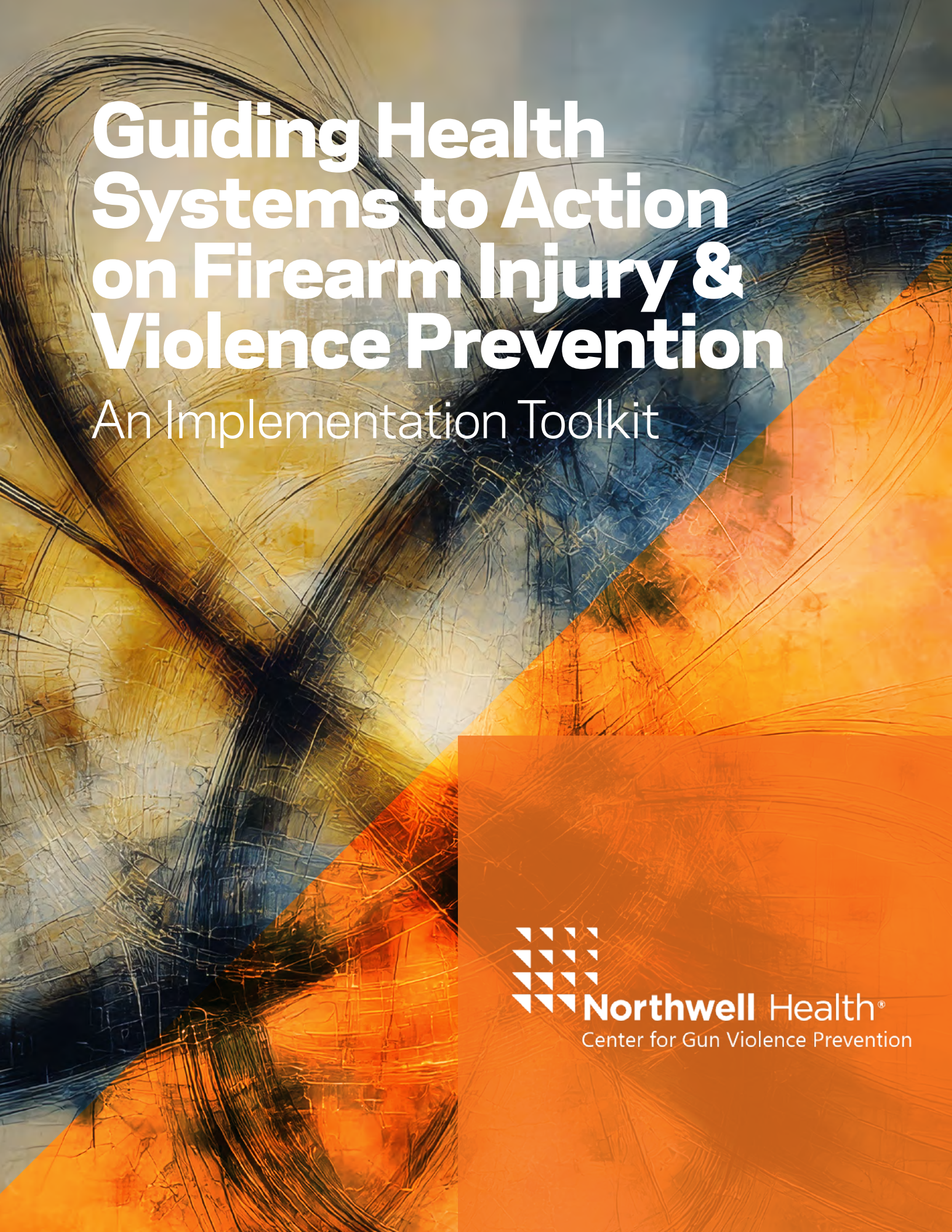

Guiding Health Systems to Action on Firearm Injury & Violence Prevention

An Implementation Toolkit

Northwell Health®
Center for Gun Violence Prevention

Foreword

This toolkit was developed with generous support from The Joyce Foundation, whose longstanding commitment to advancing evidence-based solutions to firearm injury prevention made this work possible.

Firearm injury and mortality is one of the most complex public health challenges of our time. It affects communities in profoundly different ways — through homicides, suicides, unintentional injuries, community trauma — each requiring distinct strategies, partners, and solutions. Health systems are uniquely positioned to play a central role in the prevention yet many struggle with where to begin and how to implement solutions that meet the needs of their patients and communities.

In 2019, the Northwell Health Center for Gun Violence Prevention was founded with the goal of leveraging the full power of healthcare to prevent firearm injury and death. We quickly learned that there is no single solution. What this work requires is a plethora of evidence-based approaches, targeting both upstream risk factors and downstream consequences of firearm injury and community violence exposure, adaptable to local needs. Health systems facing high rates of firearm suicide will implement different strategies than those confronting community-level homicide or pediatric injury. Health systems may not need every intervention, but all need a clear roadmap to identify what works and how to operationalize it.

While the evidence base for prevention continues to grow, implementation remains the critical gap. Evidence alone is not enough without guidance on execution, scaling, sustainability, and overcoming real-world barriers. This toolkit was developed to help close that gap by pairing proven strategies with practical lessons learned from implementation across diverse health settings, populations, and geographic contexts.

This work reflects years of collaboration with hospitals and health systems, clinicians, researchers, public health leaders, policymakers, community-based organizations, community members, and patients nationwide. It is informed by the efforts of health systems that have been advancing this work, often quietly and with limited support, for decades. Their leadership has shaped the research, practice, and progress reflected here and we thank them for developing the foundation on which this toolkit may stand.

At the time of writing this toolkit, firearm injury and death rates are declining. This progress matters. It demonstrates that prevention strategies are working, and that healthcare has a meaningful and growing role to play. Now is the time to accelerate adoption, share lessons learned, and expand implementation across hospitals and health systems nationwide.

We are deeply grateful to the many partners who made this work possible. We especially thank Michael Dowling, who catalyzed this effort in 2019 as then-CEO of Northwell Health and was among the first health system leaders to take a public stance that gun violence is a healthcare issue. We sincerely thank Dr. John D'Angelo, current CEO of Northwell Health and an emergency medicine physician, for his continued leadership and support on this. We also acknowledge the many Northwell Health leaders, healthcare workers, and employees whose commitment, courage, and persistence helped bring this work to life. This includes Northwell executives; marketing, communications, legal, and government affairs teams; clinical champions; steering committee members; and the core Center for Gun Violence Prevention staff, all of whom are part of our system wide initiative to tackle this public health crisis.

We are thankful to the health systems that participated in surveys and learning collaboratives, and to the research leaders, public health professionals, healthcare leadership, advocates, survivors, credible messengers, responsible firearm owners, law enforcement partners, faith-based organizations, medical and professional associations, and community-based organizations, in particular those leading community violence intervention efforts, whose expertise and lived experience informed this work.

This toolkit is offered as a practical guide for hospitals and health systems to adapt, implement, and scale strategies that meet the needs of their communities. But more than anything, we hope this toolkit can serve to leverage healthcare's reach and trust to prevent firearm injury, empower community resiliency, and save lives.

About this Toolkit

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A Note on Language: Language is incredibly powerful and shapes how we approach topics in healthcare and public health. For many, the term "gun violence" can evoke strong reactions and potentially biased perceptions. The term has the potential to be politically divisive and associated with terms like "gun control". In this toolkit, "firearm injury and mortality" is most often employed as it aligns with the toolkit's health focus and primary goal: to empower healthcare-led strategies to reduce the burden of firearm injury and mortality on our patients and communities. However, because language is context-specific, there will be contexts in which "gun violence" is the preferred, culturally relevant term. This underscores a central theme in the toolkit: it is essential to tailor firearm injury and mortality prevention strategies to local contexts, audiences, and communities, including what language will be most effective for whom, and why.

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Executive Summary

Hospitals and health systems are increasingly engaging with firearm injury as a core component of patient care, workforce safety, and community health. Yet despite a growing evidence base, many organizations lack a clear understanding of the range of roles they can play, how different interventions fit together, and how to move from isolated activities to durable, system-level impact. This toolkit is designed to provide that clarity.

This document serves as an implementation-focused roadmap for health systems seeking to engage in firearm injury and mortality prevention in ways that align with their mission, capabilities, and community context. It is intentionally structured to help leaders understand **what types of interventions exist**, **where health systems can exert influence**, and **how to operationalize and scale efforts over time.** The toolkit begins by grounding readers in the epidemiology of firearm injury and mortality, disaggregating the data across the diverse mechanisms and intents including suicide, homicide and community violence, mass violence, and unintentional injury and death. This framing underscores a central premise of the document: firearm injury and mortality is not a monolithic problem, and effective prevention requires differentiated strategies matched to local patterns of harm.

From there, the toolkit introduces a practical framework for health system engagement across three interconnected levels of influence:

- **System-level strategies**, focusing on systems-building, policy engagement, data infrastructure, cross-sector research partnerships, and public awareness efforts that shape the broader public health and prevention landscape.
- **Community-level strategies**, centering community-based approaches, including partnerships with community violence intervention programs, schools, workforce development initiatives, and local organizations addressing upstream drivers of violence.
- **Clinical and organizational-level strategies**, emphasizing actions within health systems, such as screening and counseling, hospital-based violence intervention programs, suicide prevention, safe storage education, and employee safety and well-being initiatives.

Rather than prescribing a single model, the toolkit is intentionally modular. Health systems are not expected to implement every strategy outlined. Instead, the document supports leaders in identifying where their organization can have the greatest impact and how to build a balanced portfolio of interventions over time.

A defining feature of this toolkit is its emphasis on **implementation and scale**. Dedicated sections focus on building internal governance structures, engaging executive leadership, empowering champions, conducting needs assessments, aligning funding and financial incentives, and applying implementation science frameworks to guide program development, evaluation, and sustainability. Common barriers, legal, operational, clinical, and cultural, are addressed directly, with practical guidance drawn from real-world experience.

Ultimately, this toolkit is intended to move the field beyond aspiration toward execution. By outlining the full spectrum of engagement opportunities and providing concrete guidance on how to operationalize them, it offers health systems a structured pathway to translate commitment into action and to integrate firearm injury prevention into the fabric of healthcare delivery and community health.

Abbreviations/Acronyms

AAP: American Academy of Pediatrics
ACEP: American College of Emergency Physicians
ACO: Affordable Care Organization
ACS: American College of Surgeons
AHA: American Hospital Association
AMA: American Medical Association
APHA: American Public Health Association

CALM: Counseling on Access to Lethal Means
CAP Law: Child access prevention law
CBO: Community-based organization
CDC: Centers for Disease Control & Prevention
CEO: Chief executive officer
CFIR: Consolidated Framework for Implementation Research
CGVP: Center for Gun Violence Prevention
CHA: Children's Hospital Association
CHIP: Community Health Improvement Programs
CHNA: Community health needs assessment
CME: Continuing medical education
CVI: Community violence intervention

DOE: Department of Education
DOH: Department of Health
DVRO: Domestic violence restraining order

ED: Emergency Department
EHR/EMR: Electronic health record/ electronic medical record
ERPO: Extreme risk protection orders
ESG: Environmental, Social, and Governance

FBI: Federal Bureau of Investigation
FIM: Firearm injury and mortality
FIMP: Firearm injury and mortality prevention

GVP: Gun violence prevention

HAVI: Health Alliance for Violence Intervention
HCM: High-Capacity Magazine
HCUP: Healthcare Cost and Utilization Project
HIE: Health Information Exchange
HVIP: Hospital-based violence intervention program

IPV: Intimate partner violence

LMC: Lethal means counseling
LGBTQ+: Lesbian, Gay, Bisexual, Transgender, Queer and other

MOU: Memorandum of understanding

NIH: National Institutes for Health
NVDRS: National Violence Death Reporting
NY: New York

OGVP: Office of Gun Violence Prevention
OSHA: Occupational Safety and Health Association

PAS: Pediatric Academic Society
PTSD: Post-Traumatic Stress Disorder
RHIO: Regional health information organizations
ROI: Return on investment

SBIRT: Screening, Brief Intervention, and Referral to Treatment
SDOH: Social determinants of health
SEM: Social-ecological model
SEL: Social-emotional learning
SHP: Sandy Hook Promise

VA: U.S. Department of Veterans Affairs
VI: Violence interrupter
VPP: Violence prevention professional
WISQARS: Web-based Injury Statistics Query and Reporting System

SECTION 1: FRAMING FIREARM INJURY AND MORTALITY IN THE UNITED STATES

The Burden of Firearm Injury & Mortality: Epidemiological Review

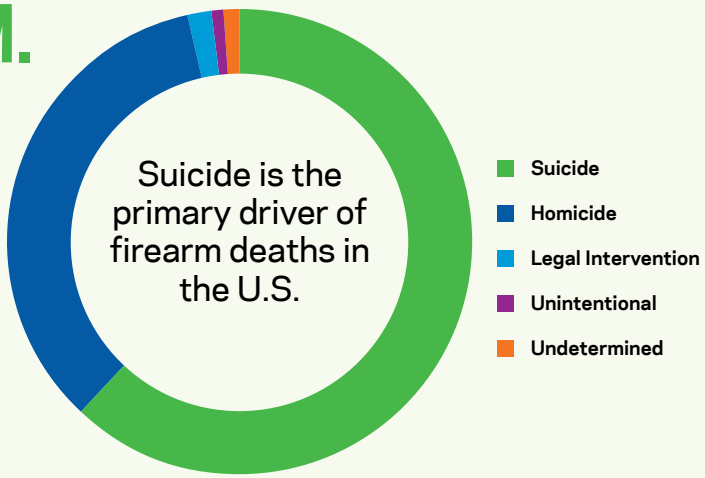
Firearm-related injuries and fatalities are a critical public health crisis in the United States (U.S), significantly impacting individuals, families, and communities nationwide. In 2024,[1] there were nearly 44,400 deaths due to firearm injury, an average of 122 deaths per day. An additional 161,000 people[2] experienced non-fatal firearm injuries, often resulting in significant disability and health consequences across the life course. Firearm violence fractures communities, leading to poor physical and mental health outcomes[3] including increased rates of mental health diagnoses[4] among those consistently exposed to firearm violence in their communities. Moreover, the healthcare cost of firearm violence is substantial — costing hospitals $7.7 billion dollars from 2016-2021.[5] These costs disproportionately impacted safety net hospitals, with more than half of these costs billed to Medicaid.[5]

Globally, the U.S experiences firearm-related deaths at a markedly higher rate than other high-income countries. For the fourth consecutive year, firearm injury was the leading cause of death[6] for American children and youth aged 1–17 years. The firearm homicide rate in the U.S. is approximately 26 times greater than that of other high-income countries, with some states reporting firearm mortality rates comparable to countries experiencing active armed conflict.[7] The COVID-19 pandemic further exacerbated this crisis, with gun purchases skyrocketing as a result of anxiety, fear, and increases in political and hate-motivated violence. Americans purchased[8] approximately 22 million firearms in 2020 and 19 million in 2021, increasing[9] the number of children living in homes with firearms to 30 million. Across the U.S. there are an estimated 393 million civilian-owned weapons, with approximately 1/3 of all American homes containing at least one firearm.[10] Further, firearm access plays a significant role in risk of firearm injury and mortality, and lack of robust regulations to stem the flow of legal and illegal firearms across the U.S. [11] undermines the success of prevention efforts.

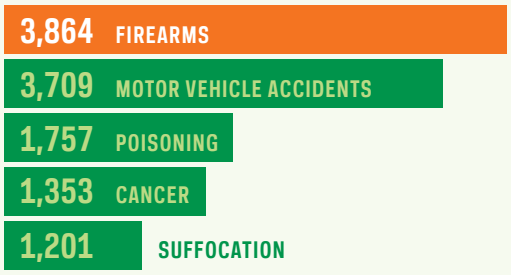
Additional nuance into the epidemiology of firearm injury and mortality is essential for many reasons. It is important to break down the broad term of the different intents and mechanisms of morbidity and mortality to truly understand the upstream risk factors, downstream consequences, and what prevention and intervention avenues will be most effective. For example, the prevention of firearm suicide, unintentional injury, and mass shooting draws on solutions like safe storage, policies that restrict firearm access for individuals at risk of harming themselves or others (e.g., ERPOs, mandatory waiting periods, etc.), and mental health interventions. On the other hand, solutions to prevent interpersonal firearm homicide and community violence must recognize how community violence exposure is shaped[12] by concentrated disadvantage, historic and on-going community disinvestment, and the social determinants of health (SDOH).

IN 2024, OVER 44,400 AMERICANS WERE KILLED BY A FIREARM.

That's an average of **121 deaths** per day.

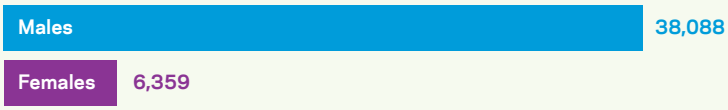


Firearms are the leading cause of death for American children and teens.

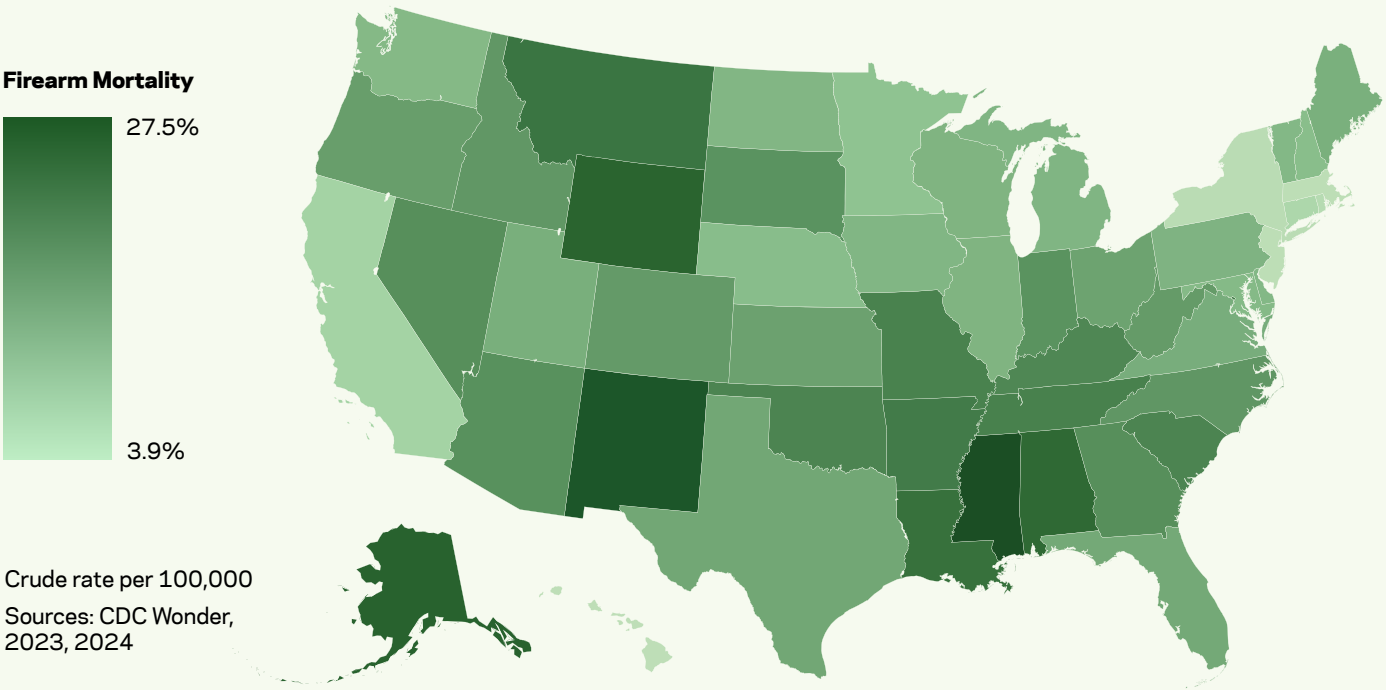


In 2023, someone was killed by a firearm every **11 minutes** and someone died by firearm suicide every **19 minutes**.

Males make up the vast majority of firearm injury deaths.



State firearm mortality rates vary significantly



Crude rate per 100,000

Sources: CDC Wonder, 2023, 2024

Firearm Suicide

Suicide is a leading cause of death in the U.S. and a primary driver of firearm-related deaths nationwide, accounting for approximately 60% of all firearm deaths.[13] In 2024, more than 48,800 people died by suicide, and many more, approximately 12.8 million, seriously considered death by suicide.[14] Between 2012-2020, the national firearm suicide rate increased by 21% overall, with a 51% increase among youth 15-24, and a startling 146% increase among youth 10-14.

Suicide attempts using a firearm have a 90% fatality rate,[15] compared to only 4% across all other methods. The lethality associated with firearms provides important context for discussions regarding suicide prevention strategies during mental health crises. The ease of firearm accessibility further amplifies suicide risk, as demonstrated in studies [16] showing households and states with higher firearm ownership see higher rates of suicide deaths; for every 10% increase in household firearm ownership in a state, suicide rates for youth 10-19 years increase by 25%. [16]

Important Trends in Firearm Suicide

- Men and boys represent 87% of firearm suicide deaths.[17]
- Veterans are 3x more likely to die by firearm suicide than the general population.[18]
- There is an average of nine youth deaths by firearm suicide per day in the U.S.[16]
- Firearm suicides rates are highest amongst Native American and Alaskan Native youth, followed by White and Black youth.[19]
- Alaska, Wyoming, Montana, Idaho, and New Mexico have the highest rates of youth firearm suicide.[16]
- Colorado, Missouri, and Indiana have seen youth firearm suicide increase by over 100% in the past decade.[16]
- Firearm suicide is higher in rural states than more urban states.[6]

GUN VIOLENCE IS EXPENSIVE

$8.7 Billion USD per Year

Direct tax payer cost of firearm-related homicides*

$11.7 Billion USD per Year

Direct tax payer cost of non-fatal firearm-injuries*

1.1 million

Years of potential life lost before age 65 attributable to firearm deaths in 2023**

$30,529 USD

Average hospital cost to treat a firearm injury***

1. *The National Cost of Gun Violence: The Price Tag for Taxpayers (NICJR)
2. ** An Overview of US Gun Deaths in 2023 (Johns Hopkins Bloomber Center for Gun Violence Solution)
3. *** Firearm Injuries: Unveiling the Unmatched Healthcare Burden and Costs (Nofi et.al, 2025)

Firearm Homicide & Community Violence

Firearm homicide is the second leading cause of firearm-related deaths, averaging 19,050 deaths per year, with a 57% increase from 2014 to 2023.[20] Nearly 79% of homicides in the U.S. involve a firearm, and when compared to rates among White Americans (2.2 deaths per 100,000 people), Black and Brown Americans experience significantly higher rates of firearm homicide, 26.1 per 100,000 and 4.9 per 100,000, respectfully.[20] Of note, firearm homicide also accounts for 65% of all pediatric gun deaths.[21] Additionally, firearms are often utilized in gender-based violence, including intimate partner violence (IPV) where 69% of all IPV homicides involve a firearm,[22] as well as violence against the LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer+) communities, particularly transgender individuals (where 73% of homicides involved a firearm).[20] In addition to the toll on human life and communities, firearm homicide contributes to the significant economic burden, with firearm homicides, assaults, and shootings by policing costing the U.S., on average, $195.5 billion per year.[20]

Communities faced with historic and ongoing disinvestment, discriminatory policies rooted in racism and segregation (such as redlining),[23] and inadequate resourcing of programs supporting the SDOH, often also face disproportionately high rates of firearm homicide[24] and community violence exposure. When individuals are faced with severe resource constraints and limited support services, survival may necessitate making decisions that directly or indirectly increase one's risk of experiencing violence. It is essential to understand the complex relationships between race and ethnicity, inequitable social structures, and poverty on firearm injury risk and exposure. Communities faced with historic disinvestment are often made up of predominantly of Black and Brown families, resulting in their inequitable shouldering of firearm injury risk and exposure. Consistent exposure to community violence traumatizes communities, and is linked to both direct and indirect adverse health outcomes[3] including post-traumatic stress, substance use, depression and anxiety. Community members living in violent crime hot spots reported[25] significantly lower levels of self-rated general health and higher levels of health limitations and problems than those in low-crime regions. Poor community health outcomes also negatively impact economic prosperity and resilience, creating a vicious cycle.

Important Trends in Firearm Homicide & Community Violence

- Young Black and Latino boys experience firearm homicide rates 12 and 4 times higher than their white counterparts,[26] respectively.
- Firearm homicide is a leading cause of death for pregnant women[27] in U.S.
- Transgender women experience the highest rate of firearm homicide.[28]
- States with the highest firearm homicide rate per 100,000 people[29] include District of Columbia, Mississippi, Louisiana, Alabama, and New Mexico.
- States with higher firearm ownership see higher rates of firearm homicide.[30]
- Firearm homicide is more common in urban areas than rural ones.[31]

Mass Shootings

Mass shootings, or an incident in which four or more people are shot and wounded or killed,[32] excluding the shooter, often dominate headlines and popular discourse, due to their substantial societal impact, and highly publicized and traumatic nature. Yet, mass shootings are not the primary driver of firearm related death in the U.S., accounting for just 2% of firearm deaths nationwide. In 2024 alone, the Gun Violence Archive reported [33] 503 verified mass shootings, reflecting a troubling trend that positions the country uniquely among high-income nations. In fact, when compared with other countries, the U.S. accounts for 76% of mass shootings,[34] despite accounting for just 33% of the combined population among impacted countries. Mass shootings are a category of firearm violence that is largely misunderstood, requiring a nuanced understanding of underlying drivers and risk factors.

The vast majority (95%) of mass shootings have fewer than 4 casualties.[32] Many of these incidents occur as a result of community and interpersonal violence, occurring disproportionately in under resourced Black and Brown communities that face significant social and economic. Shootings in predominantly Black and Brown communities represent approximately 71% of mass shootings[32] but they are less likely to receive the same national media attention as mass shootings that occur in predominantly white neighborhoods or those with more than 4 casualties.

The remaining 5% of mass shootings have more than 4 casualties and represent 30% of mass shooting deaths in the U.S. These incidents are statistically rare, and overemphasized in the media, yet they do have a substantial impact on the American consciousness. These mass shootings include targeted attacks on schools, places of worship, concerts, public gatherings and even health systems. Perpetrators of these incidents of mass violence often demonstrate [32] at least 1 warning sign prior to the incident, and are overwhelmingly male, white, and single[35] who purchased their weapons legally.[36] Assault weapons and high-capacity magazines (HCM) were used in 8 of the 10 deadliest mass shootings[37] since 2015. On average, mass shootings with an assault rifle or HCM result in 2.3 and 2.5 times more fatalities, and 22.7 and 10 times more injuries, respectively, than those without either involved.

Despite contributing relatively little to the overall burden of firearm injury, mass shootings continue to traumatize communities, with recent estimates[38] indicating 7% of all Americans have been present on scene in a situation where four or more people were shot, and 20% reporting a mass shooting in their community. These experiences can result in lasting adverse mental health consequences[39] such as anxiety, depression and PTSD. Mass shootings disrupt our collective sense of safety and play a significant role in the American culture of fear and anxiety surrounding gun violence. In the aftermath of these devastating events, survivors of mass shootings established advocacy groups such as March for Our Lives,[40] Sandy Hook Promise (SHP),[41] and Moms Demand Action,[42] to advocate for commonsense solutions and policy change to create safer communities and prevent future violence.

Important Trends in Mass Shootings

- From 2015-2022, more than 19,000 Americans[43] were shot and killed or wounded in a mass shooting.
- 87% of LGBTQ+ youth report[44] frequently worrying that a mass shooting could happen in their community.
- In 46% of mass shootings with 4 or more casualties, the perpetrator shot a family member or intimate partner.[45]
- 8 of the 10 deadliest mass shootings[32] occurred in places that allowed firearms or had staff with firearms present.
- Mass shootings involving HCMs result in 2.5x as many people[43] killed.

Unintentional Firearm Injury & Mortality

Unintentional firearm injuries and deaths occur when there is "a preponderance of evidence to suggest that the shooting was not intentionally directed at the victim,"[46] and are often labeled as "accidental" firearm injuries. These types of injuries and deaths can occur as the result of workplace injuries, hunting accidents, accidental discharges of weapons, and, tragically, often occur when children are playing with firearms[47] that are loaded and unsecured.

Unintentional injury and death by firearm are a minority of firearm related incidents but are preventable through education on safe storage and handling, training. Each year they result in an average of 526 accidental deaths and 43,729 accidental injuries,[46] which is up to 4x higher than other high-income countries. Unintentional firearm violence often occurs in among children and young adults — more than a third of which (37.8%) are self-inflicted and two thirds (66.6%) while playing with or showing the firearm to another person.[46]

Major risk factors include inadequate firearm safety education, improper storage practices, and the presence of easily accessible firearms within homes. Unintentional firearm injuries highlight the importance of targeted educational campaigns emphasizing safe firearm storage and responsible ownership.

Important Trends in Unintentional Firearm Injury & Mortality

- Children age 10–19 are at highest risk [46] of unintentional firearm death.
- The vast majority (83%) of unintentional firearm injury [46] and deaths occurred among males.
- Over half (56%) of fatal unintentional firearm[46] deaths in children occurred in their own home, 67% while playing.
- States with "locking laws" had 35% lower rates[47] of unintentional shootings by children.
- Handguns are the most used firearm in unintentional incidents.
- States where more than 50% of households own guns had 5x rate of unintentional shootings[47] by children.
- Half of nonfatal firearm injuries are unintentional.[48]

The Bottom Line

The firearm injury epidemic in the U.S. is characterized by its multifaceted nature, encompassing suicides, homicides, mass shootings, and unintentional injuries. The persistent and rising trends across these categories underscore the urgent need for comprehensive, evidence-based public health interventions. Effective solutions must address not only firearm accessibility and safety but also the underlying SDOHs and risk factors contributing to the inequitable exposure of firearm violence. Strategic policymaking, community-based prevention programs, mental health support, educational initiatives, and leadership-driven healthcare interventions are all critical components in mitigating this public health crisis. This level of nuanced understanding is critical, as effective prevention requires tailored solutions aligned with the predominant forms of firearm injury in each community, recognizing that risk profiles and needs vary widely across hospitals and health systems by geography.

Understanding the Firearm Injury and Mortality Prevention Landscape

The past three decades monumentally shaped the landscape of firearm injury and mortality prevention (FIMP). Understanding historical barriers and recent developments in the field will equip health systems with the necessary context to inform subsequent relevant decision-making.

