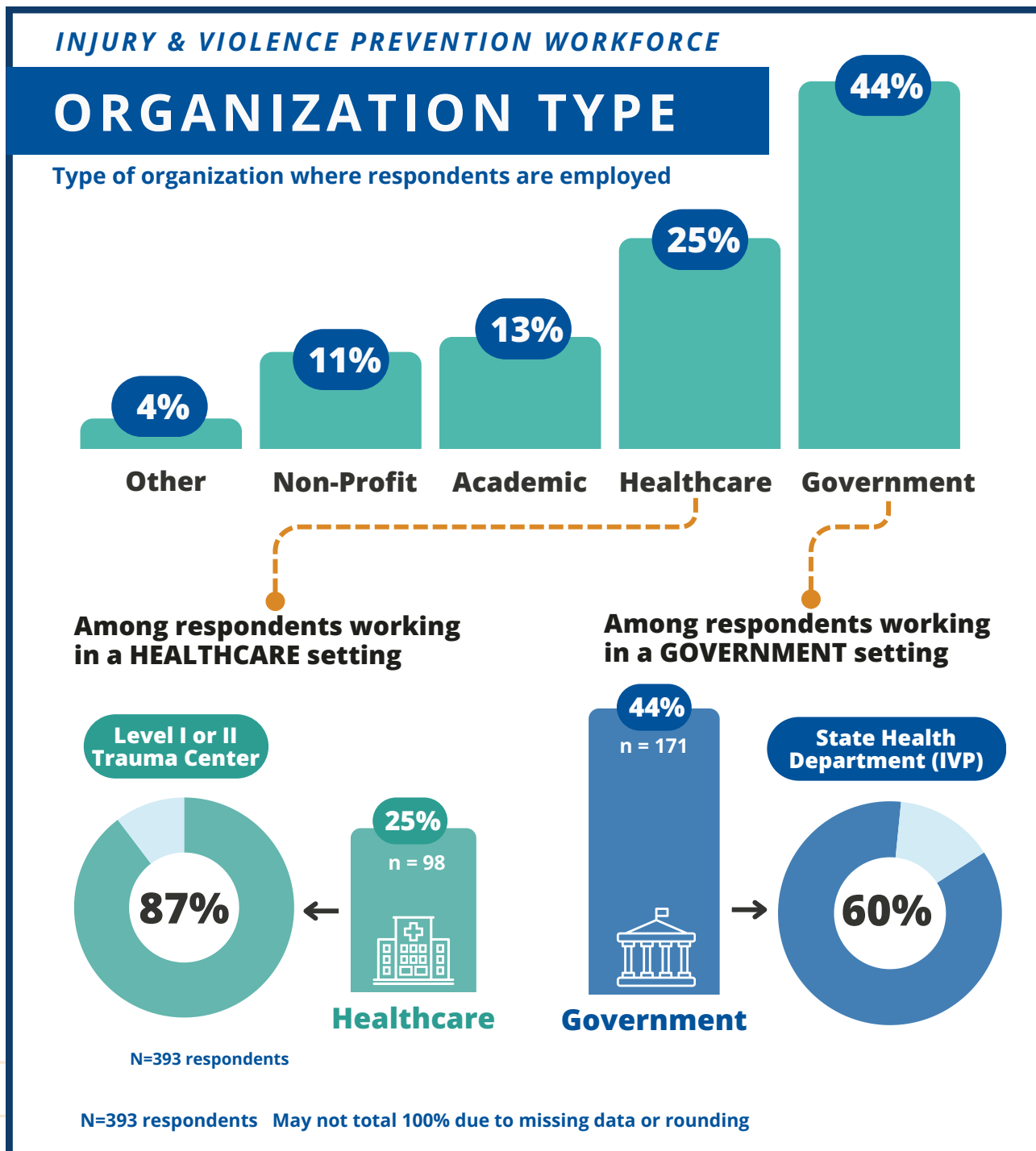
A Ready Workforce Network

The IVP workforce is positioned in public and private agencies, organizations and institutions across the US – a valuable workforce network in times of public health emergencies, disasters and other challenges.

ORGANIZATION TYPE

Nearly half (44%) of respondents work in the government sector, which includes federal, state, local, and tribal agencies/organizations. One-fourth (25%) work in the healthcare sector, 13% work at an academic institution, 11% work at a non-profit agency or community-based organization, and 4% work in other sectors, including direct practice settings and the military.

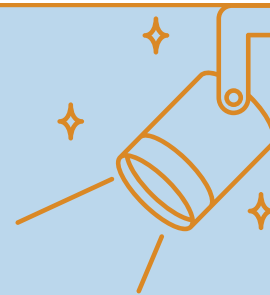
These organizational type percentages are relatively similar to current Safe States membership, comprising about 62% government sector [state health departments (52%), local health departments (8%), federal agencies (1%), tribal health IVP programs (1%)], 18% healthcare sector (hospitals/ healthcare organizations), 10% academic institution (schools/universities), and 10% private/nonprofit.



SPOTLIGHT

State Health Departments & Trauma Centers

As shown in the previous infographic, among government agencies, IVP programs are most frequently located within state health departments, which provide a strong nationwide foundation for IVP prevention efforts. IVP programs have also grown within the healthcare sector, primarily among Level I and II Trauma Centers.



State Health Department IVP Programs

Of the 44% (n=171) of respondents who work in the government sector, 60% (n = 104) are employed at a State Health Department specifically focused on IVP.

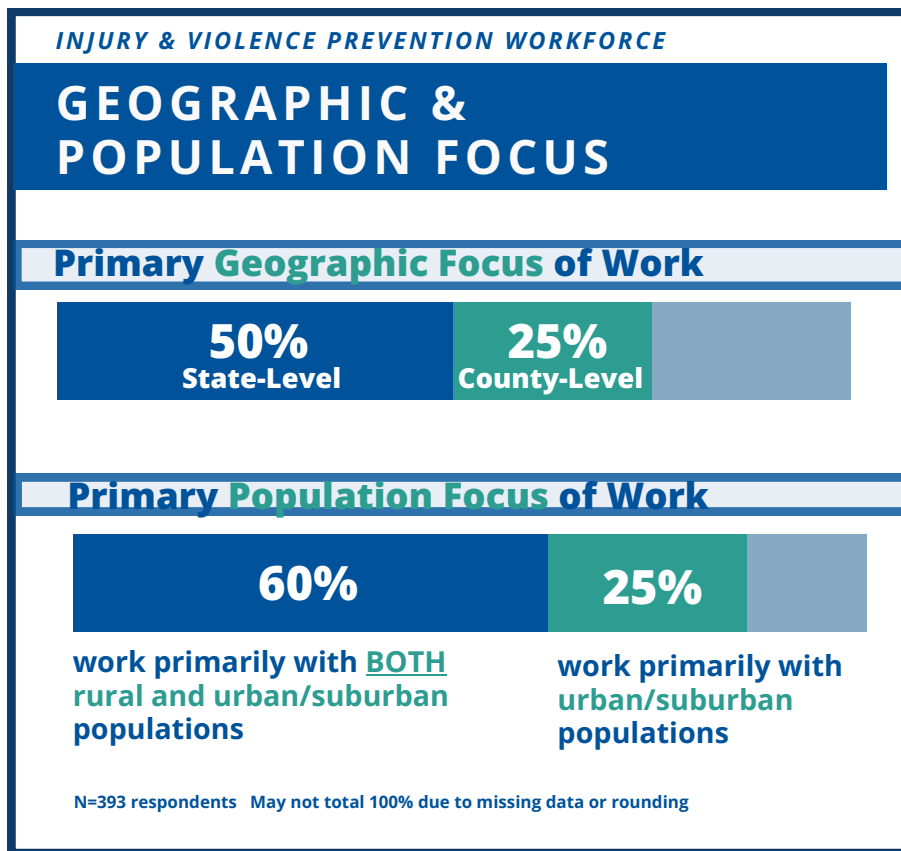
Trauma Centers

Of the 25% (n=98) of respondents who work in the healthcare sector, 87% (n = 85) are employed at a Level I or II Trauma Center.

GEOGRAPHIC & POPULATION FOCUS

Almost half of respondents (49%) reported that the state level is the primary geographic focus of their work; about a quarter report that their primary geographic focus is at the county level. This focus for the remaining respondents includes the city level (12%), national level (10%), and tribal level (2%). Tribal level includes Tribal Nation, Alaska Native, Sovereign Native, American Indian, Native Hawaiian, Other Pacific Islander.

Over half (60%) of respondents work primarily with both rural and urban and/or suburban areas; a quarter work primarily with urban and/or suburban areas.



SURVEY RESULTS: IVP WORKFORCE

WHAT WE DO



In their individual IVP jobs, respondents fulfill multiple functions and address multiple areas of injury and violence, plus cross-cutting factors related to upstream concepts such as housing, adverse childhood experiences, smart growth/community design, and mental health. This work is done in multi-sector collaboration with partners from numerous professions and disciplines.



KEY FINDINGS

Primary Role & Other Functions

Half (50%) of all respondents have **program implementation and management** as their primary role (>50% of their time). Most respondents have **multiple additional functions** – on average, they are **expected to fulfill about 7 functions**.

Supervisory Role

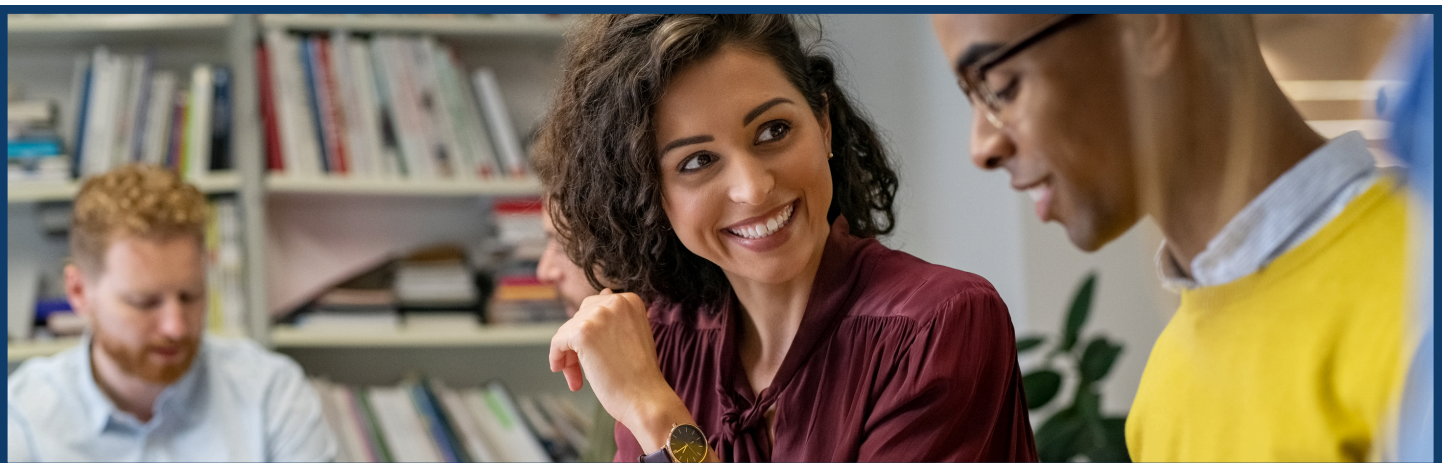
Over a third (40%) of respondents are either a **supervisor, manager and/or director/executive**; about a quarter (27%) are in a non-supervisory role.

Areas of Focus

In addition to an **overall focus on unintentional injury (78%) and violence (74%), about 50% conduct work related to upstream concepts** (e.g., housing, social drivers of health, shared risk and protective factor approaches, adverse childhood experiences, and smart growth/community design).

Partnerships

The **top five partners** cited most frequently were health care organizations/ hospitals/trauma centers and state health departments, followed by academic institutions/researchers, local health departments, and law enforcement/ criminal justice.





WHY IT MATTERS

Juggling Multiple Roles – But Often Stretched

State IVP programs often have limited capacity and resources across the [Core Components of a Model IVP Program](#). Many IVP jobs inherently require multiple roles, functions, and skills, while other multi-faceted roles are born out of necessity due to inadequate program funding and staffing. [The IVP workforce needs core IVP and cross-cutting public health skills](#) to meet the demands of hybrid, “multi-hat” roles across multiple injury and violence areas. However, IVP programs and the IVP workforce as a whole could perform better with staff who are not stretched so thinly across multiple roles. See also the [Training & Professional Development section](#) in this report.

Need for Program & People Management Skills

With many in the IVP workforce serving in supervisor, manager, and/or director/executive roles, there is a need for opportunities to develop strong program and people management skills – for the managers to be effective and to aid in staff retention.

Need for Upstream Knowledge & Skills

Likewise, the IVP workforce needs knowledge and skills that infuse upstream concepts such as housing, social drivers of health, shared risk and protective factor approaches, adverse childhood experiences, and smart growth/community design into their work.

Multi-sector Partnerships are Essential to Effective Prevention

A strength of the IVP workforce is its ability to partner across multiple sectors, professions and disciplines – a skill essential to effective IVP prevention and policy.

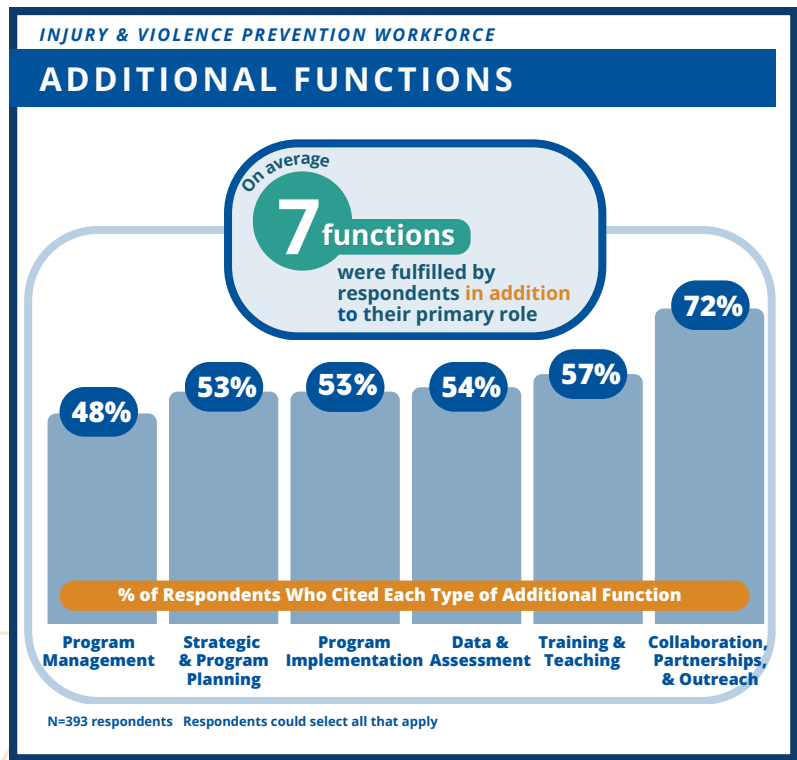
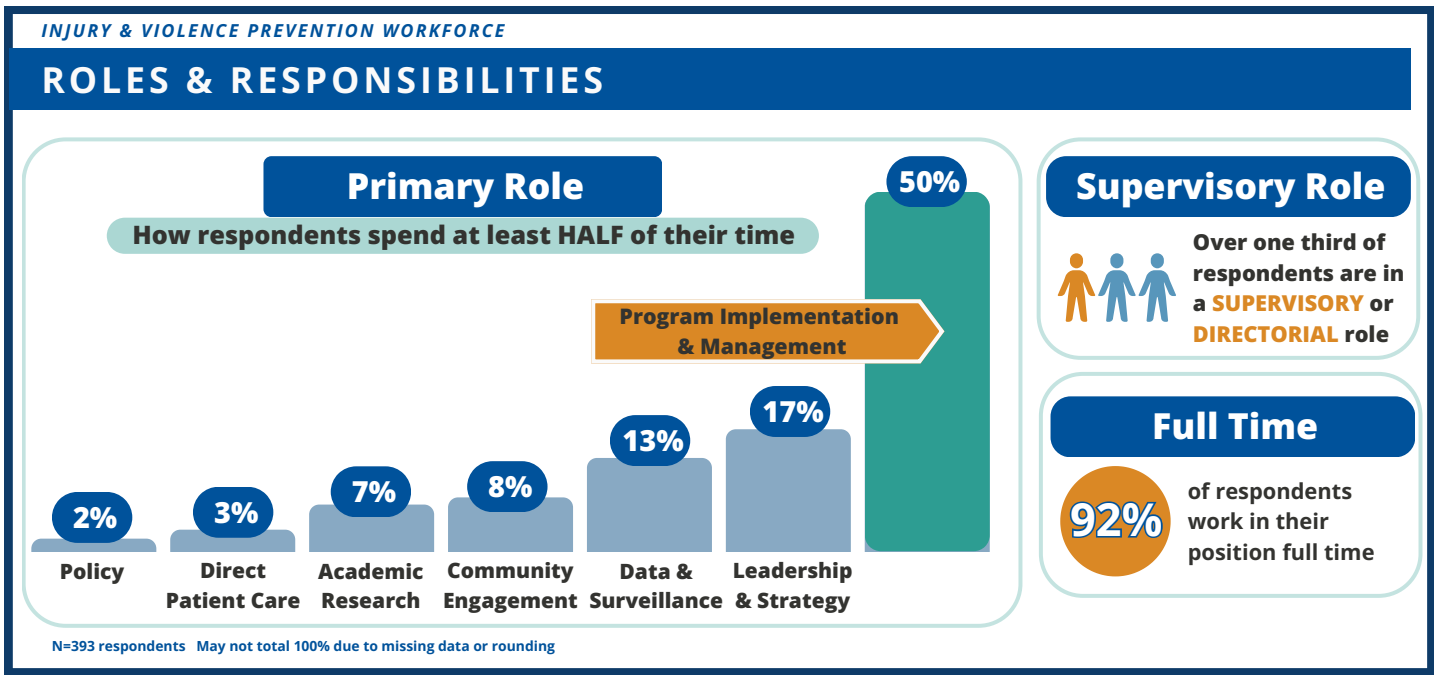


PRIMARY ROLE

Half of all respondents indicated that program implementation and management was their primary role within their organization. The primary role was defined as how respondents spend at least 50% of their time.

