The Safe States Alliance is a national non-profit organization and professional association whose mission is to serve as the national voice in support of state and local injury and violence prevention professionals engaged in building a safer, healthier America.

To advance this mission, Safe States Alliance engages in activities that include:

- Increasing awareness of injury and violence throughout the lifespan as a public health problem;
- Enhancing the capacity of public health agencies and their partners to ensure effective injury and violence prevention programs by disseminating best practices, setting standards for surveillance, conducting program assessments, and facilitating peer-to-peer technical assistance;
- Providing educational opportunities, training, and professional development for those within the injury and violence prevention field;
- Collaborating with other national organizations and federal agencies to achieve shared goals;
- Advocating for public health policies designed to advance injury and violence prevention;
- Convening leaders and serving as the voice of injury and violence prevention programs within state health departments; and
- Representing the diverse professionals that make up the injury and violence prevention field.

For more information about the Safe States Alliance, contact the national office:

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Suggested citation:

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The Public Health Injury Surveillance and Prevention Program (PHISP) was developed by the Centers for Disease Control and Prevention (CDC) in 2000 to support states in their efforts to prevent injuries and violence. The PHISP was formally known as the Core State Injury Program, as grants funded through this program supported the “core” infrastructure, capacity building, surveillance, and programmatic activities of state injury and violence prevention programs.

In 2009, 30 states were funded through the CDC Core State Injury Program. This report – a sub-analysis of the State of the States: 2009 Report – compares specific capacity measures of Core funded and non-Core funded state injury and violence prevention programs. Similar to the State of the States report, this analysis is organized around to the five core components defined by the Safe States Alliance as crucial to the development, growth, and sustainability of innovative and effective state injury and violence programs:

1. Build a solid infrastructure for injury and violence prevention;
2. Collect and analyze injury and violence data;
3. Design, implement, and evaluate programs;
4. Provide technical support and training; and
5. Affect public policy.

In comparing measures associated with these core components, the differences the between states with and without Core funding can be more clearly recognized.

It is hoped that the data presented within this report can highlight the true significance of the Core State Injury Program (now known as the Core Violence and Injury Prevention Program or Core VIPP). It is also hoped that this report will provide additional evidence to support the development of a truly nationwide Core program, with funding for all state and territorial public health departments. An adequately funded and appropriately staffed injury and violence prevention program within state and territorial public health departments is necessary to effectively prevent injuries and violence throughout the United States. By funding all states and territories through a national program, CDC will be able to more effectively provide essential support to states as they work to successfully, sustainably, and measurably prevent injuries and violence in communities throughout the United States.

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BACKGROUND

Injuries continue to be the leading cause of death among persons from 1 to 44 years of age in the United States. Injury is a significant public health problem because of the impact on the health of Americans, including premature death, disability, and the burden placed on the health care system. In 2007, more than 182,000 people died due to injury and violence. However, most of these deaths are preventable. Each year, 50 million people are injured severely enough to require medical treatment. Hospital emergency departments treat an average of 55 people for unintentional and violence-related injuries every minute.

Unintentional and violence-related injuries are not only common, but costly. The 50 million injuries that required medical treatment in the year 2000 alone will ultimately cost the U.S. $406 billion. This includes over $80 billion in direct medical costs (6% of total health care expenditures) and $326 billion in lost productivity.

Fortunately, violence and injuries are preventable. Preventing violence and injury before it occurs involves a comprehensive and coordinated approach to address the complex underlying factors that contribute to the occurrence of violence and injuries. This comprehensive and coordinated approach is often referred to as a “public health approach.” It involves data collection and analysis, identifying the populations and locations at greatest risk, identifying risk and protective factors, and developing and utilizing evidence-based strategies and programs to address violence at the individual, family, community, and societal levels.

This public health approach to violence and injury prevention is most effectively facilitated through state injury and violence prevention programs.

A comprehensive and effective injury and violence prevention program at the state health department provides focus and direction, coordinates and finds common ground among the many prevention partners, and makes the best use of limited injury and violence prevention resources. A state health department injury and violence prevention program grounded in a public health approach and attuned to the five core components is best positioned for this challenge.

