Caregivers' and Community Members' Perspectives on Firearm Safety Screening and Counseling During Pediatric Primary Care Visits

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To assess caregivers' and community members' perspectives on a potential communication framework for pediatricians to provide firearm safety counseling in primary care via focus groups. Participants recommended embedding the topic within injury prevention counseling, sharing information on safe storage, and screening for storage strategies rather than gun ownership. *(J Pediatr 2024;12:200099).*

In the US, firearm-related injury is the leading cause of death in children aged 1-19 years.[1-3] Consequently, the American Academy of Pediatrics (AAP) strongly urges pediatricians to screen for the presence and availability of firearms at well-child visits, counsel caregivers on the dangers of childhood access to firearms, and recommend caregivers remove firearms or restrict access through safe storage practices.[4] Research has demonstrated that safe firearm storage practices are protective against pediatric firearm suicides and unintentional deaths, thus a target for intervention.[5-7]

While pediatricians and pediatric residents endorse having a responsibility to counsel families on the risks of firearms, evidence suggests that most do not provide firearm-related counseling in clinical practice.[6,8-15] Reported barriers to counseling include minimal firearm-related education, limited knowledge of safe storage devices, a lack of training on firearm safety counseling techniques, and insufficient time during visits.[6,8,10,12-15] Thus, a critical need exists to enhance pediatricians' firearm safety counseling skills to support effective prevention efforts.

Although several studies have characterized physician-related barriers to firearm safety counseling, few studies exist that illuminate caregivers' perspectives on firearm safety counseling in pediatric primary care,[16,17] with even fewer on preferred communication practices for discussions on firearm safety.[18,19] Therefore, we sought to explore caregivers' and community members' perspectives on pediatricians' firearm safety screening and counseling behaviors in outpatient primary care.

Methods

Participants and Setting

Participants were recruited from 2 community organizations from a large, diverse city in the Midwest US: (1) Cincinnati Chapter of Moms Demand Action— the local chapter of a bipartisan, national grassroots organization advocating for comprehensive public safety measures to address gun violence, and (2) West End Community Research Advisory Board (WE C-RAB)— a group of residents in the West End neighborhood of Cincinnati, Ohio, who engage with researchers to support certain health goals, including decreasing neighborhood gun violence. Moms Demand Action was included as members are comfortable discussing firearm safety and represent a range of perspectives on firearm ownership. WE C-RAB was recruited as the West End of Cincinnati has been a focal point for gun violence, with more than 160 reported shootings over the last 4 years.[20,21] This study was approved by the institutional review board at Cincinnati Children's Hospital Medical Center.

Participants were recruited via email or in-person to participate in one, 60-minute focus group. Purposeful sampling procedures were conducted to solicit a variety of perspectives on firearm safety counseling, including caregivers with children currently living in the home, firearm and nonfirearm owners, and individuals from different neighborhood settings (eg, urban, suburban). Enrollment, consent, and completion of a demographic survey occurred electronically. Focus groups occurred either in-person or via a video-teleconferencing platform using a semistructured interview guide (**Appendix**). After a review of the literature, an interview guide was developed by 3 authors with expertise in medical education and firearm safety. Before use, the guide was also evaluated by an expert in qualitative methods, piloted with 4 physicians, and reviewed by the leaders from our 2

AAP	American Academy of Pediatrics
FG	Focus group
RADaR	Rigorous and accelerated data reduction
REACH	Resident Education And Counseling on Household
WE C-RAB	West End Community Research Advisory Board

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community groups. Focus groups were audio-recorded to allow verbatim transcription for subsequent analysis.

Study Procedures and Context

The semistructured interview guide was designed to (1) assess perspectives on firearm safety counseling in pediatric primary care, and (2) elicit feedback on preferred communication strategies by pediatricians. The latter discussion was anchored on a communication framework that had been developed for Resident Education And Counseling on Household (REACH) Firearm Safety, a screen-based virtual reality intervention that trains pediatric residents to screen for and counsel on household firearm safety during primary care visits. REACH Firearm Safety uses a novel communication framework derived from recommendations from the AAP, American Pediatric Surgical Association, Everytown for Gun Safety, and the Ohio AAP's Store It Safe program.[4,22-24] The communication framework consists of 3 parts. It starts with a "Contextual Announcement" to introduce household firearm safety, then is followed by "Presumptive Teaching," in which a pediatrician clarifies the 3 tenants of safe firearm storage (eg, keeping the firearm unloaded, locked, and with the ammunition stored separately), and ends with a "Screening Question" to assess storage strategies (Table I).