SUPERVISORY ROLE & FULL-TIME STATUS

About a quarter (27%) of respondents are in a non-supervisory role, while over a third (38%) are either a supervisor and/or manager or directors/executive (33% of respondents did not answer this question). The overwhelming majority (92%) of respondents work in their position full time.



OTHER FUNCTIONS

In addition to their primary role described above, respondents reported that within their organization, they are **expected to fulfill on average an additional 7 functions** among the categories below. (Respondents could select all that apply, so percentages do not add up to 100%.)

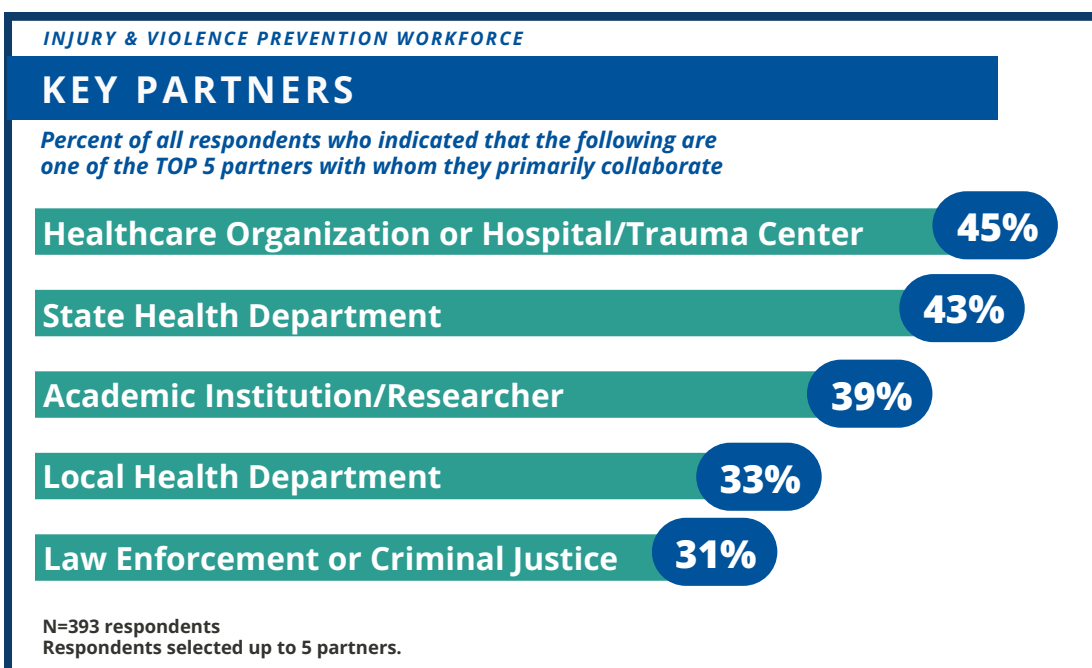
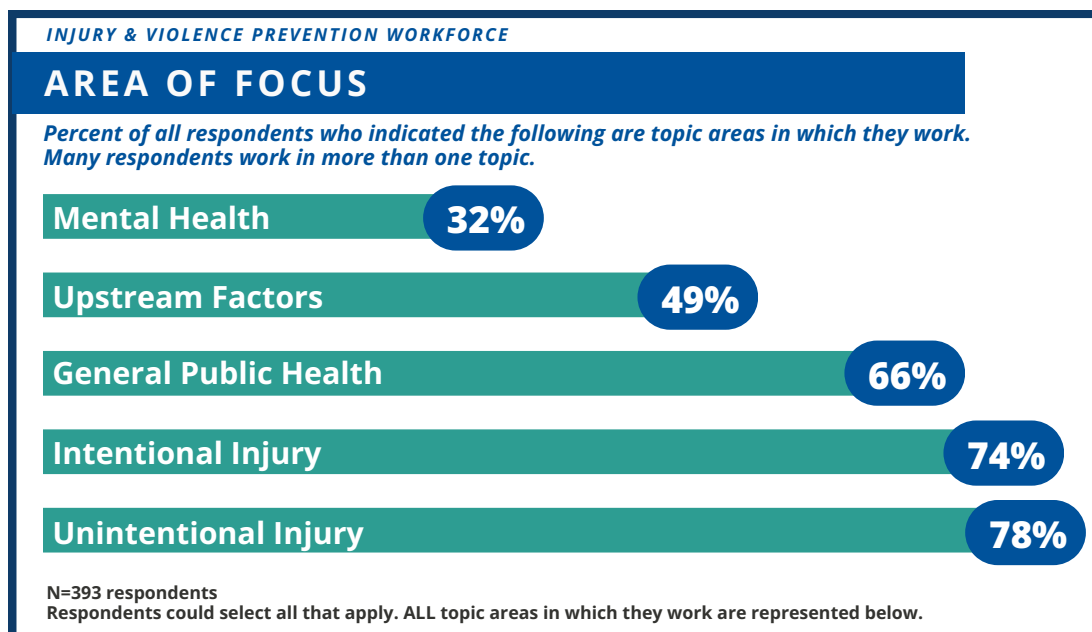
AREA OF PREVENTION FOCUS

Respondents were asked to indicate ALL the topic areas in which their work is focused. Many respondents indicated that injury (78%), violence (74%), and topics related to general public health (66%) are part of their work. These topic areas include general IVP, public health preparedness and response, climate change, and COVID-19.

Almost half (49%) of respondents have work related to upstream concepts, such as housing, social drivers of health, shared risk and protective factor approaches, adverse childhood experiences, and smart growth/community design. Nearly one third (32%) of respondents conduct work related to mental health.

PARTNERSHIPS

Respondents were asked to select the Top 5 partners with whom they primarily collaborate. Health care organization or hospital/trauma center and state health departments were selected most frequently, followed by academic institutions/researchers, local health departments, and law enforcement/criminal justice.



SURVEY RESULTS: IVP WORKFORCE



YEARS IN IVP & PATHS TO THE FIELD

Nearly equal proportions of survey respondents were early career (0-5 years + students) or mid-to-late career (6-20 years) professionals. Only a small percentage learned about IVP through an academic course – most found the IVP field after being hired for an IVP job or discovering it while working elsewhere in public health.



KEY FINDINGS

Years in the IVP Field

About **45% were students and early career professionals** (0-5 years), **40% mid-to-late career** (6-20 years), and **14% end of career/near retirement** (21+ years).

Paths to the IVP Field

The most common paths leading to a first job in IVP were by (1) seeking, applying for or **getting a job in IVP despite knowing very little about IVP prior to starting**, and (2) **discovering IVP while working in another area of public health**. Only 5% learned about IVP through an academic course.



WHY IT MATTERS

Meeting the Needs of New & Established IVP Professionals

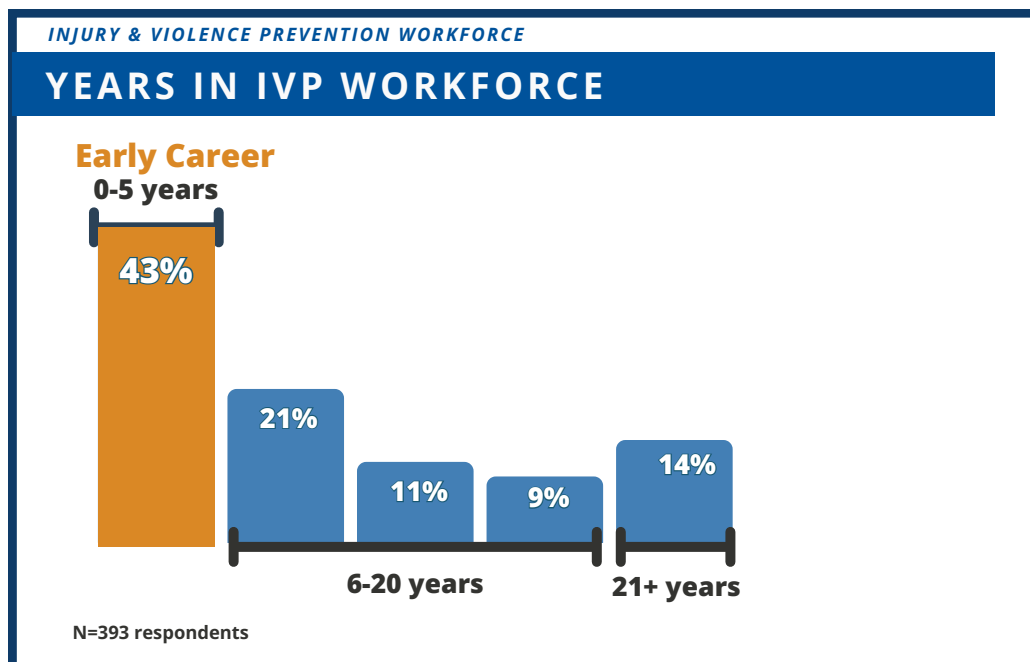
Safe States and its partners must meet the unique needs of IVP professionals new to field (e.g., onboarding, orientation to IVP and its core competencies, coaching/mentoring, and IVP-specific and public health cross-cutting skills development) and those who are established but in need of mid-career and management training and tools.

Growing the IVP Workforce Pipeline

Continued partnership with academic institutions is needed to help grow the pipeline of IVP professionals and ensure expanded opportunities to learn about IVP in undergraduate and graduate programs. Understanding how early career professionals are landing in the IVP field can help grow the workforce.

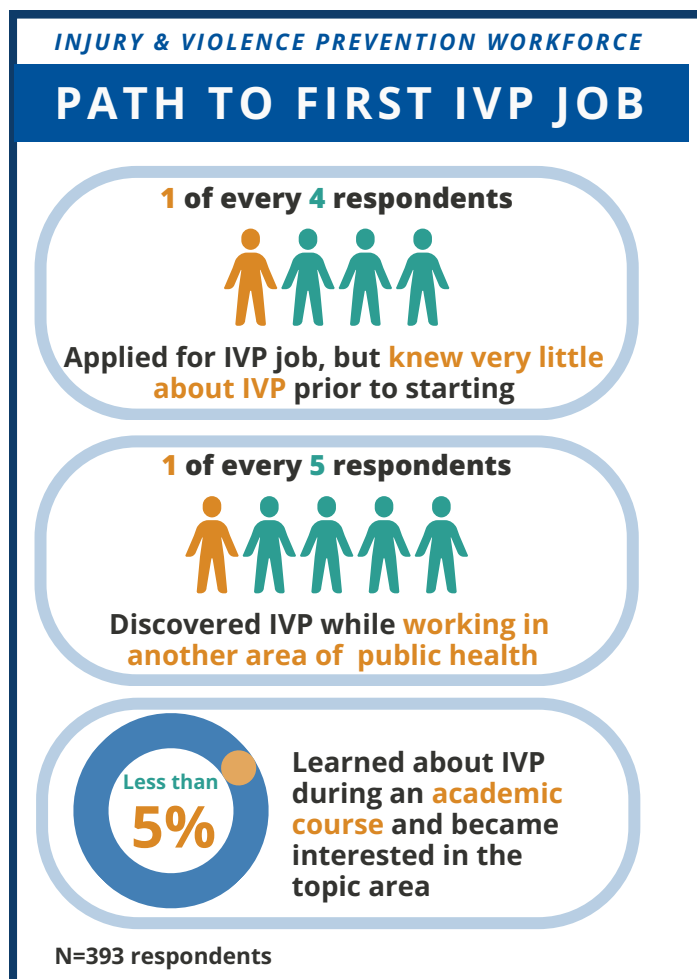
YEARS IN IVP FIELD

Most respondents (43%) were early career professionals, meaning they were current students or in the first five years of their career. A nearly equal proportion (41%) has been in the workforce for 6-20 years, while only 14% have done so for over 20 years.



PATHS TO FIRST IVP JOB

Among all respondents – and also among students/early career professionals only – the most common paths leading to their first job in IVP were by (1) seeking, applying for or getting a job in IVP despite knowing very little about IVP prior to starting (25%), and (2) discovering IPV while working in another area of public health (22%). Notably, only 5% (n=18) of respondents said they learned about IVP during an academic course and were interested in the topic area.



SPOTLIGHT

Early Career Professionals

Growing the Field of IVP

Recruiting and retaining early career professionals is integral to the future of the IVP field. Understanding how early career professionals are landing in the field of IVP may prove useful in efforts to grow the workforce.



Path to IVP

Among the 43% (n=170) of early career respondents, **30% sought out a job in the IVP field, but had limited knowledge of the field prior to starting**, while a quarter (25%) of early career respondents **worked in another area of public health and then discovered IVP**.

Training Experiences & Preferences

Understanding the training desires and practices among early career professionals is also important when considering the future of the workforce. **About 40% of early career professionals received formal onboarding at their place of employment (40%), while a nearly equal proportion (45%) did not**. Most early career professionals (88%) cited **their own desire to grow professionally as motivation** to participate in trainings.

INJURY & VIOLENCE PREVENTION WORKFORCE

EARLY CAREER PROFESSIONALS

Key findings among the 170 respondents who are early career professionals (0-5 years) in the IVP field

Early Career 0-5 years

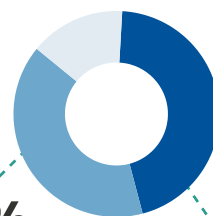


30%

Sought out a job in IVP, but **had limited knowledge of the field before starting**

25%

Worked in another area of public health and discovered IVP



40%

did **not** receive a formal onboarding

45%

did **receive** formal onboarding

88%

said their own **desire to grow professionally** motivates them to participate in trainings

SURVEY RESULTS: IVP WORKFORCE



WORK ENVIRONMENT

Most respondents prefer some type of hybrid work environment and consider this option important to future job choices. Most plan to stay in the IVP field for the foreseeable future, but the small percentage considering leaving are impacted by burnout, a perceived lack of career opportunities, and the desire for higher pay/better benefits.



KEY FINDINGS

Hybrid Work Preferred

Three-quarters (75%) of all respondents prefer a hybrid work environment, and 60% consider the option to work remotely a **very important factor in future job choices**. Reported benefits included **better productivity, work-life balance and mental health**, while barriers included **strict or inconsistent organizational policies** about working remotely.

Staying vs Leaving the IVP Field

Among all respondents, about **70% plan to stay for the foreseeable future**, **16% plan to retire** at some point **in the next 10 years**, and about **10% plan to leave in the next year** (but not retire) – mostly due to a lack of career opportunities in their current job, wanting higher pay/better benefits, or feeling burnout.

Burnout

Over 60% reported having feelings of burnout within the past year and cited an **increased workload** as a contributing factor.

Biggest Changes

The biggest changes faced by those working 10+ years in IVP were related to the **level and type of work (27%)** (e.g., increased remote work and burden of work), **funding (20%)**, and **upstream concepts (17%)**.



WHY IT MATTERS

Workforce Retention

To support and grow the IVP workforce, it is important to understand the impact that work environment factors such as the desire for hybrid/remote work options, and burnout due to increased workload. Staff and managers could benefit from resources that help navigate and respond to these and other workplace factors.

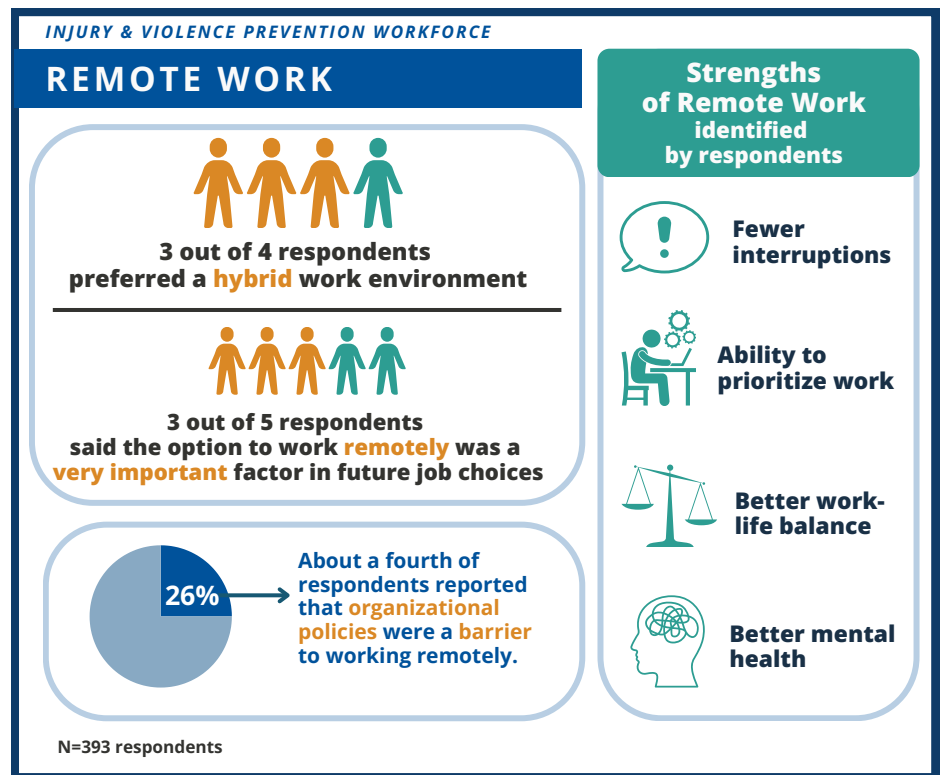
Need for Succession Planning

With about 25% of the IVP workforce potentially in flux due to plans to retire or leave the field, IVP programs could benefit from tools to aid staffing changes and succession planning.