Given the importance of state programs in preventing and addressing issues of injury and violence, it is critical to conduct regular assessments of state capacity to provide for the essential public health services and collectively make progress in reducing injury and violence related deaths and disability in each state and throughout the nation.

State of the States: 2005 - 2009 Core Funding Report

The State of the States Report is published biannually to further develop a comprehensive picture of the status of U.S. state health department injury and violence prevention programs over time.

The State of the States: 2009 Core Funding Report is a sub-analysis of the 2009 State of the States Report. It explores the relationship between core funding and the characteristics of state programs in 2009, with comparisons to 2005 and 2007. The data includes the following breakdown of core funded and non-core funded states:

- **2005** – 30 core funded states and 19 non-core funded states (N=49)
- **2007** – 30 core funded states and 21 non-core funded states (N=51)
- **2009** – 29 core funded states and 20 non-core funded states (N=49)

FIGURE 1. STATES (SHOWN IN PURPLE) RECEIVING FUNDING THROUGH THE CDC PUBLIC HEALTH INJURY SURVEILLANCE AND PREVENTION PROGRAM, 2009

Methodology

The 2009 State of the States Survey was reviewed with a pilot group of states and a contracted evaluator. Most questions remained the same between 2005, 2007 and 2009; however, some were updated for clarification purposes. Additionally, new questions were added to the 2009 survey, including some related to funding and specific injury and violence topic areas.

The 2009 State of the States Survey was administered in early 2010 to collect data on the status of programs in 2009. A total of 49 states participated in the 2009 State of the States Survey. However, not all states responded to all survey questions, so the number of states responding to each question varies, as noted in figures, tables, and the document text.

For a full description of methodology, see the State of the States: 2009 Report.

Data Analysis

The data in this sub-analysis was conducted using chi-square tests of association with an alpha of 0.05.

Special considerations regarding the data presented include:

- Results within the report are organized around each of the five core components identified by the Safe States Alliance as essential elements of a comprehensive state health department injury and violence prevention program.
- Some questions, such as those about injury and violence prevention program staff, were asked at the individual level instead of the state level. For these questions, the exact number of staff...
members referenced in each question is reported in the figures, tables, and document text.

- All totals on graphs and charts may not add up to 100% due to rounding and occurrences in which the respondents could select more than one response (i.e., “check all that apply”).

The results presented in this report were analyzed using the statistical software, Statistical Package for the Social Sciences (SPSS), Version 16.0.

Datasets used in the DATA section of this report include:

- Behavioral Risk Factor Surveillance System (BRFSS)
- Child Death Review data (CDR)
- Emergency Department data (ED)
- Emergency Medical Services (EMS or EMSC)
- Fatality Analysis Reporting System (FARS)
- Hospital Discharge Data (HDD)
- Medical Examiner Systems (ME)
- National Occupant Protection Use Survey (NOPUS)
- Uniform Crime Reporting System data (UCR)
- National Violent Death Reporting System (NVDRS)
- Vital records
- Youth Risk Behavior Surveillance System data (YRBSS)
- State surveys
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### MAJOR FINDINGS & HIGHLIGHTS

#### INFRASTRUCTURE

<table>
<thead>
<tr>
<th>Program Location</th>
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<tbody>
<tr>
<td><strong>States with core funding were significantly more likely to have a centralized program (i.e. a program in which there is a specific, identified injury and violence prevention program) than states without core funding in 2009 (p=0.032).</strong></td>
</tr>
<tr>
<td><strong>The percentage of IVP programs located in health promotion and disease prevention units decreased for both core and non-core states from 2007 to 2009, while maternal and child health/family health and other increased during this same time frame for both core and non-core states.</strong></td>
</tr>
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</table>

#### Partnerships

| **States with core funding were significantly more likely to have 11 or more strong partnerships within and outside the state health department than states without core funding (p=0.035).** |
| **The percent of states with strong state level partnerships with highway safety, the department of transportation, and criminal justice/law enforcement was at least 25% higher for core states compared to non-core states.** |
| **States with core funding were significantly more likely to have a strong partnership with the Federal Highway Administration (FHA) and the National Highway Traffic Safety Administration (NHTSA) than states without core funding in 2009 (p=0.022 and 0.035, respectively). None of the non-core states had a strong partnership with the FHA.** |