Barriers to Progress

Barriers to research, data and public health infrastructure, and funding have historically undermined the development of a unified, effective, FIMP field.

Restricted Research & Funding Opportunities

Historically, injury prevention research as a whole has been underfunded,[49] but unique restrictions limited FIMP research, most notably, the Dickey Amendment, enacted in 1996, which effectively restricted Center for Disease Control (CDC) funding[50] from supporting firearm research under the guise that such research could result in a "tainted public health model of gun control."[51]

As a result, federal funding for firearm injury research plummeted[52] from approximately $2.7 million per year before the amendment to negligible levels in subsequent decades, stalling essential progress on data collection, infrastructure development, and research.

Between 1996 and 2019, firearm injury research was dramatically underfunded relative to the scope of the crisis. A landmark analysis[53] estimated that gun violence received only 1.6% of funding expected based on mortality burden, making it one of the least studied leading causes of death in American history. Between 2004-2025, despite sepsis and gun violence having similar annual mortality rates, funding for FIMP research and the number of publications were 0.7% and 4% of those for sepsis,[53] respectively.

Additional avenues for financing FIMP research were quickly shut down. The interpretation of the Dickey Amendment was expanded to cover not only the CDC, but all Department of Health and Human Resources (DOH) agencies, including the National Institutes of Health (NIH) and National Institute on Alcohol Abuse and Alcoholism. Previously publicly available federal and state data[54] were also removed,[55] restricting the ability of researchers to conduct public health research.

Severe underfunding dramatically reduced the volume and scope of research, leaving substantial knowledge gaps in effective prevention strategies and interventions. Numerous research gaps remain[52] today, including temporal trends in prevention and intervention efficacy, and the effectiveness of program adaptation for unique populations/geographic regions.

Without consistent funding from federal agencies or private research institutions, FIMP programs such as hospital-based violence intervention programs (HVIPs) and community violence intervention (CVI) have historically relied on short-term grants, philanthropy, or patchwork state allocations. In the absence of consistent federal investment, programs struggle[56] to sustain staffing and service provision.

This fragility has stifled the development of a comprehensive violence prevention professional (VPP) workforce, sustainable partnerships, and the production of rigorous evaluations.

Inadequate Data and Public Health Infrastructure

There is a significant lack of comprehensive and consistent data[52] on non-fatal firearm injuries due to a lack of systematic surveillance and fragmented data capture systems that vary across counties and states.

The existing health system data infrastructure for capturing firearm injuries and deaths is inadequate,[57] resulting in an incomplete understanding of the true burden of firearm injury and deaths nationwide. Lack of consistent, robust data infrastructure disrupts the ability to design appropriate intervention and prevention strategies [58] tailored to the local context. Outdated public health data infrastructure in many regions hinders timely and accurate surveillance, reporting, and analysis of firearm-related incidents. The COVID-19 pandemic illustrated the importance of timely data capture and highlighted the country's vulnerabilities in preparedness, gaps in resource allocation, and lack of unified response strategies.[59]

The absence of clear research evidence and data to guide policy[60] limited the efficacy of FIMP advocacy and the development of evidence-driven state and federal policy recommendations. Moreover, many national datasets are published with 1–3-year lag, significantly impeding the responsiveness of evidence-based policymaking and resource allocation.

Additional policies protect firearm owners and distributors, undermining the accessibility and completeness of data on firearm purchasing and crimes involving firearms. For example, the Tiahrt Amendments[61] block the Bureau of Alcohol, Tobacco, Firearms and Explosives from releasing firearm trace data; requires that the Federal Bureau of Investigation (FBI) destroy firearm purchasing records obtained from legal background checks within 24 hours; and prevents the sharing of firearm purchasing data outside one's geographic region.

A Shift in Momentum

Renewed and novel funding avenues, the ascension of public-health framing, the proliferation of local and state initiatives, and cross-sector activation have created a window of opportunity for significant advances in FIMP.

Media Amplification

A 2022 publication revealed that in 2020, firearm-related injuries overtook motor vehicle crashes as the leading cause of death for American children for the first time.[62] This fact garnered significant national and international media attention, including but not limited to, articles in the New York Times, NBC News, Time Magazine, Fox News, the UK's BBC, and Canada's CBC News.[63-68]

2022 also saw numerous high-casualty mass shootings that received significant media attention, with two- the Robb Elementary School shooting[69] in Uvalde, TX, which killed 22 individuals (including 19 children) and injured 18, and the Tops supermarket shooting[70] in Buffalo, NY, where a white supremacist killed 10 individuals and injured 3- occurring only 10 days apart, prompting both public outrage over ineffective firearm legislation, and public discourse on possible solutions.

Reinvigorated Research Commitments

After Congress clarified[71] the limitations of the Dickey Amendment in 2018, the CDC and NIH awarded over $49 million and $100 million in FIMP grants, respectively,[72] between 2020 and 2022. This resulted in a 90% increase in registered clinical trials from 2017-2019, and an 86% increase in publications from 2020-2022.

In 2022, the Research Society for the Prevention of Firearm Related Harms hosted their first national conference[73] in Washington D.C with 300 attendees. In comparison, the 2024 conference saw nearly 800 interdisciplinary professionals from over 250 institutions attend, present, and ideate essential next steps for this rapidly expanding field.

In 2023, over 400 national, state, and local medical, public health, and research-based organizations signed a letter[74] advocating for increased funding for firearm morbidity and mortality research. Prominent medical organizations and physician groups, such as the American Medical Association (AMA),[75] the American Public Health Association (APHA),[76] and the American Academy of Pediatrics (AAP),[77] have actively endorsed incorporating FIMP practices into standard clinical care.

Multisector Investment

Philanthropic entities such as The Joyce Foundation[78] and the National Collaborative on Gun Violence Research[79] provided critical funding for numerous research initiatives to bridge these longstanding knowledge gaps.
Legislative advances, such as the Bipartisan Safer Communities Act[80] committed hundreds of millions of dollars for research, safe firearm policy development, behavioral health interventions, and support for CVI. Despite recent funding slashes in 2025, this landmark piece of legislature highlighted the importance and feasibility of bipartisan collaboration related to community safety.

New Stakeholders

From the passage of Extreme Risk Protection Order (ERPO) legislation to the creation of Offices of Gun Violence Prevention (OGVPs), state assemblies and governors' offices across the country began tackling the gun violence epidemic through a public health-focused lens.

In 2023, the White House Office of Gun Violence Prevention was established under the Biden-Harris administration to coordinate the government and nation-wide FIMP strategy. Despite operating for under 2 years, the White House OGVP accomplished monumental successes[81] including integrating multiple FIMP strategies into the BSCA, making it one of the most successful pieces of bipartisan FIMP legislature in over 20 years; hosting convenings for national FIMP stakeholders across the fields of education, healthcare, state government, community advocacy, and CVI; and creating the first-ever federal Gun Violence Emergency Response Team to support communities in the immediate aftermath of a mass shootings.

In 2024, the U.S. Surgeon General declared firearm violence a public health crisis,[82] outlining a four-pronged public health approach to reduce rates of FIM that emphasized (1) critical research investments;(2) community risk-reduction and education prevention strategies; (3) firearm injury risk reduction strategies; and (4) mental health action and support.

The Call to Action: Activating Health Systems

Health systems have a unique opportunity to build on growing national momentum and strengthen their engagement in FIMP. The healthcare sector has a well-established record of addressing complex public health crises through evidence-based interventions, close collaboration with local, state, and federal public health authorities, and sustained investment in prevention, education, and systems improvement.

A History of Public Health Engagement

FIMP should be approached through the same public health lens that has successfully guided prior large-scale health challenges. Health systems have repeatedly demonstrated their ability to drive meaningful population-level change when prevention, clinical care, and policy alignment are integrated.

Source: Original Essential Public Health Services Framework, CDC

For example, the dramatic decline in cigarette smoking[83] reflects the combined efforts of healthcare systems and public health agencies to embed tobacco cessation counseling into routine care, support widespread public education campaigns, and advocate for strong tobacco control policies. Similarly, healthcare providers played a critical role in curbing HIV/AIDS transmission[84] by expanding testing and counseling, supporting treatment adherence, and partnering with public health agencies such as the CDC and World Health Organization.

The long-term reduction in motor vehicle fatalities[85] further underscores the power of coordinated public health action. Through partnerships among healthcare systems, policymakers, and public health authorities, interventions such as seatbelt laws, safer vehicle design, trauma system development, and public awareness campaigns contributed to an estimated 95% reduction[85] in motor vehicle fatality rates since the early 20th century.

Collectively, these examples illustrate the essential role of healthcare systems not only as care providers, but as active public health partners capable of driving systemic change and improving population health outcomes.

Health Systems as Leaders in Firearm Injury & Mortality Prevention

Health systems are uniquely positioned to lead firearm injury and mortality prevention efforts because many of the most effective levers of change align directly with existing healthcare roles and responsibilities. Clinicians routinely interact with patients across the lifespan and across diverse settings, creating opportunities to incorporate anticipatory guidance, counseling, and education on firearm safety into routine care. Health systems also maintain trusted relationships with community-based organizations (CBOs), enabling collaboration on safe storage initiatives, violence reduction programs, and upstream prevention strategies.

In addition, hospitals and health systems play a central role in public health surveillance by accurately documenting and reporting firearm-related injuries. These data are essential for understanding local patterns of injury, identifying disparities, and informing targeted, evidence-based prevention strategies.

Framing FIMP as a public health crisis allows health systems to move the conversation beyond politically charged narratives and towards a health-centered, solutions-oriented approach, grounded in epidemiology, clinical outcomes, and community impact. This framing also facilitates multidisciplinary collaboration, strengthens stakeholder engagement, and supports rigorous, evidence-based decision-making aligned with the CDC's Essential Public Health Services[86] framework, including assessment, policy development, and assurance.

Momentum in this area is already building. Across the country, hospitals and health systems are increasingly stepping forward to address firearm injury as a core patient safety and public health priority. This includes participation in the National Learning Collaborative for Hospitals and Health Systems, engagement in the Healthcare Coalition for Firearm Injury Prevention and the national medical summits it convenes, and the establishment of health system–based CGVPs. Many systems are also making direct investments in prevention infrastructure, workforce development, research, and data capabilities, while strengthening coordination with public health agencies and community partners.

Together, these efforts signal a growing and sustained commitment by health systems to lead and scale evidence-based firearm injury and mortality prevention across diverse communities. The opportunity, and responsibility, for healthcare to act has never been clearer.

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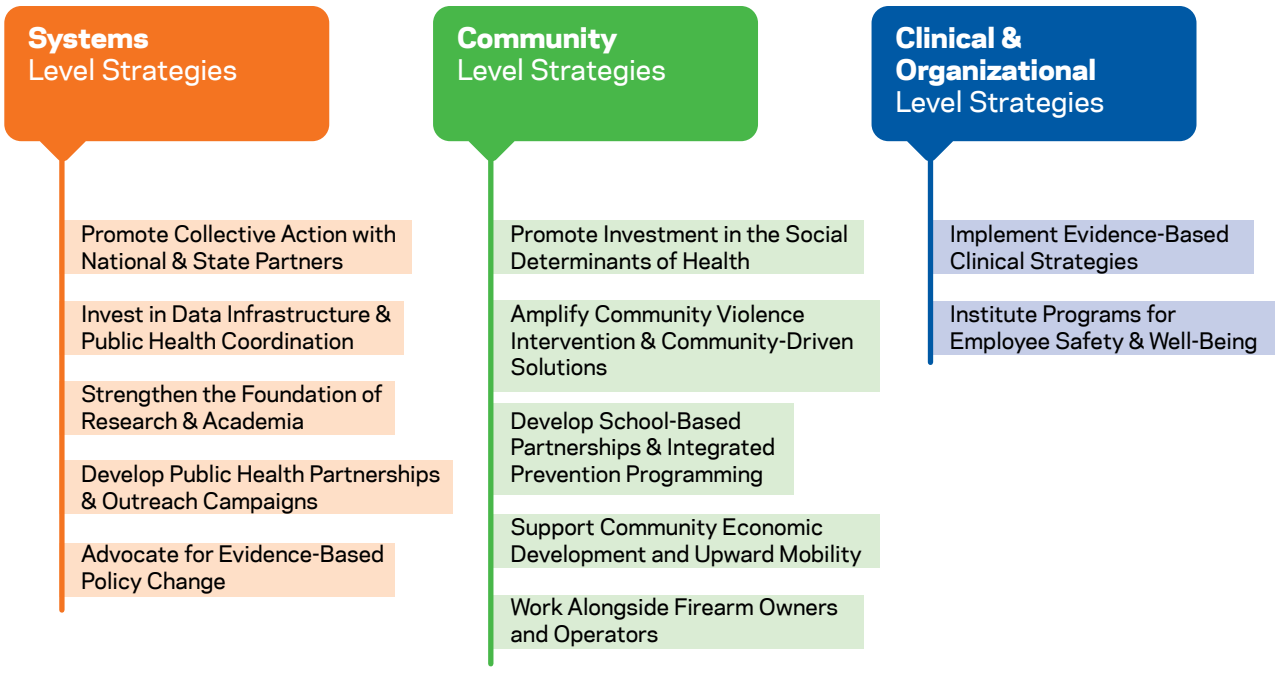
SECTION 2: WHERE DO HEALTH SYSTEMS START?

Conceptualizing the Scope of Engagement

All health systems share a responsibility to engage in FIMP, but what that engagement entails will vary by system. The CDC's Violence Prevention Framework[1] uses a four-level social-ecological model (SEM) to illustrate how an individual's risk of firearm injury and community violence exposure is the result of complex interactions between societal, community, relational, and individual variables. Each level of the model offers multiple levers for change, and no single lever can prevent firearm injury alone, thereby offering many possible opportunities for health systems to consider when building their FIMP portfolio. Health systems must distill the list of possible FIMP engagement strategies to those that will match their unique population, location, resources, and goals.

To facilitate this process, this toolkit dovetails the SEM with a systems-thinking approach[2] to better understand how FIMP strategies rely on multilevel interactions within the health system and across other social structures. Systems-level interventions address societal variables that impact firearm injury and violence exposure; these strategies often require large-scale partnerships and collective action to facilitate systems-level change. Community-level and clinical/organizational-level strategies target community and institutional levers for change, both of which allow health systems to work directly with local stakeholders, staff, and patients to reduce community, relational, and individual risk factors. Strategies are summarized below:

Opportunities for Health Systems Engaging in Firearm Injury & Mortality Prevention



Below is a high-level summary of strategies health systems may consider when building their FIMP portfolio. Each strategy is built out in detail in subsequent toolkit chapters.

Systems-Level Strategies

Promote Collective Action with National & State Partners

The siloing of FIMP efforts (whether within a health system, academic institution, agency, or state) fundamentally undermines the collective impact of prevention efforts. Health systems can join or develop partnerships with diverse national and state-level stakeholders to coordinate improve progress. These collaborations create shared goals, leverage pooled resources, and enable a larger impact that any system working alone.

Invest in Data Infrastructure & Public Health Coordination

Health systems have significant power and influence over the development of public health infrastructure. Inadequate data collection and patch-work response significantly undermine the success of FIMP efforts across the country. Investing time and capital into modernizing and strengthening the state and federal systems themselves will benefit not only FIMP efforts, but all public health coordination.

Strengthen the Foundation of Research & Academia

Research on FIMP is decades behind that of other illnesses with similar disease burden. Health systems can support and conduct research on the causes, consequences, and prevention of firearm injuries. Partnering with academic institutions and funding research initiatives generates evidence that informs policy, clinical practice, and community interventions.

Develop Public Health Partnerships & Outreach Campaigns

Health systems can engage in public education campaigns, community outreach, and media initiatives to raise awareness about firearm safety and FIMP. Working alongside other public health agencies serves to amplify messaging and build community trust.

Advocate for Evidence-Based Policy Change

Health systems can advocate for state and national legislation and policies that reduce firearm injury risk, such as safe storage laws, funding for community-led prevention, and regulations that reduce firearm access for children or individuals who may harm themselves or others. They can also advise policymakers using clinical and public health evidence to shape effective, equity-focused solutions.

Community-Level Strategies

Promote Investment in the Social Determinants of Health

Health systems can partner with local organizations, schools, and community groups to identify health needs, promote firearm safety in diverse environments, and provide

educational resources. They can also engage community members in program design to ensure interventions are culturally relevant and responsive to the needs of communities impacted by violence.

Amplify Community Violence Intervention & Community-Driven Solutions

Investing in strong relationships with local CVI experts will allow health systems to anchor FIMP efforts in equity, lived experience, and community trust. CVI organizations work alongside community partners to promote heling-centered prevention and intervention strategies that address the root causes and intergenerational impacts of violence and complement clinical care in ways health systems alone cannot achieve.

Develop School-Based Partnerships & Integrated Prevention Programming

Health systems can partner with Departments of Education (DOE) and local education system stakeholders to co-create youth FIMP and mental health programming, as well as streamline existing programs through joint campaigns, referral pathways, staff training, and data-sharing agreements.

Support Community Economic Development and Upward Mobility

Health systems can empower local economic prosperity through equitable hiring practices, workforce development support and training programs, strategic investment, and partnerships with CBOs in communities shouldering disproportionate burdens of firearm injury and violence exposure. These programs address the structural determinants of firearm injury, including community disinvestment and systemic racism.

Work Alongside Firearm Owners and Operators

FIMP programs are most effective when health systems collaborate respectfully and directly with firearm owners and operators, recognizing their cultural diversity, lived expertise, and critical role in prevention. Co-designing programs with firearm owners increases trust, cultural competence, and uptake of safe storage and prevention practices among communities with high rates of ownership and access.

Clinical & Organizational-Level Strategies

Implement Evidence-Based Clinical Strategies

Health systems can embed evidence-based FIMP strategies into routine care through risk screening, counseling on safe storage, suicide prevention protocols, and bidirectional referrals to community resources. Clinicians can use standardized protocols and evidence-based tools to intervene early with high-risk patients, as well as reduce risk among general patient populations.

Institute Programs for Employee Safety & Well-Being

Health systems can implement workplace programs and strategies that reduce risk of violence against staff and support team mental health. This can include de-escalation training, safety policies, access to counseling, and initiatives that foster a supportive, healthy organizational culture.

Creating a Strong Foundation for Engagement

Developing a strong foundation of support is essential to the sustainability of any health system initiative. The following section outlines key considerations for the early phases of FIMP engagement.

Structuring a Firearm Injury & Mortality Prevention Team

Establishing a Steering Committee and Leadership Team

A foundational step involves creating an effective interdisciplinary team or steering committee dedicated to formulating and overseeing system-wide FIMP strategies. Successful teams typically are comprised of a strategic combination of C-suite executives (i.e., leaders with titles beginning with "chief," like Chief Executive Officer (CEO), Chief Financial Officer, Chief Operations Officer, etc.), departmental leadership, and champions passionate about the mission, including front-line clinical staff, administrators, and allied health professionals. Research underscores[3] the importance of leadership buy-in and front-line engagement in driving transformative health initiatives; thus, health systems should deliberately recruit individuals known for their advocacy, leadership skills, and community trust.

Steering committees will benefit from representation across diverse clinical subspecialties (e.g., pediatric and adult emergency medicine, trauma medicine, behavioral health, community health, etc.) and administrative departments (e.g., legal, communications and marketing, government affairs, finance, etc.) to ensure a cohesive, system-wide approach to FIMP. For example, it is recommended to engage early with the health system's legal representation to ensure proposed engagement and clinical strategies align with any existing organizational and state policies.

Research Centers and Dedicated Interdisciplinary Teams

Every health system must design a team structure that reflects its needs and system capacity. Each FIMP center or dedicated research team has a unique structure and is made up of diverse, multidisciplinary professionals. Depending on institutional affiliations, partners, and funding streams, FIMP teams may form free-standing centers or be housed under schools (e.g., public health, medicine, public policy, etc.) or medical subspecialties (e.g., emergency medicine, pediatrics, etc.).

Some health systems, or their affiliated academic institutions, have created entire centers dedicated to FIMP, allowing the team to operate outside traditional healthcare silos. For example, at Northwell Health, the Center for Gun Violence Prevention (CGVP)[4] was specifically structured as its own entity, similar to an institute, facilitating system-wide efforts, the securing of dedicated funding streams, and the implementation of interventions across diverse clinical settings. The center is systematically divided into specific operational areas, including medical education, public health policy, clinical implementation, community collaboration, and research, ensuring comprehensive and coordinated action.

The following teams are just some examples of FIMP teams with diverse structures and institutional affiliations:

- Children's Hospital of Philadelphia Center for Violence Prevention[5]
- Columbia University Scientific Union for the Reduction of Gun Violence[6]
- Johns Hopkins Bloomberg School of Public Health Center for Gun Violence Solutions[7]
- Kaiser Permanente Center for Gun Violence Research and Education[8]
- Rutgers Health NJ Gun Violence Research Center[9]
- UC Davis Health Violence Prevention Research Program[10]
- University of Colorado School of Medicine Firearm Injury Prevention Initiative[11]
- University of Michigan Institute for Firearm Injury Prevention[12]
- University of Washington Center for Firearm Injury Prevention[13]
- Yale School of Public Health Firearm Injury Prevention[14]

Activating Executive Leadership

The C-suite and other health system executives can directly impact the integration of FIMP initiatives into the broader organizational framework. Literature on healthcare transformation underscores that executive sponsorship is a top predictor of successful program adoption[15] and long-term scale. For example, health systems that successfully integrated behavioral health services, population health infrastructure, or value-based care frameworks often did so through visible and sustained executive leadership,[16] which translated strategic commitments into financial alignment, operational support, and institutional culture. Their buy-in can be critical for establishing legitimacy, aligning priorities, allocating resources, and catalyzing implementation at scale.

Unfortunately, a significant barrier to advancing FIMP efforts remains the lack of consistent engagement and support from health system executives. In 2022, the National Academies of Sciences, Engineering, and Medicine collaborated with Northwell Health and the Peace Initiative to host a workshop,[17] Multiple teams who participated identified that "lack of leadership support" was a primary barrier to the development and sustainability of FIMP initiatives.

There is no single strategy that will guarantee executive buy-in. Ultimately, sustained C-suite engagement must be cultivated through deliberate framing, rigorous data, and strategic alignment. This includes showing clear return on investment (ROI), linking efforts to institutional missions, aligning with accreditation standards, and embedding efforts into system-wide strategic planning. **The success of FIMP in healthcare will hinge not only on clinical and community action, but on whether those at the helm of our health systems recognize and act on the urgency-and opportunity-of this public health imperative.**

Strategies for Driving Executive and C-Suite Engagement

#1: APPLY STRATEGIC FRAMING STRATEGIES

As health systems are increasingly held accountable for population health outcomes, the prevention of costly injuries and traumas becomes directly tied to financial performance. In order to do so, health systems may frame FIMP strategies as:

- **Linked to existing quality and safety initiatives**, such as the Joint Commission's Key Initiatives[18] (which include suicide prevention, children's healthcare, and workplace safety and well-being) standards, or the Centers for Medicare & Medicaid Services' Roadmap for Behavioral Health Integration.[19]
- **Initiatives can also be framed as expansions of existing health system programs** under the umbrellas of behavioral healthcare and suicide prevention, intimate partner violence prevention, workplace safety, and quality improvement.
- **A strategy to meet value-based care goals** (like Medicaid's Accountable Care Organization[20] targets) — by reducing emergency visits, intensive care stays, and repeat trauma admissions — improves cost-efficiency and aligns with value-based reimbursement models.
- **Positioned as integral to population health and equity mandates**, supporting community benefit obligations and enhancing health system credibility.
- **Tax Exemption Status:** Health systems can invest surplus funds into community FIMP initiatives as a means of meeting the community benefit standards required to maintain 501(c)(3) tax-exemption status.[21] Similarly, FIMP initiatives often align with the community health goals and priority areas identified in mandatory Community Health Needs Assessments.[22]
- **Aligned with workforce development goals**, addressing employee safety, workplace violence, and mental health support — particularly relevant given high burnout and workplace trauma in healthcare settings. See *Section 5, Strategy #4: Drive Economic Development and Upward Mobility* for more information.
- **Framed with financial ROI,** highlighting reduced trauma costs, shorter hospital stays, and lower readmission rates. It is estimated that each hospitalization from firearm injury costs nearly $95,000,[23] totaling over $7.8 billion[24] in direct hospital costs between 2005 and 2015. See *Section 3: Sustaining Funding for Firearm Injury Prevention Programming* for more information.
- **Incorporated into ESG priorities and mission-aligned strategy**, as health systems face increasing expectations from stakeholders, boards, accrediting bodies, and investors around measurable social impact.
- Lessons from cross-sectoral case studies offer further insight. In environmental sustainability and corporate social responsibility domains, embedding impact programs within ESG frameworks has driven long-term executive alignment[25] by linking them to fiduciary responsibilities and long-range planning.
- FIMP can be positioned as an ESG-relevant health equity and safety initiative — one that strengthens institutional resilience, public trust, and compliance with emerging regulatory and accreditation expectations.

#2 LEVERAGE PEER NETWORKS AND BENCHMARKING

Healthcare systems can also leverage peer benchmarking and learning collaboratives to engage executive audiences. CEO peer networks have been shown to influence organizational adoption of innovation and reform through competitive emulation and shared reputational incentives. Public recognition, opportunities for thought leadership, and coalition-based credibility can further support buy-in by appealing to executives' reputational and institutional ambitions.

- **The National Health Care CEO Council on Gun Violence Prevention & Safety** is one such forum where health system leaders co-develop shared standards and advocate for systemic solutions. Spearheaded by then-CEO of Northwell Health, Michael Dowling, the CEO Council has grown to include 50 executive leaders from over 50 of the nation's largest health systems and hospitals.
- Participants have formed working groups to target key aspects of FIMP including workplace and employee safety, data infrastructure, and public awareness-building. The CEO Council has led national initiatives like Agree to Agree[26] (see *Section 4, Strategy #4: Develop Public Health Partnerships and Public Awareness* for more information) and the annual Gun Violence Prevention Forum,[27] hosted in New York City.
- In 2024, the White House Office for Gun Violence Prevention collaborated with the CEO Council to convene the Summit of Health System and Hospital Executives on the Public Health Crisis of Gun Violence[28] in Washington, D.C. The event brought together over 80 healthcare executives, clinical champions, and academic experts to align national, state, and health system priorities around FIMP.

#3 SEEK SUPPORT FROM HEALTH SYSTEM BOARDS

In addition to C-suite executives, not-for-profit health systems are guided by a team of board members (e.g., a Board of Trustees) who collaborate with executive leaders to define mission, strategy, and priorities. If they are FIMP advocates, board members could be effective at framing FIMP as an effective strategy to boost public perception, support the Board's community and philanthropic mandates, and drive sponsorship.

For more information:

- Why Boards Should Focus on Suicide Prevention: Addressing challenges and priorities through the trustee role[29]
- Nonprofit healthcare boards: A mandate for change[30]

Identifying & Empowering Health System Champions

Obtaining site and staff champions will also help ensure a successful rollout of a FIMP program. Depending on the setting (outpatient, inpatient, emergency department), identify clinical "champions" who can be recognized leaders in the space, raise awareness about FIMP and new initiatives, and be a primary source of feedback regarding implementation progress. Champions could be staff who are already involved in FIMP advocacy or research; staff with a personal interest

or passion for the work; or staff looking to explore new ways to broaden their professional portfolio. The reason behind their championship is less important than their passion and commitment to furthering the work. Identifying champions across different service lines and departments (e.g., nursing, social work, physicians, administration) is essential for representation and assisting with effective program rollout among their colleagues.

The Role of Champions

Champions should be seen as experts of their site, department, and/or program, and be provided opportunities to take ownership of various aspects of the FIMP implementation process that they feel are appropriate—this could be conducting pre-implementation key informant interviews or data collection, overseeing education and training, participating in the design and rollout of FIMP programming, etc.

Throughout the implementation process, they should be tasked with empowering and supporting staff, collecting feedback, and monitoring key success metrics.

Leadership should then create routine touchpoints for champions to meet with one another, discuss barriers and facilitators, and develop strategies for continued effective implementation. This collaborative approach will help ensure no individual champion feels the success of a program or initiative is solely on their shoulders and models the importance of a FIMP *health system* approach.

Firearm Ownership and Clinical Championship

It can also be beneficial to engage health system staff who are firearm owners themselves, or who are familiar with local firearm culture, as they can provide important perspectives and build relationships between the health system and local firearm owners, such as individuals in law enforcement, current or former military personnel, and veterans, and recreational owners.

Their insight is valuable for developing culturally competent, relevant firearm education and ensuring the lived experiences of local firearm owners are considered in program implementation and dissemination. They may also be able to identify what unique barriers and facilitators may impact the effectiveness of programs among firearm owners in your community.

Moreover, physicians who own guns are more likely[31] to counsel on safe storage, in part due to their increased comfort with the topic and familiarity with local gun culture; therefore, they can be valuable champions and leaders in the space. As an organization, health systems must also model a supportive environment in order to promote positive culture change for patients and staff. Staff members should not feel stigmatized or judged for their own personal firearm safety behaviors, and there should be numerous pathways through which staff can access education and resources related to FIMP in order to support their health and safety goals.

Internal Communications: Building Awareness and Employee Collaboration

Effective, intentional internal communication efforts are essential for embedding FIMP initiatives into the organizational culture of healthcare systems. Research shows[32] that organizations with strong communication frameworks are better able to align employees with strategic goals, increase engagement, and promote collaboration[33] across departments. For FIMP initiatives to succeed, C-suite leaders must establish a clear and consistent communication plan that fosters alignment at all levels of the organization. This includes communication across leadership teams, between departments, and directly with frontline employees. Operationally, this can be achieved through the following approaches:

Communication between Executive & Departmental Leadership

Alignment across health system leadership is crucial for driving strategic clarity around FIMP initiatives. Executives should ensure that communication about FIMP efforts is not only directive but also participatory, allowing department leaders to surface operational challenges and contribute to solution development. CEOs and senior leaders can establish formal, recurring check-ins with department heads to assess progress, address administrative barriers, and offer strategic guidance. This approach promotes interdepartmental investment and engagement, facilitating staff buy-in and successful implementation at the operational level.

For example, a CEO may convene quarterly leadership forums focused on FIMP efforts, inviting department heads to report on initiatives, share best practices, and recommend policy or workflow adjustments. These forums encourage[34] transparency and create opportunities for peer-to-peer learning among leaders.