WORKING REMOTELY: PREFERENCES & OPTIONS

Among all respondents, 75% prefer a hybrid work environment (rather than all in-person or all remote work), 18% prefer working entirely remotely, and 60% reported that the option to work remotely would be a very important factor when considering job choices in the future.

Most respondents (63%) reported that in the past year, in their current role in IVP, the option to work remotely has stayed about the same, while it increased for 9% and decreased for 14% of respondents. Only about 9% of respondents do not have the option to work remotely.



WORKING REMOTELY: BENEFITS & BARRIERS

The 339 respondents who said they have the option to work remotely indicated that benefits of working remotely include working with fewer interruptions, being able to prioritize work, better work-life balance, better mental health, and saving/reducing commuting time. About a quarter (26%) of these 339 respondents reported that their organization's policies about working remotely (e.g., too strict, inconsistent, or lack of policy) were a barrier to working remotely.

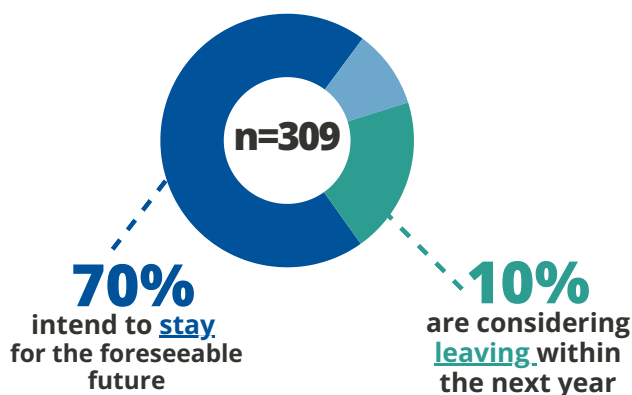
CONSIDERING STAYING vs LEAVING THE IVP FIELD

Among all respondents, about 70% (n=309) plan to stay in the IVP field for the foreseeable future, 16% (n=63) plan to retire at some point in the next 10 years, and about 10% (n=36) are considering or planning to leave the field in the next year (but not retire). Among this latter group, their reasons include:

- wanting opportunities for career advancement not currently offered in their job,
- wanting a career with higher pay/better benefits,
- feeling burnout from their IVP work, and
- misalignment with organization/leadership.

INTENTION TO STAY IN OR LEAVE THE IVP FIELD

Among those **not** planning to retire in the next 10 years



Among the 10% considering leaving, reasons include



opportunities for **career advancement** not offered in their current role



burnout from their IVP work



higher **pay** & better **benefits**



misalignment with organization/leadership

BURNOUT

over **60%**

endorsed feelings of **burnout** within the **past year**

N=393 respondents

2 out of 3 of those respondents said



increased workload contributed to their feelings of burnout

32%

indicated "**other**" reasons contributed to their burnout

1 out of 3 of those respondents said



- **emotional burden**
- **reduced staffing**
- **hiring challenges**
- **decreased funding**
- **political context**

contributed to their feelings of burnout

BURNOUT

Over 60% of respondents (n=252) reported feeling burnt out within the past year. Among these respondents, 65% gave an increased workload as a contributing factor to their feelings of burnout. (Respondents could select all that apply, so percentages do not add up to 100%.)

At least 30% of these respondents selected factors that included the emotional burden of the work, public sentiment or political context, decreased funding, having fewer staff, and hiring challenges.

Other factors noted by respondents include those related to inconsistent or lack of leadership and organizational support; administrative and structural barriers; staffing, workload, and responsibilities challenges; funding and financial challenges; workplace environment, dynamics, flexibility or remote work; personal experiences and work-life balance; insufficient capacity to respond to program growth and direction changes.

About two-thirds (67%) of respondents reported that their organization supports staff who want to engage in self-care.

SPOTLIGHT

Biggest Change in the Last 10 Years

The 135 respondents who have worked in the IVP field for more than 10 years were asked about the biggest changes they have seen in the last decade. Their 104 qualitative responses were analyzed and coded into groups. Responses frequently reported were about the level and **type of work (27%)** such as increased remote work and an increased burden of work, **funding (20%)** (often decreased funding), and **upstream concepts (17%)**, with an increased recognition of multiple upstream concepts. Other changes noted were related to an increased recognition of the IVP field, prevention and IVP areas such as suicide and substance use, and to a lesser degree, an increased use of data science and the impact of COVID.



INJURY & VIOLENCE PREVENTION WORKFORCE

BIGGEST CHANGE IN LAST 10 YEARS

The 135 respondents who have worked at least 10 years in IVP shared the biggest changes they've seen in the past decade. Common responses were related to the level and type of work, funding, and upstream concepts.

LEVEL & TYPE OF WORK

was cited by

27%

of respondents



- Increased virtual work
- Decreased meaningful connections
- Increased burden of work

FUNDING

was cited by

20%

of respondents



- Both increased & decreased funding

UPSTREAM CONCEPTS

were cited by

17%

of respondents



- Increased recognition of upstream concepts

N=135 respondents who have worked in IVP for at least 10 years

COVID & NON-IVP DETAIL

For context, since the COVID-19 pandemic began in 2020, among the 290 respondents who self-identified as working in the IVP field during the pandemic, 46% (n=179) said they were never put on non-IVP detail, 23% (n=90) had been put on non-IVP detail at some point during the first three years of the COVID-19 pandemic (2020-23) but have since been released, and only 5% (n=21) said they still conduct some non-IVP detail related to the pandemic.

SURVEY RESULTS: IVP WORKFORCE



THREATS & OPPORTUNITIES

Respondents identified reduced or inconsistent funding and burnout as key threats to the IVP field, and numerous opportunities, from research and technology advancements to upstream and system-level approaches.



KEY FINDINGS

Threats

Respondents' perceived threats included concerns about funding—and the lack of consistent IVP funding—burnout, and a **lack of support from leadership and/or the public.**

Opportunities

A variety of opportunities were reported – **research and technology advancements, collaboration, upstream and system-level approaches, training/education, and increased public awareness.**



WHY IT MATTERS

Prepare, Adapt & Grow

Being aware of perceived threats and opportunities can inform IVP workforce development strategic planning, and help the field better respond to challenges and opportunities for growth..

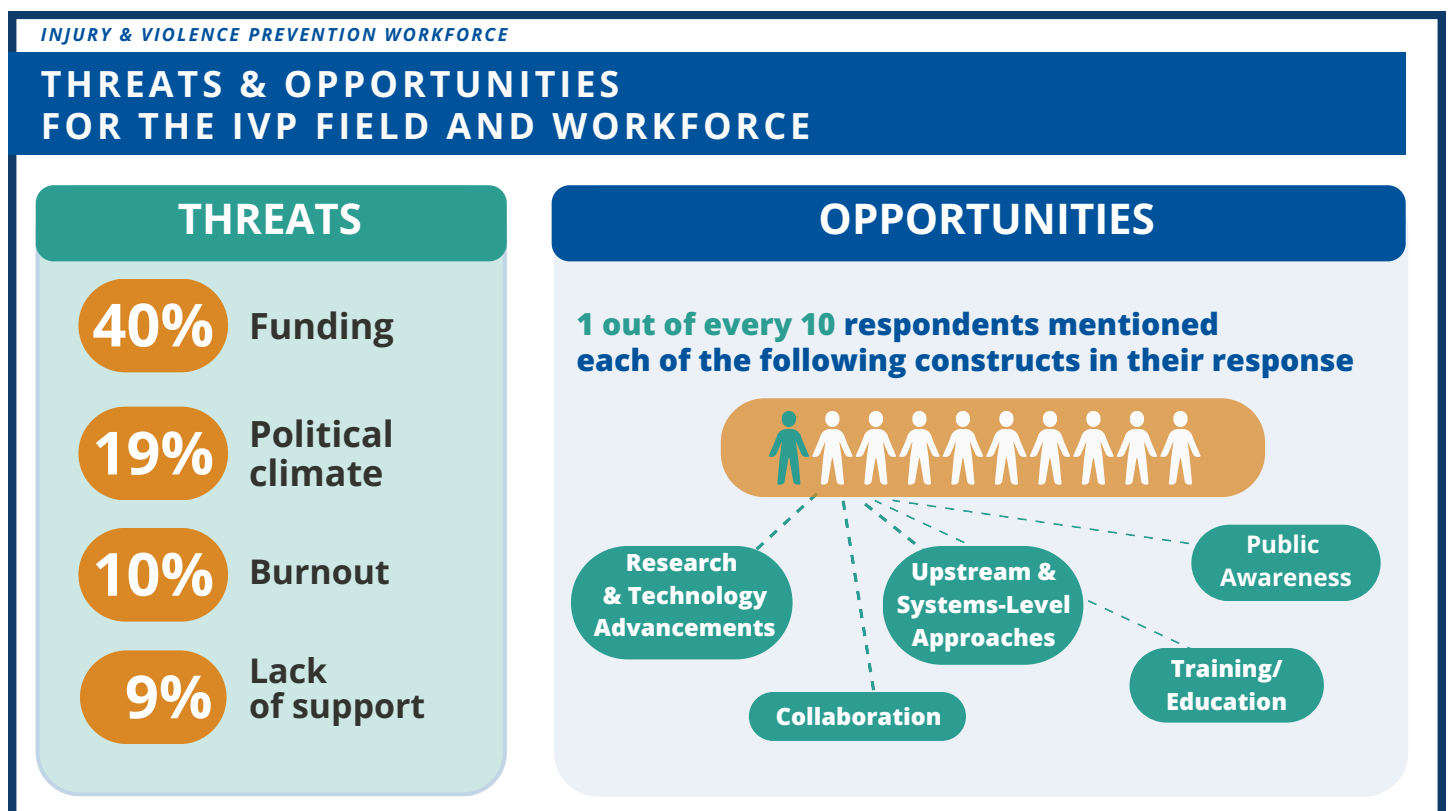


THREATS

Respondents were asked to describe the biggest threats to the field of IVP and responses to this open-ended question were qualitatively coded. Key themes that emerged were concerns about funding (including lack of consistent IVP funding), the political climate, burnout, and lack of support from leadership and/or the public.

OPPORTUNITIES

Respondents were also asked to describe the biggest opportunities for the field and responses were similarly coded. The responses reflect a wide variety of ideas about opportunities in the field of IVP. One out of every 10 respondents mentioned examples related to research and technology advancements (data collection and usage, utilization of AI), collaboration (across sectors, with communities, with IVP partners), upstream and systems-level approaches (social drivers of health, shared risk and protective factors), training/education (training within the workforce, IVP certification opportunities), and public awareness (increasing public awareness about and support of the IVP field).



SURVEY RESULTS: IVP WORKFORCE



TRAINING & PROFESSIONAL DEVELOPMENT

Training and other professional development opportunities for the IVP workforce should reflect the personal motivation to learn, preferred virtual and on-demand formats, and diverse topics such as upstream concepts and cross-cutting public health skills. Relevant and accessible opportunities for IVP orientation and onboarding, as well as coaching and mentoring, are needed.



KEY FINDINGS

Motivation to Learn

Personal desire to learn – rather than organizational or CEU requirements – was the main motivation to learn cited by respondents.

IVP Topics of Interest

Respondents indicated they particularly wanted to learn more about and/or strengthen their skills in **violence prevention topics, upstream concepts and cross-cutting public health skills**.

Preferred Format

Respondents preferred **virtual and/or on-demand formats** for training and professional development opportunities.

IVP Certificate Program

About two-thirds (64%) of respondents said they'd be likely or very likely to participate in an IVP Professional Certificate Program if offered by Safe States – **mostly to gain personal knowledge, and growth/promotion opportunities in their jobs**.

Formal IVP Orientation or Onboarding

Only about half (53%) of respondents received formal IVP orientation or a more comprehensive onboarding process.

Mentoring & Coaching

Only 15% of respondents reported they participate in a mentoring/coaching program via their organization or Safe States. Regular 1:1 sessions were a highly desired feature, followed by small group discussions, frequent informal communication, and individual development plans.



Development and Marketing of IVP Training and Professional Development

Development and marketing of IVP professional development opportunities, including a potential IVP Certificate Program, should **reflect upstream and cross-cutting topics, and a personal desire to learn** – rather than organizational or CEU requirements – and be offered in **virtual, on-demand formats**.

Resources Needed for IVP Orientation & Onboarding

With about half of respondents lacking a formal IVP orientation or onboarding process, there is a need for virtual, on-demand opportunities to better prepare the IVP workforce as it enters the field and its diverse settings. Likewise, a suite of orientation and onboarding tools and resources could expand the number of IVP program managers who conduct these important processes.

Challenges for Mentoring & Coaching Programs

Further exploration is needed to develop relevant mentoring or coaching programs with desired features.



CONTEXT

In examining respondent data about training and professional development, it is helpful to consider that over half of respondents reported that **they found their first IVP job by (1) seeking, applying for or getting a job in IVP despite knowing very little about IVP prior to starting, and (2) discovering IVP while working in another area of public health.** And notably, only 5% (n=18) of respondents said they learned about IVP through an academic course and became interested in the field or a specific IVP topic. These data underscore the need for IVP orientation and onboarding resources that can be accessed virtually on-demand, and/or that IVP program managers can easily use and adapt for their staff to provide consistent, foundational training in core IVP concepts and approaches across the workforce.

MOTIVATION FOR TRAINING/PROFESSIONAL DEVELOPMENT

The overwhelming majority of respondents (88%) said their **personal desire to learn/grow/improve** motivated them to participate in training/professional development opportunities – with only about a quarter selecting organizational requirements or earning CEUs/maintaining certification.

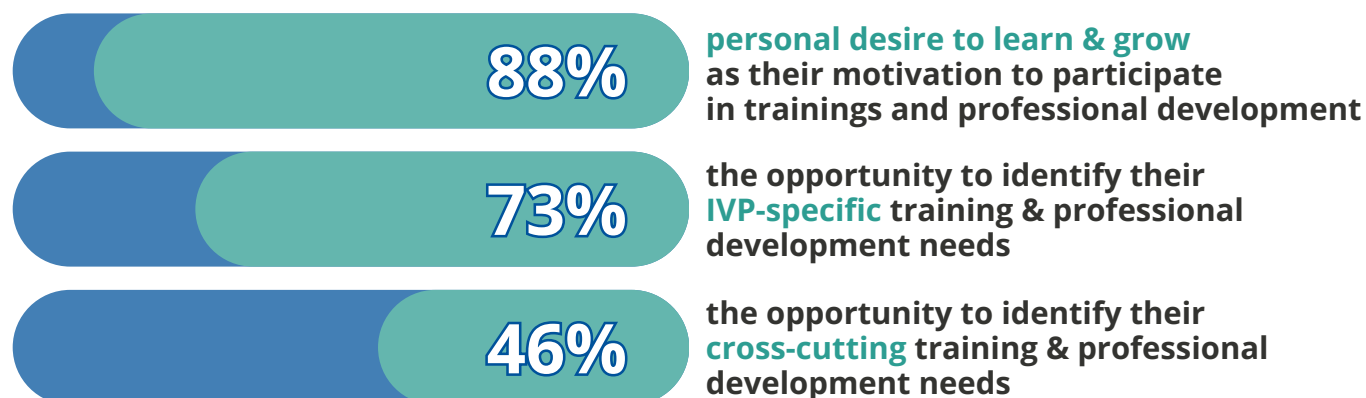
OPPORTUNITY TO IDENTIFY TRAINING NEEDS

Most respondents agreed or strongly agreed they had the opportunity to identify their IVP-specific (73%) and cross-cutting (46%) training and professional development needs and opportunities.