#### Local Support

| **The percentage of non-core states providing local support progressively decreased from 84% in 2005 to 71% in 2009.** |
| **Core states: The percentage of states supporting local efforts with pass-through funds, block grant funds, and other federal funds increased from 2005 to 2007 then remained steady in 2009.** |
| **Non-core states: The percentage of states supporting local efforts with pass-through funds, block grant funds, and other federal funds decreased from 2005 to 2007 then increased from 2007 to 2009.** |

#### Staff

| **In 2009, states with core funding (N=22) were significantly more likely than states without core funding (N=9) to have a full-time director (p=0.028). Additionally, the percentage of core states with a full-time director was higher than non-core states by at least 20% from 2005-2009.** |
| **The percentage of states with a full-time director decreased for both core and non-core states from 2005-2009.** |
| **Compared to non-core states, core states had a higher percentage of staff sizes that included six staff members or more in 2007 and 2009.** |
### DATA

#### Access to Datasets
- In 2009, core states reported having access to every dataset equal to or at a higher percentage than non-core states. Core states reported having at least 20% more access than non-core states to the following datasets: Emergency Department data (ED), Emergency Medical Services (EMSC), Hospital Discharge data (HDD), National Occupant Protection Use Survey (NOPUS), Uniform Crime Reporting System data (UCR), and state surveys.
- States with core funding (N=28, 97%) were significantly more likely than states without core funding (N=15, 75%) to have access to HDD in 2009 (p=0.025).

#### Access to Epidemiologists
- In 2009, states with core funding (N=17) were significantly more likely than non-core funded states (N=3) to have access to an epidemiologist 100% of the time or more (p=0.002). Eleven percent of non-core states did not have access to an epidemiologist at all.

### PROGRAMS

#### Primary Programmatic Focus Areas
- In 2009, states with core funding were significantly more likely than states without core funding to list motor vehicle injuries, traumatic brain injuries, and fall injuries as primary programmatic focuses (p=0.012, 0.037, and 0.003, respectively).

#### Select Topic Areas
- In 2009, states with core funding were significantly more likely than states without core funding to have programs (p=0.001) and/or activities (p=0.001) related to falls prevention among older adults and teen dating violence prevention.

### TRAINING

#### Technical Support & Training Methods
- In 2007 and 2009, the percent of states using every type of technical assistance method, such as conducting in-person trainings or offering courses for academic credit, was higher for core states compared to non-core states.

### POLICY

#### Methods Used to Inform Public Policy
- In 2009, states with core funding (N=24, 86%) were significantly more likely than non-core states (N=8, 47%) to request the opportunity to review bills (p=0.006).
- Both core and non-core states reported increases in policy-related efforts between 2005 and 2009:
  1. Meetings with policy makers increased 39% for core and non-core states
  2. Efforts to increase public awareness of laws increased 25% for core states and 23% for non-core states.
Key components and characteristics of a state injury and violence prevention program’s infrastructure include state mandates, program focus, program location, strategic planning, staffing, funding, partnerships and collaboration. Each of these components and characteristics has the potential to affect the way in which a state injury and violence prevention program is structured and how it functions.

Centralized/Decentralized Program

A centralized program is one in which there is a specific, identified injury and violence prevention program. A decentralized program is one in which injury and violence prevention efforts are dispersed, with multiple programs responsible for different aspects of injury and/or violence prevention.

- States with core funding were significantly more likely to have a centralized program than states without core funding in 2009 (p=0.032).
- Core funded states had a higher percentage of centralized IVP programs than non-core states in 2007 and 2009 despite the percentage decreased among core-funded states.
State Mandate

A state mandate for an injury and violence prevention program refers to a state-initiated policy that requires the state government to establish, expand, modify, or maintain a state injury and violence prevention program. State mandates may originate from a variety of sources including the state legislature, the state public health office, or another source. Mandates may address features such as the existence of the injury and violence prevention program, the program’s placement within the state system, the duties of the program, and program funding.

- Reported state mandates fluctuated among both core and non-core states from 2005 to 2009.
- In 2009, the percentage of reported state mandates among core funded states and non-core funded states was approximately equal.
- In 2009, 12 states had mandates.
- In 2009, only 2 of the 12 mandates were funded, both of which were in non-core states.