Interdepartmental Collaboration & Communication

It is essential to open and maintain lines of communication between departments that will be directly or indirectly involved in the FIMP portfolio. This includes leadership and operational teams across legal, internal affairs, communications, and key clinical specialties, such as behavioral health, community health, emergency medicine, trauma, and pediatrics. Health system teams often operate in silos, which can result in fragmented or disjointed efforts.[35] Ensuring success in FIMP initiatives requires intentional alignment across these teams.

CEOs and senior leaders should promote regular interdisciplinary meetings where departments share updates, discuss challenges, and identify opportunities for collaboration. For example, a hospital may establish a standing monthly FIMP task force meeting in which representatives from clinical and non-clinical departments collaborate on patient care strategies, referral pathways, and data-sharing protocols.

Communication between Executive Leadership & Frontline Staff

Establishing direct, consistent lines of communication between leadership and frontline staff is critical for building institutional trust, engagement, and sustained support for FIMP initiatives. As with any significant policy or cultural change, the implementation of FIMP programs most directly affects the day-to-day responsibilities, workflows, and emotional burden of frontline clinicians and staff. CEOs and senior leaders across all involved departments should therefore engage in visible and ongoing communication that clearly articulates how FIMP initiatives align with patient safety, workforce well-being, and core organizational values.

Effective practices include hosting listening sessions, town halls, or unit-based forums where employees can raise concerns, share operational feedback, and contribute to implementation improvements. Developing comprehensive employee support resources and robust workplace safety programs is also aligned with recommendations from organizations such as the American Hospital Association (AHA). Sustained dialogue, proactive mental health services, and rigorous safety protocols enhance workplace security, support staff resilience, and reinforce psychological safety.

Interdepartmental communication with frontline staff also provides an important opportunity to share information about health systems and community-based resources available to support not only patients, but also staff safety and well-being. Leaders who actively listen and respond to frontline input demonstrate a commitment to collaboration, which can significantly improve morale, trust, and ownership of FIMP initiatives.

Cross-departmental communication

It is essential to establish and maintain clear lines of communication between departments that are directly or indirectly involved in the firearm injury and mortality prevention (FIMP) portfolio. Alignment among leadership across these teams is critical for driving strategic clarity and ensuring coordinated implementation. Executives should ensure that communication about FIMP initiatives is not only directive but also participatory, enabling departments to share operational insights, identify challenges, and contribute to problem-solving.

To support visibility and alignment, leadership should intentionally engage departments across legal, internal affairs, communications, and key clinical specialties, including behavioral health, community health, emergency medicine, trauma, and pediatrics. Health system teams often operate in silos, which can lead to fragmented efforts and inefficiencies. Sustained interdepartmental communication helps break down these silos and reinforces shared accountability for FIMP outcomes.

Executive leaders should promote regular interdisciplinary meetings where departments share updates, discuss implementation challenges, and identify opportunities for collaboration. For example, a hospital may establish a standing monthly FIMP task force in which representatives from clinical and non-clinical departments collaborate on patient care strategies, referral pathways, and data-sharing protocols to support consistent, system-wide execution.

Conducting a Firearm Injury & Mortality Prevention Needs Assessment

As with all major programmatic developments, it is essential for health systems to begin by understanding the unique burden of firearm injury among their patient population, as well as what health system and/or community-based FIMP resources and interventions currently exist. Depending on a health system's size, it may be important to further differentiate needs assessments by county, region, or even clinical site to effectively assess burden within the local context.

By partnering with your community health, injury prevention, and trauma teams, you will be able to better understand recent trends among your patient population and design programs to better meet the needs of your community. Various cultural and regional beliefs about firearms may shape community and leadership receptivity to the introduction of clinical programs, so it is important to be able to describe the anticipated impact of a new clinical program using your unique patient and health system experience.

Additionally, understanding local patterns of firearm utilization will help to better tailor your programs to your specific context (for example, if your health system is in an area where many people own guns for hunting or sport, adopting a safe storage counseling program will likely be the most fruitful and yield the least resistance). A precise understanding of local injury patterns also allows health systems to strategically allocate resources and design targeted prevention efforts that reflect community-specific needs and priorities.

Existing expert-led guidance and frameworks can help guide early discussions:

- Towards a Safer World by 2040: Towards a Safer World by 2040: JAMA Summit Report on Reducing Firearm Violence and Harms[36]
- New England Journal of Medicine: Clinical Approaches to the Prevention of Firearm-Related Injury[37]
- Johns Hopkins Center for Gun Violence Solutions: The Public Health Approach to Prevent Gun Violence[38]
- Maryland's Preliminary State Plan for a Public Health Approach to Reducing Firearm Violence[39]
- The CDC: Violence Prevention Framework[1]
- The CDC: Community Planning for Health Assessments & Community Health Improvement Plans[40]
- Evaluation & Program Planning: Modeling a Needs Assessment Approach for Policymakers to Investigate, Understand, and Reduce Gun Violence[41]
- AHA Community Health Improvement: Community Health Assessment Toolkit[42]

Key Questions a Needs Assessment Can Address

Patient & Community Impact

In what ways are the communities we serve currently impacted by firearm injury? Given known firearm risk factors, what type(s) of firearm injury are most likely to impact the communities we serve?

In what ways are our patients currently impacted by firearm injury across our health system? Given known firearm risk factors and our patient demographics, what type(s) of firearm injury are most likely to impact our patient population?

Health System Impact

What is the total burden of firearm injury across our health system? Does our health system experience a higher volume of certain firearm injury types?

Are these trends consistent, or do they vary (e.g., by site, county, state, or over time)?

What are the average healthcare utilization metrics for a patient impacted by a firearm injury? How do these metrics change based on injury mechanisms and intent?

What is the yearly economic impact of firearm injuries on our health system? On average, how much does it cost to treat a patient impacted by a firearm injury?

Community & Health System Asset Mapping

What services, interventions, or resources does our health system *currently* offer for patients impacted by firearm injury and/or violence exposure?

Which CBOs does our health system currently partner with?

- These can be partnerships directly related to supporting patients impacted by firearm violence, but also related support around substance use, intimate partner violence (IPV), behavioral health, and SDOH programming (housing and food security, early childhood development, education, employment, etc.)

What capacity does our health system have to develop and/or scale FIMP initiatives?

What barriers could our health system experience, and what facilitators can we identify to reduce the impact of these barriers?

What services, interventions, or resources are offered by local CBOs?

Who are the community experts? How can their perspectives and experiences shape our understanding of community resources? Where do community members perceive gaps in resources and safety nets?

What assets do our communities have that can facilitate and support the development of our FIMP initiatives?

- Community Asset Mapping[43] is the process through which you identify the resources that support and strengthen a community. Assets provide the foundation on which community development and empowerment can occur.

Gun Violence Prevention Initiatives and Engagement

Does our health system currently have any active FIMP initiatives or projects?

Does our health system have any policies that may facilitate or challenge the development of FIMP initiatives?

When it comes to FIMP investment and engagement, how does our health system compare to health systems of comparable size and patient volume? How does our health system compare to others in the state?

Are there team members within our health system who are engaged in FIMP research, education, outreach, or policy/advocacy within their role?

Centering Lived Experience and Community Voice

Evidence indicates[44] that centering community voices and the experiences of directly impacted patients enhances the cultural relevance and effectiveness of interventions, fostering community ownership and ensuring sustainability.

Accurate identification of health system needs and priorities necessitates rigorous community listening sessions and inclusive engagement processes.

This could include the creation and dissemination of surveys, hosting interdisciplinary roundtables or town halls, conducting focus groups, and key informant interviews.

Health systems should engage directly with patients and families, particularly those impacted by firearm violence, as well as a well-rounded combination of the community partners identified in the previous section.

It is important to invite perspectives from firearm owners and representatives from stakeholder groups with high rates of firearm access (e.g., law enforcement, active and former military personnel, local businesses engaging in firearm retail, ranges, training, etc.)

To organize these effectively, health systems should establish clear objectives, utilize trained facilitators to ensure productive dialogue, and maintain transparency in reporting and acting upon feedback.

Conducting a needs assessment can also facilitate introductions or strengthen relationships with the diverse partners and stakeholders your health system will collaborate with to effectively build or scale its FIMP portfolio.

Data Collection for FIMP Needs Assessments

Level of Analysis	Relevant Variables	Possible Data Sources
Patient	• Demographics: age, sex, race, and ethnicity • Socioeconomic status indicators: education, income, and employment • Health insurance information	• Electronic medical records • Community health reports • Emergency department and trauma data
Health System	• Epidemiological Statistics: health system burden of fatal and nonfatal firearm injuries • Unintentional and intentional injury: firearm suicide, firearm homicide; consider other penetrating injuries (stabbings) and violent assaults. • Healthcare outcomes and average utilization metrics for patients impacted by firearm injury. • Average financial impact of firearm injuries: immediate treatment costs vs. long-term health system utilization costs; consider insurance coverage and reimbursement rates.	• Electronic medical record • Emergency department and trauma data • Insurance statements
Community	Culture and Social Norms • Attitudes towards firearm ownership and gun violence • Existing firearm access restriction policies: red flag (ERPO) laws, CAP laws Population Health and Wellbeing • Socioeconomic indicators, health outcome indicators, community deprivation indices, and community asset mapping.	• Local police and law enforcement data • Local news reports and archives • County Health Ranking[45] • Community Livability Index[46] • Social Deprivation Index[47]

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SECTION 3: SUSTAINING FUNDING FOR FIREARM INJURY & MORTALITY PREVENTION PROGRAMMING

Financial constraints pose significant hurdles to the sustainable implementation of prevention programs. That's why it's critical to demonstrate the return on investment of FIMP through cost-benefit analyses that clearly articulate the long-term savings. To overcome internal funding constraints, health systems can pursue a diverse set of funding opportunities, including local, state, federal, and philanthropic sources. Additionally, integrating firearm injury prevention into existing value-based care models can provide sustainable financial incentives.

The Financial Burden of Firearm Injuries on Health Systems

Firearm injuries impose a staggering economic burden on the U.S. healthcare system, with health systems often shouldering a disproportionate share of both direct and hidden costs. Nationally, firearm injuries generate[1] over $2.8 billion annually in direct medical costs alone, with each firearm-related hospitalization costing approximately $95,887 on average.

A substantial portion of patients impacted by firearm injuries are covered by Medicaid or are uninsured, exacerbating financial pressures on hospitals that operate under already thin margins. Studies show that Medicaid patients comprise a disproportionately high share of firearm injury admissions, yet Medicaid reimburses hospitals at significantly lower rates than private insurers. This differential reimbursement results in large amounts of unreimbursed care,[2] particularly in safety-net and public hospitals, where trauma care is frequently delivered at a loss. Hence, prevention is a much better financial strategy for hospitals and health systems.

Firearm injuries often also produce long-term expenditures related to disability, chronic care, mental health services, and social support. For example, victims of firearm injury experience higher rates[3] of post-traumatic stress disorder (PTSD), depression, and substance use disorders-requiring extended engagement with healthcare services and behavioral health systems. For hospitals engaged in value-based payment arrangements or shared-risk contracts, this ongoing utilization can impact performance metrics and financial outcomes.

Firearm injury and community violence also create hidden costs that are frequently overlooked in traditional financial analyses. Health system staff — particularly emergency department providers, trauma surgeons, and nurses — are repeatedly exposed to violence-related trauma, contributing to high rates of burnout, vicarious trauma, and psychological distress. In one survey,[4] 38% of emergency physicians reported PTSD symptoms linked to exposure to violence. This contributes to staff attrition, increased absenteeism, and greater recruitment and training costs, especially in frontline departments already facing labor shortages.

Additionally, healthcare workers may themselves become direct victims of violence. Workplace shootings, threats, or assaults in hospital settings — often involving patients or visitors — result in lost work time, disability claims, and heightened security expenditures. The AHA has emphasized[5] the urgent need for health systems to invest in workplace safety infrastructure as rates of violence against healthcare workers continue to rise.

As anchor institutions in communities, health systems also absorb the costs of firearm injuries. In communities and regions with high incidence of firearm injury, hospitals face increased demands on emergency services, reduced engagement in preventive care, and deferred elective procedures due to heightened trauma volumes.

The indirect economic effects of firearm injuries also ripple outward into the community — affecting workforce productivity, educational attainment, and employment rates — all of which influence population health and drive healthcare utilization. Hospitals committed to improving community health and meeting CHNA goals must address these upstream drivers, or risk perpetuating cycles of preventable injury and loss.

Proactive investment in firearm injury prevention is not only a moral imperative, but a financial one. Quantifying and addressing these direct, indirect, and opportunity costs is essential to advancing health equity, safeguarding institutional solvency, and fulfilling the healthcare sector's duty to protect and promote community well-being.

Aligning Firearm Injury Prevention within Larger System-Level Financial Goals

Incorporating firearm injury prevention into a hospital's broader fiscal and operational strategy is not only ethically imperative, but economically prudent. As healthcare systems shift toward value-based care and population health models, investing in upstream, preventive approaches to community violence aligns directly with both financial sustainability and long-term institutional success-especially in terms of direct and indirect cost savings for hospitals.

Demonstrate the Return on Investment

FIMP initiatives, when effectively implemented, can produce demonstrable return on investment (ROI) through reduced trauma volume, fewer readmissions, lower recidivism, and improved continuity of care. For instance, HVIPs have shown[6] a 40% reduction in violent reinjury and a 59% reduction in subsequent criminal justice involvement, generating both healthcare savings and public safety benefits.

Value-Based Care Frameworks

FIMP aligns with broader financial and quality incentives in value-based care frameworks. Under alternative payment models, such as accountable care networks (ACOs), bundled payments, and Medicaid waivers, hospitals are increasingly rewarded for reducing preventable acute care utilization. Hospitals that treat firearm injury as a chronic community burden akin to diabetes or heart failure can shift toward proactive population health management, with measurable fiscal benefits.

Lessons from other domains of community health and social care provide compelling analogies. For example, housing-first interventions for individuals experiencing homelessness have demonstrated[7] cost offsets of up to $8,000 per person per year through reductions in emergency department visits, inpatient admissions, and criminal justice system interactions. Similarly, programs targeting food insecurity, maternal home visiting, and behavioral health integration into primary care have all shown favorable ROI[8] when appropriately evaluated. These models illustrate that interventions targeting the underlying social determinants of health, if designed with rigor and implemented with fidelity, can meet both mission-driven and margin-driven objectives.

Strategies to Advance Effective Health System Framing

- **Quantify the cost of inaction:** Estimate current healthcare expenditures attributable to firearm injury (e.g., trauma admissions, readmissions, behavioral health burden) and model potential savings from preventive strategies. Tools such as cost calculators and impact modeling software can help articulate these costs in financial planning terms.
- **Integrate FIMP into value-based contracts:** Position FIMP within accountable care agreements, Medicaid value-based purchasing, or community health needs assessments to align with existing incentive structures. FIMP-related outcomes should be included in system-wide performance dashboards.
- **Leverage philanthropic and public funding:** Utilize local, state, federal, and foundation grants to initiate programs, then develop sustainability plans that blend external funding with internal budget allocations as ROI is demonstrated. Public-private partnerships can also de-risk initial investments.
- **Build dashboards and feedback loops:** Regularly track and report metrics such as emergency department utilization, hospitalizations, patient outcomes, and community violence rates to reinforce accountability and showcase impact. These data not only support program improvement but can be used to negotiate payer incentives and justify internal funding.
- **Embed FIMP in strategic financial planning:** Elevate firearm injury prevention to the level of other enterprise-wide priorities, such as maternal mortality reduction or behavioral health integration, with accompanying business cases and executive reporting. Business plans should include 3–5-year ROI projections, staffing models, and savings benchmarks.
- **Leverage Requirements for Tax Exemption:** Not-for-profit health systems can propose investing surplus funds into community violence prevention initiatives as a means of meeting their community benefit standards required to maintain 501(c)3 tax exemption status.[9]

Health systems must prioritize firearm violence prevention alongside other critical public health initiatives, recognizing that inaction carries profound health, social, and economic costs. As trusted healthcare providers and community anchors, hospitals are uniquely positioned - and morally obligated — to lead proactive, evidence-based efforts to mitigate firearm injuries and deaths, contributing meaningfully to healthier, safer communities.

Pursuing External Funding Opportunities

Health systems generally operate on thin margins, making it essential to supplement a firearm injury prevention program's budget with external cash flow. There are two main sources of income a health system can pursue to fund FIMP: public dollars allocated by federal, state, and local governments, and private dollars, most often distributed through registered philanthropic organizations, but increasingly also by private sector partners. Below is a breakdown of the strengths and weaknesses of each, along with best practices to adopt if pursuing.

State & Federal Government Funding

Note: At the time of writing, funding for these programs — especially at the federal level — has been nearly entirely cancelled, leaving the future of federally funded FIMP research in limbo. Many examples listed are time-bound opportunities that may not be available at the time of reading, but they are still emblematic of funding avenues to monitor and engage if they become available.

Public health, like other public goods such as national defense and infrastructure, is a core focus of the United States government. Health systems should actively pursue local, state, and federal grant opportunities dedicated to violence prevention, community health initiatives, and public safety enhancements. The CDC, NIH, and DOJ regularly put out "Notice of Funding Opportunities" (i.e., NOFOs) which health systems should monitor for grants related to violence prevention and public health research. Engaging a skilled grants team can help health systems successfully identify and apply for these resources.

To provide a sense of the opportunities available for health systems, below are recent examples of federal and state-level funding opportunities.

Examples of Avenues for Federal Funding

In 2022, President Biden and a bipartisan coalition in Congress passed the Bipartisan Safer Communities Act[10], which appropriated an unprecedented $1.4 billion for new and existing violence intervention and prevention programs such as:

- Byrne State Crisis Intervention Program[11] (SCIP)
- Community Violence Intervention and Prevention Initiatives[12]
- NIH's Office of Behavioral and Social Sciences Research[13], which, since 2020, has regularly announced opportunities for FIMP research funding for health systems.

Examples of Avenues for State Funding

Health systems can also tap into the budgets of state OGVPs, DOH, DOJs, etc. E.g., Colorado's OGVP has an annual budget of $3 million.[14] Health systems could tap into this funding by partnering with the state on programs such as public awareness campaigns, and training for healthcare professionals (e.g., firearm risk screening).

Important Considerations

These kinds of examples demonstrate the potential strength of public dollars for a health system to implement or expand FIMP programming, but it is important to remember that these dollars are never guaranteed. These funds, like many policies and programs, shift with state and federal political tides.

A quarter to a third[15] of total state government revenue comes from the federal government, so states will feel the belt-tightening effect of a federal administration that deprioritizes or cuts funding for FIMP research and programming. It's important for a health system to diversify its funding streams and explore opportunities outside the public sector.

Philanthropic Financial Support

Philanthropic partnerships also represent a significant funding avenue. Many foundations and philanthropic entities prioritize social determinants of health, community resilience, and public safety. It is critical that a health system partner, with its development team, deploy targeted outreach strategies to philanthropic partners, clearly outlining program goals, community impacts, and measurable outcomes, which can help secure sustainable philanthropic support. Many players in this space also publish Requests for Proposals (RFPs), which a health system and its development team should consistently monitor.

Health system executive leaders can also do their part by showing up in the spaces/circles that leaders of philanthropies/foundations frequent. This could include participating on panels and convening at events put on by major players like SXSW,[16] the Milken Institute,[17] and the Clinton Global Initiative.[18] Additionally, regular communication of program successes and demonstrating clear community benefit(s) further solidifies these partnerships and encourages ongoing contributions.

Organizations that have a history of funding FIMP efforts include, but are not limited to:

- **Arthur M. Blank Family Foundation:**[19] In addition to their portfolio dedicated to youth development, mental health, and environmental health, the Georgia-based organization has supported FIMP capacity-building through donations to SHP and the HAVI,[20] and most recently, a 25$ million investment[21] in the Fund for a Safer Future.
- **Ballmer Group:**[22] The Ballmer Group has invested in community-focused approaches to reduce the impact of firearm injury and community violence, including a reported $18 million[23] donation to organizations (like HAVI and Cities United) that advance CVI strategies.
- **Bloomberg Philanthropies:**[24] A major funder of FIMP, including founding the gun safety advocacy group Everytown for Gun Safety (originally Mayors Against Illegal Guns) and pledging large commitments (like one pledge[25] of $50 million) to build advocacy infrastructure and research aimed at reducing firearm injury and mortality.

- **Crown Family Philanthropies:**[26] A Chicago-area foundation with a dedicated gun violence prevention program[27] aimed at reducing firearm harm through direct services, policy work, and community-based strategies as part of its broader social justice and public health portfolio.
- **Fund for a Safer Future:**[28] A donor collaborative that funds a wide range of work, from research to legal strategy to community-based violence intervention. It also coordinates grantmaking among participating foundations (including many of the foundations listed here).
- **The Joyce Foundation:**[29] A Chicago-based foundation with a long-standing Gun Violence Prevention & Justice Reform[30] program, historically funding research, policy work, and advocacy aimed at reducing firearm injury and death; it is also a leading member of the Fund for a Safer Future.
- **Langeloth Foundation:**[31] Through strategic grant-making focused on CVI,[32] the Langeloth Foundation has supported organizations working to build safer, healthier communities and has been a contributor to broader philanthropic efforts like the Fund for a Safer Future.
- **Mountain Philanthropies:**[33] A donor collaborative that pools resources from multiple foundations to fund evidence-based FIMP research and advocacy.
- **Schusterman Family Philanthropies:**[34] Supports criminal justice reform and CVI,[35] and New York's Coordinated Assessment and Placement System[36], designed to support individuals transitioning from unstable to stable housing.

Strategies for Effective Philanthropic Engagement

A 2024 report[37] by the Milken Institute examines how philanthropic and private-sector capital can play a decisive role in advancing FIMP in the United States. The report argues that philanthropic capital is uniquely positioned to address these gaps by taking risks that public and private funding often cannot.

- It identifies three guiding principles for effective philanthropic engagement: (1) thinking globally while acting locally, (2) cultivating trust through inclusive and community-driven approaches, and (3) taking a long-term view through flexible, multiyear funding.
- Building on these principles, the report recommends targeting investments to unlock public funding, strengthening collaboration across sectors, expanding the evidence base for prevention, addressing trauma among survivors to prevent future violence, and supporting a narrative change to shift public attitudes and behaviors around firearm safety.
- In addition, the report highlights the largely untapped role of business and finance in FIMP. It emphasizes that FIMP is not only a moral imperative but also a matter of economic risk management, workforce safety, and community stability.
- By aligning philanthropic, public, and private capital, the report concludes, stakeholders can build sustainable funding models that scale evidence-based interventions, strengthen community infrastructure, and meaningfully reduce firearm injuries and deaths over the long term.

Private Sector Financial Support

Collaborating with the private sector extends the reach, scale, and sustainability of FIMP efforts. Businesses, industry leaders, and cultural influencers bring unique assets - financial resources, technological innovation, social media reach, and advocacy platforms - that can amplify public health strategies in ways health systems alone cannot.

Public health has a long history of effective cross-sector collaboration. For example, AT&T's "It Can Wait"[38] campaign partnered with schools and organizations nationwide to reduce distracted driving, demonstrating how private sector leadership can shift norms and behaviors at scale. Similar models can be applied to firearm injury prevention, particularly around safe storage, suicide prevention, and youth engagement.

Health systems are well-positioned to engage private sector partners through existing executive relationships, shared community presence, and aligned interests in safety and well-being. Increasingly, corporations are stepping forward as part of their corporate social responsibility efforts, recognizing firearm injury as both a public health and economic issue that affects employees, customers, and communities. Health systems can partner with private sector leaders to co-develop public awareness campaigns, support research and implementation, invest in community-based programs, and leverage social media platforms to normalize prevention-focused messaging. With appropriate checks and balances (e.g., ethical guardrails, public transparency, and alignment with evidence-based practice) these partnerships offer a powerful opportunity to align healthcare, business, and culture around a shared goal: reducing firearm injury and saving lives.

Corporate and Business Leadership

Major corporations have taken tangible steps to address firearm injury, signaling the growing role of business leadership in prevention. Companies such as Dick's Sporting Goods[39], Walmart [40], and PayPal[41] have adopted policies or made investments that prioritize safety, restrict firearm-related transactions, or support prevention efforts. These actions demonstrate how corporate policy, capital, and governance structures can contribute meaningfully to public health goals while establishing internal checks and balances that reduce firearm-related harm.

Technology & Innovation

The private sector plays a critical role in advancing innovation and establishing safeguards. Technology and social media companies have updated content moderation, advertising, and age-restriction policies to limit the spread of firearm-related harm and misinformation. Following sustained advocacy efforts by Everytown for Gun Safety[42], Google updated YouTube's firearm policies[43] to ban content intended to sell firearms, make firearms, promote firearm violence, or allow live streams involving firearms, and additional protective restrictions for viewers under 18.

At the same time, emerging partnerships with the firearm industry focused on safety innovation, including companies developing smart gun and personalized firearm technologies such as Biofire[44], highlight opportunities to advance harm reduction through design, accountability, and built-in safety features. Thoughtful engagement with industry leaders working on safer technologies can strengthen prevention while respecting lawful firearm ownership.

Sports, Entertainment, and Cultural Influence

Sports leagues, artists, filmmakers, and public figures play an important role in shaping social norms. Since 2017, the Chicago Sports Alliance - representing the Chicago Bears, Blackhawks, Bulls, Cubs, and White Sox - has contributed more than $11.75 million[45] to support firearm injury prevention and community safety initiatives, including partnerships with institutions such as University of Chicago Medicine. National campaigns such as the NFL's My Cause My Cleats[46] have partnered with organizations including Everytown for Gun Safety[47] and Guns Down America[48] to raise awareness and funding through athlete-led advocacy, including auctioning customized cleats to support prevention efforts.

In the entertainment industry, musicians and performers have supported youth engagement, advocacy, and safe storage messaging. In 2022 and 2023, Everytown for Gun Safety partnered with Harry Styles' Love on Tour[49] to promote youth engagement through Students Demand Action, alongside a $1 million contribution to support education, research, and policy work. In 2023, Northwell Health partnered with singers Aly and AJ[50] to promote safe storage during their "With Love From" tour.

Actors and filmmakers have also helped advance firearm safety through storytelling. High-profile advocates, including Julianne Moore, have supported efforts such as the Brady Show Gun Safety Initiative, which works with the entertainment industry to promote safe storage and responsible firearm portrayals in film and television. Moreover, over 150 artists have partnered with Everytown's Creative Council[51] on a variety of projects, using their platform and reach to amplify FIMP activism.

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SECTION 4: SYSTEM-LEVEL ENGAGEMENT STRATEGIES

These strategies address the national and state structures, systems, and norms that shape the FIMP landscape, drawing on the power of collective action.

Strategy #1: Promote Collective Action with National & State Partners

1. State Government & Agency Partnerships

From the enactment of ERPO laws to the establishment of state-level OGVPs, governors and local legislatures nationwide are increasingly addressing firearm violence through a public health framework. States such as Colorado, Illinois, and California have created sustainable funding mechanisms that dedicate hundreds of thousands of dollars annually to implement health-driven, multisectoral prevention strategies. These include developing and disseminating public awareness campaigns, expanding research and data collection initiatives, and allocating resources to HVIPs and CVI efforts.

Collaboration among health systems, medical licensing and regulatory bodies, and state agencies has proven critical in advancing effective policy and programmatic responses. Beyond traditional alignment with local Departments of Health, health systems can explore creative partnerships with other departments and associated agencies with vested interests and explicit priorities related to FIMP. These can include, but are not limited to Departments of Justice, Education, Veterans Affairs (VA), Occupational Health and Safety, Labor, Social Services, etc.

Through these important partnerships, health systems can act as drivers of systems-level change, advocating for evidence-based, community-centered policies. Engagement strategies are summarized in *Section 4, Strategy #5: Advocate for Evidence-Based Policy Change* and are explored in greater detail in the Northwell Health State Policy Playbook (coming March 2026).[1]

2. National Firearm Injury and Community Violence Prevention Organizations

There are many national organizations that work tirelessly to produce the knowledge, resources, and collaborative networks necessary to effectively address FIMP on a national, state, and local level. **Partnerships between these organizations and health systems are essential for developing and disseminating best practices in the health care field and strengthening the national movement of organizations targeting FIMP together.**

Below are just a few examples of the **hundreds of national champions driving change in their communities** through partnerships and collective action:

Brady: United Against Gun Violence[2]: Founded after the 1981 shooting of James Brady, Brady uses litigation, public education, and policy reform to hold the gun industry accountable. Brady often collaborates with public health agencies, schools, the Ad Council,[3] and community groups to promote safe firearm practices and solutions that reduce the flow of firearms into communities.

Project Examples

- Combating Crime Guns[4]
- End Family Fire[5] campaign

Everytown for Gun Safety[6]: One of the largest FIMP organizations (which houses Mayors Against Illegal Guns,[7] Moms Demand Action,[8] and Students Demand Action[9]). Everytown mobilizes policymakers, educators, students, and health leaders to tackle firearm injury. They also drive advocacy efforts through their comprehensive, dedicated research arm.

Project Examples

- Be SMART[10] safe storage campaign
- Everytown Research & Policy Resources11

Cities United:[12] Formed in 2011, Cities United advocates for holistic, evidence-based solutions to reduce community violence and firearm homicide rates among Black men and boys. Cities United challenges partners, city champions, leaders, and youth to reimagine healthy, safe communities.

Project Examples

- Guide to Investing in Safe, Healthy, and Hopeful Communities (Part 1[13] and Part 2[14])
- Roadmap to Safe, Healthy, Hopeful Communities[15]

Giffords:[16] Founded by former Congresswoman Gabrielle Giffords, Giffords uniquely combines policy advocacy, research, and community prevention. Giffords routinely partners with the Johns Hopkins Center for Gun Violence Solutions,[17] state OGVPs, and health systems to advance evidence-based policies, framing gun violence as a public health issue.

Project Examples

- Giffords Law Center's Legal Research [18]
- Giffords Law Center's Gun Law Scorecard[19]

Health Alliance for Violence Intervention (HAVI):[20] The HAVI's mission is to advance coordinated, community-led solutions and HVIPs to reduce the impact of violence, particularly in communities of color. The HAVI provides technical assistance and resources to support health systems and CVI ecosystems.