INJURY & VIOLENCE PREVENTION WORKFORCE

TRAINING & PROFESSIONAL DEVELOPMENT OPPORTUNITIES

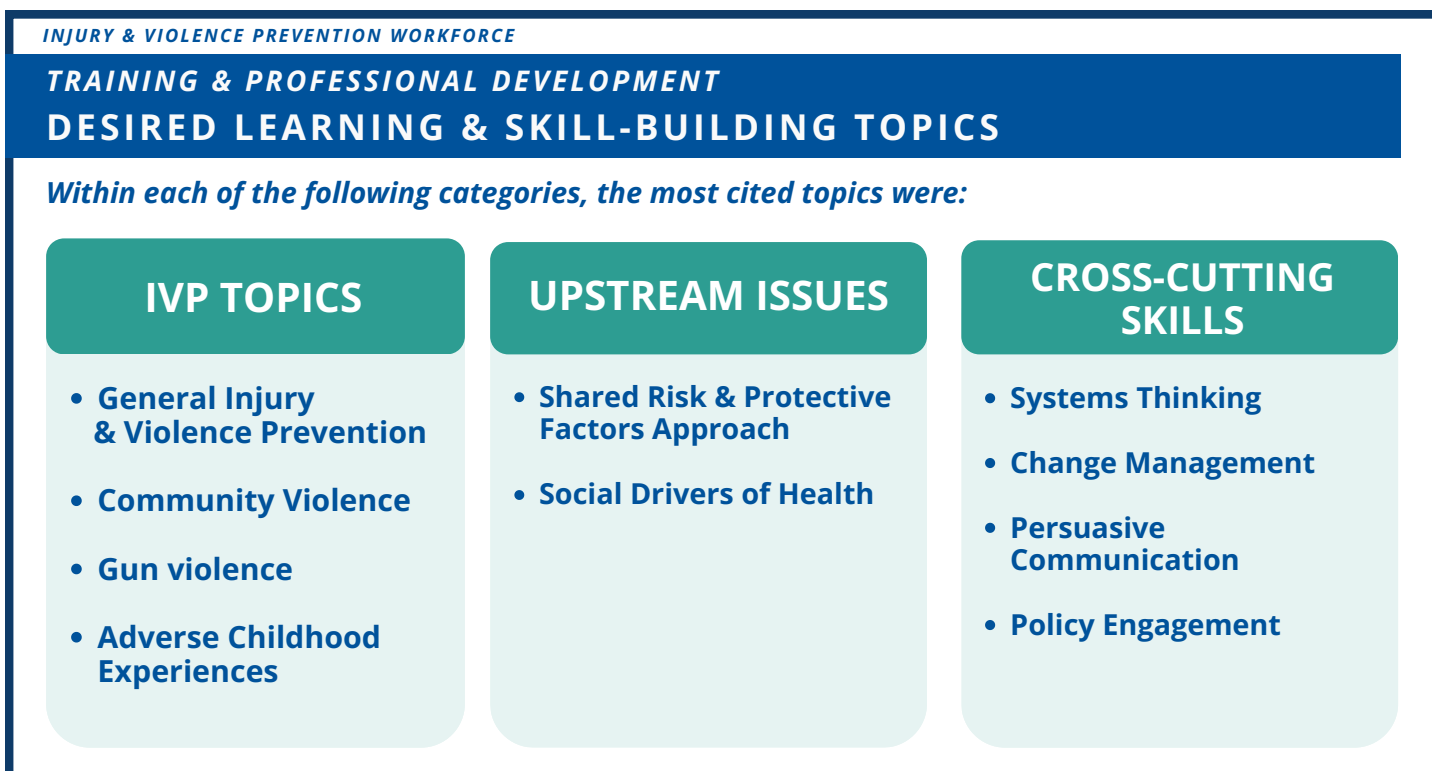
Percent of all respondents who indicated they have:



N=393 respondents

DESIRED AREAS OF LEARNING & SKILL-BUILDING

Respondents were asked about desired areas of learning and skill building for IVP topics broadly (**Top 5**), specific upstream issues (selected in order of **importance**), and cross-cutting public health skills (**Top 5**).



FORMAT PREFERENCES FOR TRAINING & WORKFORCE DEVELOPMENT OPPORTUNITIES

One of every three respondents (**33%**) **cited webinars as their preferred format** for trainings and workforce development opportunities.

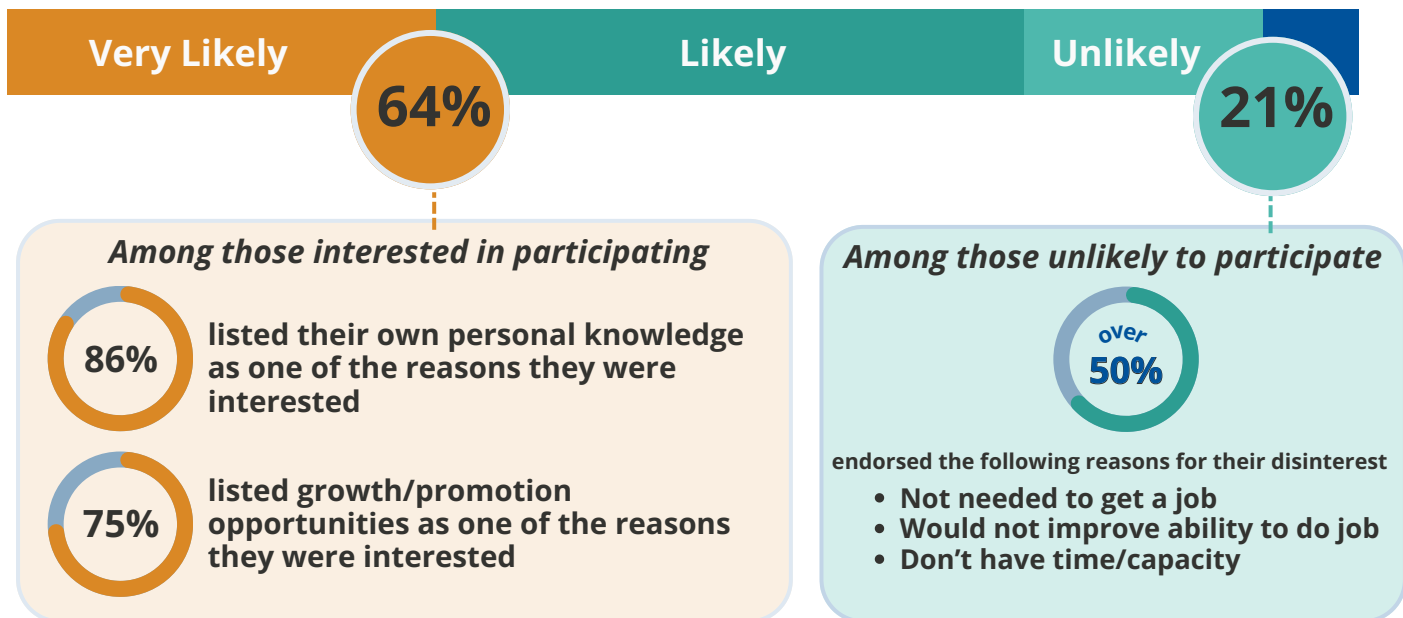
IVP CERTIFICATE PROGRAM

About two-thirds (64%) of respondents said they would be likely or very likely to participate in an IVP Professional Certificate Program if offered by Safe States. Among those respondents (n=254), their interest in the certificate program is mostly based on **gaining personal knowledge and growth or promotion opportunities in their job**.

Among those **unlikely or very unlikely to participate (n=82)**, their reasons included a **lack of need for the certificate for getting a job, improved chances of getting a job, or improving their ability to do their job**.

IVP CERTIFICATE PROGRAM

Two thirds (64%) of respondents said they would be very likely or likely to participate in an IVP Professional Certificate Program if offered by Safe States

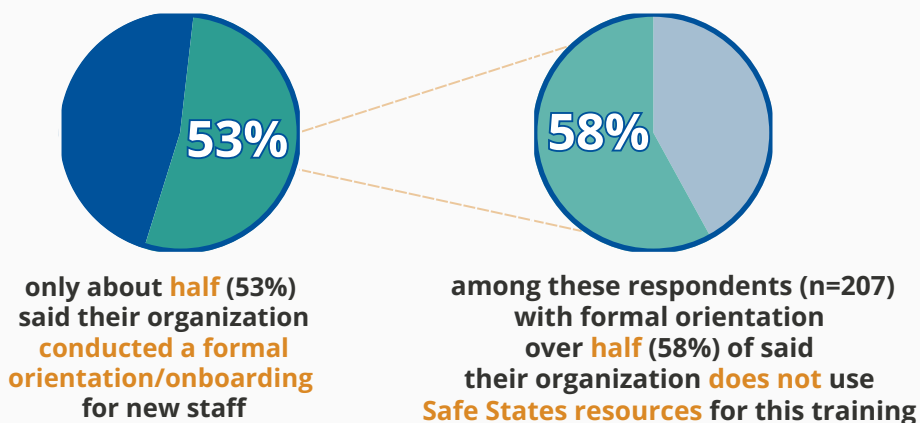


N=393 respondents

ORIENTATION & ONBOARDING

Orientation often refers to the initial, one-time introduction to an organization or job, while onboarding is a more comprehensive process that involves ongoing training – often spanning several weeks or months to develop a deeper understanding of the role and the professional field and better– integrate into a program or project team. Only about half of respondents (53%, n=207) said their organization or IVP program **conducted a formal orientation/ onboarding for new staff**.

TRAINING & PROFESSIONAL DEVELOPMENT ORIENTATION & ONBOARDING



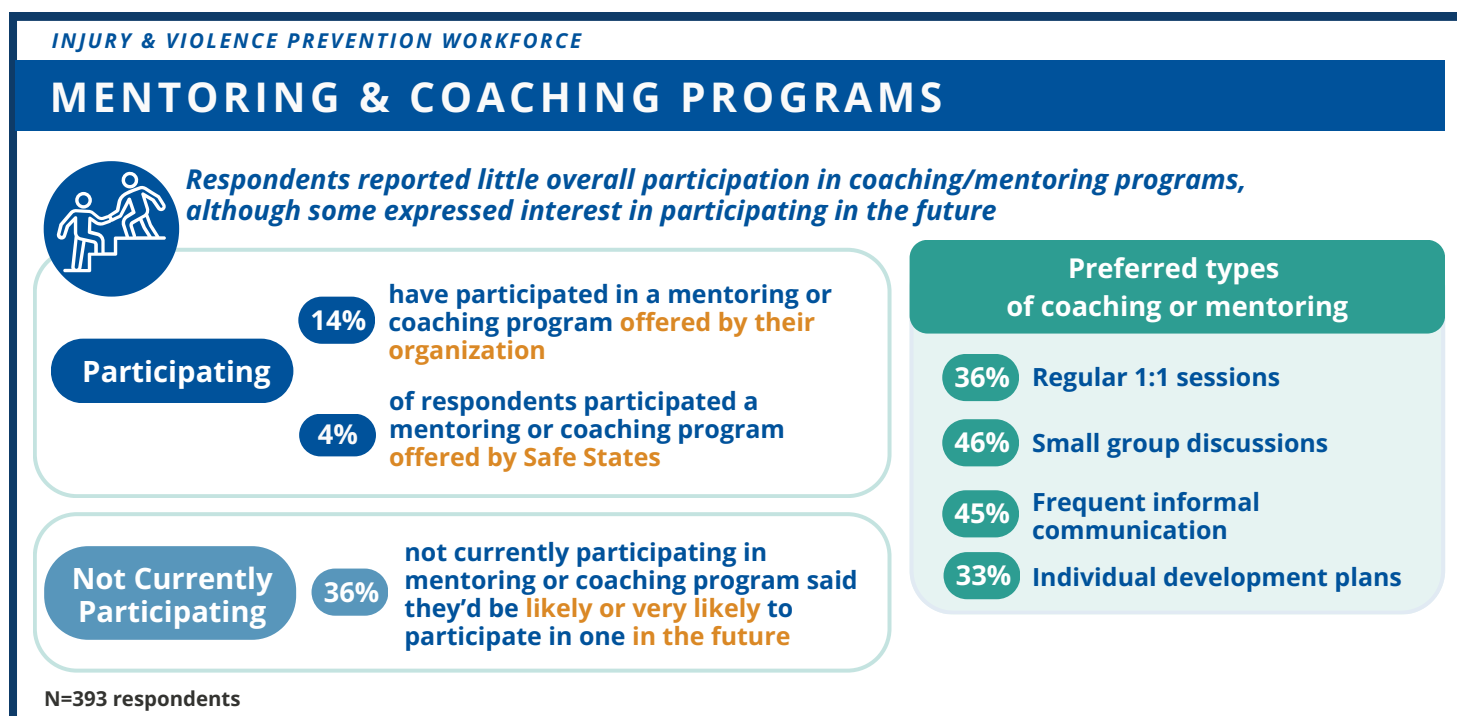
N=393 respondents

COACHING & MENTORING

Respondents reported little overall participation in coaching and/or mentoring programs at either their organization or as part of Safe States' mentoring program. Among the 343 respondents who do not currently participate in the Safe States' mentoring program, only about a third (36%) said they would be likely or very likely to participate, while another (32%) said they are unlikely or very unlikely to participate, and the remaining third (32%) said they're not sure.

MENTORING PROGRAM FEATURES

Regular 1:1 sessions was selected by 61% of respondents as their preferred mentoring or coaching program feature, with small group discussions, frequent informal communication, and individual development plans as other desired features.



SURVEY RESULTS: IVP WORKFORCE



IVP CORE COMPETENCIES & PUBLIC HEALTH STRATEGIC & CROSS CUTTING SKILLS

Respondent data provide a snapshot-in-time view of the workforce development and training needs of IVP professionals at the individual level. Findings reflect a need for opportunities for individuals to learn how to apply – and build confidence in applying – the Core Competencies for IVP and public health strategic and cross-cutting skills, including upstream concepts such as social drivers of health.



KEY FINDINGS

Core Competencies for Injury & Violence Prevention

Over half of respondents indicated they could *apply a competency or skill in four key areas* of the [Core Competencies for Injury and Violence Prevention](#): describing problem of IVP, accessing/using data, designing/implementing programs, and disseminating communicating information.

Public Health Strategic & Cross-Cutting Skills

Compared to the Core Competencies for Injury and Violence Prevention, *fewer respondents indicated that they could apply strategic public health skills*.

Upstream Concepts

Among upstream concepts such as social drivers of health and shared risk and protective factor approaches, respondents *reported their knowledge and ability to apply these skills was higher than their confidence in applying them*.



WHY IT MATTERS

Build Up Skill Application & Confidence

Resources exist to help build knowledge of IVP core competencies, public health core competencies, and strategic public health and cross-cutting skills. However, there is likely a *gap in training and professional development resources to develop the ability to apply this knowledge and build confidence in applying this knowledge and skills*, especially in upstream concepts.

CONTEXT: CORE COMPETENCIES

Core competencies can inform workforce development efforts on organizational and individual levels, and can be used to:

- Develop trainings;
- Assess organizational or individual competencies;
- Advocate for additional funding to achieve organizational competency;
- Plan strategically for program growth;
- Identify proficiencies needed in community partners; and
- Assist in evaluating potential applicants for positions within an organization.

The [Core Competencies for Injury and Violence Prevention](#) encompass essential knowledge and skills that are widely considered necessary to work in the field of injury and violence prevention. Individuals are not expected to be experts in all competencies, but rather be competent in a combination of skills needed to best conduct their injury and violence prevention work in specific settings. These core competencies are currently being updated, with an anticipated release in late 2025.

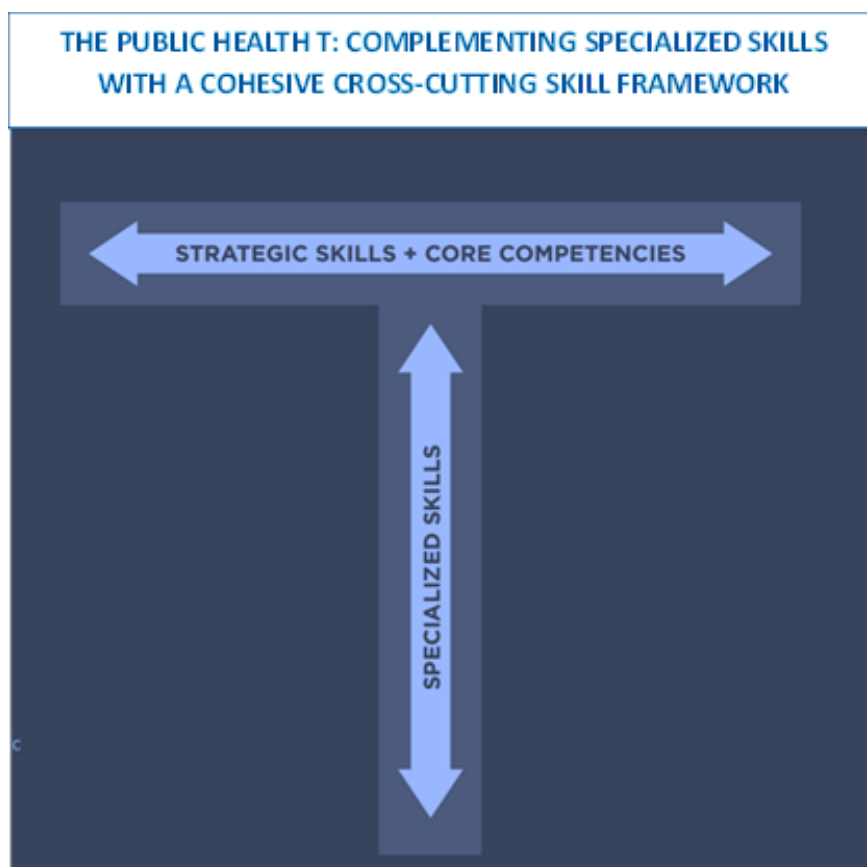
CORE COMPETENCIES FOR INJURY & VIOLENCE PREVENTION

1. Ability to **describe and explain** injury and/or violence as a major social and health problem.
2. Ability to **access, interpret, use and present injury and/or violence data**.
3. Ability to **design and implement** injury and/or violence prevention activities.
4. Ability to **evaluate** injury and/or violence prevention activities.
5. Ability to **build and manage** an injury and/or violence prevention program.
6. Ability to **disseminate information** related to injury and/or violence prevention to the community, other professionals, key policy makers and leaders through diverse communication networks.
7. Ability to **stimulate change** related to injury and/or violence prevention through policy, enforcement, advocacy and education.
8. Ability to **maintain and further develop competency** as an injury and/or violence prevention professional.
9. **Demonstrate the knowledge, skills and best practices necessary to address at least one specific injury and/or violence topic** (e.g. motor vehicle occupant injury, intimate partner violence, fire and burns, suicide, drowning, child injury, etc.) and be able to serve as a resource regarding that area.