Location

Location refers to the type of organization as well as the division within an organization that is responsible for state injury and violence prevention efforts.

General Location

- Nearly all IVP programs have been located in state health departments since 2005.
Location Within State Health Departments:

- The most common location for IVP programs was the health promotion and disease prevention division for both core and non-core states from 2005 – 2009.

- The percentage of IVP programs located in health promotion and disease prevention units decreased for both core and non-core states from 2007 to 2009, while program located in maternal and child health/family health divisions and other divisions increased during this same time frame for both core and non-core states.
State Plan

State plan refers to either a statewide or health department strategic plan that includes activities to prevent injury and violence.

- All core-funded states had at least one type of state plan in 2007 and 2009.
- The percentage of non-core states with a state plan has increased from 84% to 90% from 2005 to 2009.

Strong Partnerships

The strength of partnerships refers to the level of collaboration and coordination state IVP programs have with internal and external stakeholders.

Strong partnerships overall

- States with core funding were significantly more likely to have 11 or more strong partnerships than states without core funding (p=0.035)

Within the state health department:

- Core states had a higher percentage of strong partnerships with vital statistics, maternal and child health, health promotion/education, and epidemiology than non-core states.

---

5 Includes 2009 data only.
With other state agencies

- Core states had a higher percentage of strong partnerships with each of the most common state agencies compared to non-core states, but none were significantly different.
- The percent of states with strong partnerships with highway safety, the department of transportation, and criminal justice/law enforcement was at least 25% higher for core states than non-core states.

With non-governmental organizations

- Core states had a higher percentage of strong partnerships with each of the most common non-governmental organizations compared to non-core states, but none were significantly different.

With non-state governmental organizations

- Core states had a higher percentage of strong partnerships with CDC, NHTSA, local health departments, HRSA, and FHA than non-core states.
- States with core funding were significantly more likely to have a strong partnership with FHA and NHTSA than states without core funding in 2009 (p=0.022 and 0.035, respectively).
- None of the non-core states had a strong partnership with the Federal Housing Administration (FHA).

### TABLE 3. STRONGEST PARTNERSHIPS WITH OTHER STATE HEALTH DEPARTMENTS BY CORE FUNDING STATUS

<table>
<thead>
<tr>
<th>Partner</th>
<th>Core (N=28)</th>
<th>Non-Core (N=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highway Safety</td>
<td>86%</td>
<td>61%</td>
</tr>
<tr>
<td>Department of Transportation</td>
<td>68%</td>
<td>39%</td>
</tr>
<tr>
<td>Criminal Justice/Law Enforcement</td>
<td>68%</td>
<td>39%</td>
</tr>
<tr>
<td>State Universities</td>
<td>61%</td>
<td>56%</td>
</tr>
<tr>
<td>Fire Dept/Fire Marshall</td>
<td>57%</td>
<td>56%</td>
</tr>
</tbody>
</table>

### TABLE 4. STRONGEST PARTNERSHIPS WITH NON-GOVERNMENTAL ORGANIZATIONS BY CORE FUNDING STATUS

<table>
<thead>
<tr>
<th>Partner</th>
<th>Core (N=28)</th>
<th>Non-Core (N=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Kids Coalitions</td>
<td>86%</td>
<td>67%</td>
</tr>
<tr>
<td>Brain Injury association</td>
<td>64%</td>
<td>50%</td>
</tr>
<tr>
<td>Children’s Safety Network</td>
<td>61%</td>
<td>33%</td>
</tr>
<tr>
<td>Injury Prevention Research Center</td>
<td>29%</td>
<td>22%</td>
</tr>
<tr>
<td>Safety Council</td>
<td>29%</td>
<td>17%</td>
</tr>
</tbody>
</table>