Project Examples

- Emerging HVIP Technical Assistance[21]
- Violence Prevention Professional Training[22]

March for Our Lives:[23] Formed after the Parkland shooting in 2018, March for Our Lives is dedicated to mobilizing youth to lead the fight for a safer future, free from the fears and realities of gun violence. They use art, political advocacy, and storytelling to shift public perceptions and motivate young generations of activists.

Project Examples

- Action Hub[24]
- Strategic Plan (2026-2030)[25]

Sandy Hook Promise[26] (SHP): Founded and led by family members whose loved ones were killed in the Sandy Hook Elementary School shooting in 2012, SHP seeks to educate and empower youth to take action to prevent firearm violence in schools, homes, and communities. SHP has age-and-stage-appropriate programming for students on topics like social-emotional learning, violence prevention, and suicide awareness.

Project Examples

- Start with Hello Program[26]
- Say Something Program[27]
- Anonymous Reporting System[28]

3. Academic & Medical Partnerships

Partnerships within the medical field can amplify collective advocacy efforts, foster shared knowledge exchange, and enhance capacity for meaningful, scalable interventions. Strengthening partnerships through these collaborative platforms significantly contributes to achieving sustained reductions in firearm violence. These initiatives include activating existing levers for advocacy efforts, forming coalitions, participating in specialized conferences, and developing standardized best practices to reduce firearm-related injuries and deaths.

Academic and Professional Societies/Associations

Numerous societies and associations have used their collective voice to drive messaging about FIMP to the forefront of medical conversation, both broadly and within unique disciplines. **These messages often urge society members and the public to act as well, demonstrating how trusted messengers, like healthcare professionals, can drive community activism.**

- **American Academy of Child and Adolescent Psychiatry**: Statement on Gun Violence Crisis from 60 National Organizations[29]
- **American Academy of Nursing**: Statement on Firearm Safety and Violence Prevention[30]
- **American Academy of Pediatrics**: Firearm-Related Injuries and Deaths in Children and Youth: Injury Prevention and Harm Reduction;[31] and their Advocacy Efforts and Working Group[32]

- **American Association for the Surgery of Trauma:** Statement on Firearm Injury[33]; and Statement on Firearm-Related Injuries[34] (joint statement with *Eastern Association for the Surgery of Trauma* and *Western Trauma Association*)
- **American College of Emergency Physicians**: ACEP Commends Passage of Firearm Injury Prevention Legislation;[35] and website: Firearm Injury Prevention.[36]
- **American College of Surgeons**: A Public Health Crisis: The Gun Violence Epidemic in America[37]; ACS Commends U.S. Surgeon General's Advisory on Firearm Violence[38]
- **American Medical Association**: "AMA adopts new policies on firearm violence"[39]
- **American Nurses Association:** American Nurses Association Endorses AAN's Statement "Firearm Safety and Violence Prevention"[40]
- **American Public Health Association**: "APHA welcomes Surgeon General's Advisory on Firearm Violence"[41]; and their website: "Dive Deeper into Public Health Topics: Gun Violence"[42]
- **American Pediatric Surgical Association**: Promoting Firearm Injury Prevention and Advocacy as Pediatric Surgeons: A Call to Action From the APSA/AAP Advocacy Committee[43]
- **American Trauma Society**: TPC Releases Joint Firearm Safety and Violence Prevention Statement[44]
- **Pediatric Trauma Society**: Position Statement on Gun Violence[45]

Similarly, organizations and stakeholders come together to create **websites with resource guides, educational materials, and program outlines** to ensure their patients and communities have access to the most up-to-date information on FIMP:

- **American Hospital Association (AHA):** Public Health Approach to Addressing Gun Violence[46]; Hospitals against Violence[47]
- **Children's Hospital Association (CHA):** Keeping Kids Safe With Firearm Injury Prevention[48]
- **50+ organizations, including AAP, AMA, CHA, AMA:** Hospitals United[49] and Agree to Agree[50]
- **National Academy of Social Workers:** Gun Violence Resources[51]

Coalitions & Learning Collaboratives

1. Healthcare Coalition for Firearm Injury Prevention[52]

Established in 2019 by leading medical and public health organizations to advance FIMP through research, education, advocacy, and community-centered approaches. This coalition exemplifies the healthcare community's commitment[53] to implementing a comprehensive public health strategy to mitigate firearm violence.

- **Founding member societies** include the AAP, ACEP, ACP, ACS, and the Council of Medical Societies.
- **Medical Summit on Firearm Injury Prevention**
  - Proceedings from the Medical Summit on Firearm Injury Prevention: A Public Health Approach to Reduce Death and Disability in the US[54]
  - Proceedings from the Second Medical Summit on Firearm Injury Prevention, 2022: Creating a Sustainable Healthcare Coalition to Advance a Multidisciplinary Public Health Approach[55]

2. Northwell Health's CGVP Coalitions

These coalitions also host multiple national forums that support collective action and shared learning:

- **The Gun Violence Prevention Learning Collaborative for Health Systems and Hospitals** [56] provides a platform for hospitals and health systems nationwide to exchange best practices, resources, and implementation strategies for FIMP.
- **Gun Violence Prevention Forum**[57] fosters national dialogue and actionable strategies among healthcare leaders, researchers, policymakers, and advocates.
- **National Health Care CEO Council on Gun Violence Prevention & Safety**,[58] spearheaded by former Northwell Health CEO Michael Dowling, unites healthcare executives to advocate for policy changes and preventive measures, emphasizing the role of leadership in addressing this public health crisis.

3. The Black and Brown Collective[59]

The multidisciplinary research group leverages collective knowledge and community partnerships to enhance health and safety among Black and Brown communities who face disproportionate risk and rates of firearm injury and death. They also offer mentorship opportunities for young Black and Brown researchers and clinicians, striving to strengthen the representation of diverse voices in the clinical and academic FIMP spaces.

Conferences

- **National Research Conference for the Prevention of Firearm-Related Harms,** organized by the Research Society for the Prevention of Firearm-Related Harms,[60] highlights the current state of science and research on FIMP across the lifespan.
- The national biannual conference[61] brings together organizations from across the country to celebrate the continued commitments, progress, and innovations in the field of CVI.
- CVI Organizations like the **HAVI**[62] are instrumental in organizing events that focus on HVIPs and CVI strategies. These gatherings provide platforms for multi-disciplinary teams (including VPPs) to share insights, research findings, and best practices in violence prevention.
- Many other academic medical conferences have featured FIMP in the past, including but not limited to the Society for the Advancement of Violence and Injury Research,[63] the Injury Free Coalition for Kids[64] and annual conferences hosted by the PAS, APHA, and AAP.

Strategy #2: Invest in Data Infrastructure & Interagency Coordination

High-level change is not possible without a foundation of relationships and partnerships between the diverse stakeholders discussed above. **When addressing gaps and innovation in public health infrastructure, effective collaboration between health systems, hospitals, and public health authorities is essential for addressing contemporary public health challenges comprehensively and sustainably.** Historically, however, such coordination has encountered significant obstacles, including fragmented communication, inadequate data sharing practices, and divergence of operational priorities between clinical care and public health initiatives.

At the same time, there is growing recognition that health systems and public health agencies are mutually dependent in responding to complex issues like FIMP. Hospitals confront the immediate and acute consequences of violence while carrying responsibility for trauma care, recovery, and long-term rehabilitation. Public health agencies provide population-level surveillance capacity, community partnerships, and prevention frameworks that address upstream drivers of risk. Aligning these sectors creates conditions for shared accountability, more meaningful surveillance, and coordinated intervention that responds to both individual and community needs.

The Landscape of Firearm Injury and Mortality Data Collection and Surveillance

There is currently no single comprehensive source that health systems can rely on for state or national trends. Instead, experts must draw on multiple datasets, each with strengths and limitations. Effective program design requires understanding how to interpret and contextualize these data, and how to use surveillance gaps to inform system improvement.

Many of the primary data systems used to monitor firearm injury are strained, inconsistently funded, or limited in scope. Even major national surveillance systems, including those traditionally operated by the CDC, have historically faced delays in reporting, underreporting of nonfatal injuries, and gaps in intent and circumstance data. These limitations can lead to incomplete or outdated signals that impede timely action.

Datasets

Note: *At the time of writing (December 2025), the teams dedicated to maintaining the CDC's WISQARS and National Violent Death Reporting System (NVDRS) systems have been nearly entirely disbanded. The future completeness of these datasets and their future surveillance capabilities, therefore, cannot be guaranteed, but they remain important for health systems to be aware of.*

The following are datasets that provide essential data on fatal and non-fatal firearm injuries, and additional associated trends, in the U.S:

Web-based Injury Statistics Query and Reporting System (WISQARS[65])

- **Sponsor:** CDC
- **Overview:** Provides national estimates of injury and includes details on injury intent, mechanism, geographic location, and demographics of the injured person.

National Violent Death Reporting System (NVDRS[66])

- **Sponsor:** CDC
- **Overview:** Combines data from medical records, coroners' reports, police reports, and other circumstantial variables (e.g., mental health history and status, significant life events, history of interpersonal conflict, etc.) to provide the most robust picture of fatal injury.

Healthcare Cost and Utilization Project (HCUP[67])

- **Sponsor:** Agency for Healthcare Research and Quality
- **Overview:** Pulls administrative coding data from state and federal government organizations, hospital associations, and private data to create a variety of encounter-level healthcare datasets.
- Facilitates analyzing medical practice patterns, healthcare program access and delivery, healthcare cost and quality, and treatment outcomes at the local, state, and national levels.

Everytown Research & Policy[68]

- **Sponsor:** Everytown for Gun Safety
- **Overview**: An independent, detailed, and up-to-date research portfolio is one of the most important sources of data available in the field. Most notable are their state-level analyses, policy impact analyses, and easily digestible summaries of key issues and relevant solutions.
- New AI-powered tool, EveryShot, tracks shootings across the US in near real-time and reports details such as shooting intent, outcome, firearm type, location, and victimology.

Gun Violence Prevention Archive[69]

- **Sponsor**: Gun Violence Prevention Archive
- **Overview**: Independent "online archive of gun violence incidents collected from over 7,500 law enforcement, media, government, and commercial sources daily in an effort to provide near real-time data about the results of gun violence."
- Provides significant background information regarding the research and data methodology, and compiles diverse data into accessible tables, graphs, and maps.
- Assessing the Gun Violence Archive and Public Police Data as Comprehensive Sources for Gun Violence[70]

Opportunities for Innovation and Collaboration

There is ample opportunity and urgent need for innovation in how data is collected, synthesized, and communicated across both public and private sectors. Strengthening FIMP requires moving from parallel systems of health care delivery and public health surveillance toward a coordinated model in which data, workforce capacity, intervention planning, and accountability structures are shared. Collaboration must be grounded not only in shared goals but in shared infrastructures and routine operational practices that integrate clinical and public health perspectives.

Data Coordination and Shared Infrastructure

Enhancing coordination between health systems and public health agencies[71] is critical for achieving effective violence prevention. This collaboration must prioritize: (1) Identifying and rectifying data gaps; (2) improving electronic health record data collection fields and workflows; (3) expanding health system capacity to capture clinical and contextual indicators of firearm injury.

- Engagement with technology companies, research partners, and health information networks can accelerate innovation in data capture, visualization, and predictive analytics.
- Hospitals and health systems can play an important role in advocating for improved data quality in existing healthcare databases.
- This includes (1) supporting accurate intent coding for injuries and deaths; (2) participation in Regional Health Information Organizations (RHIOs); and (3) broader Health Information Exchange (HIE) platforms to improve the continuity and completeness of longitudinal patient and community-level data, and incorporation of standardized screening questions that capture exposure, access, and social determinants relevant to firearm injury risk.
- EHR leadership on FIM initiatives is paramount. Many clinical initiatives rely on seamless EHR integration for screening, referrals, and accurate data capture. Northwell Health is working with EPIC to integrate our firearm injury risk screening questions into the foundational build, a feature that will be available to all end users by mid-2026. EHR technology has the power to remove barriers to screening and intervention, streamlining processes and aiding in improved data visibility.

Shared Public Health Intelligence

Effective prevention requires data flowing in both directions. Health systems generate real-time clinical encounter information that can serve as an early signal for escalating community-level risk, yet this information is rarely structured to feed public health response systems. At the same time, public health agencies maintain broader surveillance contexts that rarely return to frontline clinical teams.

- Establishing formal bidirectional data-sharing pathways allows hospitals to function as sentinel surveillance sites while enabling public health agencies to deliver timely risk intelligence and intervention guidance back into clinical and community settings.

Coordinated Case Identification and Referral Pathways

- Joint protocols can be developed to identify individuals and communities at elevated risk and ensure timely referral into violence intervention programs, behavioral health services, HVIPs, and CBOs.
- This creates a closed-loop model in which those most likely to benefit are identified, connected to support, and followed over time.

Shared Workforce, Training, and Accountability

- Integrated systems will benefit from staff who are equipped to bridge clinical and public health approaches. Joint training, shared staffing of violence intervention teams, interdisciplinary analytic workgroups, and aligned performance metrics can reinforce unified practice norms.
- Shared accountability frameworks that span patient-level and community-level outcomes ensure alignment across institutions.

Models of Successful Collaborations

Below are examples of programs and tools that model an integrated, coordinated approach to FIMP data surveillance and infrastructure development:

Maryland Firearm Violence Dashboard[72]: This dashboard is one of the state's health dashboards and includes collaborative data agreements between Maryland's Vital Statistics Administration, Office of the Chief Medical Examiner, NVDRS, and state health system emergency departments.

SAFEWatch Houston Firearm Injuries Dashboard[73]: This dashboard represents a multisector collaboration[74] between the office of city council member Abbie Kamin, UT Health Houston, Harris Health, Harris County Institute of Forensic Science, Memorial Hermann, Texas Children's, Rice University's Baker Institute of Public Policy, Houston Fire Department, and Houston Police Department.

Pediatric Health Information System (PHIS)[75]: Led by the CHA, the PHIS is a national database summarizing clinical and resource utilization data from 50 children's hospitals.

The CHA Research Network's Firearm Injury Prevention Research Group[76] has leveraged PHIS data to deepen shared understanding of demographic and geographic trends in pediatric FIM, as well as evaluate the role of the SDOH on violence exposure risk.

Strategy #3: Strengthen the Foundation of Research & Academia

Why Research Matters

As previously stated, progress in firearm injury research has lagged behind other areas of comparable disease burden. As a result, the field lacks the level of standardized data systems, risk modeling tools, and evidence-based care pathways that exist for other major causes of injury and chronic disease. Where cancer and cardiovascular medicine benefit from longitudinal registries, multi-site consortia, and established intervention algorithms, FIMP still operates with fragmented data and uneven research infrastructure.

Academic medical centers and health systems are uniquely positioned to change this trajectory. Hospitals treat patients at the moment of injury, observe long-term recovery patterns, engage with families and communities affected by violence, and sit at the intersection of clinical care, public health, and policy. This provides direct access to information, populations, and partnerships essential for developing a modern research and prevention ecosystem.

Advancing firearm injury research also attracts national funding, academic recognition, and top clinical and scientific talent, while ensuring that prevention strategies are evidence-based, measurable, and financially sustainable.

Advancing firearm injury research requires investment in several key domains:

- **Clinical Research:** Identifying best practices in acute trauma care, rehabilitative services, trauma-informed care practices, and post-discharge follow-up.
- **Implementation and Systems Science:** Understanding which interventions are effective in real-world clinical settings and how to scale them across diverse contexts and populations.
- **Community-Based Participatory Research:** Partnering with CBOs, faith-based institutions, schools, and local leaders to design and evaluate prevention strategies that reflect lived experience and cultural context.
- **Longitudinal Outcome Tracking:** Studying physical, psychological, social, and economic impacts of firearm injury over time to inform recovery, reintegration, and tailored prevention pathways.
- **Interdisciplinary Training Pipelines:** Developing clinicians, researchers, and public health practitioners who understand trauma medicine, behavioral health, epidemiology, implementation science, and community partnership work.

These domains form the foundation of a sustainable and scientifically rigorous FIMP research agenda and align directly with the core mission and capabilities of health systems.

Strategic Priorities for Health Systems

Establish Dedicated Research Infrastructure:

- Create cross-disciplinary centers or programs for FIMP research that link trauma, emergency medicine, pediatrics, behavioral health, and community health.
- Develop data and analytics cores capable of integrating Electronic Health Record (EHR) data, trauma registries, claims data, geospatial mapping, and RHIO and HIE data to support high-quality longitudinal research.
- Ensure rapid IRB pathways for time-sensitive studies, particularly in high-risk communities or in the aftermath of acute injury events.
- See the prior section on developing infrastructure for additional details.

Secure Sustainable Funding:

- Advocate for endowments and philanthropic gifts to support endowed chairs, fellowships, and core research staff.
- Pursue federal, state, and foundation grants.
- Allocate internal pilot funding to accelerate promising research concepts and generate preliminary data needed for larger external awards.
- See *Section 3: Sustaining Funding for Firearm Injury & Mortality Prevention Programming* for more information.

Develop the Academic Pipeline:

- Offer formal research tracks for medical students, residents, and fellows that include mentorship, protected project time, and methodological training.
- Provide protected research effort for junior faculty and clinician-investigators with clear milestones and support.
- Recognize and reward community-engaged scholarship and policy impact as core elements of academic promotion and tenure.

Develop Impact Goals for a Health System Research Agenda:

- Align FIMP impact goals with larger health system goals and metrics of success. For example:
- Increase external funding for FIMP research by X percent over 5 years.
- Develop and deploy EHR-based screening and intervention tools across the health system within 3 years.
- Generate and disseminate high-quality research that informs national guidelines, clinical standards, and policy decisions.
- Demonstrate measurable reductions in firearm-related injury rates and disparities in priority populations.

Incentivize and Recognize Contribution:

- Launch annual pilot grant competitions to stimulate clinical, community, and policy-focused innovation.
- Reduce the relative value unit[77] expectations for clinicians conducting funded prevention research or engaged in HVIPs.
- Highlight investigator achievements across internal communications, grand rounds, research days, and leadership forums.

Translate Research into Impact:

- Prioritize implementation science to ensure that evidence-based strategies move into routine practice, such as integrating safe storage counseling into EHR workflows or standardizing behavioral health referrals after injury.
- Disseminate research findings in policy briefs, community reports, and clinical practice guidelines to ensure uptake beyond academic journals.
- Partner with CVI organizations, schools, and public health agencies to co-design, evaluate, and scale prevention programs.
- See *Section 7: Implementing Evaluating and Scaling Programs in Healthcare Settings* for more information.

Key Actions for Leaders

1. Embed FIMP into the organizational research agenda alongside cancer, cardiovascular disease, mental health, and maternal-child health.
2. Invest in people to ensure a sustained, well-supported pipeline of expertise.
3. Protect research time intentionally and predictably.
4. Establish recognition systems so that contributions to FIMP research are valued in promotion, tenure, and performance evaluations.
5. Build multi-site collaborations across health systems to expand evidence, increase statistical power, and drive national impact.

Resources to Inform Research Development

Resources from the Black & Brown Collective:

- Guiding Research Principles and Priorities for the Black & Brown Collective for Community Solutions to Gun Violence[78]
- The Case for More Equitable and Community-Engaged Research to Address Firearm-Related Violence in Black and Brown Communities[79]

Article: *Toward a Safer World by 2040: The JAMA Summit Report on Reducing Firearm Violence and Harms*[80]

Article: *Addressing Key Gaps in Existing Longitudinal Research and Establishing a Pathway Forward for Firearm Violence Prevention Research*[81]

Strategy #4: Develop Public Health Partnerships & Public Awareness

Public health education and public awareness campaigns are an essential part of building the standing and visibility for a health system's FIMP program that can unlock opportunities at every stage of the program's development.

Public health education and awareness campaigns are an opportunity to activate a health system's chief marketing officer, as well as marketing, communications, and public affairs teams, who have both the expertise in health communications and oversight of external communications channels to amplify the message.

Strategies for Health System Engagement

Below is a list of high-level external strategies health systems can deploy to develop effective public health education and awareness campaigns. Each strategy should involve generating both owned media (media that you have full control over, such as LinkedIn posts, social media, and blog posts) and earned media (media you do not fully control, such as print and cable stories, op-eds, and podcasts) to amplify the work.

Foster Community Presence

Community events and local forums are a great way for a health system to continue building its influence, credibility, and visibility in the communities it serves. For instance, the SAFE team (Scrubs Addressing the Firearm Epidemic)[82] hosts dozens of virtual and in-person events[83] across the country, promoting dialogue between healthcare professionals and local communities. Hospitals can organize similar events focused on firearm safety, providing educational resources and fostering open dialogues within the community.

Leverage Community

Organizations and Stakeholders: Hospitals should work closely with local community partners and patients to identify effective messaging. With input from relevant community stakeholders, health systems should either use internal resources (from departments like marketing and government affairs) to pressure test and refine messaging to ensure that FIMP efforts are framed as public health interventions rather than political statements. It is also imperative to collaborate with a diverse spectrum of constituency groups. **From firearm owners, CVI groups, to patient advocacy groups, building a diverse coalition can foster trust and enhance the credibility of a health system's prevention initiatives.** Additionally, hospitals should prioritize uplifting the voices of frontline healthcare workers engaged in this work and sharing unique survivor stories that reflect the real-life consequences of firearm injury, and the hope generated through prevention and recovery. See *Section 5: Community-Level Engagement Strategies* for more information about effective collaborations.

Weigh In on Policy Debate

Many health systems strive to remain bipartisan or nonpartisan. And while this is important, health systems are uniquely positioned to weigh in on policy issues related to public health, and specifically FIMP. Working closely with government relations teams, health systems can carefully advocate for policies such as Medicaid reimbursement of preventive interventions, securing sustainable funding streams for FIMP programs, and incorporating firearm violence prevention within broader SDOH strategies.

Develop Public Health Education/Awareness Campaigns

Ongoing evidence from various public health campaigns underscores the effectiveness of strategic communication in changing health behaviors. Studies suggest that such campaigns can positively influence vaccination beliefs and behaviors, contributing to higher vaccine uptake rates. Similarly, anti-smoking campaigns have demonstrated success; the "Truth" campaign, for example, has been widely credited with contributing to a significant drop in teen smoking rates in the U.S. These examples highlight the potential of well-designed public health campaigns to effect meaningful behavior change.

Examples of Public Health Education & Awareness Campaigns

- Agree to Agree[84]: The *Agree to Agree* campaign is a first-of-its-kind, nationally scaled initiative funded and catalyzed by leading U.S. health systems,[85] in partnership with the Ad Council and major medical associations. It represents the first health system-funded national campaign to approach FIMP explicitly as a public health crisis.
  - Unveiled at Northwell Health's Sixth Annual Gun Violence Prevention Forum, the campaign is intentionally nonpartisan and innovative in its design, with distinct pillars focused on equipping healthcare workers to have evidence-based conversations about firearm injury risk with patients; engaging students, parents, and educators around prevention and safe storage; and, notably, elevating CVI programs.
  - By centering shared values and prevention, *Agree to Agree* seeks to address the full spectrum of firearm injury, including suicide, interpersonal violence, and unintentional injury, while mobilizing action across healthcare, education, and community systems.
- End Family Fire[86]: This campaign is a joint effort by Brady and the Ad Council that aims to raise awareness about the dangers of unsecured firearms in the home and encourages safe storage practices to prevent unintentional shootings, suicides, and other incidents.
- ASK (Asking Saves Kids) Day[87] is a successful sub-campaign of the End Family Fire campaign. June 21 is recognized as National Ask Day, a day to empower family members, guardians, and, notably, clinicians, to ask about unlocked firearms where children play. The campaign also includes many educational resources to support these conversations
- Be SMART[88]: In the realm of FIMP, several campaigns have been initiated to promote safe firearm storage and reduce gun-related incidents. The Be SMART program, developed by Everytown for Gun Safety Support Fund, emphasizes the importance of secure gun storage to protect children and communities. The campaign focuses on educating adults about the life-saving benefits of storing firearms locked, unloaded, and separate from ammunition.
- Stop the Iron Pipeline[89]: Maryland has one of the highest rates of out-of-state illegal firearm imports. To raise awareness of this issue and the role the I-95 (nicknamed the "Iron Pipeline") plays in the movement of firearms along the eastern coast, LifeBridge Health[90] partnered with local artists and community members to develop a multi-faceted campaign to promote collective action and safety.

Strategy #5: Advocate for Evidence-Based Policy Change

A Spectrum of Engagement

Health systems often underestimate their ability to influence FIMP policy at the local, state, and federal levels. However, the reality is that health systems already operate at the intersection of public safety, public health, and public trust. With the right strategy and structure, they can make an impact in ways that align with their core mission and their broader communications and government affairs priorities.

There is a diverse set of ways to engage. Health systems and hospitals can tailor their involvement to the needs of the populations they work with, whether that means focusing on clinical care, public education, community partnerships, or policy change. For example, suicide is the leading driver of FIM, and for many health systems, the policy levers designed to address self-harm may look different than interpersonal violence or mass shootings. This could include heavily leaning into firearm risk screenings, public awareness campaigns, or education related to ERPOs as opposed to HVIPs.

The range of potential engagement can be thought of in three overlapping buckets, each offering opportunities for health systems to contribute meaningfully.

Engagement Strategies

Support for Evidence-Based Programs

Health systems can advocate for public or private funding to operate HVIPs and other trauma-informed care programs. This could take the shape of direct advocacy (e.g., meeting with state and federal policymakers), convening stakeholders (across healthcare, business, advocacy, education, etc.), or an outside-game media strategy (op-eds and other forms of thought leadership).

Public Education/Awareness

Health systems remain trusted messengers, especially locally, and can play a critical role in educating patients and communities about safe firearm storage, risk factors associated with firearm violence, and mental health support. This can be accomplished through public education and awareness campaigns, provider training, and firearm risk screenings in clinical settings. This bucket of work has a low barrier to entry but can have a substantial impact on the community.

Policy Advocacy

Health systems can also engage directly in policy change outside of program-specific requests. This bucket itself includes a spectrum of activity from supporting expanded background checks and assault weapon and large capacity magazine bans, to research funding. In many states, coalitions aimed at passing these kinds of legislation at the national and local levels already exist. Once a health system determines its policy priorities, it can identify the relevant partner and bring the weight of its outsized political influence and community standing to support ongoing efforts.

Each of these pathways offers health systems an opportunity to lead or lend their voice — incrementally or as pace setters — depending on institutional priorities.

Developing an Internal Strategy

For health systems to engage effectively, advocacy must be rooted in internal consensus. Long-term success requires a structured and cross-functional approach to policy and advocacy. The following steps can guide internal strategy development specific to the FIMP policy and advocacy space:

Set Clear Goals & Timelines

Health system leaders should develop a strategy that maps tailored policy goals over a given timeframe. No matter the target — whether it's an ERPO bill or legislation increasing funding for FIMP programs across the board — health systems should identify the timeline of their policy/advocacy strategy. This can range from short-term (i.e., over the course of a state legislative session) to long-term plans (identifying opportunities over the course of a given Presidential or Gubernatorial administration). Establishing a timeline will drive the tentpole moments for a health system to show up, the public affairs tactics, and the execution speed needed to reach their goals

Define the Institution's Role

Will the health system lead the charge? Or play a behind-the-scenes role? A health system›s capacity, political standing, and risk tolerance may dictate the role a health system plays in a public affairs campaign. For example, smaller health systems may not have the resources to spearhead a comprehensive public awareness campaign around ERPOs and thus may opt to provide auxiliary resources by amplifying the work of a trusted organization. Conversely, a health system that has identified legislation it would like to support (e.g., a FIMP research funding bill) may decide to put the full weight of the institution behind an owned campaign. Both strategies, if executed properly, are effective ways to engage in policy and advocacy.

Identify Teams Focused on Engagement

To maximize the deployment of internal resources, health systems should leverage the expertise of program officers and the government relations team. Cross-team collaboration will ensure that the full extent of a health system's capacity and network is used to reach advocates, policymakers, and other key stakeholders. It will also increase transparency across staff, an important feature of successful teams.

Engage Local Stakeholders

To reach their goals, healthcare leaders should establish relationships with other key stakeholders focused on the implementation of FIMP programs at the local, state, and national levels. For example, collaborations with CBOs, CVI organization, educators, community leadership, law enforcement, and public health agencies are essential for the successful implementation of FIMP policies and programs. Cultivating these partnerships can ensure that a health system's programs are culturally relevant, accessible, and tailored to the unique needs of populations at risk of firearm injury and violence exposure. Similarly, advocacy groups play a crucial role in raising awareness, mobilizing public support, and influencing policymakers to adopt stricter regulations and supply resources to FIMP programming.

Specific Avenues for Health System Engagement

Once outlining goals, explore the potential areas for engagement and choose opportunities that align with the institutional agenda. They may include, but are not limited to:

Programmatic and Clinical Support

- HVIPs: Health systems can advocate for increased funding to implement and expand HVIP programming. This could be done in partnership with CBOs and advocates to apply public pressure on policymakers, or alternatively, could be an owned effort that a health system pursues by working behind-the-scenes to educate policymakers about the importance of this work.
- Firearm Access Screening: Firearm access and risk screening is a relatively novel intervention, but programs such as the ones being driven by Northwell Health are already boasting promising results. Northwell initially received a $1.4 million grant from the NIH[91] to pilot the program in 2021. Now, as a peer-reviewed program, it is receiving state funds to expand the screening program to five additional trauma centers across the state. Health system leaders can leverage this research to encourage states to administer similar funds that implement and scale risk screening programs.

Healthcare Access and Survivor Support

- Health systems can push for policies that provide resources to survivors of firearm injury and community violence exposure, such as mental health care, temporary shelter, and case management. Recently, significant Medicaid cuts have also put communities and survivors at risk[92] of losing essential services that promote long-term health and safety. Health systems can both leverage their collective bargaining power to push back against Medicaid cuts as well as strive to expand equitable and accessible healthcare services within their own system.

Violence Prevention Workforce Development:

- Health systems can support state policies that establish training pipelines, certification standards, and sustainable career pathways for violence interrupters and other CVI professionals. These policies should recognize the trauma of frontline violence prevention work and include access to mental health supports, fair compensation, and benefits.