Likewise, the [Core Competencies for Public Health Professionals](#) are a “consensus set of knowledge and skills for the broad practice of public health, as defined by the [10 Essential Public Health Services](#). Developed by the [Council on Linkages Between Academia and Public Health Practice](#) (Council on Linkages), the Core Competencies reflect foundational or crosscutting knowledge and skills for professionals engaging in the practice, education, and research of public health. These competencies are organized into [eight domains](#), representing skill areas within public health, and [three tiers](#), which describe different types of responsibilities within public health organizations.”

CONTEXT: STRATEGIC SKILLS

These two sets of core competencies described above are complemented by cross-cutting strategic skills applicable to the entire public health workforce regardless of specialty or discipline. Known as the Consortium Strategic Skills, they were identified through a consensus process by the National Consortium for Public Health Workforce Development, led by the de Beaumont Foundation, and published in 2017 in [Building Skills for a More Strategic Public Health Workforce: Call to Action](#) (see table below). A [2021 de Beaumont Foundation report](#) updated these skills and used a T-shaped graphic to illustrate how public health employees can have *depth* in specialized skills and *breadth* in cross-cutting skills that reflect the Strategic Skills and the Core Competencies for Public Health Professionals.



Source: de Beaumont Foundation. “Adapting and Aligning Public Health Strategic Skills,”. March 2021. <https://debeaumont.org/strategic-skills/>

ASSESSING CURRENT KNOWLEDGE & SKILLS

To help identify the workforce development and training needs of IVP professionals, respondents were asked to assess their current knowledge and skills in the following areas:

- Core Competencies for Injury and Violence Prevention
- National Consortium for Public Health Workforce Development Strategic Skills
- Upstream Concepts (e.g., social drivers of health, shared risk and protective factor approaches)
- Advocacy and Policy Skills

Respondents assessed their knowledge and skills using this continuum:

- NOT AWARE (not aware or familiar with competency/skill)
- FAMILIAR with (can recall previously learned information about competency/skill)
- Have KNOWLEDGE (can explain this competency/skill to someone else)
- Can APPLY this skill (apply this competency/skill to actual situations)

Results of these self-assessments are presented below. *Assessments about advocacy and policy skills are presented with related content later in this report.*

IVP CORE COMPETENCY SKILLS

Over half of respondents indicated they could apply four IVP Core Competency skills – describing the problem of IVP, accessing/using data, designing/implementing programs, and disseminating/communicating information. Slightly less than half of the respondents indicated they could apply skills in the competencies of evaluating programs, managing programs or stimulating change.

STRATEGIC PUBLIC HEALTH SKILLS

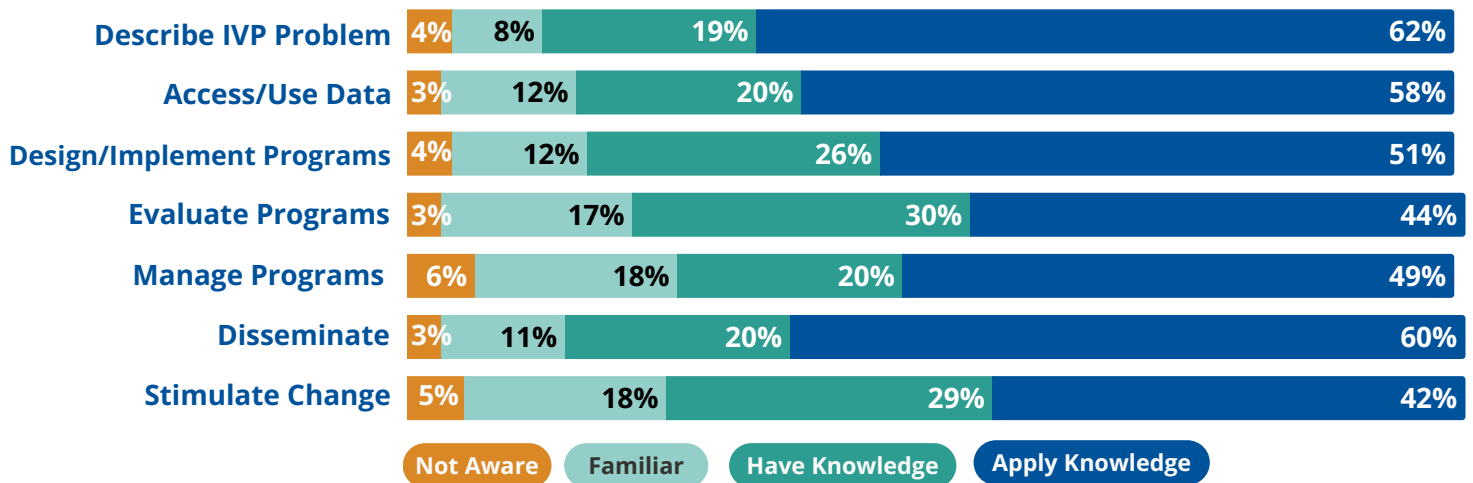
Compared to the IVP Core Competencies, fewer respondents indicated that they could apply Strategic Public Health Skills.

- About a quarter to a third (25-31%) have knowledge in each skill, but only about a third (27-30%) reported they could apply skills in policy engagement, resource management, and change management.
- In addition to these areas, less than half of respondents (39-42%) indicated they could apply skills in the area of data analytics, persuasive communication, or systems thinking.
- About half (55%) indicated they could apply problem solving skills.



IVP CORE COMPETENCIES

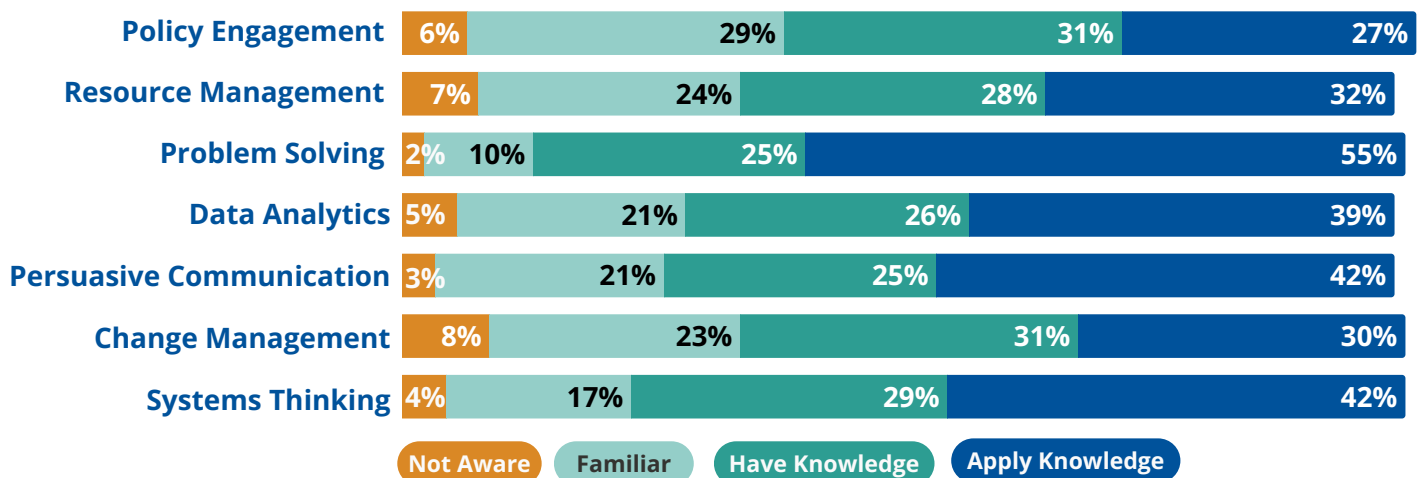
Respondents rated their current status for each Core Competency of IVP



N=393 respondents May not total 100% due to missing data or rounding

STRATEGIC & CROSS-CUTTING PUBLIC HEALTH SKILLS

Respondents rated their current status for each Strategic & Cross-Cutting Public Health Skill



N=393 respondents May not total 100% due to missing data or rounding



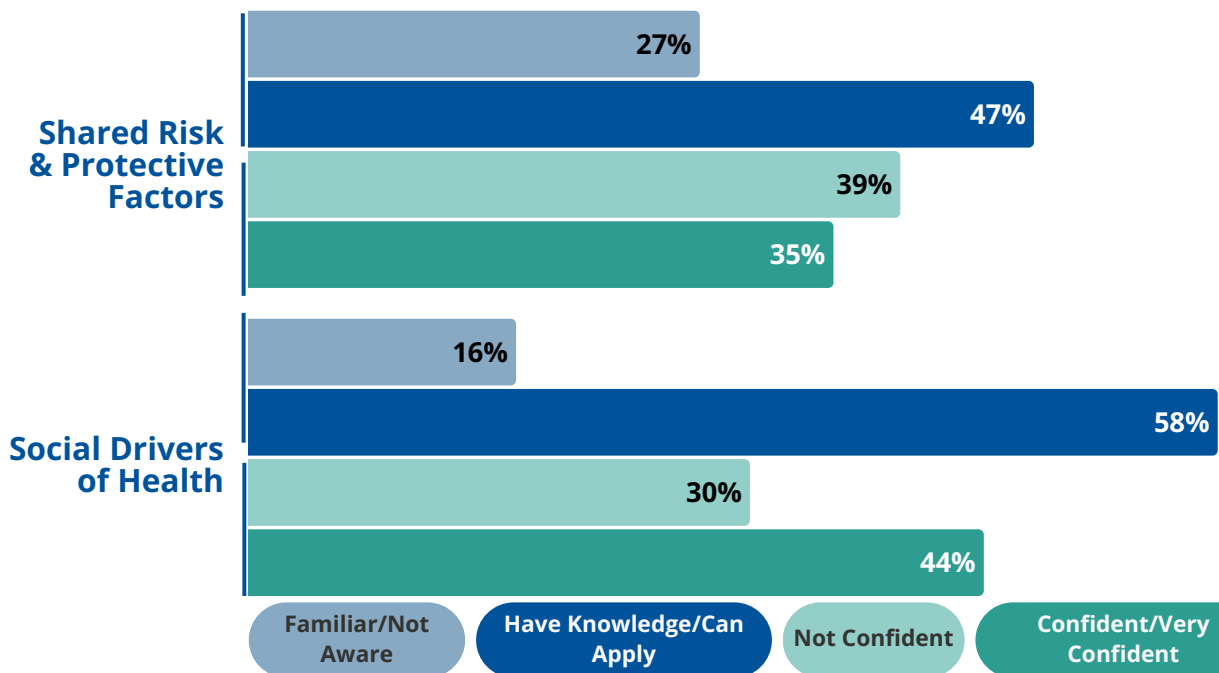
UPSTREAM CONCEPTS

Among upstream concepts, respondents indicated that their knowledge and ability to apply these skills was higher than their **confidence** in applying them. About half of respondents indicated they have knowledge of or can apply skills in the area of shared risk and protective factor approaches (47%) and social drivers of health (58%), but only 35% and 44% of respondents, respectively, said they feel confident or very confident that they can apply this knowledge and skills.

INJURY & VIOLENCE PREVENTION WORKFORCE

UPSTREAM CONCEPTS: INDIVIDUAL KNOWLEDGE VS CONFIDENCE

Respondents rated their current knowledge vs confidence status for each upstream concept



N=393 respondents May not total 100% due to missing data or rounding

SURVEY RESULTS: IVP WORKFORCE



UPSTREAM CONCEPTS

Organizational Level

Based on respondents' perceptions of their organizations' actions, there is an opportunity for IVP programs and their home organization or agency to better translate their intent to address upstream concepts into action, and to do so more consistently.



KEY FINDINGS

Perceived Acknowledgement vs Active Support by Organization

For each upstream concept (social drivers of health, and shared risk and protective factor approaches), respondents reported much higher levels of *acknowledgement* by their organizations than *active support*.



WHY IT MATTERS

Translating Intent Into Action

The mismatch between perceived acknowledgement and active support for upstream concepts reflects an opportunity to develop and disseminate resources that can enable IVP programs and their organizations to better translate their acknowledgement into action.



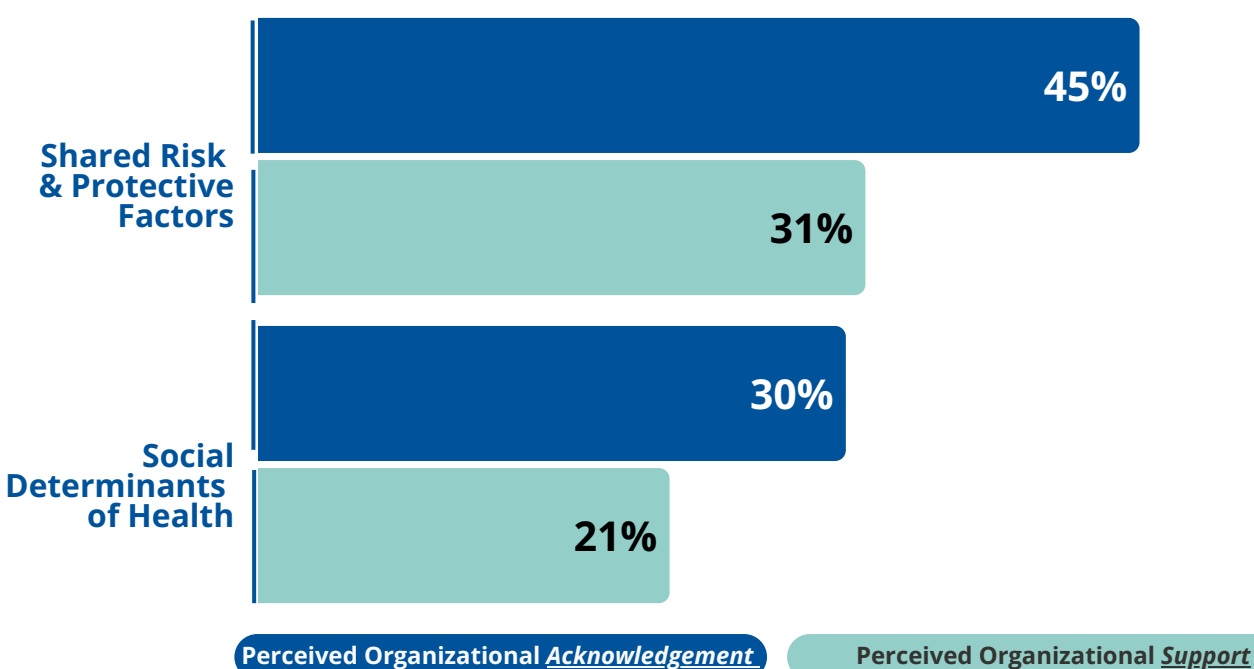
PERCEIVED ORGANIZATION ACKNOWLEDGEMENT & SUPPORT

- Respondents were asked to consider organizational-level efforts to address upstream concepts in their workplace, including via the use of **shared risk and protective factor approaches or social drivers of health**. They were asked to indicate the extent to which their organization **acknowledges** these upstream concepts AND the extent to which they perceive their organization **actively supports** these upstream concepts.
- The graphic here shows a disconnect between organizational *acknowledgement* and perceived organizational *support* for each upstream concept. **Respondents indicated much higher levels of acknowledgement by their organizations than active support.**

INJURY & VIOLENCE PREVENTION WORKFORCE

UPSTREAM CONCEPTS: ORGANIZATIONAL IMPORTANCE

Respondents' perception of their organization's acknowledgement vs support of upstream concepts



N=393 respondents May not total 100% due to missing data or rounding



SURVEY RESULTS: IVP WORKFORCE

ADVOCACY & POLICY



Less than half of respondents indicated they could apply the three key advocacy or policy-related skills of coordinating with stakeholders, disseminating stories of success or challenges met, or educating policymakers and stakeholders. At least a quarter perceived a lack of organizational support to participate in these activities.



KEY FINDINGS

Advocacy & Policy Skills

Less than half of respondents indicated they could apply the advocacy and policy-related skills of coordinating with stakeholders (40%), disseminating stories of success and challenges met (35%), or educating policymakers and stakeholders (27%).

Ability to Participate & Organizational Support

About one half of respondents said they are allowed to – and perceive a **moderate or high level of organizational support to – coordinate with stakeholders and disseminate stories of success and challenges met**. At least a quarter of respondents (25%-36%) reported either a **low level of organizational support or that they were not allowed to participate in the three key advocacy/policy activities**.



WHY IT MATTERS

Elevating IVP

Educating and coordinating with policymakers and stakeholders are essential activities to raise the visibility of IVP programs, communicate their impact, and build capacity for these programs and the field of IVP. Continued efforts are needed to help IVP practitioners understand how to educate and work with policymakers, and how to apply these skills at local, state or national levels.

Respondents were asked to consider three key advocacy or policy-related areas:

- (1) Coordinating with stakeholders,
- (2) Disseminating stories of success or challenges met, and
- (3) Educating policymakers and stakeholders.

They were asked to assess their **individual skills** in these areas, as well as the **extent to which they are able or allowed to participate** in these activities in their current role/job.