### TABLE 5. STRONGEST PARTNERSHIPS WITH NON-STATE GOVERNMENTAL ORGANIZATIONS BY CORE FUNDING STATUS

<table>
<thead>
<tr>
<th>Partner</th>
<th>Core (N=29)</th>
<th>Non-Core (N=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centers for Disease Control and Prevention (CDC)</td>
<td>86%</td>
<td>60%</td>
</tr>
<tr>
<td>National Highway Traffic Safety Administration (NHTSA)</td>
<td>66%</td>
<td>30%</td>
</tr>
<tr>
<td>Local Health Departments</td>
<td>55%</td>
<td>25%</td>
</tr>
<tr>
<td>The Substance Abuse and Mental Health Services Administration (SAMHSA)</td>
<td>28%</td>
<td>30%</td>
</tr>
<tr>
<td>Health Resources and Services Administration (HRSA)</td>
<td>24%</td>
<td>20%</td>
</tr>
<tr>
<td>Federal Housing Administration (FHA)</td>
<td>28%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Local Support

Local support refers to any financial or in-kind support that state IVP programs to address injury and violence prevention at the local level.

General Local Support

- Core states consistently provided local support at a higher percentage than non-core states in 2005, 2007, and 2009.
- The percentage of non-core states providing local support progressively decreased from 84% in 2005 to 71% in 2009.

Funding Sources

- Core states: The percentage of states supporting local efforts with pass-through funds, block grant funds, and other federal funds increased from 2005 to 2007 then remained steady in 2009.
- Non-core states: The percentage of states supporting local efforts with pass-through funds, block grant funds, and other federal funds decreased from 2005 to 2007, then increased from 2007 to 2009.
Methods of Local Support

- For every method used to provide local support in 2007 and 2009, the percentage of core states was higher than the percentage of non-core states (except in-kind support for training in 2009).

- In-kind support for epidemiology and data: The percentage of core states using this method increased from 19% from 2005 to 2009 while the percentage of non-core states using this method decreased 13%.

- In-kind support for program development: The percentage of core states using this method increased 21% from 2005 to 2009 while the percentage of non-core states using this method decreased 25%.

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6 In 2005, in-kind support for program development was grouped with in-kind support for evaluation.
Staff

Hiring and maintaining capable staff with experience in the Core Competencies for Injury and Violence Prevention is essential to successfully operating effective state injury and violence prevention programs. Having a balance of experienced staff, with opportunities for new staff is critical for building and sustaining statewide injury and violence prevention efforts.

Full-time Director

- In 2009, states with core funding (N=22) were 1.69 times more likely than states without core funding (N=9) to have a full-time director.
- The percentage of states with a full-time director decreased for both core and non-core states from 2005-2009.

Staff Size

- Compared to non-core states, core states had a higher percentage of staff sizes that included six staff members or more in 2007 and 2009.
- The majority of non-core states had five or fewer paid staff in 2007 (76%) and 2009 (59%).
To track health problems, state injury and violence prevention programs use a public health approach that begins with consistent access to accurate data. However, the wide range of circumstances under which injuries and violence occur means that there are many different types of injuries (i.e., motor vehicle crashes, drownings, falls, fires, homicides, and suicides), risk factors, and degrees of severity for which to collect data. No single data source can provide all the data needed to accurately describe the burden of injury and violence. As a result, programs collaborate closely to collect information about each injury from a variety of sources such as hospital emergency departments, vital records (death certificates), crime reports, and special registry systems.

**Access to Datasets**

- Overall, both core and non-core states had the most accessibility to BRFSS, CDR, FARS, HDD, Vital Records, and YBRSS.
- In 2009, core states reported having access to every dataset equal to or at a higher percentage than non-core states. Core states reported having at least 20% more access than non-core states to the following datasets – ED, EMSC, HDD, NOPUS, UCR, and state surveys.
- In 2009, states with core funding (N=28, 97%) were significantly more likely than states without core funding (N=15, 75%) to have access to hospital discharge data (HDD) (p=0.025).

**Trends: Core and Non-Core States**
- Access to CDR, FARS, and UCR increased progressively from 2005 to 2009.
- **Trends: Core States Only**
- Access to BRFSS, ED, EMSC, and YRBSS increased progressively from 2005 to 2009.
- **Trends: Non-Core States Only**
- Access to HDD, NOPUS, and NVDRS increased progressively from 2005 to 2009.

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7 Access to datasets includes states that had incomplete data.