Legal Interventions

- Extreme Risk Protection Orders (ERPOs): At the time of publishing, 21 states[93] currently have ERPO legislation. However, public awareness and utilization of these policies vary drastically by state. Hospitals can play a key role in encouraging legislators to use government resources to launch public awareness campaigns to increase public visibility of the tool and create technical assistance programming to educate key stakeholders, such as law enforcement, educators, and health practitioners.
- Safe Firearm Storage/Child Access Prevention (CAP) Laws: Health systems can push state legislatures to pass safe storage/CAP laws. As of the publication of this toolkit, only 26 states have safe storage and/or CAP laws, but there is documented bipartisan approval of these policies, making it a less controversial priority to pursue. According to a poll[94] commissioned by Brady, 77% of Republican voters and 81% of firearm owners support safe storage laws in homes with children. In addition to/in lieu of legislative action, health systems can adopt an educational role around safe storage and CAP laws. Through public awareness campaigns or public service announcements, health systems can educate their patient populations on the importance of safe storage, even if there is no legal requirement.

Consumer Safety Standards for Firearm Storage Devices:

- In addition to education and legal requirements, states can reduce firearm injury by establishing minimum consumer safety standards for firearm storage devices sold within the state. Treating gun safes, lock boxes, and locking devices as consumer products — subject to basic performance, testing, and labeling standards — can help ensure that storage devices function as intended and support safer storage practices. Health systems can support these efforts by sharing clinical insights on injury prevention, child access, and product effectiveness.

Workplace Violence Prevention and Firearm Injury Risk

- States can incorporate firearm risk into existing workplace safety and violence prevention standards, particularly for public agencies, healthcare facilities, and other high-risk settings. Health systems, as both employers and care providers, can support policies that require workplace violence prevention plans, employee training, and incident response protocols that address firearm-related threats, helping protect workers while reducing preventable injury.

Research Support

- Since the ban on federal funding of FIMP research was lifted, the government has been the backbone of research across the country. Health systems could pursue a legislative advocacy campaign — particularly at the state level — pushing for additional research funding on new and existing approaches to violence reduction.

Medicaid Financing for Violence Prevention

- Health systems can advocate for states to leverage Medicaid authorities (including Section 1115 waivers and state plan amendments) to fund evidence-based FIMP strategies such as HVIPs, CVI, and firearm risk screening and counseling. CMS has issued guidance clarifying that many of these services are eligible for reimbursement under existing Medicaid frameworks.

Value-Based Purchasing and Quality Incentives

- States can integrate firearm injury prevention into Medicaid quality strategies and value-based payment models by rewarding hospitals and clinics for implementing evidence-informed practices such as firearm risk screening, safe storage counseling, and referral to HVIPs or CVI programs. Health systems can play a leadership role in shaping these metrics and demonstrating feasibility.

Engagement of Private Health Insurers:

- Health systems can encourage state insurance regulators and Medicaid agencies to engage private payers in covering FIMP services through value-based contracts, wellness benefits, and injury prevention incentives. Without private payer participation, prevention efforts remain overly reliant on public funding and strain safety-net providers.

Trauma Center Accreditation Standards

- Health systems can urge governors and state leaders to use their convening power to call on national accrediting bodies — such as the American College of Surgeons — to incorporate firearm injury prevention practices (e.g., risk screening, referral pathways, and community partnerships) into trauma center verification standards.

See below for additional details.

Healthcare Facility and Professional Licensure Requirements

- States can require hospitals and licensed healthcare professionals to demonstrate capacity for firearm injury prevention as a condition of licensure. This may include having a violence intervention strategy, providing secure firearm storage counseling, or completing continuing education on firearm injury prevention, trauma-informed care, and ERPO processes.
- Mandate **continuing education** on firearm injury prevention, trauma-informed care, and ERPO processes for clinicians.
- E.g., New York's controlled substance prescriber training requirement[95] (3-hour pain management course every 3 years).

Supporting State Policy

Below is a summary of Northwell's Policy Report[1].

Executive Branch

Governors possess the executive authority to enact substantial health-centered FIMP measures (such as program development, data infrastructure improvement, and interagency coordination) without requiring new legislation or additional appropriations.

Develop Policymaking Infrastructure

Establish or expand state OGVPs:

- Create or enhance OGVPs through executive action (e.g., Wisconsin Gov. Tony Evers' 2025 executive order,[96] establishing the state's OGVP and $10 million budget).
- OGVPs coordinate data systems, agencies, and funding for prevention programs.
- Support health systems and local OGVPs in violence prevention and response.

Key OVP Functions:

- Run or fund public awareness campaigns on firearm storage safety and risks.
- Partner with health systems on universal firearm risk screening in healthcare (e.g., primary care, ED, pediatrics).
- Serve as resources for HVIPs and coordinate across systems.
- Convene CBOs to identify service gaps.
- Provide technical assistance for CBOs applying for grants.
- Develop implementation guides for state laws (e.g., ERPOs).

Create firearm violence data dashboards

- Track fatalities, injuries, and related variables with dynamic dashboards that aggregate data across multiple datasets and allow for different geographic levels of analysis (city, county, state)

Maryland's Firearm Violence Dashboard,[97] and Houston's SAFEWatch Firearm Injuries Dashboard[98]

Use data to inform funding decisions (e.g., Medicaid allocations, hospital budgets, and CVI programs).

Improve data coordination

- Establish a cross-agency commission to standardize nonfatal gunshot injury data collection.
- Collaborate with universities, EMR vendors, and health systems for better monitoring.
- Build on CDC progress to complete national nonfatal injury tracking.

Enhance crisis response systems

- Develop or expand statewide crisis response programs

Program Example
New York's Crisis Management System[99].

- Train providers to address firearm suicide and IPV.
- Educate providers on protective orders and firearm-related risk factors

Program Example
UC Davis' BulletPoints Project[100].

- Use mobile crisis teams, stabilization centers, and telehealth for rapid response.

Real-Time Firearm Injury Surveillance Systems

- Health systems can support the development of statewide, real-time firearm injury surveillance systems that integrate hospital, EMS, medical examiner, and law enforcement data. These systems can help states better understand non-fatal firearm injuries, target resources, and evaluate program effectiveness.

Standardization of Non-Fatal Gunshot Injury Data

- States can require standardized coding and reporting of firearm injuries across healthcare settings. Health systems can partner with state agencies, EMR vendors, and research institutions to improve data quality and ensure firearm injury data informs funding and policy decisions.

School-Based Behavioral Threat Assessment Partnerships

- Health systems can partner with states and school districts to support Behavioral Threat Assessment and Management programs (multidisciplinary, evidence-informed approaches that identify and address concerning behaviors before they escalate into violence). Health systems can contribute clinical expertise, mental health referrals, and crisis response capacity, helping schools move away from punitive approaches and toward early identification and prevention.

Take Executive or Agency Action

- Direct the Departments of Health (DOHs) to promulgate regulations related to firearm injury risk screenings in hospital/clinical settings:
- Include expert recommendations for adaptations for diverse clinical settings, including hospitals (emergency department, behavioral health) and outpatient clinics (OB-GYN, pediatrics, family medicine).
- Develop standardized screening tools and statewide training.

Program Example
Rhode Island's "Levels of Care"[101] was the first set of state-based standards of care for overdose and opioid use disorder published by the state's DOH.

Assess trauma care access

- Conduct statewide assessments mapping population density, firearm violence rates, and care capacity. Identify and address trauma care coverage gaps.

Resource Example

Pennsylvania Trauma Systems Foundation[102] conducted a broader version of an access assessment (recommendations were based on general trauma data, not specifically firearm violence rates) that resulted in a set of concrete recommendations for the state to implement.

Run public awareness campaigns

- State campaigns are able to reach a wider audience and ensure education and advocacy efforts are amplified.
  - See *Section 4, Strategy #4: Develop Public Health Partnerships & Public Awareness* for examples.

Regulatory Action by State Health Departments:

- Governors can direct state Departments of Health to issue regulations establishing standards of care for firearm risk screening, patient education, and referral pathways across hospitals and clinical settings, similar to existing regulatory approaches used for overdose prevention and substance use disorder.

Designation of Gun Violence as an Essential Public Health Issue

- Governors can formally designate gun violence prevention as a core public health responsibility, enabling states to align existing public health infrastructure, funding streams, and strategic planning processes around prevention and intervention.

Use the Bully Pulpit to call on the American College of Surgeons to expand and diversify requirements for trauma centers.

The Trauma Verification, Review, and Consultation Program[103] is the process through which the ACS validates the presence of the most up-to-date standards in trauma patient care.

The *Resources for Optimal Care of the Injured Patient (2022 Standards)*[104] is the most recent iteration of the "principles regarding resources, performance improvement, patient safety processes, data collection, protocols, research, and education for a trauma center." These standards are often revised to better reflect changing norms and requirements in trauma medical care. The inclusion of a spectrum of assessment/intervention standards for firearm injury risk and community violence in future *Resources for Optimal Care of the Injured Patient* would incentivize trauma centers across the country to integrate the requirements to maintain or improve their trauma center level designation.

- It would further assist in the standardization of data collection for patients impacted by firearm injury and community violence and facilitate FIMP program monitoring and evaluation.

Legislative Actions

Develop Policymaking Infrastructure

- Codify statewide OVPs: Pass legislation establishing permanent OGVPs and providing sustained funding.
- Fund grants, training, fellowships, and research on public health approaches to GVP.

Establish State Trauma System Advisory Committees:

- Create multidisciplinary committees (e.g., NJ, NY models) with subcommittees on firearm violence.
- Advise resource allocation, system planning, and inter-hospital coordination.

Create Regional Health Information Exchanges (HIEs):

- Use memoranda of understanding (MOUs) between states to share FIM outcome data.
- Include nonfatal injuries, ED visits, and behavioral risk indicators to guide responses.

Appropriate Funding

- Fund health-focused prevention and intervention:
  - Support trauma centers in high-violence areas with resources for risk screening and HVIPs.
  - Equip health agencies to run firearm safety campaigns

Funding Example
Larimer County, CO "Juvenile Gun Safety"[105] initiative.

  - Fund hospital distribution of safe storage devices

Funding Example
The Children's Hospital of Pennsylvania distributed 500 gun locks[106] that were donated by the Philadelphia Sheriff's Department.

Create Gun Violence Prevention Tax Increment Financing

- Designate "gun violence prevention districts" and use future tax revenue from revitalization to fund GVP programs.
- Use revenue for HVIPs, CVI initiatives, and infrastructure.
- Include anti-displacement measures, such as affordable housing investments.

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SECTION 5: COMMUNITY-LEVEL ENGAGEMENT STRATEGIES

Healthy communities are safe communities. Much like the integrated, comprehensive strategies for the prevention of chronic illnesses[1] like cancer and asthma, health systems have a responsibility to look beyond acute clinical care and invest in primary prevention strategies that can curb firearm injury and community violence risk before it occurs. The majority of health systems are already investing in general SDOH programming, but there is ample opportunity to strengthen or expand existing programs to align with a FIMP portfolio.

Notably, all strategies in this section rely on and amplify the importance of **intentional, sustainable partnerships between health systems and community stakeholders** including but not limited to educators, CVI organizations, firearm owners, CBOs, employers, law enforcement, families, youth, and local religious, political, and cultural leaders. **These strategies exemplify the importance of developing integrated bidirectional communication channels and referral pathways between clinical and community resources. These partnerships will also help ensure healthcare-led FIMP programs are culturally relevant, accessible, tailored to the unique needs of local communities, and reflective of the lived experience of community members.**

Strategy #1: Promote Investment in Community Social Determinants of Health

Support for Upstream Investment

Community violence and firearm injury are more likely to occur in communities that have experienced historic and on-going disinvestment the SDOH.[2-6] One study revealed[7] that children growing up in neighborhoods with a low Child Opportunity Index (a variable that assesses education, socioeconomic resources, and access to health spaces) were more likely to experience a firearm injury, and were more likely to be reinjured in the year following the initial injury. Programs that address the SDOH- such as those that reduce food and housing insecurity, increase access to high quality education and healthcare, and create economic opportunity- help support sustainable pathways[8] to community health and safety.

Health systems have a responsibility to increase the availability and accessibility of these protective programs, particularly in neighborhoods bearing a disproportionate burden of firearm injury and community violence due to SDOH disinvestment. Community and population health teams are well positioned to support these interventions, helping create a coordinated safety net of resources that directly and indirectly reduce firearm injury risk. SDOH programs with significant health system partnerships also have stronger outcome tracking and data collection practices[9] which can help strengthen evidence needed to sustain and scale effective programs.

Investment in SDOH can also be a pragmatic strategy for health systems that face political or social barriers to launching dedicated FIMP programs. Because SDOH initiatives are a normalized and widely accepted area of health system engagement, they may reduce internal and external resistance while still advancing upstream violence prevention. Public opinion data support this approach:[10] regardless of firearm ownership status, most adults surveyed in the 2023 Colorado Firearm Injury Prevention Survey expressed support for investments in upstream strategies such as quality education, access to health and mental health care, employment opportunities, and parks and open spaces.

Opportunities for Portfolio Alignment

Social Determinants of Health Screening Protocols

- Health systems can strengthen SDOH screening to identify patients and families facing socioeconomic vulnerabilities that undermine health and safety. Comprehensive screeners can detect housing instability, food insecurity, unemployment or underemployment, inadequate access to health care or insurance, unsafe relationships, substance misuse, and other risk factors that contribute to firearm injury risk and numerous health conditions. Rather than limiting screening to perceived high-risk patients, health systems should adopt universal, comprehensive screening and referral approaches across diverse clinical settings to enable early identification and connection to wrap-around services.

Program Example
Embedding SDOH screeners into the EMR is an effective strategy to increase screening rates and support referrals to appropriate health system and community resources. Epic's platform offers diverse Population Health tools[11] to support screening and intervening for SDOH-based health disparities.

Early Intervention, Family Support, and Community-Based Workforce Models

- Early intervention and family-centered support are critical to addressing upstream drivers of firearm injury and community violence. Interventions that stabilize housing, strengthen economic supports, and provide family-focused services are associated with reduced violence risk and improved safety and health outcomes. Health systems can deploy interdisciplinary teams (including social workers, community health workers, care coordinators, and behavioral health specialists) to identify risk early and connect individuals and families to stabilizing resources.
- Social workers can offer trauma-informed support and navigation of complex social and legal systems, while community health workers provide trusted, culturally responsive engagement that bridges clinical care and community services. Embedding these professionals in emergency departments, pediatric clinics, or primary care settings enables timely referrals to housing, food, behavioral health, and family support services following identified risk or crisis, strengthening protective factors before harm occurs.
- This approach also creates opportunities to educate clinical staff about the role of CVI organizations and to establish bidirectional referral pathways that link community members to both clinical care and community-based resources, supporting families, improving quality of life, and reducing exposure to violence (see CVI Engagement below for more).

Program Example
The Atlanta Regional Collaborative for Health Improvement[12] employs community health workers in Community Resource Hubs[13] to improve access, reduce disparities, and support communities more effectively.

Investing in the Built Environment

- Research demonstrates the positive effects neighborhood restoration and beautification have on reducing violence and improving health outcomes and perceived community safety.[8,14,15] This presents two avenues for health system investment.
- As significant property owners and managers, health systems should ensure the grounds around their clinical and administrative properties model the highest standards for neighborhood safety. Property and parking lots around health system buildings should be well-lit, free of garbage, accessible, well-maintained, and monitored. Health systems can also invest in community beautification through landscaping and planting gardens, trees and greenery, adding benches, and even establishing parks/shared green spaces for patients, families, and health system staff to enjoy.
- As recognized community institutions, health systems can provide financial or staff resources to community-led revitalization initiatives that clean up streets, rejuvenate abandoned or dilapidated spaces, plot community gardens, etc. Health systems can model the importance of community-building by offering these events as volunteer opportunities for staff.

Program Example

In Baltimore,[16] the Bon Secours health system has converted more than 640 vacant lots into green spaces and actively engages local businesses to join community clean ups.

Strategy #2: Amplify Community Violence Intervention & Community-Driven Solutions

Understanding Community Violence Intervention

CVI groups are essential partners for health systems looking to develop FIMP initiatives. Their teams are experts on the lived experience of their community and can speak not only to the impacts of violence and trauma, but also to a community's resiliency and strengths that should be recognized and uplifted. Often, many local groups collaborate, sharing knowledge and developing an ecosystem of support concentrated in areas with increased exposure to community violence.

Importantly, CVI work is steeped in racial and health equity,[17] as their teams witness how the consequences of historic and on-going disinvestment and racially discriminatory policies have systematically undermined the health and well-being of their community members, the majority of whom are Black and Brown Americans. Moreover, CVI is a holistic, healing-centered alternative to traditional criminal justice models of violence reduction which have historically led[18] to the over-surveillance of Black and Brown neighborhoods, mass incarceration, and the intergenerational dissolution of community and family structures.

CVI organizations reduce community violence through prevention and intervention pathways that often involve family models, as they recognize and validate the intergenerational harm of community violence and the importance of intergenerational healing.

Prevention programing

Prevention programs work upstream to address the SDOH and systemic inequities that may increase an individual or community's risk of violence exposure. They also work to assist families healing in the aftermath of violence exposure. This may include programming and initiatives addressing:

- Basic needs: safe housing, food security, health insurance
- Youth engagement and mentorship
- Employment and job-readiness
- Counseling and mental health support
- Alternative education programs
- Legal aid services

Intervention Programming

Intervention programs seek to interrupt existing cycles of violence among families and individuals currently, or at high-risk of, experiencing or perpetrating violence. These programs rely on credible messengers who are trusted community members with lived experience, who can guide impacted individuals away from violence. These teams may engage in:

- Crisis management
- Conflict mediation
- Targeted violence interruption (both in the community and in clinical settings through HVIPs)
- Re-entry programs
- Support and programs for current or formerly gang-involved individuals

Thoughtful Health System Engagement

Health systems should seek to support and amplify the work of local CVI organizations; invest in the development of effective partnerships; and explore the different ways CVI voice can be integrated into day-to-day clinical practice and program implementation. The first step must be listening and learning from local and national CVI leaders. For example, the HAVI's Racial Equity Framework for Community Violence Intervention Solicitations[18] outlines 9 recommendations that health systems should familiarize themselves with.

One of the most common strategies for aligning clinical and community FIMP is through the development of an HVIP, which are proven to improve patient health outcomes, prevent reinjury, and strengthen bridges between clinical and community stakeholders. See *Section 6 Strategy #1: Implement Evidence-Based Clinical Strategies* which provides a detailed overview of HVIP program implementation and examples of HVIP successes across the country.

However, HVIPs may not meet the needs of all health systems across the country, especially those that do not operate trauma centers and therefore may not work directly with a high enough volume of patients impacted by community violence. This doesn't preclude health systems from working alongside local CVI organizations and leaders and imbedding local community expertise in program service delivery. Health systems should learn from local CVI organizations and leaders to identify what engagement strategies would yield the most benefits for community member and patients. These strategies may include, but are not limited to:

Strengthen Bidirectional Communication Channels

- Invite CVI leaders to sit on the FIMP Steering Committee or form a Community Advisory Board with community members representing CVI organizations, spiritual leaders, trusted messengers, patients, and family members.
- See *Section 2: Conducting a Firearm Injury & Mortality Prevention Needs Assessment* for more.

- Schedule routine check-ins with CVI groups throughout the implementation process to provide updates, share preliminary data, and seek feedback. See *Section 7: Implementing, Evaluating, and Scaling Programs in Healthcare Settings* for more information.
- Send health system representatives to attend local townhalls, events, and other engagements either hosted or attended by CVI organizations to build relationships and speak directly from community members.
- Facilitate opportunities for CVI and CBO leaders to represent their communities at health system leadership meetings or host specific meetings to allow executive leadership to learn about local CVI efforts.

Identify Financial Support for Local Partners

- Educate partners on the different pathways for financial support from the health system. This may include grants opportunities that are open to community applicants or that are seeking community partners for community-based participatory research, sponsorship opportunities for community events, or funding dedicated to community-led SDOH programming.
- Reduce inequitable barriers to funding by offering access to institutional resources and/or technical assistance for grant writing and management.
- If part of an academic research institutions, advocate for increased equity in the grant application and funding process, including increased financial support for Black and Brown researchers, and requirements that all research follow community-based participatory research best practices.

Resource Example

Explore guidelines and best practices outlined by The Black and Brown Collective: The Case for More Equitable and Community-Engaged Research to Address Firearm Related Violence in Black and Brown Communities[19] and the Guiding Research Principles and Priorities for the Black & Brown Collective for Community Solutions to Gun Violence.[20]

Diversify Opportunities for Programmatic Integration

- Offer opportunities for site visits with organizations where CVI groups are invited to tour relevant programmatic clinical spaces, and clinical teams can tour organizations' sites.
- Strengthen bidirectional referral pathways for patients struggling with substance misuse, IPV or domestic violence, child maltreatment, behavioral health crises, etc. Integrating CVI strategies in diverse patient care can reduce the risk of firearm injury at times of heightened vulnerability.

Program Example

BOSS's (Building Opportunities for Self Sufficiency) Trauma Recovery Center,[21] in collaboration with West Oakland Health, provides free mental, physical, financial, and spiritual resources/support to survivors of interpersonal violence or individuals who have experienced loss through violence.

- Work alongside local and state CVI stakeholders to produce best practices, frameworks, or crisis support networks.

Resource Example
The New York City Department of Health's Community Violence Prevention Framework.[22]

Collaborate on Educational Initiatives, Events, and Resources

Host educational sessions where local CVI partners can educate multidisciplinary students, trainees, and staff. This could be accomplished through traditional educational platforms like seminars, Lunch & Learn sessions, Grand Rounds, etc.

- **Offer CME credits** to increase buy-in and attendance.

Program Example
Northwell's Learning Collaborative for Health Systems & Hospitals features multiple sessions that are co-created with CVI partners and amplify their work:

- *Hospital-Based Violence Intervention Programs and Community-Based Organizational Partnerships* (July 2021)[23]
- *Mental Health and Community Resources for Survivors of Gun Violence* (Sept. 2021)[24]
- *Hospital-Based Violence Intervention Programs and Working with Communities* Part A (March 2024)[25] and Part B (April 2024)[26]

- **Co-host events and engagements** between academic, community, and health system stakeholders to remove silos, promote dialogue and co-create solutions.

Program Example
In 2025, over 100 champions attended the REACH Clinical-Community-Academic Forum: Healing from Community-Based Violence,[27] an event co-hosted by the Denver Youth Program, the CU Anschutz School of Medicine's Firearm Injury Prevention Initiative and Injury and Violence Prevention Center, and the Trailhead Institute Office of Firearm-Related Harm and Violence Prevention.

The Denver R.E.A.C.H Clinic[28] offers multidisciplinary, wraparound care to survivors of violence and integrates HVIP services, targeting resources to support patients impacted by gang violence, and standard medical and behavioral healthcare.

- **Co-host events around local and national campaigns** that often receive significant health system engagement.
- Examples:
  - Gun Violence Awareness Month[29] (June), Wear Orange[30] Day (first Friday in June)
  - Suicide Prevention Awareness Month[31] (Sept.), 988 Day[32] (Sept.8), and World Suicide Prevention Day[33] (Sept.10)
  - Domestic Violence Awareness Month[34] (Oct.)
  - National Injury Prevention Day[35] (Nov. 10)

Program Example: Northwell Health's Wear Orange Day event in 2024[36] hosted youth survivors of firearm injury, local CVI organizations, clinical champions, and executive leadership, including opening remarks from then-CEO Michael Dowling.

- **Co-create educational FIMP materials** for staff and patients, including information about local CVI partners and CBOs who can support patients, families, and staff members impacted by violence.

The Bottom Line

Investing in strong relationships with local CVI experts will allow health systems to anchor FIMP efforts in equity, lived experience, and community trust. CVI organizations offer prevention, intervention, and healing-centered strategies that address the root causes and intergenerational impacts of violence and complement clinical care in ways health systems cannot achieve alone.

By listening first, investing equitably, and building strong pathways for communication, clinical integration, and shared learning, health systems can strengthen partnerships, improve patient outcomes, and support sustainable reductions in community violence.

Strategy #3: Develop School-Based Partnerships & Integrated Prevention Programming

Health systems and schools often work collaboratively to support healthy student development through the creation of health education and provision of health services within schools by embedding nurses and social workers to facilitate referrals and simplify access to healthcare. They also share a responsibility to prevent gun violence and mitigating its impact on youth mental health and safety. Schools are uniquely positioned to notice emerging warning signs and social stressors, while health systems are uniquely positioned to assess and support students in crisis; together, they form the core of the youth safety net. **By aligning school-based prevention programs with healthcare expertise, communities can address the risk factors (e.g., firearm access, trauma, untreated mental illness) and amplify the protective factors (e.g., belonging, mentorship, access to care) that shape student outcomes.**

Health systems should consider building partnerships with local DOEs, school boards, administrators, and educators to either a) co-create and pilot FIMP and student mental health initiatives or b) enhance existing programs through joint education campaigns, referral pathways, staff training, and data-sharing agreements. These collaborations are most effective when they include shared decision-making structures, warm handoff pathways, and ongoing communication. When implemented collaboratively, these strategies strengthen prevention, improve access to mental health care, and build community resilience.

Below are examples of areas for collaborative engagements between health systems and school systems, including relevant programs and implementation and policy considerations.

Early Identification & Threat Recognition:

Early identification and threat recognition help prevent school gun violence by spotting warning signs-like violent talk, behavioral changes, or withdrawal-early. This allows timely interventions for both mass shootings and student suicide through counseling, threat assessment, and connection to mental health or safety resources.

Program Example

SHP's violence prevention program, *Say Something*,[37] teaches students to recognize warning signs of potential violence and report concerns to trusted adults or an anonymous system. The program's focus on early detection complements health systems' role in assessing behavioral and environmental risk factors for violence. In Massachusetts,[38] SHP partnered with the state Attorney General's office and schools to provide violence prevention and mental health training to nearly 140,000 students and teachers across 52 school districts.

Health System Integration

- Embed clinical expertise: Health systems can work with school systems to assign behavioral health professionals to school threat-assessment teams, ensuring that referrals from programs like "Say Something" are clinically evaluated and linked to appropriate care. Encourage schools to explore evidence-based threat assessment protocols.[39]
- Establish warm referral pathways: Create MOUs so that students identified through reporting systems can be rapidly referred to mental health providers or HVIPs.
- Integrate screening protocols: Align threat-recognition efforts with universal screening for violence exposure, firearm access, and suicide risk in pediatric and adolescent clinics.
- Policy recommendation: Health departments and hospital associations should fund joint training for clinicians and educators on threat assessment and trauma-informed de-escalation.

Firearm Safety & Reducing Student Access

Overview: Safe storage education and programming reduce school gun violence by teaching families to securely store firearms, limiting access to guns. Proper storage helps prevent impulsive acts, lowering the risk of student suicide, and reduces the availability of weapons that could be used in mass shootings.

Program Example

The Be SMART for Kids[40] campaign promotes responsible firearm storage through the principles of **S**ecure, **M**odel, **A**sk, **R**ecognize, **T**ell. Schools serve as trusted messengers for parents, and health systems provide credible medical voices and practical resources. Be SMART recently celebrated 10 years[41] of successful implementation, which included partnerships with school, health systems, religious organizations, and gun ranges.

Health System Integration:

- Partner with schools for outreach: Co-host community outreach and educational session about Be SMART, co-led by clinicians and school nurses, providing gun locks and educational materials.
- Embed consistent messaging: Align public health campaigns, parent communications, and school newsletters to reinforce secure storage norms. Co-create educational materials that can be posted in both school and clinical settings to promote dialogue and demonstrate partnership.
- Education: Have healthcare professionals provide relevant education to school administrators and educators on the evidence demonstrating the efficacy of safe storage.
- Policy recommendation: Advocate for public health funding that supports the distribution of firearm safety devices through school health clinics, similar to programs for car seats or naloxone.

Mental Health & Trauma Support

Exposure to gun violence is linked to depression, PTSD, and poor educational outcomes. Conversely, students who experience mental health challenges and trauma may also be at risk of harming themselves or others if they gain access to a firearm. Collaborations between schools and health systems can ensure students receive preventive social-emotional learning (SEL) curricula, are educated on the importance of mental health, and when necessary, develop crisis responses that are trauma-informed and connect at-risk students to school and health system-based immediately.

Program Example

In Michigan, Trinity Health Muskegon received a grant[42] to embed community health workers in school districts via the SafERteens Program[43] partnering with schools to reach at-risk youth and connect them with violence-prevention services. The program uses evidence-based tools like motivational interviewing and goals-based discussion to support youth make healthy, positive decisions. Research has demonstrated[44] that teens who receive the SafERteens program are less likely to report aggression, victimization and violence-related consequences at follow-up. It has also been effective[45] at reducing symptoms of depression.

Health System Integration

- Expand school-based behavioral health services: Embed clinicians within school health centers or create telehealth partnerships to provide counseling and follow-up for students exposed to violence.
- Develop cross-sector care pathways: Create integrated referral systems that connect school counselors and hospital social workers for continuity of care.
- Train staff jointly: Offer co-led professional development on trauma-informed classroom practices, suicide prevention, and youth firearm risk factors.
- Policy recommendation: Support state-level policies that reimburse behavioral health services delivered in schools and allow Medicaid billing for tele-mental health visits for students.

Community Violence Intervention Partnerships

Partnerships and collaborations between schools, health systems, and CVI organizations can help create safer environments before and after school, reduce student exposure to community violence, and provide positive role models who reinforce conflict resolution and nonviolent norms.

Program Examples

S.T.R.O.N.G Youth,[46] a local CVI in Long Island, NY, operates a program called **S.T.R.O.N.G Chapters**[47] with schools in their service area. This program works within schools to support youth development and addresses community violence through counselling and mentorship by trained CVI staff members; group sessions on SEL, conflict resolution, and emotional regulation; community service projects; and family engagement.

In Connecticut, the **Hartford Hospital-based Violence Intervention Program Collaborative**[48] brings together health systems, schools, local youth CBOs, and agencies to coordinate screening, long-term care, and school-linked supports for youth exposed to violence.

Health System Integration

- HVIP Referral Pathways: Engage local CVI organizations and schools when developing pediatric HVIPs to ensure referral pathways are built between and within school and community-based programs (see Clinical Strategies: HVIPs for more information).
- Amplify partnerships between schools and CVI: Strengthening existing relationships by providing funding and sponsorship for events co-hosted by CVI organizations and schools, share information about the partnerships with community health teams, and attend events to build bidirectional relationships.
- Advocate for CVI: Encourage school boards to engage with local CVI organizations and build productive partnerships where they do not already exist. Help school administrators understand the role CVI plays in reducing community violence and supporting families and students impacted by violence.

Youth Empowerment & Advocacy

Youth empowerment and advocacy in schools help prevent gun violence by fostering hope, resiliency, and a sense of agency. Through mentorship, peer leadership, and opportunities to engage in positive change, students build coping skills, strengthen social connections, and are more likely to intervene constructively, reducing risks of both violence and self-harm.