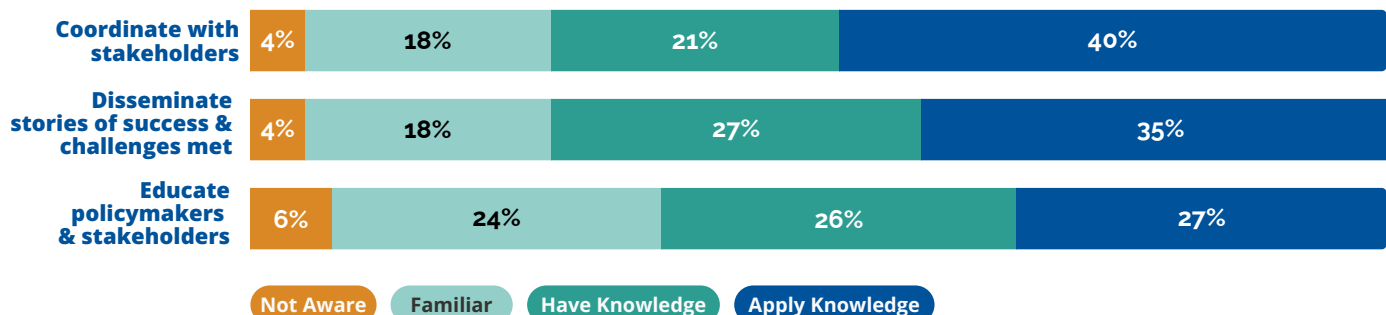
ADVOCACY & POLICY-RELATED SKILLS – Individual level

To assess their current IVP advocacy and policy-related skills, respondents used a scale of NOT AWARE OR FAMILIAR with, FAMILIAR with (can recall previously learned information), have KNOWLEDGE (can explain this skill to someone else), or can APPLY this skill (apply this skill to actual situations). **Over a third of respondents indicated they could apply the skills of coordinating with stakeholders (40%) and disseminating stories of success and challenges met (35%), but only about a quarter (27%) said they could apply the skill of educating policymakers and stakeholders.**

INJURY & VIOLENCE PREVENTION WORKFORCE

ADVOCACY & POLICY: SKILLS

Respondents rated their current status for each advocacy or policy-related skill



N=393 respondents May not total 100% due to missing data or rounding

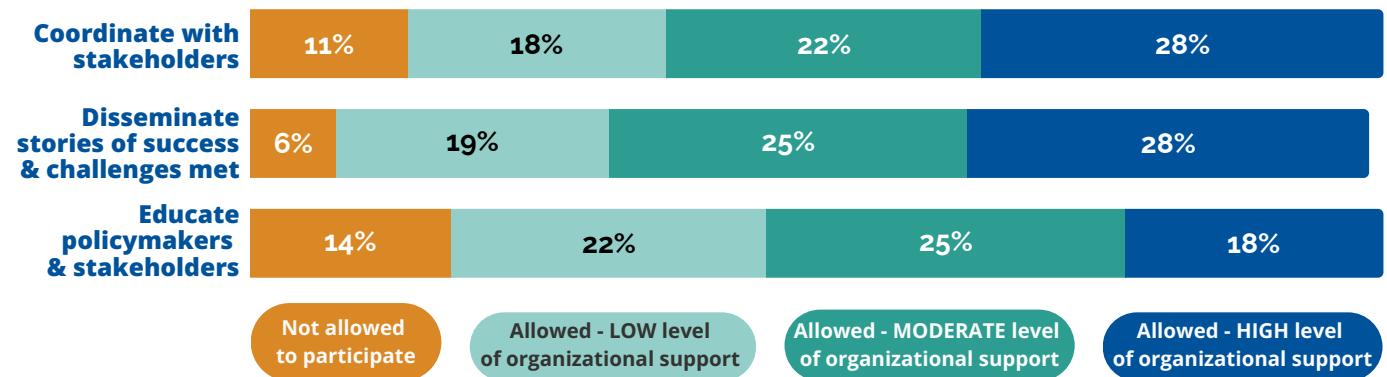
EXTENT ALLOWED TO PARTICIPATE IN ADVOCACY & POLICY-RELATED ACTIVITIES

Respondents were asked, given their current role or job, to what extent they are able or allowed to participate in the three key advocacy or policy-making activities. Excluding respondents who indicated advocacy or policy is not relevant to their work (4-5%), **about half of respondents (50%-53%) said they are allowed, and perceive a moderate or high level of organizational support to coordinate with stakeholders and disseminate stories or success and challenges met**, with a smaller percentage (43%) for educating policymakers and stakeholders. However, **at least a quarter of respondents (25%-36%) reported either a low level of organizational support or that they were not allowed to participate** in these three activities.

INJURY & VIOLENCE PREVENTION WORKFORCE

ADVOCACY & POLICY: ACTIVITY PARTICIPATION

Respondents indicated the extent to which they are able or allowed to participate in the following three advocacy or policy-making activities given their current job



N=393 respondents May not total 100% due to missing data or rounding





STATE IVP PROGRAM INFRASTRUCTURE: SURVEY RESULTS SECTION

Safe States is home to the State Designated Representatives (SDRs), a member group comprising appointed representatives of state IVP programs who are currently active in 43 states. An additional set of survey questions was disseminated to these leaders to gather essential state IVP program information and insight into what IVP looks like across the U.S. A total of 30 SDRs responded. Survey results include the eight topics listed below.

- **Overview of State IVP Program Infrastructure**
- **State IVP Program Leaders: Who We Are & What We Do**
- **State IVP Program Leaders: Years In IVP, Retention & Program Succession Planning**
- **State IVP Programs: Organizational Home**
- **State IVP Program Capacity: Staffing**
- **State IVP Program Capacity: Funding**
- **State IVP Program Capacity: Resources Needed & Infrastructure Challenges**
- **State IVP Program Capacity: Threats & Opportunities**



SURVEY RESULTS

STATE IVP PROGRAMS

SURVEY RESULTS: STATE IVP PROGRAM INFRASTRUCTURE

OVERVIEW



Leaders of 30 state IVP programs across the U.S. provided insight into their state IVP program capacity, needs, challenges, and opportunities. Federal funding remains essential to maintaining and building additional state IVP program capacity. Identified challenges to and opportunities for state IVP programs – and the IVP field as a whole – include funding, workforce, and policy/advocacy issues.



KEY FINDINGS

State IVP Program Leaders: Years in the IVP Field & Intent to Stay or Leave

Half (50%) of state IVP leaders are mid-career professionals, meaning they have worked in the IVP field for 6-15 years. While over half (57%) of state IVP program leaders plan to stay in the IVP field for the foreseeable future, 43% plan to retire at some point in the next 10 years.

State IVP Program Capacity: Funding, Workforce, and Policy/Advocacy

Input from state IVP program leaders on infrastructure challenges, resources needed, and threats to and opportunities for the IVP field mostly centered on three key areas – funding (need for sustained, reliable program funding), workforce (staffing/hiring challenges, yet opportunities to expand workforce) and policy/advocacy (challenges seeing IVP as a leading public health issue, yet opportunities to mainstream IVP issues and leverage cross-discipline partnerships).

State IVP Program Capacity: Essential Federal Funding

State IVP programs implement and receive federal funding for a variety of essential programs and activities – from core program functions to suicide prevention and opioid and other drug overdose surveillance systems.



WHY IT MATTERS

State IVP Programs Play Essential Coordinating Role

State IVP programs can serve as central leaders to convene prevention partners and coordinate IVP approaches. Foundational to successful IVP is building capacity of state IVP programs – and that of their local, territorial, tribal, and regional affiliates and partners – to implement interventions based on the best available evidence.

SURVEY RESULTS: STATE IVP PROGRAM LEADERS



WHO WE ARE & WHAT WE DO

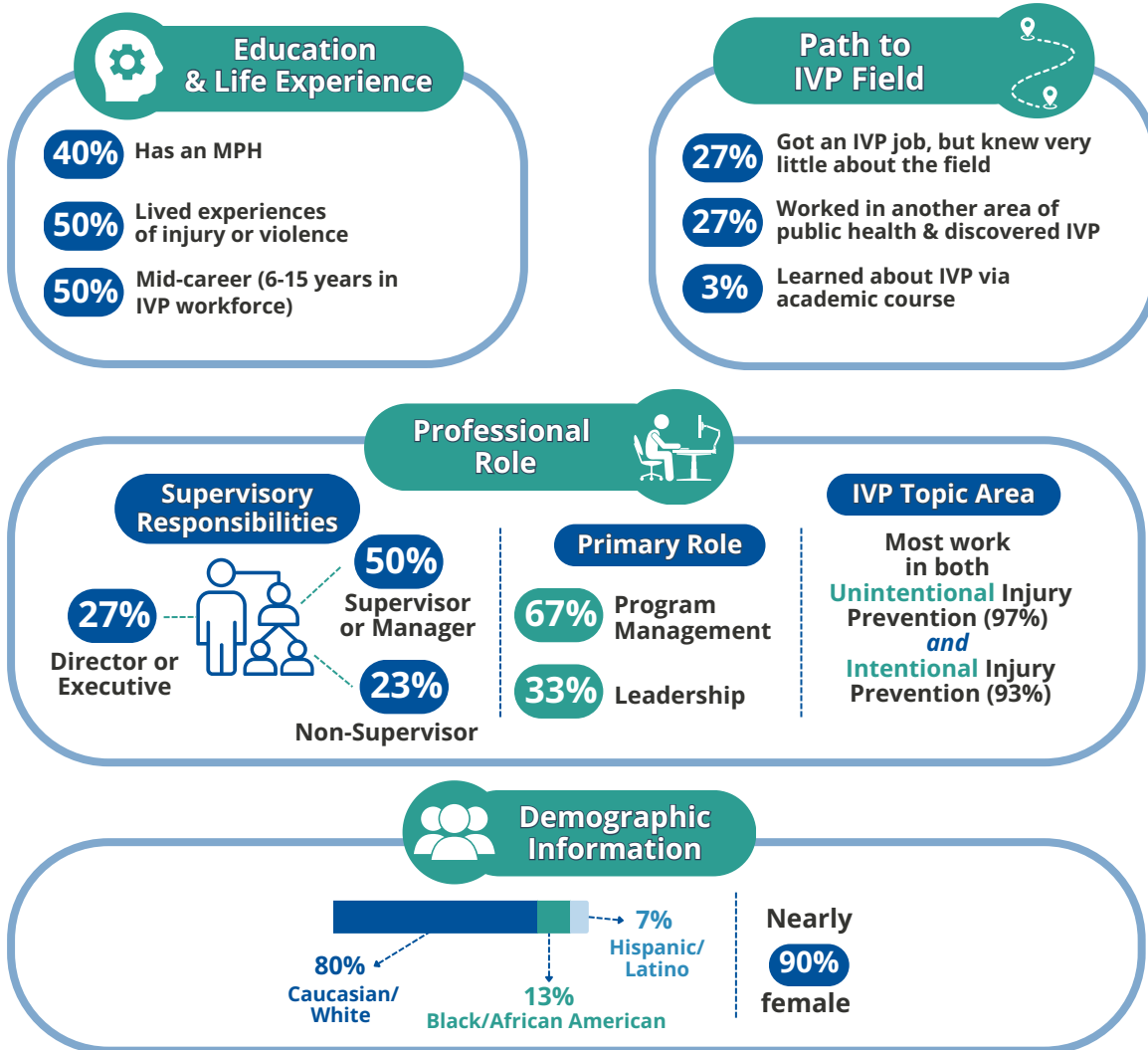
DEMOGRAPHICS

Key demographic characteristics show that most of the 30 state IVP program leaders self-identify as female (90%) and white/Caucasian (80%), while 13% identified as Black/African American and 7% as Hispanic/Latino.

STATE INJURY & VIOLENCE PREVENTION PROGRAMS

STATE INJURY & VIOLENCE PREVENTION PROGRAM LEADERS

Safe States Alliance's State Designated Representatives are injury & violence prevention (IVP) program leaders in their respective states. Representatives from 30 states across the U.S. responded to the survey.





EDUCATION, LIVED EXPERIENCE & PATHS TO THE FIELD

Among the 30 state IVP program leaders, 40% of reported degrees were master's level or higher. Half (50%) identified as persons with lived experiences of injury and/or violence. The most common paths leading to their first job in IVP were (1) seeking, applying for, or getting a job in IVP despite knowing very little about IVP prior to starting (27%) and (2) discovering IVP while working in another area of public health (27%). *Notably, only 3% (n=1) said they learned about IVP during an academic course and were interested in the topic area.*

PROFESSIONAL & SUPERVISORY ROLES

Most (67%) of all state IVP program leaders have program implementation and management as their primary role (>50% of their time), and 33% primarily fill a leadership role. Most of these respondents have multiple roles – on average, they are expected to fulfill about 9 roles. Over three-quarters (77%) are either a supervisor, manager, and/or director/executive; about a quarter (23%) are in a non-supervisory role. Almost all work in both unintentional injury (97%) and intentional injury/violence (93%) prevention.

SURVEY RESULTS: STATE IVP PROGRAM LEADERS



YEARS IN IVP, RETENTION & PROGRAM SUCCESSION PLANNING

YEARS IN THE FIELD

While 13% of state IVP program leaders are new to the IVP field (had worked for only 2-5 years), half (50%) are mid-career professionals, meaning they have worked in the IVP field for 6-15 years. Another 10% have worked 16-20 years, and 23% have worked 21+ years.

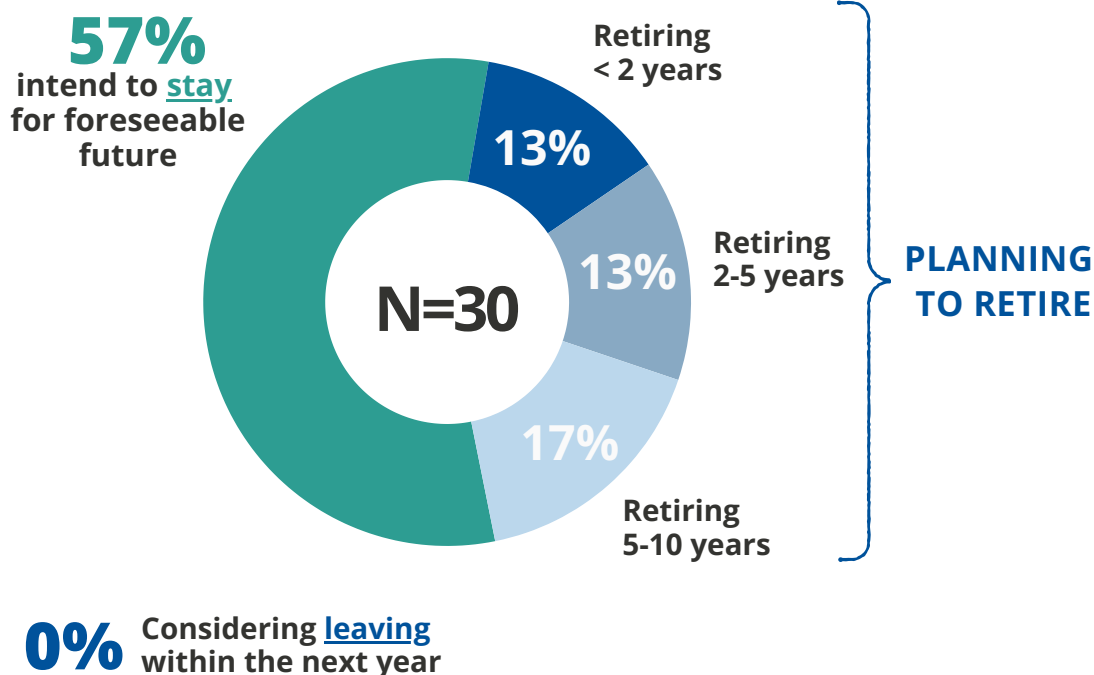
INTENTION TO STAY IN OR LEAVE THE FIELD

Over half (57%) of state IVP program leaders plan to stay in the IVP field for the foreseeable future, and 43% plan to retire at some point in the next 10 years. None indicated they are considering or planning to leave the field in the next year (but not retire).

STATE INJURY & VIOLENCE PREVENTION PROGRAMS

INTENTIONS TO STAY OR LEAVE IVP FIELD

Among 30 state IVP program leaders





PROGRAM SUCCESSION PLANNING

Almost half of the state IVP program leaders (47%) view their program and/or their organization (mostly state health departments) to be “moderately prepared” to conduct succession planning for leadership and staff, meaning the topic was discussed and some steps were taken. Only 30% selected “slightly prepared” meaning the topic was sometimes discussed, but no action had been taken.