Use of Datasets

- Overall, core states reported higher use of datasets in both 2005 and 2009 compared to non-core states.
- However, comparing core states’ usage in 2005 to core states’ usage in 2009, reported usage decreased among nine datasets. Similarly, comparing non-core states’ usage in 2005 to non-core states’ usage in 2009, reported usage decreased among two datasets. On average, dataset usage decreased 8% for core states and increased 7% for non-core states from 2005 to 2009.

TABLE 6. PERCENT CHANGE OF DATA USAGE BY CORE FUNDING STATUS FROM 2005 TO 2009

<table>
<thead>
<tr>
<th>Dataset</th>
<th>Core (%)</th>
<th>Non-Core (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRFSS</td>
<td>-10</td>
<td>12</td>
</tr>
<tr>
<td>CDR</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>ED</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>EMSC</td>
<td>-46</td>
<td>5</td>
</tr>
<tr>
<td>FARS</td>
<td>-20</td>
<td>14</td>
</tr>
<tr>
<td>HDD</td>
<td>-4</td>
<td>-20</td>
</tr>
<tr>
<td>ME</td>
<td>-4</td>
<td>4</td>
</tr>
<tr>
<td>NOPUS</td>
<td>-4</td>
<td>-26</td>
</tr>
<tr>
<td>UCR</td>
<td>-16</td>
<td>41</td>
</tr>
<tr>
<td>NVDRS</td>
<td>25</td>
<td>8</td>
</tr>
<tr>
<td>Vital Records</td>
<td>-4</td>
<td>7</td>
</tr>
<tr>
<td>YRBSS</td>
<td>-17</td>
<td>8</td>
</tr>
</tbody>
</table>

8 Use of datasets only includes those states that had access to datasets.
Access to Epidemiologists

- Seventy-nine percent of core states reported they had sufficient access to an epidemiologist compared to 58% of non-core states in 2009.

- In 2009, states with core funding (N=17) were significantly more likely than non-core funded states (N=3) to have access to an epidemiologist 100% of the time or more (p=0.002).

- Eleven percent (N=2) of non-core states did not have access to an epidemiologist at all.

FIGURE 20. PERCENT OF TIME STATES HAVE ACCESS TO AN EPIDEMIOLOGIST BY CORE FUNDING STATUS IN 2009
Collaboration with internal and external stakeholders is critical to promote the development, implementation, evaluation, and sustainability of injury and violence prevention programs. Ideally, these prevention programs should serve a variety of populations across the lifespan, address multiple types of injuries and violence, be built upon evidence-based research, include a multi-faceted evaluation, and disseminate evaluation findings. State injury and violence prevention programs should also support and monitor injury and violence prevention activities at the local level. However, given limited resources, programs should prioritize interventions that have the strongest evidence base available and can reach those at highest risk of injury.

Primary Programmatic Focus Areas

States were provided with a list of prevention program areas and asked to identify whether the area was a primary area of focus, secondary area of focus, minimal focus, or not a focus.

- In 2009, states with core funding were significantly more likely than states without core funding to list motor vehicle injuries, traumatic brain injuries, and fall injuries as primary programmatic focus areas (p=0.012, 0.037, and 0.003, respectively).
- Core states cited an average of nine primary programmatic focus areas compared to only an average of five primary programmatic focus areas for non-core states in 2009.
- In 2009, the majority of core states (over 50%) cited motor vehicle injury, children passenger safety, fall injury, injuries to children, suicide/self inflicted injury, and traumatic brain injury as areas of primary programmatic focus. In contrast, non-core states did not have any areas joint of programmatic focus (i.e. where over 50% of states listed it as “primary”).

Trends

- Core states: The percentage citing fall injury as a primary focus increased progressively from 2005 to 2009 (32% increase).
- Non-core states: The percentage citing injuries to adolescents as a primary focus decreased progressively from 2005 to 2009 (17% decrease overall).
- Traumatic brain injury: The percentage citing TBI as a primary focus progressively increased for core states (18% increase) but decreased for non-core states (17% decrease) from 2005 to 2009.
- Intimate partner violence: The percentage citing TBI as a primary focus progressively decreased for both core (12%) and non-core states (22%) from 2005 to 2009.