Program Examples

Students Demand Action[49] mobilizes high school and college students to advocate for evidence-based FIMP. Their advocacy[50] also expands to include safe dating, youth mental health support, health equity, and youth engagement in voting and political advocacy. In 2024, SDA partnered with the What I Wish I Knew Foundation[51] to bring conflict resolution and violence prevention training tour[52] to 5 schools in Philadelphia. Health systems can strengthen this movement by connecting with local SDA chapters to offer mentorship, education, and employment opportunities that link advocacy with professional growth and encourage future careers in healthcare.

The Center for the Study and Prevention of Violence at University of Colorado Boulder has multiple strategies to amplifies youth voice and agency to drive community violence prevention, including their Youth Advisory Council[53] and Game Changers Program.[54]

RomoGIS's educational programs[55] combines Geographic Information Systems (GIS) technology training and youth advocacy to empower a new generation of data scientists capable of harnessing local data to drive community health and safety solutions. Their programs have been successfully implemented in New York,[56] Tennessee,[57] and Michigan.[58]

Health System Integration

- Create mentorship pipelines: Develop mentorship programs that connect youth advocates with clinicians, public health leaders, and hospital administrators to learn about careers in violence prevention and community health.
- Offer internships and paid opportunities: Employ students through summer or year-round programs in health communication, research, and data analysis focused on FIMP.
- Collaborate on advocacy campaigns: Partner with student organizations to co-host town halls, public health awareness events, and policy forums.
- Policy Recommendation: Establish sustainable funding streams within health systems and schools for youth leadership development in violence prevention, recognizing civic engagement as a determinant of community health.

Data Infrastructure, Evaluation & Joint Training

Coordinated data collection and shared training between schools and health systems can strengthen prevention efforts, improve resource allocation, and support continuous improvement.

Program Example

In Colorado, the Colorado Department of Public Health and Environment partnered[59] with the Colorado School of Public Health and other academic partners to build a statewide gun-violence prevention resource bank and interactive dashboard-linking school-based, health system and public-health data and resources.

Health System Integration

- Develop shared data frameworks: Collaborate on de-identified databases linking school-reported threats, hospital injury data, and community violence trends to identify intervention hotspots.
- Co-lead evaluation studies: Health system researchers can assess outcomes of school-based programs, like reduction in violent incidents, increased reporting, or improved mental health metrics, and disseminate findings through local and national channels.
- Institutionalize joint training: Develop continuing education modules for both educators and clinicians on threat recognition, lethal means counseling, and trauma response.
- Policy recommendation: Advocate for state and federal grant programs that fund cross-sector data infrastructure and evaluation partnerships between hospitals, schools, and public health agencies.

Social Media Risk & Digital Harm Prevention

Social media platforms are now primary spaces where adolescent identity, peer dynamics, and conflict unfold. Online environments can amplify risk factors for gun violence by normalizing retaliatory behavior, exposing youth to violent content, facilitating bullying and harassment, and increasing access to individuals or groups who promote firearm use. Conflicts that begin online frequently escalate into in-school fights or community-based violence. Additionally, young people often disclose distress, suicidal ideation, or intentions to harm others through posts or direct messages prior to acting. Addressing digital environments is therefore a critical component of school and health system violence prevention efforts.

Program Examples

NotMYkid[60] offers curated resources and education for teachers, students, caregivers, and administrators on how to recognize early warning signs of negative social media usage, self-harm, aggression, or social withdrawal and provides skills-based training in emotional regulation and conflict de-escalation.

Project Unloaded[61] supports data-driven digital campaigns, created by youth, for youth, to shift perspectives on firearm ownership, provide education and resources, and reduce youth fear around gun violence. Their work was featured in a session of Northwell's Learning Collaborative for Health Systems & Hospitals: *Social Media Technology and Youth Social Media Engagement in Gun Violence Prevention* (Oct. 2025).[62]

Health System Integration

- Integrate digital behavior into clinical screening: Pediatric, adolescent medicine, and behavioral health providers can incorporate open-ended questions about online activity, peer conflict, exposure to violent content, and emotional impact of social media during routine visits.
- Train clinicians to recognize digital expressions of distress: Hospital-based behavioral health staff and HVIP teams should receive training on interpreting digital cues of crisis or risk and providing guidance to families on supportive responses rather than punitive restrictions.
- Develop digital conflict interruption capacity: HVIPs and community partners can train credible messengers and youth program staff in strategies to de-escalate conflicts that originate in group chats or social media posts.

The Bottom Line

FIMP is most effective when schools and health systems work in tandem to identify risk, promote safety, and support healing. Through collaboration with community leaders, trauma-informed safety programs, and educators, health systems can leverage their expertise, infrastructure, and credibility to expand prevention efforts beyond the hospital walls. **By embedding clinicians in schools, integrating firearm safety into pediatric care, supporting youth advocacy, and co-developing data-driven evaluation systems, these partnerships can help break cycles of violence and build lasting community resilience.**

Strategy #4: Drive Economic Development and Upward Mobility

As previously stated, FIM risk is deeply connected[63] to structural and social determinants, including income inequality, systemic inequality, educational disruption, unemployment, low economic mobility, community disinvestment, and trauma.[63-65] One of the strongest predictors of firearm homicide risk is lack of access to stable employment and meaningful economic opportunity. Programs that support economic stability (like income support policies[66] and the building of safe, protective environments are demonstrated to have protective influence against violence across the life course.

Health systems are uniquely positioned to address these conditions. As the largest industry in the country,[67] the healthcare field influences job access, workforce training, wages, neighborhood investment, and long-term economic stability. Health systems employ approximately 13% of the workforce (more than 17 million people nationally),[68] a number that is expected to grow exponentially[69] in the near future. The healthcare field is often misunderstood to be inaccessible to many who can't afford the significant investment in higher education required for clinical positions; in reality 70% of top healthcare occupations[69] require minimal qualifications and many career paths begin as entry-level positions. This also provides significant opportunity for upward mobility for lower-wage workers.

Heath systems are both economic engines and key drivers of social mobility. Through youth mentorship, intentional hiring and workforce development, and local investment, they can continue to grow their workforce and build community economic health- an essential, yet often overlooked, component of FIMP.

In short: creating economic opportunity, especially among communities with historic disinvestment, is FIMP. When health systems hire locally, train and advance residents, and invest in neighborhoods, they generate upward mobility, safety, and well-being. The strategies below outline how health systems can operationalize this role.

Youth Engagement & Mentorship

Youth mentorship programs foster stability, belonging, and future orientation- key protective factors against community and gun violence. By creating trusted relationships and exposure to meaningful education and career pathways, health systems can interrupt cycles of trauma and poverty that elevate violence risk. Mentorship also strengthens self-efficacy and emotional regulation, helping youth cope with adversity and make positive life choices.

Program Examples

NYC Health + Hospitals' Guns Down, Life Up[70] connects youth ages 10–18 with mentors, tutoring, and safe after-school spaces focused on healing and leadership.

University of Kansas Health System is a key partner in the REVIVE[71] (Reducing the Effects of Violence through Intervention and Victim Empowerment) and ThrYve[72] (Together Helping Reduce Youth Violence for Equity) programs that connect youth impacted by violence to the resources and programs necessary to break cycles of violence, promote well-being, and reach educational and career goals.

Recommendations for Health Systems

- Integrate youth mentorship programs within hospitals and community health centers to provide consistent engagement and role models.
- Partner with schools and CBOs to offer shadowing, internships, and health-care career exploration.
- Train mentors in trauma-informed care and connect participants with behavioral health services and academic supports.

Educational & Employment Support

Employment stability is one of the most powerful predictors of long-term health and safety. Adults who experience by violence, incarceration, or economic marginalization often face systemic barriers to employment which can perpetuate cycles of violence and poor health. Health systems, as major regional employers, can promote violence prevention through equitable hiring, workforce training, and supportive employment practices. Beyond stable income avenues, health systems also often offer comprehensive employment benefit packages including paid sick leave, health insurance, and retirement plans.

Program Examples

Johns Hopkins Medicine's Project REACH[73] (Resources and Education for the Advancement of Careers at Hopkins) addresses gaps in healthcare positions by offering career coaching, paid release time for training/continued education, and career re-training in emerging fields.

The Transitions Clinic Network[74] is a national organization that hires and trains formerly incarcerated individuals to work as community health workers in clinics, with patients who are re-entering the community after incarceration.

Recommendations for Health Systems

- Implement trauma-informed and fair chance hiring practices that reduce barriers for individuals with justice involvement or unstable work histories.
- Invest in workforce training pipelines for in-demand healthcare roles (e.g., certified nursing assistants, medical assistants, IT technicians).
- Provide mental-health and financial counseling, flexible scheduling, and mentorship to support job retention and advancement.
- Develop employment pipeline programs in association with CBOs and CVI groups to promote economic stability among families closely impacted by violence.

Community Economic Investment & Anchor Institution Leadership

Health systems are anchor institutions (major employers, purchasers, and investors) with the power to shape neighborhood conditions that drive violence. Community economic investment strengthens protective social structures, reduces poverty, and rebuilds trust in local systems. By leveraging procurement, real estate, and philanthropic resources, health systems can foster safer, more equitable communities that promote long term health and well-being.

Program Examples

Rush University Medical Center's West Side United[75] has invested over $10 million in small-business development, education, and job creation across Chicago's West Side.

Kaiser Permanente's Thriving Communities Initiative[76] uses impact investment funds to expand affordable housing[77] and local employment opportunities in violence-affected regions.

Recommendations for Health Systems

- Dedicate community-benefit dollars and investment funds toward local small businesses, affordable housing, and workforce hubs.
- Invest in community development projects.
- Partner with municipal and nonprofit organizations to align investments with community violence prevention priorities.

Data and Evaluation of Economic Interventions

Robust data collection and evaluation enable health systems to identify violence trends, measure intervention impact, and refine prevention strategies. Linking economic, health, and violence data helps demonstrate the relationship between financial stability and safety. Continuous learning also strengthens cross-sector collaboration and accountability.

Program Examples

Philadelphia's Accelerate Health Equity Initiative[78] unites 19 hospital systems to coordinate hiring and evaluate neighborhood health, equity, and safety outcomes.

The CDC's National Centers of Excellence in Youth Violence Prevention[79] funds local partnerships between community, health systems, and academic institutions to evaluating and disseminating effect youth prevention strategies.

Recommendations for Health Systems

- Work alongside public health agencies and other health systems in the region to strengthen the timely collection of complete data.
- Identify opportunities for potential data sharing agreements and health system engagement in economic evaluations conducted by private or government agencies.
- Encourage research teams to consider how economic variables could be captured in FIMP research.

Local Hiring and Procurement

As major regional employers and purchasers, health systems have the power to influence the economic conditions of surrounding neighborhoods. Prioritizing local hiring and contracting with community-based small businesses strengthens household stability, reduces unemployment, and reinvests dollars directly into communities most impacted by violence. Many neighborhoods with high levels of firearm injury have experienced decades of job loss and disinvestment; health systems can counter this by shifting hiring pipelines and vendor relationships closer to home, promoting economic mobility and community trust.

Program Examples

The Cleveland Clinic's Greater University Circle Initiative[80] is committed to hiring and contracting locally, resulting in increased employment of residents from historically disinvested neighborhoods and expanded opportunities for local vendors.

As part of the Detroit at Work[81] initiative, three hospitals (Detroit Medical Center, Henry Ford Health System, and St. John Providence) partnered with the city to educate and hire[82] 240+ locals into essential entry-level health system positions.

Recommendations for Health Systems

- Set clear targets for local hiring and vendor procurement in communities with high firearm injury burden.
- Partner with local workforce agencies, CVI organizations, and community colleges to build pipelines into hospital roles across clinical and non-clinical departments.
- Prioritize procurement from minority-owned, women-owned, and locally owned businesses to strengthen local economic ecosystems.
- Track and publicly report progress on local hiring and procurement as part of community benefit and equity commitments.

Supportive Services for Job Access and Retention

Access to stable employment is necessary but not sufficient for long-term economic security. Structural barriers such as lack of childcare, transportation challenges, legal or housing instability, medical debt, and inconsistent mental health support can disrupt job retention, particularly in communities heavily impacted by violence and trauma. Health systems can improve stability and advancement by providing or partnering to deliver supportive services that enable individuals to obtain, maintain, and grow careers, strengthening protective factors against violence.

Program Examples

StreetCred[83] (a partnership between Boston Medical Center and Boston University School of Public Health) provides on-site tax credit assistance and income support services to families and employees, helping reduce financial stress and build the economic stability necessary for sustained employment.

To support nurse retention, the Children's Hospital of Philadelphia replaced their traditional clinical "ladder" system with the PEAK (Professional Excellence & Advancing Knowledge)[84] model to empower nursing staff to explore diverse, cross-disciplinary opportunities within the hospital. Professional development and training expenses are covered so participants can succeed in new roles.

The Child Enrichment Center at Arkansas Children's Hospital (Little Rock, AR) and the Children's Learning Center[85] at Driscoll Children's Hospital (Corpus Christi, TX) are two examples of hospitals supporting staff recruitment and retention[86] by providing access to high-quality, education-based childcare on site.

Recommendations for Health Systems

- Provide or subsidize childcare, transportation assistance, and flexible scheduling to support employees facing competing caregiving or family responsibilities.
- Establish medical-legal partnerships or embed legal aid organizations within community clinics to assist with expungement, housing insecurity, benefits navigation, and domestic violence protection.
- Offer financial counseling, debt relief planning, and credit-building support for employees and program participants.
- Ensure mental health services are accessible and stigma-free for both staff and community members involved in workforce programs.

The Bottom Line

For health systems looking to address community violence and gun violence, this underscores a dual opportunity: to leverage their economic weight and workforce potential to create pathways for impacted communities, and to align employment, job training and community investment with prevention goals.

Strategy #5: Work Alongside Firearm Owners and Operators

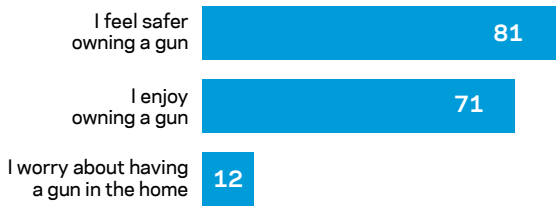
Health systems that aim to meaningfully reduce firearm-related harms cannot succeed without intentional, respectful collaboration with firearm owners and operators. Firearm ownership is widespread, culturally diverse, and deeply embedded in identities tied to self-protection, recreation, profession, and service. Evidence from research, practice, and lived experience shows that firearm owners are not a monolith and that programs designed *about* them, rather than *with* them, are less effective, less trusted, and less sustainable.

Effective partnerships must begin with listening and meeting firearm owners where they are

In order to effectively reduce the impact of firearm injury on patients and communities, health systems must commit to learning from and collaborating alongside:

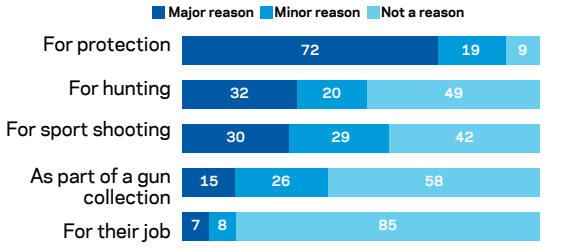
- Community members, patients, and staff who own firearms
- Firearm retailers, ranges/clubs, and trainers
- Law enforcement
- Active and former military personnel and organizations
- Other local groups with high rates of firearm access

Most gun owners say they feel safer owning a gun
% of gun owners who say ___ describes how they feel



Source: Survey of U.S. adults conducted June 5-11 2023
PEW Research Center

Nearly three-quarters of U.S. gun owners cite protection as a major reason they own a gun
% of gun owners who saying each is a ___ why they own a gun



Note: No answer responses are not shown
Source: Survey of U.S. adults conducted June 5-11 2023
PEW Research Center

Framing Access & Risk

Firearm access increases[87] the risk of firearm suicide and homicide. Individuals who died by firearm suicide are most likely[88] to use their own firearm or the firearm of a family member or intimate partner. Firearm suicide is especially elevated among professions with high firearm access, including active and former military personnel and law enforcement.

Current Landscape

- In a 2023[89] report by the Department of Defense (DOD), 523 active military service members died by suicide, 65% of which involved a firearm. In 2022,[89] 93 spouses and 53 dependents of military service members died by suicide, 61% and 43% of which involved a firearm, respectively.
- Every day, an average of 13 veterans[90] die by firearm suicide.
- In 2024, the national Law Enforcement Suicide Data Collection[91] reported 83% of suicides[92] among law enforcement officers involved a firearm.
- In circumstances of IPV, a woman's risk of homicide increases 5-fold[93] when the abuser has access to a firearm.
- The vast majority[94] of pediatric suicides (80%) and unintentional shootings of themselves or others (70%) occur in the home.
- Over half (53%) of veterans[95] report keeping at least 1 firearm unlocked and loaded in their home.

Implications for Implementation

- Health systems should consult and collaborate with professional organizations like the U.S Department of Veterans Affairs (VA);[96] local, state and federal law enforcement; and organizations that represent firearm owners in the community are essential to best understand the factors associated with firearm ownership and/or access among their constituents.
- Like all health programming, FIMP programs must be designed with high-risk populations in mind and tailored in a way that is culturally competent and respectful of the perspectives of firearm owners and stakeholders.

Shifting Misconceptions in the Public Narrative

There are significant gaps in firearm owner and stakeholders' perception of risks associated with firearm ownership. There is a significant need[8] for health systems to help shift the narrative on firearm injury risk, especially among firearm owners who often receive and share inaccurate health information from non-medical organizations who control the discourse.

Current Landscape

- The majority of Americans[97] describe crime as a very serious or extremely serious problem, and believe crime rates are increasing, despite ample data to indicate crime rates have been decreases for years.
- In a nationally representative survey, respondents who owned firearms for personal protection and who displayed a higher level of threat sensitivity were more likely[98] to store their firearm unlocked and loaded.
- Firearm owners on a military installation were significantly less likely[99] than non-owners to agree that firearm access increased risk of suicide (for themselves and others), interpersonal violence, or unintentional shootings.
- In a survey[100] of U.S Air Force mental health providers and behavioral health technicians, there was not widespread agreement that personal firearm ownership and nonsecure storage practices were associated with increased suicide risk.

Implications for Implementation

- Tailored education and community outreach should be prioritized prior to implementing FIMP strategies into healthcare settings in order to slowly reduce the misinformation present in the firearm ownership community and maximize the likelihood of program acceptability.
- Consider how misconceptions and myths about firearm injury risk may impact a patient or community's receptivity to FIMP. Begin by exploring perceptions about firearm injury risk, ask questions to clarify and learn where they may be receiving their information from.
- Consider who will be most effective to **deliver safety education**[101] to firearm owners, in order to effectively combat myths and misinformation (see below for more information on credible messengers).

Working Collaboratively with Firearm Owners & Operators

Firearm owners are experts in their own experience and their unique perspectives can help shape FIMP initiatives to maximize acceptability, effectiveness, and reach among their peers. The majority of firearm owners recognize the value of safe firearm ownership and encourage the implementation of certain FIMP strategies.

Current Landscape

- When asked to consider specific patient scenarios who may be at elevated risk of firearm injury (e.g., a patient experiencing suicidal ideation, cognitive decline, or substance misuse) 76–89% of respondents[102] in a nationally representative survey felt clinicians should "sometimes" or "always" discuss firearm safety with these patients.
- The majority (77%) of surveyed firearm retailers in New Hampshire recognize and support their role in suicide prevention and 57% disseminate safe storage resources and suicide prevention information through the state's Gun Shop Project[103] (see more information about this program below).
- When surveyed, the majority of rural youth[104] agreed a firearm safety course should be required before obtaining a hunting license (89%), background checks should be required before purchasing a firearm (89%), and safe storage in the home should be required by law (61%).

Implications for Implementation

- Firearm owners should be invited to co-create or provide feedback on FIMP educational materials, resources, and the implementation process of FIMP initiatives in order to ensure they are culturally competent and best reflect the lived experience of firearm owners who will be impacted by the program.
- In focus groups about effective firearm safety messaging,[105] rural firearm owners rated community storytelling, safe storage solutions, and education on firearm policies as the most essential content to include. Statistics and data were rated as the least essential.
- In the same study, when asked about safety education for families with children, respondents emphasized the need to involve parents and children together, schools as potential spaces for firearm safety curriculum integration, and the importance of "community conversation" to increase awareness and tailored strategies.

Firearm ownership is not monolithic therefore every program must consider what specific community/patient population(s) they are working alongside and the role of firearms in *their* experience. The roles of firearms and their associated risks are significantly impacted by a patient's age, sex, race, ethnicity, culture, geographic context, socioeconomic status, etc. Programs must be shaped by the lived experiences of the communities/patients they seek to support, and this must include the unique experiences of firearm owners within this community.

- In a nationally representative sample of 10,000 firearm owners, safe storage rates varied greatly[106] and were impacted by sex, age, the presence of children in the home, personal exposure with gang and community violence, motivations for firearm ownership, fear of victimization, number of firearms owned, and experience of firearm injury, among others.

Firearm owners can act as credible messengers and help bridge gaps between healthcare professionals and the firearm owning communities.

- In a safe storage campaign comparative effectiveness study,[107] the profession of the messenger was most associated with military personnel's shifts in willingness to store firearms safely.
- In a survey of 3146 firearm owners, many reported[108] willingness to store a firearm with a retailer (41%) or law enforcement (34%) in at least 1 circumstance, especially in circumstances in situations where they felt someone in the home would use the firearm to hurt someone else.
- It is also essential to incorporate the voices of the family members of firearm owners, including military families, as they have unique insights on the role, and potential risks, firearms play in their homes. They can advocate for safe storage and encourage family members to connect with social and mental health services they may need.[109]

Firearm owners in the healthcare community can be especially valuable credible messengers who can provide insight on how to best develop and implement culturally competent FIMP initiatives in healthcare settings.

- In a survey of surgeons who own firearms[110] respondents felt: (1) surgeons felt they had a role to play in FIMP but worried about damaging patient/physician relationships; (2) surgeons should advocate for FIMP without politicizing firearms; (3) resources and environmental factors impacted the success of clinical integration; and (4) patient context and surgeons' perceived credibility as messengers impacted their likelihood of engaging in FIMP discussions with their patients.

FIMP trainings for healthcare professionals should include firearm owner perspectives and include the voices and lives experiences of firearm owners.

- Northwell's Learning Collaborative for Health Systems & Hospitals session, *Building Partnerships: Perspectives from Responsible Gun Owners* (Oct. 2021)[111]
- *What the Talk America's*[112] free Cultural Competency Classes[113] were co-created by mental health professionals and firearm owners to strengthen clinician's understanding of firearm culture and how it can impact care.

Examples of Collaborative Programming

Many communities with high firearm ownership support firearm safety initiatives and want to work alongside healthcare professionals and FIMP organizations to reduce firearm injuries and deaths. Multi-disciplinary partnerships with firearm owners and stakeholders will yield more effective programs because they will: (1) reflect the needs and lived experiences of firearm owners; (2) increase program reach and accessibility by activating novel bidirectional communication channels unique to their communities; and (3) model the importance and feasibility of respectful collaboration rooted in safety, rather than personal beliefs or politics. Examples of successful collaborative projects include, but are not limited to:

1. **Gun Shop Project:**[103] As a part of the larger Means Matter[114] campaign (led by the Injury Control Research Center[115] at the Harvard T.H. Chan School of Public), the Gun Shop Project was developed by partners in New Hampshire to empower suicide prevention advocacy among firearm business owners.
2. **Lock, Stock, and Barrel:**[116] In Wisconsin, clinician champions and firearm retail owners co-created a monthly firearm education training session for medical students and healthcare professionals. The training includes overviews of different firearm types, safe storage options, and firearm culture. It also includes the opportunity for learners to engage with firearms at a partnering range, promoting comfort and strengthening relationships between community partners and healthcare.

3. **Be SMART at the National Night Out:** Moms Demand Action partnered with local law enforcement[117] across 16 states to promote safe storage education and the Be SMART campaign during the annual community-led "National Night Out." [118]
4. **Pause to Protect:**[119] This program (funded by the DOD's Defense Suicide Prevention Office and USAA's Face the Fight[120] in collaboration with CU School of Medicine's Firearm Injury Prevention Initiative) provides firearm owners and local businesses with safe storage tools,[121] and tailored educational resources and collateral[122] so firearm owners can support peer-led safe storage advocacy. They have detailed overviews of home safety planning, safe storage options, and a national repository of out-of-home storage solutions,[123] including 40+ partners who offer free, exclusive or reduced cost storage options to service members.
5. **Project Safe Guard:** Originally piloted in Mississippi,[124] Project Safe Guard was specifically designed by mental health professionals to increase safe storage practices among firearm owners in the National Guard though lethal means counseling and the distribution of cable locks. After its demonstrated success, the program has been implemented in numerous states[125] and expanded to address other behaviors[126] including abuse, harassment, and suicide.
6. **Summit on Firearm Suicide Prevention in the U.S:**[127] This collaborative event was co-hosted by the Colorado University's Firearm Injury Prevention Initiative and the Center for Combat Medicine and Battlefield Research in order to promote interdisciplinary solution-building between academic, medical, and military leadership and included attendees from the Army, Marine Corps, Navy, Air Force, Space Force, National Guard, VA, and Defense Suicide Prevention Office.[128] The inaugural Summit in 2022 resulted in the creation of 10 recommendations[127] to improve the availability and quality of evidence-based interventions for suicide prevention in the military.
7. **Youth & Police Initiative:**[129] Youth & Police Initiative's goal is to support community safety by challenging stereotypes and fostering mutually respectful, trusting relationships between community members and law enforcement agencies. Founded in 2003, the program centers open communication, conflict mediation, restorative justice, and youth empowerment. It is constantly adapted based on changing norms in youth and law enforcement culture, and has been successfully implemented in 45 cities across the U.S.

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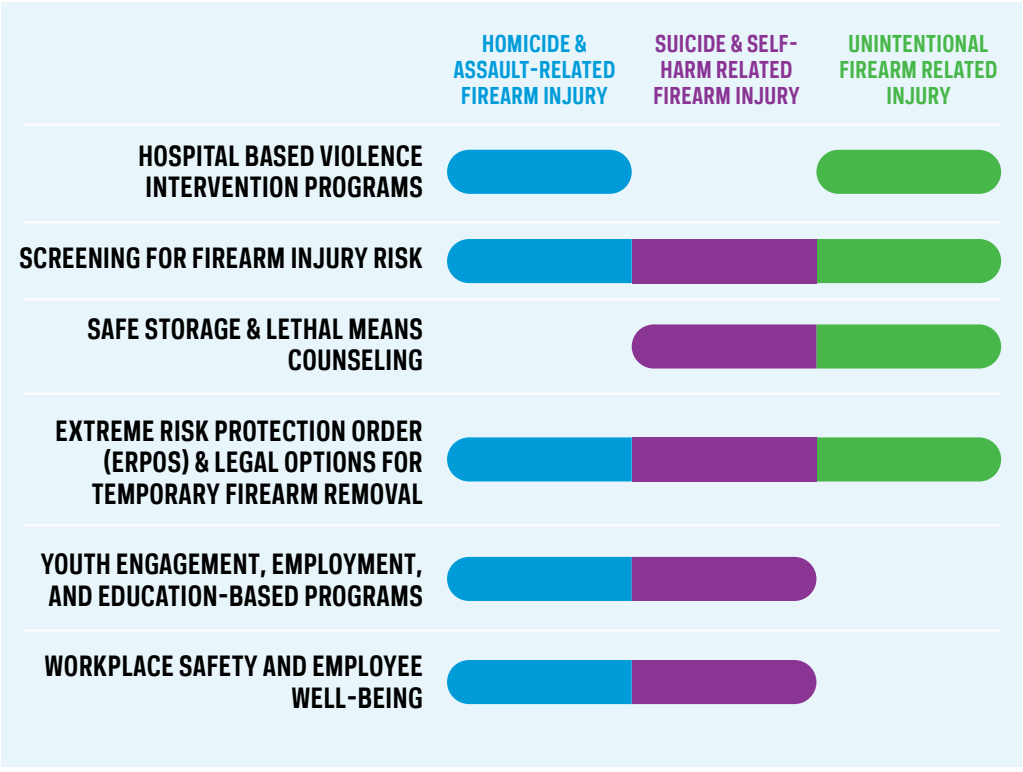
SECTION 6: CLINICAL AND ORGANIZATIONAL-LEVEL STRATEGIES

The strategies below can be implemented in diverse clinical and operational settings to support the safety and well-being of health system staff and patients.

Strategy #1: Implement Evidence-Based Clinical Strategies

Health systems and clinicians interested in implementing FIMP programs have numerous evidence-based strategies available. The decisions around program implementation should be informed by the results of a needs assessment (See *Section 2: Conducting a Firearm Injury and Mortality Prevention Needs Assessment*) to ensure increased adoption and reduce barriers to implementation, as well as ensure intervention strategies should address the highest burden of injury experienced by patients.

Interventions and Desired Impact



Hospital-Based Violence Intervention Programs

Program Overview

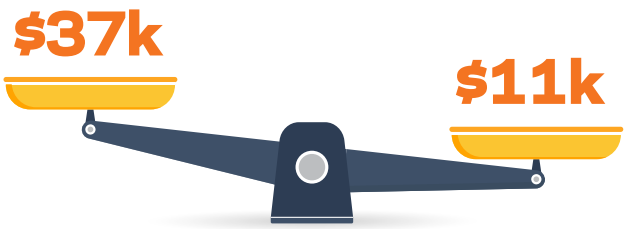
HVIPs seek to support survivors of firearm injury by providing comprehensive case management and support services for people injured by violence, utilizing trauma-informed practices that recognize unique vulnerabilities and challenges faced by violent injury survivors. These programs are grounded in evidence demonstrating a "teachable moment"[1] or time period following violent injury, where survivors may be more receptive to behavioral changes and interventions to interrupt cycles of violence and reduce violent reinjury in the future. Given the substantial injury burden and numerous adverse health outcomes associated with firearm injuries, HVIPs are a vital programmatic response to support firearm violence survivors, serving as a mechanism to reduce additional morbidity and mortality associated with firearm violence in the US.