STATE INJURY & VIOLENCE PREVENTION PROGRAMS

SUCCESSION PLANNING STATUS

Very prepared
Currently doing

13%

Moderately prepared
Discussed
& some steps taken

47%

Slightly prepared
Sometimes discussed
but no action taken

30%

Not prepared at all
Need more information
on how to plan in our work

7%

N=30 state IVP programs
May not total 100% due
to missing data or rounding

SURVEY RESULTS: STATE IVP PROGRAMS



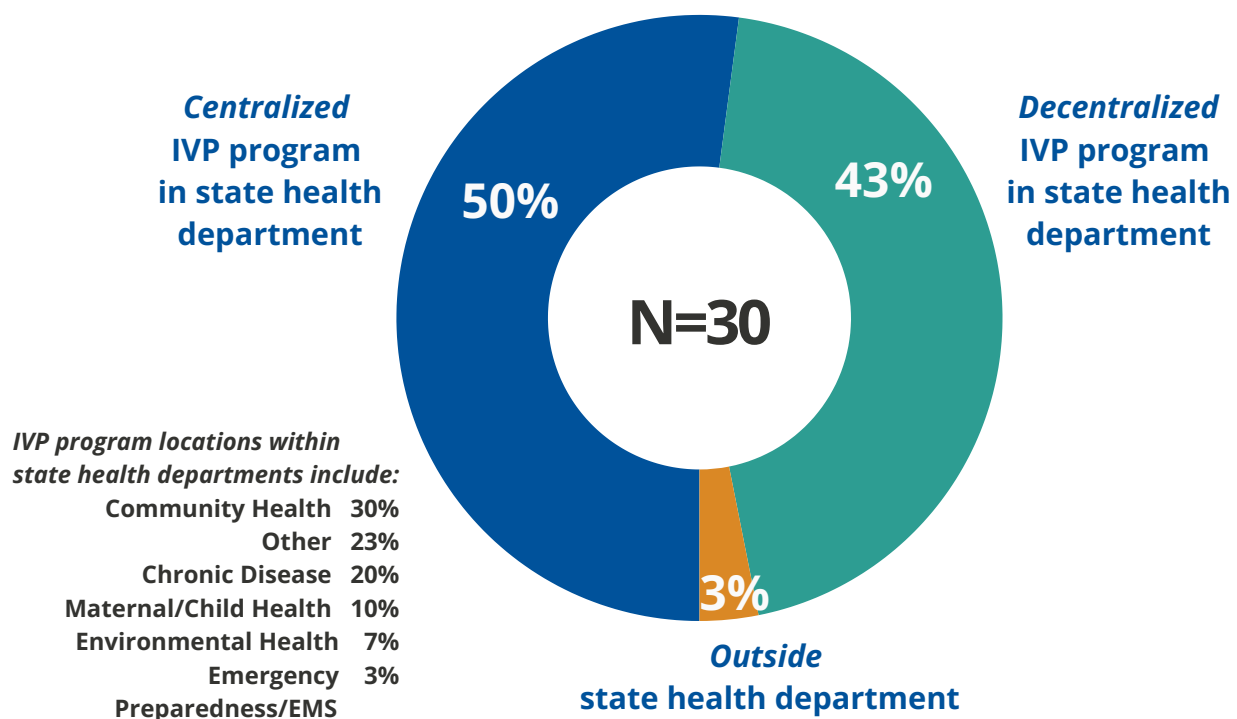
ORGANIZATIONAL HOME

ORGANIZATIONAL HOME

Half (50%) of the 30 state IVP program leaders indicated their state IVP programs are centrally located within their respective state health departments, meaning there is a designated IVP program that is primarily responsible for conducting IVP activities for the state. A similar proportion (43%) of the 30 leaders indicated that IVP activities in their states are decentralized within the state health department, meaning IVP activities are conducted by multiple organizational units across the state health department. While some state IVP programs may be their own organizational unit (e.g., IVP section), many of the 30 centralized and decentralized state IVP programs are located in units such as community health, chronic disease, maternal and child health, or other departments. Only one (3%) of the 30 state IVP program leaders indicated their state IVP program is located outside of the state health department (in this case, within an academic institution).

STATE INJURY & VIOLENCE PREVENTION PROGRAMS

ORGANIZATIONAL HOME



N=30 state IVP programs

May not total 100% due to missing data or rounding

SURVEY RESULTS: STATE IVP PROGRAM CAPACITY



STAFFING

FULL & PART-TIME EMPLOYEES

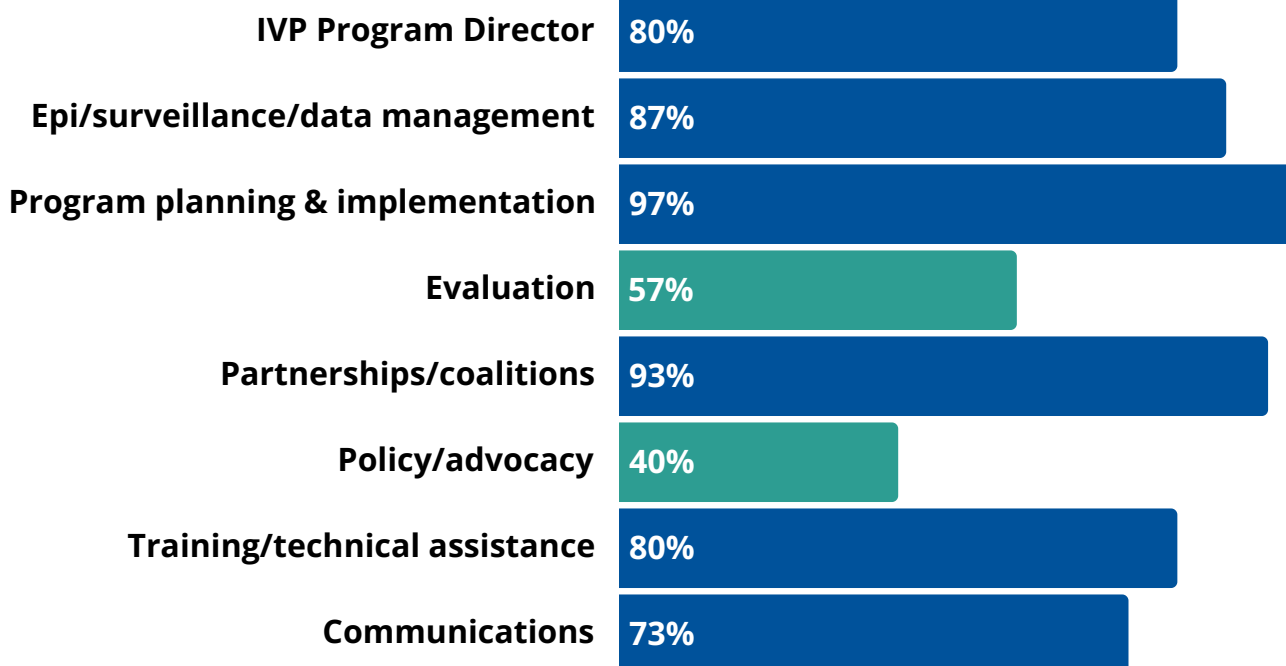
Staffing levels among the 30 state IVP prevention programs vary. About a third (30%) have only 1-5 full time employees. Overall, half (50%) have 1-10 full-time employees. Over a third (37%) of programs have 1-4 part-time employees. About 73% of state IVP program leaders indicated that their staff somewhat reflects the populations whom they serve.

STAFF: KEY FUNCTIONS

State IVP program staff typically fulfill multiple functions within their individual roles or positions. About three-quarters of the 30 state IVP programs (73% and above) had staff whose primary job descriptions included one or more of the following functions: epidemiology/ surveillance/data management, partnerships/coalitions, training/ technical assistance, and communications. The functions of evaluation (57%) and policy/advocacy (40%) were less likely to be included. Respondents could select all that apply, so percentages do not add up to 100%.

STATE INJURY & VIOLENCE PREVENTION PROGRAMS

PROGRAMS WITH STAFF IN KEY FUNCTIONS



*N= 30 state IVP programs
Respondents could select all that apply, so percentages do not add up to 100%*

SURVEY RESULTS: STATE IVP PROGRAM CAPACITY



FUNDING

FUNDING: TYPE & PERCENT OF BUDGET

Federal funding makes up the majority of funding for state IVP programs – 70% of state IVP program leaders indicated that federal funding typically comprises 71-100% of their state IVP program budget. About 70% of the 30 state IVP programs have an approximate annual budget of over \$1 million. This funding may go directly to state IVP programs, or may support IVP activities located in other state health department programs or other state agencies.

STATE INJURY & VIOLENCE PREVENTION PROGRAMS					
FUNDING: TYPE & PERCENT OF BUDGET					
State IVP program leaders indicated the approximate percent of funding their state IVP programs typically receive in each of the 5 funding sources					
% OF FUNDING TYPE TYPICALLY IN IVP PROGRAM BUDGET	FUNDING SOURCES				
	FEDERAL	STATE	LOCAL	NON- GOVERN- MENTAL	OTHER
0-10 %	0 %	37 %	43 %	43 %	37 %
11-30 %	7 %	20 %	0 %	0 %	0 %
31-50 %	7 %	10 %	0 %	0 %	3 %
51-70 %	10 %	3 %	0 %	0 %	0 %
71-90 %	33 %	7 %	0 %	0 %	0 %
91-100 %	37 %	0 %	0 %	0 %	0 %

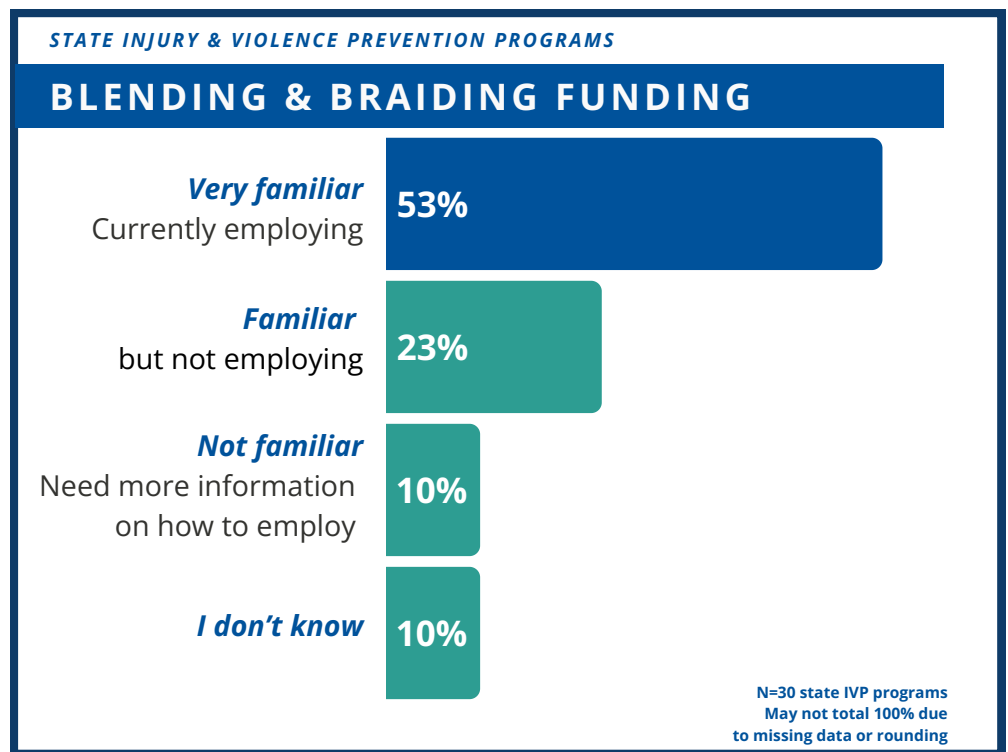
N=30 state IVP programs

FUNDING: FEDERAL FUNDING BY STATE

State IVP programs implement and receive federal funding for a variety of essential injury and violence prevention programs and activities – from core program functions to suicide prevention and opioid and other drug overdose surveillance systems. Access the [National Center for Injury Prevention and Control \(NCIPC\) State-Specific Funding Brief](#), a Safe States resource separate from this survey, for a comprehensive list of federal funding by state among all 50 states.

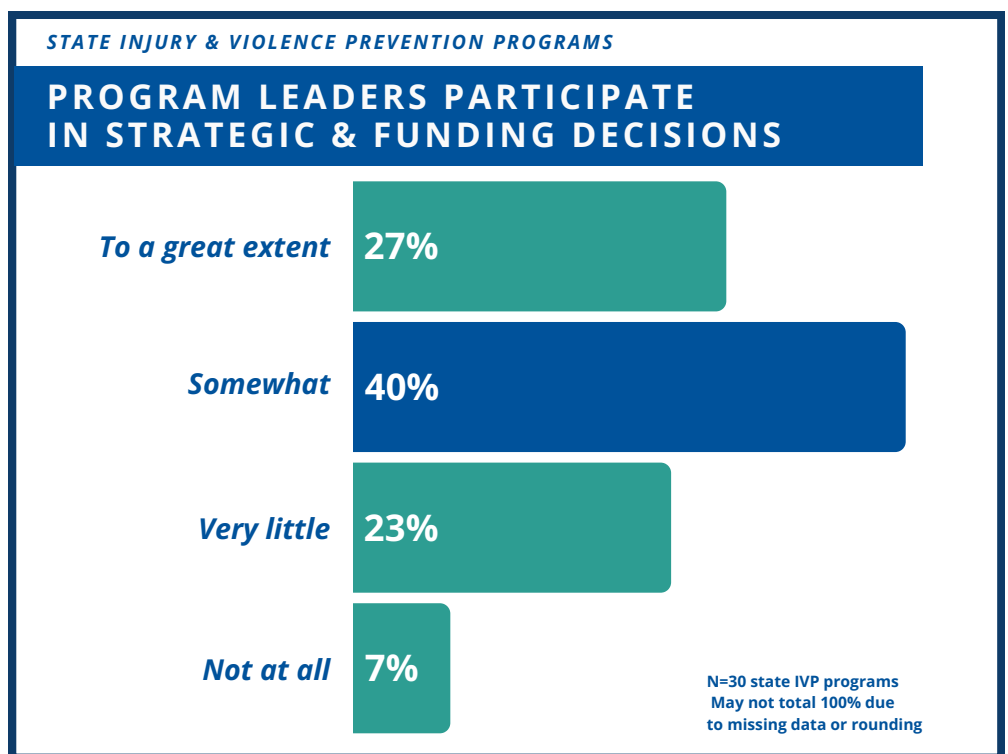
FUNDING: BLENDING & BRAIDING

About half of the state IVP program leaders are very familiar with and can use a budgeting approach that blends or braids funding from different sources to support a common goal or program, such as state IVP program activities. This approach can also help programs to scale or sustain IVP efforts.



PLANNING & FUNDING DECISIONS WITH SENIOR LEADERSHIP

Participation in strategic planning and funding decisions with senior leadership can be a helpful factor in building state IVP program capacity. Only 27% of the 30 state IVP program leaders indicated their program had been involved in these senior-level discussions in the past year to a great extent, with most (40%) being somewhat involved, and almost a third (30%) being very little or not at all involved. However, overall, 63% of state IVP program leaders indicated that their state leadership aids them in doing their job.



SURVEY RESULTS: STATE IVP PROGRAM CAPACITY



RESOURCES NEEDED & INFRASTRUCTURE CHALLENGES

RESOURCES NEEDED

State IVP program leaders identified the top three resources they considered most helpful in expanding the work of their respective programs. Most leaders (80%) selected sustained, reliable funding, as well as increased funding (67%). Skilled programmatic staff (47%) and the ability to hire them were also top choices, followed by senior leadership support (37%) and policy support (23%). Sustained, reliable funding would mean IVP program staff and resources could remain focused on essential IVP work, rather than being diverted to prepare repeated applications for short term funding.

STATE INJURY & VIOLENCE PREVENTION PROGRAMS

RESOURCES NEEDED

Percent of all respondents who indicated the following are among their TOP 3 resources needed to expand the work of their state IVP program

Sustained funding - reliable for more than 1 - 5 years **80 %**

Increased funding to expand IVP program work **67 %**

Skilled programmatic personnel **47 %**

Senior leadership support **37 %**

Policy support **23 %**

N=30 state IVP programs

INFRASTRUCTURE CHALLENGES

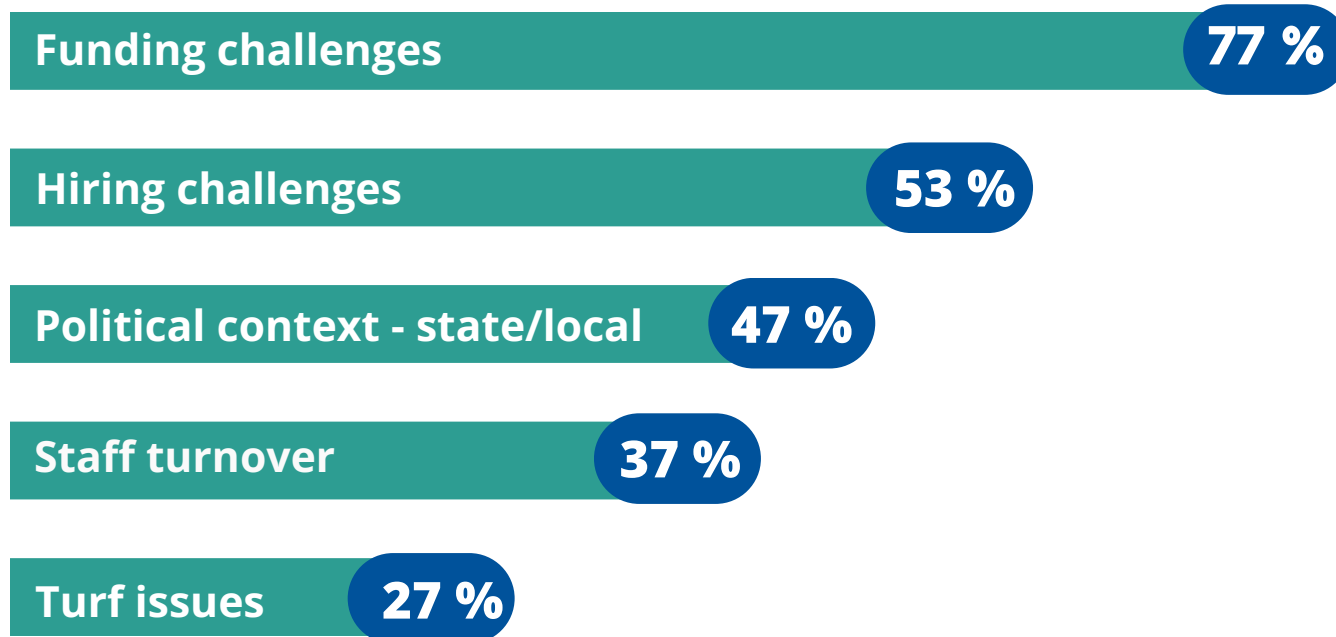
State IVP program leaders indicated their top three challenges to building IVP program infrastructure and capacity. Funding challenges (77%) was a top concern, as were hiring challenges (53%) and to a lesser extent staff turnover (37%). Political context at state and local levels (47%) and turf issues (27%) are also challenges.