<table>
<thead>
<tr>
<th>TABLE 7. TOP AREAS OF PRIMARY PROGRAMMATIC FOCUS BY CORE FUNDING STATUS IN 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core States (N=29)</td>
</tr>
<tr>
<td>Motor vehicle injury</td>
</tr>
<tr>
<td>Child passenger safety</td>
</tr>
<tr>
<td>Fall injury</td>
</tr>
<tr>
<td>Injuries to children</td>
</tr>
</tbody>
</table>
Select Topic Areas

In the 2009 State of the States Survey, as in previous surveys, states were asked about select injury and violence prevention topic areas in greater detail. In 2009, states were asked about program integration, falls among older adults, child maltreatment, and teen dating violence.

Preventing child maltreatment

- The percent of core states that included child maltreatment prevention programs/activities decreased 14% from 2007 to 2009, but was still higher than that of non-core states in both 2007 and 2009.

Preventing falls among older adults

- The percent of core states that had programs/activities addressing falls among older adults increased 23% from 2007 to 2009 and was higher than the percent of non-core states in both 2007 and 2009.

Preventing teen dating violence

- 61% of core states had programs/activities to address teen dating violence compared to 28% of non-core states in 2009, a 33% difference.

Significant differences

- In 2009, states with core funding were significantly more likely than states without core funding to have any programs and/or activities related to falls prevention among older adults and teen dating violence prevention (p=0.001 for both).
Knowledgeable staff members are necessary for a state injury and violence prevention program to succeed. Training for staff should include:

- Foundational training in the principles, practices, and competencies necessary to successfully conduct injury and violence prevention activities;
- On-the-job training; and
- Continuing education.

Areas of training may include how to conduct strategic planning, build and sustain coalitions, collect and analyze data, evaluate prevention programs, and affect public policy. The core competencies for injury and violence prevention practitioners, developed by the National Training Initiative (NTI) for Injury and Violence Prevention\(^9\) are an essential resource that can provide guidance for training.

State injury and violence prevention programs should also be equipped to provide practical injury and violence prevention training and technical support at both basic and advanced levels to state and local professionals, students, and the public. The transfer of knowledge and skills is an essential part of building capacity for injury and violence prevention, especially at the local level.

**Technical Support & Training Methods**

- In 2007 and 2009, the percent of states using every type of technical assistance method was higher for core states compared to non-core states.
- **Offering courses for academic credit:** The percentage of states using this method progressively increased for core states (31%) and non-core states (14%) from 2005 to 2009.
- **Responded to requests for technical assistance:** In 2009, 90% of core states used this method compared to 75% of non-core states.

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\(^9\) Safe States Alliance has partnered with the Society for the Advancement of Violence and Injury Research (SAVIR) to create a joint initiative known as the National Training Initiative (NTI). Through NTI, both organizations have worked together to develop Core Competencies to address the training needs of professionals working in the field of injury and violence prevention.
• **Offered practical experience:** The percentage of states using this method decreased 18% for core states and decreased 7% for non-core states from 2005 to 2009.

• **Conducted video conference via computer:** The percentage of core states using this method increased from 10% to 31% from 2005 to 2009 (21% increase), while only 5% of non-core states used this method in both 2005 and 2009.

**Communication Methods Used**

Communication methods include those used to communicate injury and violence prevention-related information to other injury and violence prevention professionals and to the general public.

• In 2009, every communication method was used at a higher percentage among core states compared to non-core states.

• **TV/radio/newspapers:** The percentage of core states using this method gradually increased 18% from 2005 to 2009 but decreased 20% for non-core states.

• **Regular mailings:** The percentage of states using this method decreased 9% for core states and 43% for non-core states from 2005 to 2009.

• Use of the following communication methods decreased for non-core states from 2005 to 2009:
  - Listserv (28% decrease)
  - Website (14% decrease)
  - Participating in steering committees/meetings (14% decrease)

**TABLE 8. COMMUNICATION METHODS USED IN 2009 BY CORE FUNDING STATUS**

<table>
<thead>
<tr>
<th>Communication Method Used</th>
<th>Core (N=29)</th>
<th>Non-Core (N=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participated in steering committees, community meetings, and professional meetings</td>
<td>93%</td>
<td>75%</td>
</tr>
<tr>
<td>Website</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>Listserv</td>
<td>52%</td>
<td>35%</td>
</tr>
<tr>
<td>TV/radio/newspaper</td>
<td>48%</td>
<td>35%</td>
</tr>
<tr>
<td>Newsletter</td>
<td>24%</td>
<td>10%</td>
</tr>
<tr>
<td>Regular mailings</td>
<td>24%</td>
<td>10%</td>
</tr>
</tbody>
</table>
Policy interventions are important and effective community and societal level strategies for improving the public’s health. Public health policy interventions influence systems development, organizational change, social norms, and individual behavior to promote improvements in the health and safety of a population.