Data Analysis

The rigorous and accelerated data reduction (RADaR) technique[25] was used for thematic analysis of the transcribed focus groups. The RADaR technique uses a 5-step process to support data analysis, which includes (1) data transcription, (2) development of tables capturing all data, (3) data reduction to include just content specific to research objectives, (4) further data reduction to highlight the most critical content, and (5) determination of key project deliverables (eg, themes). This rapid, pragmatic qualitative research method[26] was well-suited for the current study which assessed perspectives on a narrow content area to refine a potential communication framework. Moreover, this approach allowed us to quickly modify the educational materials based on stakeholder feedback.[27]

Rigor in Qualitative Analysis

To enhance the trustworthiness of the data, 2 authors jointly shared their initial impressions from the focus groups and independently reviewed the data. Subsequently, 1 author generated the data tables and another author independently reviewed all data tables to ensure consensus before subsequent data reduction. Key project deliverables and subsequent themes were refined by perspectives of other team members. To support credibility, we used interview items that focused on descriptions to allow probing for further insights. To enhance dependability, we used rigorous procedures and peer debriefing. To support confirmability, we recorded procedures and data analysis steps.

Results

From November 2022 to June 2023, 40 individuals participated in a total of 6 focus groups. Four focus groups were conducted via a video-teleconferencing platform with members of Moms Demand Action, and 2 were conducted in-person with members of WE C-RAB. One focus group included firearm owners, 2 focus groups included nonfirearm owners, and 3 were mixed with firearm and nonfirearm owners. Participants were predominantly female (n = 37, 93%), White (n = 22, 55%), non-Hispanic (n = 29, 73%), between 30 and 49 years of age (n = 23, 58%), and caregivers to at least 1 child living in their home (n = 24, 60%). Participants lived in urban (n = 22, 55%), suburban (n = 16, 40%), and rural (n = 1, 3%) neighborhoods. Almost one-quarter (n = 9, 23%) endorsed having a firearm. Twelve participants (30%) were affected by firearm violence either personally or within their immediate family. The majority (n = 33, 83%) reported never receiving counseling on household firearm safety from their pediatrician.

Across all focus groups, participants expressed a desire for their child's pediatrician to discuss firearm safety without dissent toward this shared recommendation. Three themes emerged from the focus groups related to caregivers' and community members' perspectives on communication

Table I. Resident Education And Counseling on Household (REACH) Firearm Safety communication framework to introduce screening for access to firearms and safety counseling

Steps	Purpose	Example language
Step 1: Contextual announcement	To frame the conversation of firearm safety within the context of safety counseling and anticipatory guidance	*"I'm glad to hear that Alex* is using an age-appropriate car seat. As part of safety counseling for all my patients, I like to talk about firearms as those can pose a safety risk to children as well."*
Step 2: Presumptive teaching	To introduce basic teaching regarding safe firearm storage practices	*"Research has shown the safest way to store firearms is locked, unloaded, and with the ammunition stored separately from the firearm."*
Step 3: Screening question	To assess current household firearm storage practices	*"For firearms in your home or other homes that Alex* may visit, do you know if they are kept locked and unloaded?"*

Practices are based on national recommendations from the American Academy of Pediatrics (AAP), American Pediatric Surgical Association, and Everytown for Gun Safety, as well as the Store It Safe Firearm Safety Campaign led by the Ohio Chapter of the AAP.
*Alex: Gender-neutral name of an example patient.

strategies for pediatricians: (1) embed firearm safety within injury prevention counseling, (2) share information on safe firearm storage, and (3) screen for storage strategies rather than gun ownership. Additional quotes supporting themes are included in Table II.

Theme I: Embed Firearm Safety within Routine Injury Prevention Counseling

The first theme focused on how a pediatrician should introduce firearm safety screening and counseling during primary care visits. Participants expressed that embedding firearm safety within injury prevention counseling, such as safe sleep, water safety, or car seat safety, was appropriate and preferable. One participant noted, "I also think about having this conversation as part of baby proofing the house. Like you would talk about putting up gates and covering outlets, that this would be part of that baby proofing conversation early on" (Focus group [FG] 4). Participants also identified the importance of a pediatrician emphasizing safety and relaying inherent dangers of firearms to children. "…Just teaching them about the safety and letting them know it's true that if they pick it up and don't know how to handle it, they can shoot [them]self or somebody they don't want to be shot" (FG 6). There were several consistent recommendations participants identified to assist pediatricians in firearm safety screening and counseling: (1) Discuss firearm safety at all well-child visits. Participants unanimously identified the importance of discussing firearm safety at all well-child visits and starting early, sharing "I don't think there's an age too early to have those conversations, even just with the parents to get them in the mode of thinking of gun and firearm safety" (FG 3). (2) Let families know that you talk about firearm safety with everyone. Participants wanted pediatricians to share that it is part of their standard practice to have conversations around firearm safety "…So that a parent doesn't feel singled out, saying that they (pediatricians) discuss this with all of their patients" (FG 2). (3) Use either "firearm" or "gun" in conversation with families. Participants shared it was acceptable to use either "firearm" or "gun." Most participants felt the word "gun" was more accessible and recognizable for children, whereas the word "firearm" was more academic and all-encompassing. A few participants shared their concern that the word "gun" might be triggering for individuals with a history of gun violence. (4) Consider sharing local and national data on pediatric gun violence. Participants suggested it would be helpful for pediatricians to include information on the epidemiology of pediatric firearm-related injury and mortality. One remarked, "…the statistic that guns are the number one killer of young people, I think that's a real shocker" (FG 3). Some participants emphasized the importance of connecting counseling to local violence. "I think they (pediatricians) also need to know about local gun violence and what's going on. They just need to be educated about the current events…" (FG 5).