Additionally, the state IVP program leaders were asked to assess their current program and staff capacity to maintain their core functions while responding to future public health emergencies. Almost 40% indicated they could maintain their core functions to a great extent, 40% could somewhat, and 20% indicated this would be possible to a very small extent or not at all.

STATE INJURY & VIOLENCE PREVENTION PROGRAMS

INFRASTRUCTURE CHALLENGES

Percent of all respondents who indicated the following are among their TOP 3 IVP program infrastructure challenges



N=30 state IVP programs

SURVEY RESULTS: STATE IVP PROGRAM CAPACITY



THREATS & OPPORTUNITIES

THREATS & OPPORTUNITIES

State IVP program leaders identified what they perceive as key threats to the IVP field and its workforce, as well as opportunities, as shown in the graphic below. These qualitative responses include threats and opportunities related to funding, workforce and staffing, and policy and advocacy.



This table provides additional details on potential threats to and opportunities for the IVP field and its workforce. In addition to the three common areas of funding, workforce, and policy and advocacy, respondents identified upstream concepts as an area of opportunity. This input included:

- Working to better demonstrate how IVP topics intersect with other public health priorities and upstream concepts, which can help IVP programs play a more prominent role in strategic prevention planning and implementation; and
- Addressing needs and challenges through shared risk and protective factor approaches.

THREATS & OPPORTUNITIES FOR IVP FIELD & WORKFORCE

THREATS	OPPORTUNITIES
FUNDING	
• Funding for IVP programs is often disproportionate given the burden of injury and violence • Inconsistent funding for IVP programs contributing to staff burnout, overwork, and limited program sustainability • Funding by injury/violence mechanism versus funding for program capacity	• Sustained funding for sustained federal and state funding to support IVP infrastructure and adequate staffing not tied to one particular injury mechanism • Capacity to establish formal, structured systems with dedicated leadership to manage and execute IVP work effectively
WORKFORCE	
• Staffing & hiring challenges, e.g., attracting and retaining IVP professionals due to non-competitive salaries, bureaucratic challenges, and heavy workloads • Lack of succession planning and loss of institutional knowledge • Burnout due to long hours, inadequate compensation, and minimal support	• Broadening the workforce to include adjacent and connected professions • Strategic training opportunities to foster connections across programs and risk areas • Practice-academia partnerships to develop workforce pathways for the next generation of IVP professionals • Expertise from lived experience brings authentic and effective strategies
POLICY & ADVOCACY	
• Insufficient public and political recognition of IVP as a critical public health issue, resulting in limited advocacy, support, and resources for the field • Short-term policy decisions impact long-term progress and can undermine momentum built in recent years, e.g., violence prevention efforts • Political and social challenges, e.g., political climate, particularly around firearms, social programs, and public health policies, hampers IVP efforts and makes securing funding and support difficult	• Mainstreaming IVP issues, e.g. gun violence, falls, and suicide becoming more mainstream topics for discussion and policy change • Cross-disciplinary collaboration from various sectors (e.g., education, law enforcement, healthcare) • Empowering local change to promote safety and well-being at the grassroots level



The Appendices section of this report provides supplementary information that supports the findings and analysis presented in the report. It includes terms and definitions, additional charts, and other relevant materials that offer deeper insights into the survey process, methodology, and results. This section is designed to provide readers with additional details and resources used in the development and analysis of the survey while keeping the main report focused on key findings and recommendations.



APPENDICES

APPENDIX A

SURVEY TERMS & DEFINITIONS



INFRASTRUCTURE

IVP Core Component: Build and Sustain a Solid & Stable Infrastructure

State of the States 2015: 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.

For context, [Healthy People 2030](#) defines infrastructure as “A strong public health infrastructure includes a capable and qualified workforce, up-to-date data and information systems, and agencies that can assess and respond to public health needs.”

Based on recent Safe States work on IVP Core Components & Standards, includes:

- Leadership
- Resources (staff/workforce, funding)
- Training and professional development
- Strategic planning
- Communications

IVP WORKFORCE & WORKFORCE DEVELOPMENT

For this survey, the term “workforce development” reflects the definition developed by the Injury and Violence Prevention (IVP) Workforce Development Strategic Plan Steering Committee in 2014. The committee, comprised of Safe States and SAVIR members, developed and implemented the 2014 Workforce Development Survey and used its results to develop a joint Injury and Violence Prevention Workforce Development Strategic Plan: FY 2015-2019.

The IVP workforce reflects numerous disciplines, roles, and work settings, and these individuals have various experiences and training in public health and/or IVP. This workforce includes, but is not limited to:

- Individuals new to public health and IVP;
- Experienced (5+ years) IVP professionals;
- Experienced public health professionals who are new to IVP;
- Program partners such as coalition members who have lived experience, but may not have formal public health or IVP knowledge or experience;
- Cross-discipline and IVP-adjacent disciplines, e.g., hospital, trauma and EMS professionals; maternal and child health professionals; adolescent health professionals; and mental health/substance abuse professionals.

The term acknowledges that, in general, **workforce development** includes a variety of strategies that are aimed at turning awareness and knowledge into mastered skills and practices to prevent injury and/or violence, and expanding the field. This includes training, professional development and other learning opportunities that are in-person and/or virtual and may address **specific IVP topics** (e.g., child passenger safety, traumatic brain injury, suicide) and/or **skill-related areas** (e.g., program management, evaluation, surveillance, health communication).

ORGANIZATION

For this survey, “**organization**” is the broad term used for all agencies like state and local health departments, trauma centers, non-profits, etc.

UPSTREAM CONCEPTS

For the purposes of this report, the term “upstream concepts” refers to Social Drivers of Health (SDOH) and Shared Risk and Protective Factor (SRPF) approaches.

Social Drivers of Health

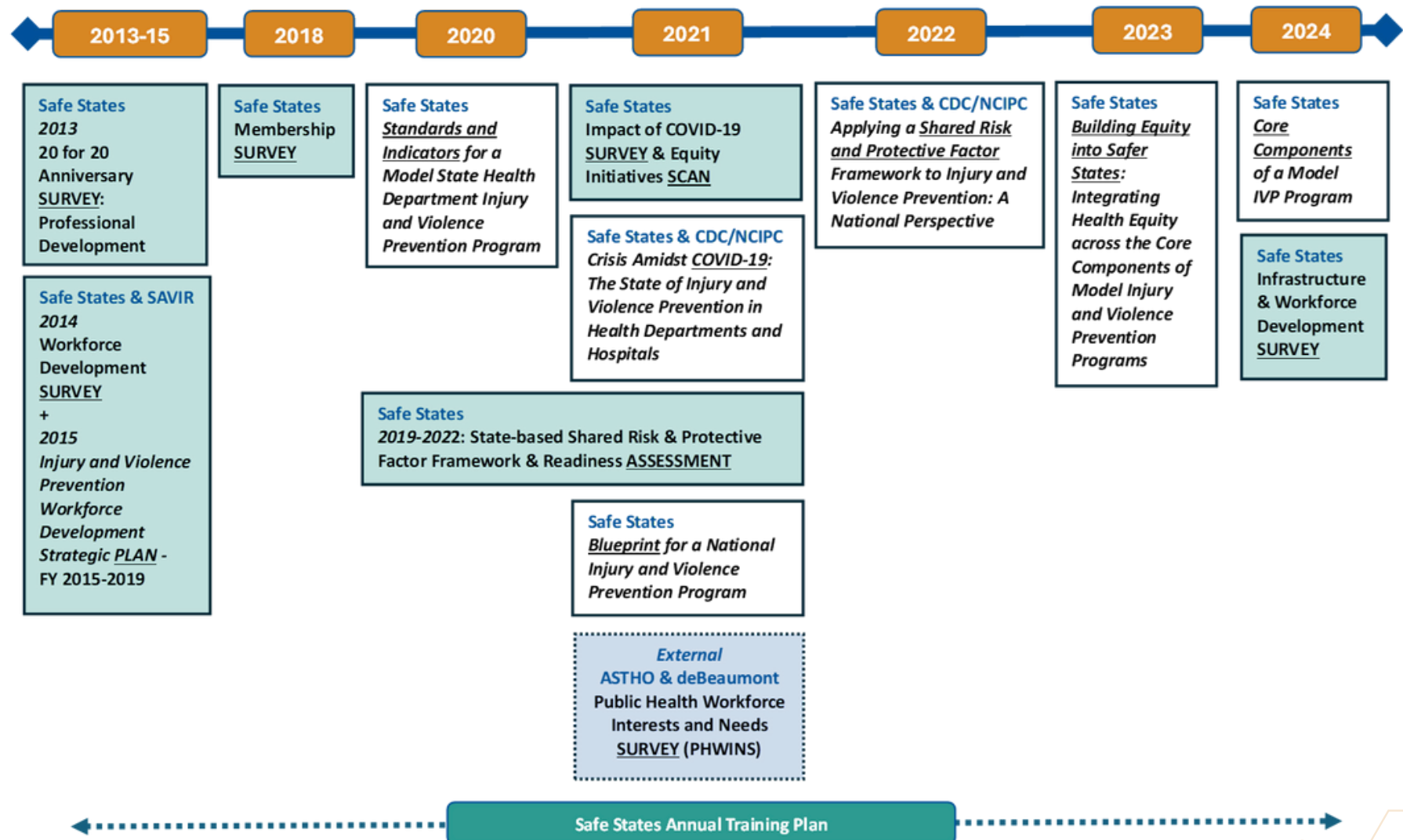
The social drivers (also referred to as determinants) of health can be defined as conditions and contexts in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions can be social, economic, or physical, and they include policies, systems, and environments. They also encompass common risk and protective factors to extend far beyond individual factors. Social drivers of health can be attributed to larger factors that influence individual choices, and not individual choices alone. (Adapted from: [U.S. Department of Health and Human Services, HealthyPeople.gov; Centers for Disease Control and Prevention; Jones, 2016](#))

Shared Risk and Protective Factor Approaches

These approaches can be defined as efforts to improve multiple population health and quality-of-life outcomes by aligning a variety of multisector interventions that positively impact the social drivers of health. 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.

APPENDIX B

OVERVIEW OF SAFE STATES' SURVEYS, ASSESSMENT, SCAN & REPORTS





SURVEY METHODS – Content development

The survey had 96 total potential questions, with a reduced number of questions for most respondents due to numerous skip patterns. The key content asked of all survey respondents is presented in Figure 2. Respondents who indicated through skip patterns that they are one of Safe States' current 43 State Designated Representatives were asked an additional, separate set of questions focusing on state IVP program capacity.

To develop survey content, Safe States staff conducted online research of existing public health and IVP workforce development surveys and publications to gather information on potential content (e.g., key IVP or public health concepts or topics in need of further understanding or updating) and context. Existing Safe States surveys, assessments, scans, and reports were also reviewed, including the Safe States IVP Workforce Development Survey conducted in 2014.



NOTE

The data collection, analysis and report preparation for this survey was conducted in 2024, prior to the issuance of Executive Order "Ending Radical And Wasteful Government DEI Programs And Preferencing" on January 20, 2025. This report is conveying the findings of that assessment. Future workforce development efforts to enhance capacity across the injury and violence prevention workforce will be developed in compliance with current federal guidance.

**Figure 2. KEY CONTENT of the Safe States Alliance
2024 Injury & Violence Prevention Program Infrastructure & Workforce Development Survey**

DEMOGRAPHICS • State/Territory • Organization type • Supervisory level • Primary role • Other roles • Area of focus • Geographic focus of work • Rural - Populated areas • Key partners • Full vs Part Time • Years of IVP work experience • Path to first IVP job • Retention & retirement • Education/Certifications • Gender • Race/ethnicity	REMOTE/VIRTUAL WORK • Preferred work situation • Importance • <u>Current status</u>	ORIENTATION & T RAINING/ PROFESSIONAL DEVELOPMENT • Organization type • Staff orientation/onboarding process • Individual training plan • Training motivation • Use of Safe States resources • Participation in Safe States programs/ opportunities • Barriers to participation in Safe States programs or opportunities • Coaching/mentoring program: Participation, desired features • Desired WFD opportunities/ training in: - IVP Areas - Upstream approaches - Cross-cutting skills • Format of WFD opportunities • IVP Certificate Program interest
BURNOUT • <u>Current status</u> • Contributing factors		
IVP FIELD & WORKFORCE • Threats • Opportunities		
ADVOCACY & POLICY Ability/allowed to: • Coordinate • Educate • Disseminate		
UPSTREAM CONCEPTS of HEALTH/RACIAL EQUITY – SOCIAL DRIVERS OF HEALTH - SHARED RISK & PROTECTIVE FACTOR APPROACH • Organization's <u>current status</u> & level/type of involvement • Influencing factors • Respondent's knowledge and confidence applying • Format of WFD opportunities • IVP Certificate Program interest		
STATE IVP PROGRAM CAPACITY (completed by Safe States State Designated Representatives only) A separate set of questions was asked from respondents who serve as the State Designated Representative (SDR) to Safe States Alliance and typically lead their state IVP program. Questions about their state IVP programs included: • Organizational home • Staff number, roles & succession planning • Programs implemented • Funding type & amount • Infrastructure challenges • Resources needed		SKILLS (Respondent self-assessment) • IVP core competency skills • Strategic & cross-cutting public health skills

SURVEY METHODS – Dissemination

Dissemination of the survey included the following:

- The survey was conducted May 1 – June 14, 2024.
- An email was sent to 3,000+ Safe States members and partners with a brief overview of the survey and its purpose, plus a shareable survey link. Survey recipients reflect diverse disciplines, roles, work settings, training, and experience.
- Email recipients could forward the shareable survey link to their contacts and promote the survey through their internal and partner communications.
- Safe States communications metrics showed that the email requesting survey participation was forwarded to at least one other person 451 times. Some of these individuals likely also forwarded the email with survey information to their networks, providing a reach beyond the initial email.
- The survey was promoted via Safe States' online newsletter and website, periodic member and partner emails to encourage survey completion, and via direct communication with committees and special interest groups by Safe States staff.

A separate Safe States webpage was created to provide details about the IVP Program

Infrastructure & Workforce Development survey. An excerpt is shown below. The webpage had information on the purpose of the survey, intended audience, reasons to complete the survey, examples of how the survey data will be used, and key terms and definitions.

WHO This survey is meant for anyone whose work includes injury and/or violence prevention in some capacity. Safe States is sending this survey to all its members and partners. Share the survey link with colleagues and partners so the survey reflects the variety and breadth of the IVP workforce

Share the survey link!
Anyone can forward the survey to their IVP colleagues & partners

IVP PROFESSIONALS ARE prevention practitioners, researchers, healthcare and mental health care providers, community organizations, law enforcement, criminal justice, fire/EMS, teachers and professors, college and graduate students, social workers, policy makers, persons serving in the U.S. military, engineers, sociologists, *and many other*

WHY Here are some compelling reasons why it's worth your effort to participate in this unique survey:

1. Reflect the IVP Workforce
2. Voice Your Perspective
3. Make a Case for Advocacy and Funding
4. Inform Strategic Planning
5. Stronger Future

Top 5 Reasons
to complete the
Infrastructure & Workforce Development Survey

STRONGER INFRASTRUCTURE & WORKFORCE

SURVEY METHODS – Response & Analysis

Survey response

A total of 393 respondents were included in the full survey analysis. While 414 individuals started the survey, 21 respondents were excluded from analyses because they only filled out the first question and nothing beyond that point.

As noted in the previous dissemination information, Safe States communications metrics showed that the email requesting survey participation was forwarded to at least one other person 451 times. Some of these individuals likely also forwarded the email with survey information to their networks, providing a reach beyond the initial email.

The additional set of questions about state IVP program capacity was completed by 30 of the current 43 State Designated Representatives, the Safe States members who are leaders of state IVP programs and activities. Fourteen of these State Designated Representatives only completed the additional set of questions and not the full survey. The results of these questions on state IVP program capacity were analyzed separately and also are presented in a separate section of this report.

Survey analysis

Quantitative data were analyzed using Strata and Excel. Frequencies and percentages were calculated for responses to each quantitative survey question. The percentages presented in the survey results, tables and graphics represent the number of respondents who answered a given question, and do not account for missing data. The response options to a few selected variables were grouped by similar variables and/or categorized by higher-level themes following initial analyses.

- In addition, qualitative codes were generated for open-ended questions and questions with at least 5-10 responses that had enough alignment to generate meaningful codes. Inductive coding techniques (building codes from the ground up rather than using pre-determined codes to analyze the answers) were used to glean salient themes. For questions with a high response rate and robust qualitative data (i.e., many participants providing detailed qualitative responses), higher-level themes were also generated. These higher-level themes are intended to categorize the salient themes generated into a few meaningful categories.