HVIPs recognize the socioecological context of violent injury by providing holistic, patient-centered care based upon an understanding that healing from a violent injury is impossible if structural inequities (i.e. racism, food insecurity, housing insecurity, lack of health insurance) directly impacting patient health outcomes are not also addressed. By framing violent injury as a public health problem requiring a health systems response, these programs seek to provide optimal surgical and medical care for patients sustaining a firearm injury while simultaneously utilizing a network of hospital and community-based resources to provide concurrent psychosocial care,[2] including case management, legal support, and access to long-term healthcare resources. By following patients after discharge, and providing wraparound case management services, these programs ensure that patients with violent injuries remain engaged in care, and focused on healing, and aim to prevent violent reinjury.

Community Violence Intervention Ecosystem

Source: The HAVI

HVIPs, while challenging to evaluate, provide substantial meaningful support to patients and families during periods of acute vulnerability following a firearm injury. Research has demonstrated that HVIPs can reduce violent injury recidivism, reduce adverse mental and physical health outcomes such as PTSD and attendance and medical follow up visits.[3,4] Additionally, estimates reveal HVIPs may reduce costs[5] associated with firearm-related injuries, by preventing additional hospital visits and physical complications following a violent injury, the majority of which are incurred by the hospital, while simultaneously improving patient-centered care outcomes and the experience of those directly impacted by violence.



$37,435
Average medical cost per assault-related gun injury

$10,798
Average HVIP cost per participant

Source: Everytown USA

Considerations for Effective Implementation

- Program Focus: Some programs work exclusively on patients impacted by firearm injuries, while other programs include patients with additional violent or penetrating injuries such as stab wounds or assaults.
- Staffing: Typically, an HVIP is comprised of a multidisciplinary team including physicians or advanced care providers, social workers, mental health professionals, and VPPs, sometimes referred to as "hospital responders," who are credible messengers with lived experience related to violent injury, or exposure to community violence. These highly trained professionals work quickly to engage patients and families impacted by violence, gaining their trust and providing immediate support as well as case management services following hospital discharge.
  - Hospital responders often serve as a bridge between the health system and the community, with strong links to CBOs, and help to facilitate warm referrals to appropriate programs outside the walls of the hospital.
  - Hospital responders can either be employed directly by the health system, for example Project Ujima,[6] a pediatric HVIP operating through the Medical College of Wisconsin's Pediatric Emergency Medicine department, or, employ CVI organizations with hospital responders who enter the hospital to support patients impacted by violence, for example New York City Health and Hospitals Jacobi Hospital's Stand Up to Violence program.[7]

Programmatic Resources

- HAVI Resources and Education[8]
- Cure Violence Global[9]
- ROCA's Impact Institute[10]
- Northwell Health Learning Collaborative for Hospitals and Health Systems Session 17: HVIPs and Working with Communities[11]
- Features the Yale-New Haven HVIP, Project Ujima, UC Davis Health Wraparound program, and AIM Program at UC Health Colorado
- ACS: Primer for Development of Violence Intervention Programs[12]
- The HAVI[8] provides training and technical assistance for HVIPs, including standards and indicators for program development[8] and implementation.[13]

Firearm Injury Risk Screening

Program Overview

Screening for firearm injury and community violence risk involves asking patients and families about access to a firearm and exposure to violence as part of usual clinical care during a health care encounter, and then providing appropriate resources, education, and intervention based on the answers provided. This includes providing families with firearm safety resources like safe storage counseling and gun locks, offering resources that reduce violence risk such as referrals to CVI programs, and ensuring timely and better access to trauma-informed care.

Screening can take many forms and occur in many healthcare settings. Often, pediatric healthcare providers screen and provide anticipatory guidance at well-child visits in accordance with the AAP's *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*,[14] which recommends provision of anticipatory guidance on firearm safety for all well-visits. Additionally, behavioral health providers routinely ask questions about access to lethal means including firearms, as part of intake assessments and suicide risk screening. Increasingly, national organizations such as the Joint Commission,[15] U.S. Preventative Services Task Force[16] and the ACS[17] are recommending screening for depression, suicide risk, and trauma, which serve as opportunities to embed questions about firearm injury risk into existing clinical workflows.

Northwell Health's CGVP[18] implemented a first-of-its kind universal screening protocol in emergency departments to help normalize conversations around FIMP and provide appropriate intervention resources based on identified risk. Under this protocol, all emergency department patients are asked about firearm injury risk using questions from the SaFETy score, a validated tool to predict future firearm violence among youth,[19] along with a question about access to a firearm within or outside of the home. Northwell has screened over 250,000 patients using this universal screening approach and is working to scale the screening across the entire health system.

Considerations for Effective Implementation

- Educating providers on how to screen for firearm injury risk, including appropriate language usage, motivational interviewing techniques, and availability of resources for patients who screen positive is crucial. Often, healthcare providers report a willingness to screen patients, but a lack comfort and education about the right way to screen. To this end, implementation of screening must emphasize provider education for those conducting screening as well as providers who support patients who screen positive.
- Awareness of locally specific resources for patients screening positive is key. By researching local gun safety groups, options for provision of gun safety devices such as trigger locks or gun safes, local CVI groups, and CBOs that support additional SDOH that contribute to violence risk are all vital to the development of successful intervention resources for patients who screen positive.
- Prior to screening go-live, communicate with key services lines and health system (nursing, support staff, social workers, community health workers, legal departments, security staff) to ensure all parties are aware of the screening program and protocol.

Suicide Prevention Protocols

Program Overview

As rates of suicidality including suicidal ideation and attempts have increased in recent years, health care providers and health systems are essential to treating patients who are at risk for suicide and increasingly must expand programs to better support patients experiencing behavioral health crises. Effective suicide prevention strategies are comprehensive,[20] incorporating multi-modal efforts for acute behavioral health crises, while also bolstering promotion of positive mental health and resilience.

Traditionally, behavioral health providers including psychology and psychiatry are primarily tasked with supporting patients experiencing mental health crises including suicidal thoughts and behaviors, however, many healthcare providers will routinely interact with these patients and should be aware of the ways in which their patient populations may be uniquely vulnerable. In fact, evidence indicates that 83% of patients who die by suicide[21] had some level of interaction with a healthcare provider in the year prior to their death, while only 5% had contact with an inpatient psychiatric provider, further illustrating the necessity of involving additional healthcare providers in suicide prevention. Healthcare providers have meaningful opportunities to routinely discuss depression and suicidality as part of a primary health assessment, and deliver anticipatory guidance focused on reducing risk during periods of vulnerability.

Considerations for Implementation: Patient Populations

- Palliative care, oncology and hospice providers can support patients by screening for depression and suicide risk, and providing appropriate case management and mental health support to patients with terminal or life-limiting diagnoses given the documented increased incidence of suicide among patients with terminal diagnosis.[22]

- Providers working with LGBTQ+ patients may encounter suicidality among patients[23] struggling to obtain gender-affirming, culturally-competent care.
- Providers caring for veterans and active-duty military members will likely encounter patients experiencing suicidality and mental health crises, who often have increased access to lethal items such as firearms, which tragically has resulted in an average of 13 veterans dying each day by firearm suicide.[24]
- Obstetrics and gynecology providers may encounter acute suicidality for patients experiencing postpartum depression or psychosis, given suicide is a leading cause of maternal mortality among pregnant and postpartum people.[25]
- Providers serving indigenous and tribal populations should be aware of the numerous suicide prevention programs specifically designed using community-based cultural interventions[26] created in response to increased rates of suicide among American Indian and Alaskan Native patients.
  - Pediatricians are increasingly exposed to young patients experiencing suicidal ideation, as youth suicide rates have increased significantly in recent years.[27]
  - Older adults and geriatric patients require additional care and attention, as they have increased risk of depression and suicidality,[28] which can be compounded by cognitive decline.

Considerations for Implementation: Effective Strategies

- Integrate behavioral health into routine medical practice: Integrated care aims to holistically address multiple factors impacting a patient's health and wellbeing by co-locating behavioral health care with physical health care, for example by embedding a mental health clinician within a primary care practice or clinical service lines.[29] Clinicians can routinely screen for mental health concerns and provide warm referrals for patients who need additional mental health support, thereby expanding treatment capacity and engaging in preventative care.
  - Yale New Haven Hospital successfully integrated[30] behavioral health care into medical and surgical hospital units.
- Encourage destigmatization of mental health: Despite significant progress to destigmatize mental health and normalize help-seeking, barriers remain, contributing to reluctance to seek care for behavioral health concerns or disclose suicidal ideation to healthcare providers. Stereotypes and prejudices surrounding mental illness and suicidality can discourage individuals from pursuing treatment options, leading to isolation and adverse health outcomes.[31] It is important that healthcare providers speak openly about mental health to normalize the topic, using appropriate, person-centered language, and practices that reduce stigma such as universal screening and provision of anticipatory guidance.
  - AMA's Behavioral Health Integration webinar series focused on dismantling stigma and normalizing treatment for mental health
- Use trauma-informed language: Talking about suicide can be uncomfortable. It is very important that clinicians use accurate, trauma-informed language when discussing suicide and mental illness. Suicide prevention experts recommend using precise language when talking about suicide, including using person-centered language,[33] and avoiding language that places a judgement or implies morality or legality[34] associated with suicide (for example, the preferred terminology is "death by suicide" rather than "committed suicide").

Programmatic Resources

- Zero Suicide is a health systems approach to reduce suicide,[35] created in partnership with the Educational Development Center, the Suicide Prevention Resource Center, and the national Action Alliance for Suicide Prevention that provides training, resources, technical assistance and support for healthcare providers and health systems to adopt evidence-based practices to prevent suicide.
- The AAP offers this toolkit[36] for youth suicide prevention strategies in clinical settings, which includes a helpful guide for how to talk about suicide risk with patients and their families:
- The Celebrating Life Suicide Prevention Program is an evidence-based, community-led suicide prevention program[37] run through the Johns Hopkins Center for Indigenous Health and the Bloomberg Health Initiative, designed specifically to support Native American communities using culturally-relevant mental health workers and case management.
- Northwell Health Learning Collaborative Session on Firearms and Suicide [38]

Safe Storage & Lethal Means Counseling

Program Overview

Safe storage counseling and lethal means counseling (LMC) are two examples of healthcare provider led interventions that can address suicide and other forms of firearm injury. LMC is an evidence-based intervention designed to help patients and families to take steps to promote safety at home through provision of education and resources emphasizing the importance of reducing access to dangerous items (such as firearms, medications, or weapons) during a mental health crisis.[39] LMC acknowledges the role of impulsivity and easy access to lethal items and seeks to facilitate behavior change through use of motivational interviewing to empower caregivers to safely store items such as medications or guns to prevent youth access. By creating barriers to easy access, through simple steps such as storing firearms unloaded and locked in a safe and separate from the ammunition, parents and caregivers can reduce the likelihood that someone experiencing a mental health crisis will easily and quickly access a potentially lethal item during a period of heightened vulnerability.

Considerations for Effective Implementation

- Lethal Means Counseling: LMC can be conducted in a variety of settings including primary care clinics, and emergency departments, in addition to designated mental health clinics, and is associated with behavioral changes, including safer storage of firearms and medications, with 75% of patients who received LMC reporting a specific plan for safe storage following discharge from care.[40]
- Incorporate into safety planning: For patients with behavioral health concerns, LMC should be included in the creation of a safety plan.[41] Evidence indicates that many behavioral health patients may still have access to lethal items in the home, yet LMC is not universally completed. Supporting providers to expand LMC provision can help, as it is effective and associated with a decreased risk of suicide.[42]
- Healthcare provider training is necessary to empower clinical team. Proper training must include:
  - Locally relevant resources for safe storage, such as local gun ranges that offer temporary storage, police precincts that participate in gun buy-backs, as well as online options to purchase gun locks and lock boxes.
  - Opportunities for providers to practice communication skills specific to LMC
  - Offering templated language and conversational guides to increase comfort and confidence engaging in conversations about firearm safety with patients.

Considerations for Implementation: Safe Storage

- Firearm Safety Counseling, also called safe storage counseling centers around the idea that the safest firearm is one that is stored unloaded, locked, with ammunition separate from the firearm.
- Safety counseling seeks to use a harm reduction approach, to empower patients and families to increase their safety by taking small tangible steps (for example separating ammunition from a firearm) or purchasing a gun lock. Recognizing the many reasons our patients and families may own firearms is important to tailoring appropriate safety counseling. Framing safe firearm storage counseling as anticipatory safety guidance, alongside advice about helmets, seatbelts, and pool safety can help to destigmatize conversations with patients and families.
- The 5 Ls of Firearm Safety:
  - 5L's of Firearm Safety[43] provide a helpful mnemonic device for healthcare providers to discuss the variety of ways that unsafe firearm storage can adversely impact different patient populations.
  - This mnemonic helps to engage patients who may feel that conversations about safe firearm storage are not relevant to their own individual experience. By asking patients to think about their inner circle (close friends, family members, grandchildren, stepchildren) all of whom may enter their home where a firearm may be easily accessible, this mnemonic encourages a broader view of safe firearm storage that recognizes the harms associated with easy, unsecured access to weapons in the home.

5 L's OF FIREARM SAFETY

Safe storage counseling is relevant across the lifespan. **The 5L's of Firearm Safety** provide a helpful mnemonic device for healthcare providers to discuss the variety of ways that unsafe firearm storage can adversely impact different patient populations:

Programmatic Resources:

- Counseling on Access to Lethal Means (CALM) training:[44] Free training for healthcare providers for lethal means counseling.
- Bullet Points Project: Compiles resources for clinicians[45] including videos[46] on how to have conversations about safe storage.
- Northwell Health Learning Collaborative for Hospitals and Health Systems Session[15]: Clinical Protocols for Suicide Prevention at Duke University and Kaiser Permanente Colorado[47]
- Children's Hospital of Philadelphia Center for Violence Prevention: provides videos, tip sheets, and conversation guides[48] for physicians to use when speaking with patients and families about safe firearm storage.
- AAP provides example videos[49] demonstrating various options for safe storage conversation among different pediatric populations.

Extreme Risk Protection Orders & Legal Options for Temporary Firearm Removal

Program Overview

ERPOs, also known as red-flag laws, are a civil court order that utilizes due process to temporarily remove firearm access for someone who poses an immediate risk of harm to themselves or others. ERPOs provide a legal mechanism to both temporarily restrict a person (called a *respondent*) from purchasing new firearms *and* simultaneously temporarily remove firearms already in that person's possession. Numerous states have ERPO laws, which enable a *petitioner* (teachers, law enforcement, social service providers, attorneys, family members, healthcare providers) to document dangerous behaviors such as threats of mass violence, threats of self-harm or violence towards others, and histories of violent acts.

- ERPOs are a public health-informed policy tool that seek to minimize risk associated with access to lethal means during periods of acute vulnerability. Evidence indicates that ERPOs are effective at preventing mass violence[50] and suicide.[51] Clinicians often witness "red flags" in patient behavior' similar to lethal means counseling, ERPOs are a tool that clinicians can offer to families and patients to reduce risk of violent injury[52] during periods of acute vulnerability or crisis.
  - E.g., A family medicine doctor at a VA hospital may observe a patient who is experiencing acute suicidality and complex PTSD, expressing an active plan for suicide and discussing access to his service weapon.
  - E.g., A psychiatrist has a session with a young adult who described a plan to commit mass violence using a parent's firearm.

Evidence from ERPO Data

- Data from four ERPO states estimates that for every 17-23 ERPOs issued, one suicide is prevented.[53]
- An analysis of 6,787 ERPOs[54] revealed 10% of cases filed were for multiple victim or mass violence threats (i.e. 3 or more people); 20% of these threats were directed towards K-12 schools.
- More than half (54%) of California's ERPO cases analyzed[54] involved threat to others,15% involved threats of harm to self, and 25% involved threats of harm to self and others.
- In a nationally representative survey,[55] 3 in 4 Americans supported allowing licensed health care clinicians to ask courts to temporarily remove firearms from patients at risk of harming themselves or others.
- In states where clinicians can file an ERPO petition, it is important that health system legal services understand the process and create streamlined ways to facilitate completion and support clinician filers. In states where clinicians are not permitted to petition, clinician awareness of ERPOs is still important-patients and families should still be counseled about the availability of ERPOs and options for filing as part of safety planning conversations.

Domestic Violence Restraining Orders

DVROs are similar legal mechanisms to ERPOs but specifically are intended to protect survivors of domestic violence from further abuse. The intersection of domestic violence and firearms is particularly lethal; when an abuser has access to a firearm, they are five times more likely to kill their partner, and each month 76 women are shot and killed by a current or former intimate partner.[56] Given the prevalence of IPV, healthcare providers should be aware of this policy tool to offer patients and families to reduce the lethality associated with domestic violence. Similar to ERPOs, the court is petitioned for an order of a protection and the judge rules on a DVRO which (1) requires abusers to avoid contact with survivors and (2) prohibits owning and purchasing new firearms

Programmatic Resources:

- National ERPO Resource Center[57] (Johns Hopkins Bloomberg School of Public Health Center for Gun Violence Solutions)
- ERPO Navigators[58] — a pilot program at Johns Hopkins Hospital that employs specialists who can help support clinicians in filing ERPOs.
- APA Resource Document on Risk-Based Gun Removal Laws[59]
- Integration of extreme risk protection orders into the clinical workflow: Qualitative comparison of clinician perspectives[60]

Strategy #2: Institute Programs for Employee Safety & Well-Being:

Violence Against Healthcare Workers

According to data from the U.S. Bureau of Labor Statistics, workplace violence against healthcare workers and social service providers has increased in recent years, with healthcare providers being five times more likely[61] to experience workplace violence when compared to employees in other industries. In addition, healthcare provider burnout and exposure to trauma, including increased violence in the workplace, has contributed to distress and adverse mental health outcomes including increases in healthcare provider suicide.[62] To compound this increase in depression, anxiety, PTSD, and burnout, healthcare providers are often less likely to seek help for mental health concerns due to stigma and fear of penalization.[63] Health systems must take proactive steps to create a positive and supportive environments for their employees, which in turn can increase employee retention and productivity.[64] There are several ways health systems can protect employee health and wellbeing, while simultaneously investing in community-driven solutions to reduce root causes of firearm violence.[65]

Workplace Violence Prevention

Emotional, physical and clinical stressors on patients, visitors and staff can create a volatile environment - the most common workplace violence dynamic occurs between a patient/visitor and staff. Health systems should invest in robust, multi-modal strategies to proactively curtail violence while maintaining patient care, working closely with hospital security, local law enforcement, hospital legal teams, as well as providers to best understand the unique risks facing healthcare workers.

In recent years, efforts to bolster workplace safety and reduce violence against staff have gained traction following increased violence against healthcare workers. For example, The AHA's Hospitals Against Violence[66] initiative has resources and a *Building a Safe Workplace and Community Framework* [67] that can help inform health system engagement.

Hospitals Against Violence- Building a Safe Workplace and Community Framework

Source: Hospitals Against Violence

Promising strategies to address violence against healthcare team members include

- **Training**: OSHA's Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers.[68]
- **Evaluation** Hospitals Against Violence's tiered approach for addressing concerns and targeted violence,[69] in collaboration with the FBI.
- **Engineering**: Installing metal detectors and weapons detection systems.[70]
- **Culture**: Displaying signage affirming a safe workplace for healthcare team members[71] and resources to report safety concerns.

Staff Burnout & Mental Health Support

Health systems offer many employee benefits, however an area for further development remains staff mental health support and mitigating burnout. COVID-19 illustrated the gaps in structures to support the mental health and wellbeing of healthcare providers who experience vicarious trauma. However, if the organizational culture does not support help-seeking, and penalizes team members for prioritizing mental health, these efforts remain largely ineffective and do nothing to reduce adverse mental health outcomes among providers. System-level culture change that enacts operational level improvements to reduce barriers to care and the subsequent burden on individual healthcare providers sends an important message to employees: leadership supports and values their mental health and wellbeing.

- Change licensing and credentialing applications to removing stigmatizing questions that ask about past mental health care and treatment.
  - The Lorna Breen Heroes' Foundation's[72] Licensure & Credentialing Strategy[73] provides tangible steps to remove intrusive mental health questions from credentialing applications, directly addressing a barrier healthcare providers face when seeking mental health care.
- Establish programs to specifically support healthcare provider mental health that offer free, confidential services such as therapy, peer-to-peer support, resilience coaching, and support with burnout and occupational stress.
  - Northwell Health's Center for Trauma, Stress and Resilience[74] was established during the COVID-19 pandemic to support the mental health of frontline staff in light of the immense burden placed on healthcare providers. The center also offers 1:1 and team mental health support, post-crisis management, and resource navigation.

Additional Resources and Programs

- AHA's Workforce and Workplace Violence Prevention Resource Page[75]
- AHA's Suicide Prevention: Evidence-Informed Interventions for the Health Care Workforce[76]
- Joint Commission Workplace Violence Prevention Standards[77]
- Hospital Association of Oregon Workplace Violence Prevention Toolkit[78]
- AHA Guide to Trauma Support following an Incident or Threat of Violence[79]

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SECTION 7: IMPLEMENTING, EVALUATING, AND SCALING PROGRAMS IN HEALTHCARE SETTINGS

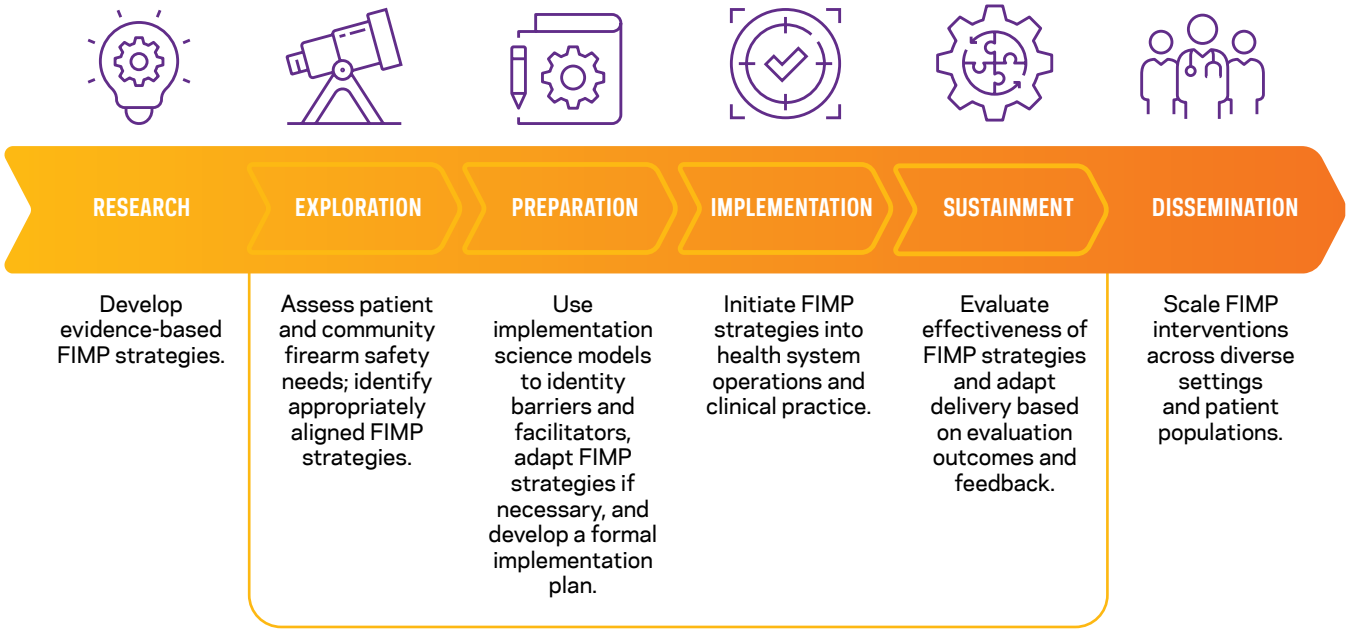
Implementation Models & Frameworks

Program roll-out should be thoughtful and informed by implementation science so as to minimize barriers, maximize health equity and program delivery success, and increase program longevity. By applying evidence-based models, health systems can play an important role in strengthening and diversifying the body of evidence that supports the efficacy of FIMP strategies across different clinical settings.

Applying an Implementation Science Framework to FIMP Programming

Each framework is designed to be adapted to recognize the unique implementation considerations within a given context or field. In addition to drawing on frameworks, each phase of the implementation process should be adapted to best meet a health system's needs. For example:

Adapted EPIS Model for Firearm Injury and Mortality Prevention (FIMP) Implementation



SYSTEMATIC APPROACH TO FIMP IMPLEMENTATION

Implementation Science Frameworks
There are many summaries[1] and online tools[2] outlining the many implementation frameworks. The frameworks offer guidelines, and it can be helpful to draw on lessons or strategies from multiple frameworks at various points in the implementation process. Well-known frameworks that have been applied to health system program delivery include, but are not limited to:

- CFIR[3] (**C**onsolidated **F**ramework for **I**mplementation **S**cience)
- RE-AIM[4] (**R**each, **E**ffectiveness, **A**doption, **I**mplementation, **M**aintenance/**S**ustainment) and PRISM[5] (**P**ractical, **R**obust **I**mplementation and **S**ustainability **M**odel) Frameworks
- PRECEDE-PROCEED[6] Planning Model (**P**redisposing, **R**einforcing, and **E**nabling Constructs in **E**ducational/environmental **D**iagnosis and **E**valuation-**P**olicy, **R**egulatory, and **O**rganizational **C**onstructs in **E**ducational and **E**nvironmental **D**evelopment)
- EPIS[7] (**E**xploration, **P**reparation, **I**mplementation, **S**ustainment) Framework

Program Pre-Implementation

This phase identifies the existing and/or emergent needs of a patient population or community and assesses which of the available strategies may best fit those needs.

- Relevant community and health system stakeholders and leadership should be involved in each step and ultimately decide together what program(s) are chosen to pilot.
- Together, *Section 2: Conducting a Firearm Injury and Mortality Prevention Needs Assessment* and *Section 6: Clinical and Organizational-Level Strategies* cover the necessary information relevant to this phase.

Considerations for Pre-Implementation

Identifying Barriers and Facilitators

The primary goal of this phase is to identify relevant facilitators and barriers that may impact the effective delivery of the chosen program(s).

- Applying the CFIR model[3] can be extremely helpful. It provides standardized tools, constructs, and an organizational framework through which to identify facilitators and barriers.
  - E.g., Northwell's CGVP team applied the CFIR framework to outline the many facilitators and barriers to effective implementation in their mixed-methods universal screening protocol.[8]

Learning from Other Health Systems

It is also important to learn from the experiences of health systems with similar patient volumes, geographic distribution, operational structures, etc.; drawing on the solutions and strategies other teams have developed to overcome anticipated challenges can make the implementation process smoother for your team.

- E.g., The HAVI published a retrospective evaluation[9] of New Jersey's HVIP implementation, outlining numerous facilitators and barriers with each phase of the pilot.
- See section "Evaluation" below for additional examples of program evaluations that could inform your health system's implementation process.

Pre-Implementation Data Collection

It is essential to capture pre-implementation data not only to facilitate the implementation process itself but also to use as baseline references when conducting process and outcome evaluations in the future.

- *Pre-implementation surveys*, informed by CFIR and/or other frameworks, can help identify site and staff readiness and potential challenges, providing essential insights to tailor the pilot effectively. The surveys can be delivered to front-line staff, administrators, leadership, and even patients and CBOs, ensuring multi-faceted perspectives are captured.
  - Learn more about effective community collaboration during the implementation process: Collaborating with Communities to Improve Health Care System Implementation Success and Destigmatize Gun Violence Prevention.[10]
- *Key informant interviews* with departmental leadership and front-line staff can provide additional details beyond those of a survey to further inform how workflows, staff scheduling, EHRs, patient volume, and other important variables may impact implementation, and what steps may be recommended to minimize potential friction.
- It is appropriate at this phase to also capture baseline health system and community epidemiological data on key FIMP metrics that your program may seek to influence so you understand where these metrics are prior to program implementation.

Selecting an Appropriate Pilot Site

The site should be *supportive, adequately resourced, and well-staffed*, and the program chosen for implementation should meet the needs of the site's patients and surrounding community. There should also be *staff champions* available at this site who can drive staff engagement and support programmatic logistics on a day-to-day basis, particularly in the earliest phases of a pilot (see Section Where Do Heath Systems Start: Clinical Champions).

Developing Detailed Workflows & Program Protocols

Crucially, the full scope of the intervention—including workflows, breakdowns of staff responsibilities and expectations, data collection and monitoring, community partnerships, resource distribution (such as gun locks), follow-up mechanisms, etc.—should be thoroughly developed *before* implementation begins. Without robust interventions and support structures in place, program efforts (such as screening) may falter and diminish staff engagement.

- Co-creating workflows with front-line staff and departmental leadership is essential to respect existing processes and ensure no individual service line is expected to shoulder a program's success.
- Establishing streamlined communication channels between teams and leadership in the planning phase will facilitate early identification of barriers/challenges impeding program roll-out, and the reception of feedback necessary to adapt and pivot to a changing clinical environment.
- Many implementation frameworks mentioned above include outlines that can guide the development of effective workflows and protocols.

The Implementation Process

Adaptation

Steps taken in the implementation process will differ based on the program/initiative chosen and the patient-population of the clinical setting. Unique considerations for the implementation of each FIMP strategy are outlined in the above sections Clinical Strategies

- Adapting the Safety Check Intervention for Wide-Scale Implementation in Health Systems for Prevention of Pediatric Firearm Injury and Mortality.[11]
- See *Section 7: Scaling and Sustaining FIMP Strategies* for resources for effective FIMP program adaptation.

Education

Prior to launch, comprehensive, multi-stage educational initiatives should be provided to ensure staff feel prepared and ready to begin program roll-out. The process of educating all necessary team members may take anywhere from 3-6 months, but it should not be rushed. It establishes the foundation on which the program pilot will stand.