The most effective policy changes are grounded in scientific evidence, embraced by a variety of stakeholders, and approved by policy makers. It is important for a state injury and violence prevention program to have established methods to inform policy decisions that have an impact on injury and violence given that state and local policies and statutes can substantially contribute to reducing the burden of injury and violence.

Methods Used to Inform Public Policy

- In 2009, states with core funding (N=24, 86%) were significantly more likely than non-core states (N=8, 47%) to request the opportunity to review bills (p=0.006).

- The following were among the top five policy methods used by core and non-core states in 2005, 2007, and 2009:
  - Assessed/monitored impact of laws;
  - Recommended health department positions on bills; and
  - Worked to increase public awareness of laws.

- Assessed/monitored the impact of laws: 79% of core states used this method in 2009, up from 43% in 2005. Only 53% of non-core states used this method in 2009.

- Worked to increase public awareness of laws: Use of this method increased 25% for core states and 23% for non-core states from 2005 to 2009.

- Met with policy makers: Use of this method increased 39% for both core and non-core states from 2005 to 2009.

- Invited a Congressional delegate to meetings/event: This method was not used by any state in 2009 (no data for 2005 or 2007).
An additional question on the 2009 State of the States Survey asked states to describe changes to the injury and violence prevention program, state health department, and/or state between 2007 and 2009.

Changes to Programs

TABLE 9. MOST COMMON CHANGES TO THE IVP PROGRAM, STATE HEALTH DEPARTMENT, OR STATE BETWEEN 2007 AND 2009 BY CORE FUNDING STATUS

<table>
<thead>
<tr>
<th>Change</th>
<th>Core</th>
<th>Non-Core</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reorganization led to changes in responsibilities and/or priorities</td>
<td>10 (34)</td>
<td>4 (20)</td>
</tr>
<tr>
<td>Less funding</td>
<td>9 (31)</td>
<td>3 (15)</td>
</tr>
<tr>
<td>Fewer staff</td>
<td>8 (28)</td>
<td>4 (20)</td>
</tr>
<tr>
<td>Leadership changes at the state level</td>
<td>6 (21)</td>
<td>3 (15)</td>
</tr>
<tr>
<td>Staff changes within the IVP program</td>
<td>5 (17)</td>
<td>1 (5)</td>
</tr>
</tbody>
</table>
State public health agencies (SHAs) have a responsibility for assuring the conditions in which people can be safe – free from injuries and violence. The Safe States Alliance believes that every SHA must have a comprehensive injury and violence prevention programs to provide direction, coordinate and find common ground among partners, and make the best use of limited prevention resources in response to this leading cause of death and disability. State programs:

- Guide and direct evidence-based programs to prevent injuries and violence;
- Conduct surveillance, data reporting, and analysis;
- Develop and maintain statewide coalitions to support programs and policies;
- Work across communities within the state, including developing regional approaches and providing leadership in underserved communities;
- Ensure effective dissemination of evidence-based programs; and
- Facilitate state and local policy changes.

Currently, injury and violence prevention programs within SHAs have a wide range of capacity and resources to adequately address the burden of injury and violence within their respective states. Injury and violence prevention tends to be overlooked as a key public health program at the national, state and local levels and is often under-resourced as well. Currently the CDC Injury Center is able to provide financial and technical support for only 28 SHAs through the Core Violence and Injury Prevention Program to build the capacity needed to effectively implement, evaluate, and disseminate injury and violence prevention programs and policies based on best practices. This report illustrates the impact of Core VIPP funding for states and the need for all states to have such funding at minimum to provide coordinated and comprehensive leadership for statewide injury and violence prevention.