Goals of Staff Education

- **Relevant**: Center firearm injury epidemiology within the local context of how firearm injuries are impacting your patients and your local communities to maximize staff buy-in and relevance. Education should also be relevant to the service line receiving the education—for example, a detailed understanding of firearm suicide prevention and intervention will be more relevant to the psychiatry service line than information pertaining to unintentional injuries, which are most commonly seen in the ED.
- **Tailored:** Explore how to tailor aspects of the education, so they reflect the roles and responsibilities of different service lines and clinical roles within a service line. For example, while all staff in an ED should have a high-level understanding of a program being piloted, only staff working 1:1 with patients to provide the intervention require the detailed understanding of how and when to activate referral pathways to community resources. By keeping the content relevant to staff responsibilities, you increase buy-in and maximize staff's time spent on education.
- **Mandatory**: Mandatory education helps develop a culture that places value on FIMP initiatives and reduces the likelihood of gaps in staff training, especially at times of high staff turnover. While education should be mandatory, there should be ample opportunities/formats to receive the education (e.g., in-person vs. virtual, live vs. self-directed) to meet staff where they are and respect the unique schedules/responsibilities of different service lines and clinical roles.
- **Consistent**: Repeated training and refresher sessions can help staff remain up to date on relevant programmatic changes, allow for the sharing of updates and data collected, and provide opportunities for feedback from staff on challenges and how the program can be optimized.

FIMP Education & Curricula

FIMP Education Publications

- Northwell Health: multi-layered FIMP education and evaluation plan[12] for interdisciplinary healthcare professionals.
- Johns Hopkins Hospital: used a simulation-based methodology[13] to educate clinicians on firearm safety counseling.
- Cincinnati Children's Hospital Medical Center: used a virtual reality-based educational curriculum[14] to train clinicians in safe firearm storage counseling.
- Article: Consensus-Driven Priorities for Firearm Injury Education Among Medical Professionals[15]

Publicly Available Curricula

- The Science of Firearm Safety Among Children & Teens Massive Open Online Course[16]: Developed by the University of Michigan's Institute for Firearm Injury Prevention and the Firearm Safety Among Children and Teens (FACTS) Consortium.
- Counseling on Access to Lethal Means Counseling (CALM)[17] : Developed by the Zero Suicide Institute.
- Reducing Gun Violence in America: Evidence for Change[18]: Developed by Johns Hopkins Bloomberg School of Public Health's Center for Gun Violence Solutions *Note: Requires registering for a free learner account.*
- ERPO: A Civil Approach to Gun Violence Prevention Teach-Out[19]: Developed by: Johns Hopkins Bloomberg School of Public Health's Center for Gun Violence Solutions
- Understanding Violence[20]: Developed by the Emory University Center for Injury Control

Data Collection and Monitoring

It is necessary to systematically collect and monitor data throughout a pilot because this is the time when a program is likely to experience the most barriers and friction. Capturing quantitative and qualitative data will illustrate not only the program's reach and efficacy, but also the lived experience of staff delivering the intervention and patients' experience.

It is recommended to share data summaries with administrative and front-line staff at regular intervals so they may provide feedback, context, and use the data to inform implementation protocol adaptations. Data can also be a powerful motivator to increase staff buy-in—seeing a program succeed, or how a program positively impacts patient care can inspire staff and bolster program success.

Evaluation & Sustainability

The Importance of Program Evaluation

Health systems routinely conduct evaluations of their protocols and programs whether as a result of grant requirements, quality improvement, or federal and state mandates. The results derived from program evaluations are used to inform decisions, drive action, and justify resource allocation. In order to maintain and justify ongoing funding, evaluations often focus on metrics that best capture program effectiveness, efficacy, and ultimately, impacts (through either economic or patient outcomes) observed within a set delivery timeline.

Many health programs across the country are successfully piloted but fail to achieve sustainability due to unstable funding, limited time, and health system prioritization. A strong evaluation can improve the likelihood that a program is sustained and scaled as it provides leadership with the data necessary to justify maintaining, or increasing, the funding and human power needed to continue.

Evaluation processes should be incorporated into all phases of program piloting and implementation, not restricted to the end of a grant period or program timeline. Collecting data from program outset is the most effective way to gather feedback from staff and participants/patients, identify barriers and course correct as needed, and demonstrate early success to leadership.

The CDC's 2024 Program Evaluation Framework [21] outlines the basics of public health program evaluation.

Conducting Thoughtful FIMP Evaluations

Traditional uniform evaluation protocols can be challenging and even harmful if applied to FIMP programs without consideration and intentionality as they often undervalue (or fail to capture) metrics related to participant/patient and staff experience, overemphasize short-term health care utilization metrics, and perceive success through a lens of economic efficiency. FIMP evaluations must consider how patient experiences and program outcomes are shaped by the same complex individual, community, and societal variables that shape violence exposure.

To reduce potential harm and maximize effectiveness, all FIMP program evaluations should be grounded in implementation science and public health best practices, and apply a health equity framework:

1. Engage community and clinical stakeholders at each step.
   - *Note:* Seeking community feedback (e.g., through a community advisory board) in the program planning process can proactively mitigate possible unintended harms and protect trust with community partners. This will also facilitate discussions about equitable data collection, sharing, and ownership; co-created evaluation tools; and community-centered dissemination tactics.

2. Amplify patient-centered and healing-centered metrics of success alongside traditional outcome and financial metrics.

3. Apply mixed-methods[22] approaches to capture a wide depth and breadth of data that explain not only what happened, but how and why.

4. Incorporate experimental[23] (e.g., randomized designs) or quasi-experimental[24] designs (e.g., step-wedge designs, difference-in-difference estimations, etc.) when possible to reduce threats to internal validity.

5. Apply implementation science frameworks to increase the standardization and generalizability of evaluation procedures/results across sites.

6. Evaluate process and outcome metrics[25] to deepen understanding of the implementation process itself (ex: barriers/facilitators to successful implementation) as well as the program's overall impact on desired outcomes.

7. Evaluate different outcomes and metrics at various time periods to capture proximal and distal impacts. Many FIMP programs require time to demonstrate ROI or patient-level outcomes; process evaluations can provide funders/leadership with concrete metrics of success in the interim.

8. Thoughtfully outline data collection processes and governance of data once collected.

9. Develop rapid, actionable feedback loops throughout program implementation and evaluation.

10. Disseminate evaluation results to community and clinical stakeholders.

Resources for Effective FIMP Program Evaluation

There is a growing body of research dedicated to the effective evaluation and dissemination of FIMP programming. Rather than reinvent the wheel, health systems should strengthen their evaluation protocols by applying best practices outlined by topic experts, incorporating standardized metrics of success, and tailoring evidence-based evaluation protocols to their local context, patient population, and program design.

Below ar**e general and program-specific resources/tools and examples of evaluations** that can help inform effective FIMP evaluations in healthcare settings:

1. General Program Evaluation Resources & Tools

- CDC's Program Evaluation Framework, 2024[26]
- Equity Bibliography for Program Evaluation[27]
- Evaluating Rural Community Health Programs[28]
- Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science[29]

- Health Equity Science: Research and Evaluation[30]
- Program Evaluation for Health Professionals: What It Is, What It Isn't and How to Do It[31]
- Public Health Program Evaluation Explained[32]
- Steps for Planning Health Program Evaluations: From Program Logic to Data Collection and Reporting Plans[33]
- UC Berkeley Library: Health Programs & Evaluation[34]

2. Evaluating HVIPs

Resources/Tools

- Standards & Indicators for Hospital-Based Violence Intervention Programs (HVIPs) [35]
- Hospital-Based Violence Intervention Programs: A Guide to Implementation and Costing[36]

Examples

- Evaluating the structural, financial, and legal aspects of hospital-based violence intervention programs implementation on psychosocial outcomes and violence reduction: A systematic review[37]
- Development of a Brief Client Satisfaction and Quality Improvement Tool for Hospital-Based Violence Intervention Programs: Opportunities for Enhancing Client Perspectives[38]
- Hospital-based violence intervention programs: An analysis of costs and key components[39]
- Long-term Evaluation of a Hospital-Based Violence Intervention Program using a Regional Health Information Exchange[40]
- Saving lives and saving money: hospital-based violence intervention is cost-effective[41]
- Effectiveness of a Mentor-Implemented, Violence Prevention Intervention for Assault-Injured Youths Presenting to the Emergency Department: Results of a Randomized Trial[42]
- Formative Evaluation of a Hospital-Based Violence Intervention Programs and Victims Services in Chicago[43]

3. Evaluating Firearm Screening Programs

Note: There are limited resources specific to the evaluation of FIMP screening programs. The resources below can help guide evaluation design as they pertain to programs with similar protocols, patient populations and barriers/facilitators.

Resources/Tools

- Principles of Screening for Disease and Health Risk Factors in the Emergency Department[44]
- Best Practice Guidelines: Screening and Intervention for Mental Health Disorders and Substance Use and Misuse in the Acute Trauma Patient[45]
- Universal Screening for Firearm Injury Risk Could Reduce Healthcare's Hesitancy in Talking to Patients About Firearm Safety[46]

Examples

- Development, dissemination and survey evaluation of layered education for healthcare professionals to support implementation of firearm injury and mortality prevention strategies in emergency care settings, New York, USA[47]
- Screening for Patient Firearm Access Among Mental Health Care Clinicians[48]
- Primary Care Patients' Perspectives on Health Care Screening for Firearms in a Diverse, Urban Area[49]
- Documentation of Screening for Firearm Access by Healthcare Providers in the Veterans Healthcare System: A Retrospective Study[50]
- Integrating social determinants of health screening and referral during routine emergency department care: evaluation of reach and implementation challenges[51]
- Clinician Attitudes, Screening Practices, and Interventions to Reduce Firearm-Related Injury[52]

4. Evaluating Suicide Prevention Strategies

Note: These evaluation resources are suitable for multiple firearm suicide prevention strategies (screening, lethal means counseling, safe storage) given the significant overlap in protocol and success metrics.

Resources/Tools

- The practice of lethal means restriction counseling in US emergency departments to reduce suicide risk: a systematic review of the literature[53]
- National Strategy for Suicide Prevention[54]
- Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care[55]
- Challenges And Recommendations for Evaluating Suicide Prevention Programs[56]
- ZeroSuicide Implementation Toolkit,[57] particularly the Improvement Resources[58]

Examples

- Evaluating the Effect of Routine Lethal Means Counseling in the Emergency Department on Suicide Mortality Among Mental Health Patients[59]
- Suicide Screening, Risk Assessment, and Lethal Means Counseling During Zero Suicide Implementation[60]
- Lethal Means Counseling, Distribution of Cable Locks, and Safe Firearm Storage Practices Among the Mississippi National Guard: A Factorial Randomized Controlled Trial, 2018-2020[61]
- A Quasi-Experimental Analysis of Lethal Means Assessment and Risk for Subsequent Suicide Attempts and Deaths[62]
- Implementing a systems approach to suicide prevention in a mental health service using the Zero Suicide Framework[63]
- Counseling on Access to Lethal Means-Emergency Department (CALM-ED): A Quality Improvement Program for Firearm Injury Prevention[64]
- Evaluation of a community-based safe firearm and ammunition storage intervention[65]
- Improving Firearm Storage in Alaska Native Villages: A Randomized Trial of Household Gun Cabinets[66]
- Is Office-Based Counseling About Media Use, Timeouts, and Firearm Storage Effective? Results From a Cluster-Randomized, Controlled Trial[67]

5. Evaluating Legal Interventions for Temporary Firearm Removal

Note: Demonstrating the efficacy of ERPOs often requires multisystemic evaluations and access to large state-level data, but health systems may be involved in the evaluation process, particularly by evaluating patient and clinician experiences.

Resources/Tools

- ERPO Resource Center: Clinician Implementers[68]
- Extreme Risk Protection Orders-A Tool for Clinicians to Prevent Gun Violence[69]

Examples

- Research on Extreme Risk Protection Orders, An Evidence-Based Policy that Saves Lives[70]
- Preventing the most common firearm deaths: Modifiable factors related to firearm suicide[71]
- Firearm Violence Following the Implementation of California's Gun Violence Restraining Order Law[72]
- An Empirical Assessment of Homicide and Suicide Outcomes with Red Flag Laws[73]
- Assessment of Extreme Risk Protection Order Use in California from 2016 to 2019[74]
- The impact of gun violence restraining order laws in the U.S. and firearm suicide among older adults: a longitudinal state-level analysis, 2012-2016[75]
- Effects of Risk-Based Firearm Seizure Laws in Connecticut and Indiana on Suicide Rates, 1981-2015[76]

Disseminating Program Results and Evaluation Findings

The dissemination of evaluations findings is essential to strengthen the field of FIMP and is a necessary aspect of the evaluation process regardless of whether or not a program demonstrates robust success. Every implementation pilot and subsequent evaluation presents the opportunity to reflect on the pros and cons of an approach, amplify successes, identify opportunities for improvement, and contribute to the growing body of literature outlining how different programmatic, demographic, sociopolitical, and geographic variables impact the outcomes of a FIMP program.

Dissemination allows evaluation findings to drive clinical, operational, and policy decisions, yielding a greater impact for a larger number of people.

Considerations for an Effective Dissemination Strategy

Effective dissemination is not comprised of a single publication but rather a *deliberate multi-pronged strategy to deliver succinct, timely, usable information to relevant stakeholders*. The dissemination process will therefore likely include multiple audiences, each with unique dissemination strategies, communication channels, and report formats.

Goal

Beginning with the overarching goals of the dissemination process will ensure alignment across subsequent decisions and maximize the likelihood that the dissemination helps yield the intended outcomes.

- **Examples**: securing sustainable funding for program maintenance/scaling, adapting health system protocols, contributing to a body of research literature, informing policy change, providing data and relevant updates to leadership or community partners, educating staff members.

Audience

Audience directly impacts how findings are summarized and what communication channels are activated to effectively reach the intended group.

- **Examples**: patients, frontline staff, health system executives, community partners, funders, policymakers, other health systems, the general public, etc.

Content

Disseminated content should be tailored to the audience's role and responsibilities. For example, funders and executives may be interested in more nuanced financial metrics and sustainability projections, while clinical team members responsible for the day-to-day program operations may prefer detailed program utilization metrics and summaries of patient and staff feedback.

- **Note**: It is essential to ensure results are communicated in a way that maintains the highest standard of data privacy. Data sharing (especially if it contains

protected health information) should occur only through approved, encrypted health system channels and restricted to only approved, essential program personnel. Data shared with a larger audience should be summarized, de-identified, and contain no protected health information.

Communication Format(s)

Results should be summarized and communicated through format(s) that audience members are familiar with, and in accessible language that is comfortably digested.

- **Examples**: summary reports, academic research articles, executive summaries/ briefs, policy briefs, quality and safety/QI reports, social media posts, media articles, presentations, implementation guides, curricula, patient pamphlets/ resources, etc.

Communication Channel(s)

Once summarized in the chosen format, results can be distributed to stakeholders through internal and external communication channels.

- **Internal**: Hospital reports (quality improvement, patient experience, quarterly/ yearly reviews, etc.), staff email listservs, presentations at meetings (from staff meetings to executive board meetings), internal websites and staff education platforms (see Section _internal comms__ for more).
- **External**: Social media channels, local news, academic journals, conferences, public-facing websites, hospital resource boards, newsletters and organization listservs, town halls and public events, etc. (see section external coms for more).

Timeline

Dissemination of findings can't just occur at the conclusion of a program's implementation and evaluation. It is essential to disseminate findings throughout the process in order to provide program participants, staff, stakeholders, and/ or community partners with timely, relevant data to inform effective program implementation and any necessary adaptations as a result of feedback.

Tools for Dissemination

NIH:

- Dissemination Approaches for Different Stakeholders[77]
- Dissemination Strategies in Evidence-based Policy and Practice[78]
- Dissemination & Implementation (D&I) Research[79]

Editorial: Ten simple rules for innovative dissemination of research[80]

Article: Designing for dissemination among public health and clinical practitioners in the USA[81]

Practice Report: Getting the Word Out: New Approaches for Disseminating Public Health Science[82]

Article: 'Meet People Where They Are': Facing the Public Health Communications Crisis[83]

Sustaining & Scaling FIMP Programs

Program Evaluation as a Tool for Sustainability

Once a program demonstrates acceptability and positive outcomes, the challenge becomes sustaining the resources necessary to sustain the program over a long period of time. Sustainability requires more than just demonstrated programmatic impact- it also requires aligning that impact with institutional goals, values, and incentives. Program evaluations can be effective tools to support program growth and longevity within a health system as they can provide the foundation of data and evidence on which to build a case for support that can be presented to leadership and/or external funders. When considering program sustainability, consider how evaluation findings can be used to inform strategies for sustainable financing (see *Section 3: Sustaining Funding for Firearm Injury & Mortality Prevention Programming*) and effective C-suite activation (see *Section 2: Creating a Strong Foundation for Engagement*).

Resources for Program Sustainability:

- Rural Health Information Hub: Planning for Funding and Sustainability[84]
- Community Toolbox: Planning for Sustainability[85]
- Agency for Healthcare Research & Quality: Sustainability Tool - Sustainability Module[86]
- New York State Health Foundation: Sustaining Improved Outcomes: A Toolkit[87]
- Office of Health & Human Services: Resource Guide for Building Sustainable Programs[88]

Thoughtful FIMP Program Adaptation

Similarly to sustaining existing programs, scaling or adapting a program to a novel patient population, clinical setting, or external setting requires a strong foundation of programmatic and financial support, and intentional planning prior to program rollout.

In addition to what is covered in the FIMP implementation best practices (see *Section 7: Implementing, Evaluating, and Scaling Programs in Healthcare Settings*) and the unique considerations for FIMP clinical strategies (see *Section 6: Clinical and Organizational-Level Strategies*), consider the following when adapting a FIMP program to a unique setting or population:

- **Define core programmatic components that must be maintained for program fidelity and adaptable components that do not impact program effectiveness.**
  - E.g., Credible messengers are essential to an effective HVIP, safety planning is essential to effective suicide prevention protocols
  - E.g., Community partners and referral pathways can and *should* be adapted so they best reflect the needs of the new patient population and/or program setting.

- **Apply implementation science models designed to support evidence-based adaptations.**
  - Apply ADAPT-ITT Model[89] to outline key components of the adaptation.
  - Use the FRAME-IS framework[90] to accurately capture and evaluate how the adaptations made impacted the implementation process and outcomes.
- **Consider how within and between-system phased scaling protocols could be adopted to strengthen external validity and the generalizability of findings.**
  - *Within system*: expanding from an ED pilot to a multi-site trial using a step-wedge designs.
  - *Between systems:* partnering with a regional health system, public health department, or other health systems to scale to a new institution.
  - *Community-scaling*: piloting a program in a community setting rather than a clinical setting.

Examples of FIMP Adaptations:

- Adapting Safety Check as a Universal Suicide Prevention Strategy in Pediatric Primary Care[91]: Describes the adaptation of an existing evidence-based secure firearm storage intervention ("Safety Check") using the ADAPT-ITT framework to make it more acceptable and scalable in pediatric primary care.
- Implementation of a Secure Firearm Storage Program in Pediatric Primary Care[92]: Compares an EHR-only strategy vs. EHR + facilitation ("nudge" vs. "nudge+") to improve clinician delivery of the firearm storage program (counseling + free gun locks). This is one of the first large pragmatic trials across multiple health systems testing strategies to embed firearm injury prevention into routine pediatric care.
- Equitable Implementation of S.A.F.E. Firearm: A Multi-Method Pilot Study[93]: Applies health equity implementation frameworks to explore whether delivery of a firearm safety intervention varies by race, ethnicity, or patient subgroups in pediatric primary care settings. Includes both quantitative signals and clinician qualitative insights.

Addressing Common Barriers to Entry

By systematically identifying and addressing these barriers through targeted, evidence-based strategies, healthcare systems can effectively implement and sustain FIMP initiatives, enhancing overall patient safety and community wellbeing.

1. Negative Patient Interactions

Evidence suggests many patients feel discussing firearm safety is appropriate and relevant in healthcare settings in contrast to concerns from FIMP providers. In one study[94] 78% of caregivers in a pediatric ED agreed or strongly agreed that "doctors should talk about safe storage." At three-month follow-up, 95% recalled the video content and 89% felt the video was somewhat or very helpful. In a 2016 survey[95] of over 1,300 parents, 75% agreed pediatricians should advise on safe storage of firearms, and viewpoints did not differ significantly based on firearm ownership. This is also not unique to certain regions of the country- the aforementioned studies were conducted in Colorado[96] and Missouri[97] respectively, and similar findings have been observed in Georgia.[98]

Normalizing firearm safety

While it is impossible to anticipate and control all patient interactions, health systems can reduce potential discomfort by incorporating firearm safety into existing medical education and training, including instruction in navigating challenging conversations like the delivery of bad news and death, and other health topics that can be perceived as stigmatizing. Educational strategies like role play can prepare staff to respond to potential concerns and practice the language necessary to have productive conversations about firearm safety.

Drawing parallels between FIMP and more familiar health and safety practices can also help place firearm safety initiatives within a larger, more accessible context for patients, but also for staff who are potentially uncomfortable with addressing the topic. Familiar examples include:

- Seat belts and age-appropriate car seats to reduce motor vehicle crash injuries and deaths
- Swimming lessons and pool fences for drowning prevention
- Helmets for traumatic brain injury prevention when riding bikes or motorcycles

These parallels can also help sidestep potentially uncomfortable conversations related to political and cultural beliefs around firearms and the 2nd amendment and reframe a focus on safety as seen with cars, pools, and bikes – all of which can present inherent risks to safety and well-being that are mitigated through safety behaviors.

Navigating away from politics and towards safety can ensure conversations remain respectful and non-judgmental.

See *Section 5, Strategy #5: Working Alongside Firearm Owners & Operators* for more effective collaboration.

2. Time Constraints and Workflow Disruptions

Time constraints and workflow disruptions frequently discourage healthcare providers from adopting new interventions. Studies indicate that clinicians often perceive insufficient time as a barrier to discussing firearm safety. Because no single solution can fully address these challenges, health systems should consider a combination of strategies that collectively reduce the burden on staff.

- Ensuring staff education is robust and realistic, and highlights succinct, effective strategies for patient engagement will improve staff confidence and willingness to incorporate screening into a visit.
- Integrating digital screening, counseling tools, and templated language directly into EHRs can streamline workflows and reduce the additional time burden.
  - E.g., scripts and prompts built into EHRs can also improve provider comfort and self-efficacy and reduce mental load.
- Developing patient-facing screening tools that patients complete independently at check-in prior to provider interactions can significantly alleviate provider burden, ensuring that critical information is efficiently captured without impacting clinical workflows.
- Employing team-based approaches—leveraging nurses, social workers, community health workers, etc.-can further distribute tasks effectively, ensuring comprehensive patient education and intervention without overwhelming individual providers.
  - E.g., at Northwell Health, universal screenings for firearm access and community violence risk are conducted primarily by nursing staff as part of the ED nurse note. Then social workers and CGVP staff conduct interventions for the patients who screen positive.
- Creating and maintaining intentional feedback pathways for staff to communicate difficulties and suggestions to address programmatic pain points, like time constraints and workflow disruptions.

See *Section 6: Clinical & Organizational-Level Strategies* for more tools to address programmatic barriers.

3. Provider Comfort & Self-Efficacy

Provider comfort and confidence in addressing firearm safety are also significant barriers. Many healthcare professionals express uncertainty regarding risk assessment and initiating firearm safety conversations due to limited education on how to lead these discussions and concerns about appearing judgmental or harming the doctor-patient relationship. A 2021 survey[99] of Ohio pediatric care providers demonstrated that 55% of respondents would counsel more patients if given additional training. Addressing this issue involves implementing targeted education and structured training programs. The curricula should emphasize effective communication strategies, risk identification, and cultural competence.

Standardizing training across medical education can enhance provider preparedness and confidence, fostering more comfortable and productive conversations around firearm safety. By making education mandatory, frequent, and relevant, health systems can address many barriers to implementation.

Health systems may also leverage and incorporate existing curricula and courses developed by experts across the country to lay the foundational knowledge and bolster health system-specific education. Some trainings also offer CME credits, meaning staff can be encouraged to deepen their understanding of FIMP while also meeting their mandated CME requirements. Recommended trainings and courses include:

4. Lack of a Specialized Workforce

It may be perceived that programs designed to support patients who have been involved in gun violence and prevent future violence, like HVIPs, require hiring, training, and supporting a specialized team of staff. However, recruiting and retaining such staff is challenging for all health systems, but particularly for smaller or underfunded hospitals, where there are considerable financial and geographic constraints.

There are many options that can assist in the development of an effective HVIP that does not necessitate immediately hiring a large, specialized workforce.

- **Training your team:** There are also opportunities for healthcare professionals to develop the core competencies of a VPP, by learning from local or national CVI organizations, like the HAVI, who provide training and technical assistance.
- **Collaborating with the community:** Health systems in regions with established CVI ecosystems may seek to develop MOUs with local CVI organizations that can allow community CVI staff to support HVIP patients in clinical spaces. These collaborations can be extremely effective not only at supporting hospital staff, improving patient health outcomes and increasing warm referrals to community resources, but also at reducing retaliatory violence through improved seamless bidirectional communication between health systems and CVI ecosystems. Health systems should engage their legal and human resource departments and local CVI leaders to explore the feasibility of MOUs, volunteer contracts, or other options available to facilitate community and clinical program integration.

See *Section 7: The Implementation Process* for specific educational resources for HVIP staff.

5. Legal and Political Concerns

Legal and ethical misconceptions can deter clinicians from discussing firearm ownership. Studies clarify that these conversations are both legal and consistent with preventive healthcare standards. Health systems can overcome this barrier by establishing clear institutional guidelines and offering explicit policy statements affirming the legality and ethical responsibility of healthcare providers to address firearm safety with patients. For more information, explore resources related to medical-legal partnerships in the Kaiser Permanente/HAVI Prevention & Intervention Library."[100]

Political sensitivities surrounding firearm safety discussions can be addressed by framing initiatives around universal public health goals, such as community safety and child protection, which transcend political divides. Engaging in local coalitions and bipartisan groups further strengthens program credibility and fosters community acceptance.

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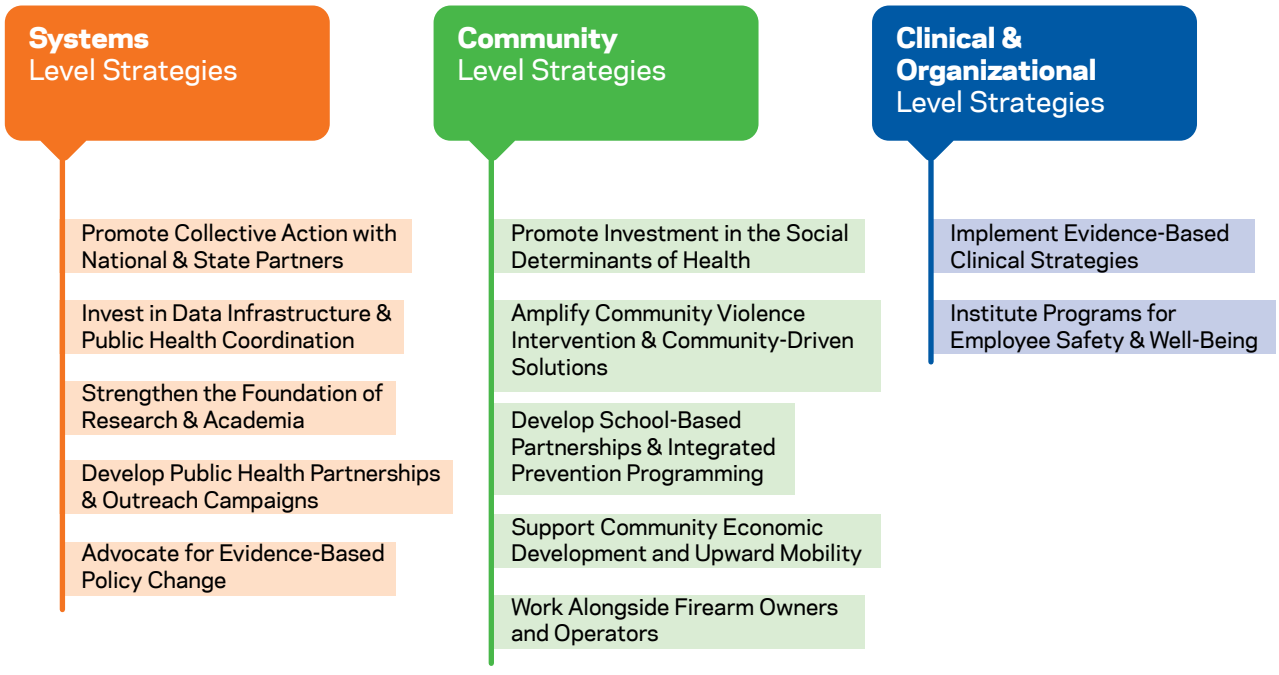
CONCLUSION

Firearm injury and mortality represent a complex and pervasive public health crisis that affects every community in the United States and is encountered daily across health systems. Whether through suicide, interpersonal violence, unintentional injury, or mass shootings, no health system is immune, and the consequences are borne by patients, families, clinicians, and communities alike.

A growing body of evidence demonstrates that firearm injury is preventable. Interventions such as universal screening, HVIPs programs, safe storage counseling, behavioral health integration, and community partnerships are effective. Yet implementation remains uneven and fragmented, leaving a critical gap between what is known to work and what is consistently delivered at scale.

Health systems are uniquely positioned to close this gap. As trusted institutions and community anchors, hospitals and health systems have both the responsibility and the capacity to lead FIMP. This toolkit provides a data-driven, systems-level roadmap grounded in national best practices, lived experience, and implementation science. Its impact depends on intentional, context-specific adoption and sustained leadership.

Opportunities for Health Systems Engaging in Firearm Injury & Mortality Prevention



This call-to-action urges health systems to:

1. Reframe firearm injury as a preventable public health issue integrated into routine healthcare delivery and population health strategy.
2. Prioritize evidence-based interventions across the continuum of prevention, from suicide prevention, to CVI, to staff health and safety.
3. Mobilize leadership through clear governance, clinical champions, and alignment of strategic, financial, and operational priorities.
4. Build durable partnerships with CBOs, public health agencies, academic institutions, and peer health systems.
5. Design for scalability and sustainability by embedding prevention into quality improvement, medical education, workforce development, and strategic planning.
6. Address upstream SDOH health through cross-sector collaboration and investments that reduce structural and systemic risk.
7. Implement robust evaluation and continuous quality improvement systems to guide adaptation and measure impact.
8. Engage in national coalitions to advance firearm injury and mortality prevention as a core healthcare function.

There is no single solution. Rural hospitals, urban trauma centers, and integrated health systems will each deploy different strategies based on local needs and resources. **What unites them is a shared responsibility to act.**

Firearm injury intersects with mental health, substance use, poverty, structural inequities, but at its core lies a fundamental value: the right of every person to live in a safe and healthy community. This moment calls for decisive, coordinated, evidence-informed action- and health systems must lead.

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