Theme II: Share Information on Safe Firearm Storage

The second theme centered on what information caregivers and community members prefer pediatricians convey about firearm storage. Participants reported a preference for pediatricians to define safe firearm storage to establish a mutual understanding and to share knowledge about what safe storage consists of regardless of firearm ownership status. One participant shared, "I definitely think you should always offer that, that tidbit of information, because you don't know where you are sending your kids…" (FG6). Again, there were several consistent recommendations participants identified to assist pediatricians in sharing actionable information on safe firearm storage with patient families: (1) Discuss specific storage devices. "I think if you're going to talk the subject you (the pediatrician) should know the basic pros and cons of each (storage device)" (FG 3). (2) Consider offering a visual aid or handout. Several participants shared it would be useful for a pediatrician to offer a visual aid or handout. "I think if they're going to talk about it, they should already have a flier on the different safety mechanism they have for a gun. Just have a printout on it" (FG 5). (3) Have safe storage devices available in clinics or be able to offer information on where patient families can find the devices at low or no cost. "I'm here, where you can connect me and give me resources" (FG 5). "Yeah, I think they need to know where all of those (storage devices) can be bought…every single one" (FG 5).

Theme III: Screen for Safe Storage Strategies Rather Than Gun Ownership

The third theme was that participants emphasized that pediatricians should avoid directly asking whether firearms are in the home. "I like that you don't ask straight out, are there firearms in your home?…You're just broaching it in a way that, yes, there might be firearms in the house, but how can we do it in a safe manner?" (FG 1). Rather, participants shared that it is preferable for a pediatrician to screen for the use of safe firearm storage strategies presuming that firearms are present in the household to avoid any perceived judgment regarding gun ownership. Participants also recommended pediatricians focus on the patient's primary residence initially. "If I was a pediatrician, the most important thing would be making sure that kid lived in a home where the gun was stored securely" (FG 4). If there were no firearms present in the primary household, then participants thought the conversation should be broadened to include other locations (eg, friends/relatives' homes, school). Steering the conversation in this direction was felt to be integral to normalizing conversations around safe firearm storage within families and communities.

Discussion

This qualitative study provided insight into caregivers' and community members' perspectives on pediatricians' firearm safety screening and counseling behaviors in outpatient primary care. Focus group discussions were anchored within the REACH Firearm Safety communication framework. Three themes emerged from these focus groups: (1) embedding the topic within injury prevention counseling, (2) sharing information on safe storage, and (3) screening for

Table II. Themes exploring caregivers' and community members' perspectives on firearm safety communication strategies during pediatric primary care visits

Themes and recommendations	Exemplary quotes*
I. Embed firearm safety within routine injury prevention counseling	*"This reminds me…of best practice for safe sleep. I think approaching it from…this is a children's health issue…research shows, and as I'm an expert in my field, this is what we're seeing. Research shows that it's a best practice, same as car seats, same as smoke detectors." (Focus Group (FG 1))*
	"It fits right in with other things that you expect your pediatrician to ask about. Like they used to ask, do you wear a helmet when you ride a bike or roller skate, that sort of thing? It just, to me, it fits right in with that other safety information that they give you or questions that they ask." (FG 4)
Recommendations:	
(1) Discuss firearm safety at all well-child visits	*"I would love it if my pediatrician always asked about this...I personally feel like it should be a pretty standard question when you're seeing a pediatrician because of the safety issue with firearms." (FG 2)*
	"...[Screening and counseling should occur for] all ages because if you've got an infant, depending on how they develop, you're talking 3 months to get ready before they start getting handsy." (FG 3)
	"I also would say every age. I mean, for me, the way that we like to do our parenting is you don't have to have a fixed talk if you talk about it all the time." (FG 4)
(2) Let families know that you talk about firearm safety with everyone	*"I like that it says, all my patients, because I think people that own guns might be like, are they targeting me? Do I look like I own a gun? Or do they say this to everyone who comes in? So, I think that's good, for all of my patients, to just open it up that way." (FG 1)*
	"I like that it normalizes that this is something the pediatrician is chatting with everybody about." (FG 4)
(3) Use either "firearm" or "gun" in conversation with families	*"I like both words. I like to interchange [them]. If the pediatrician had used the word firearm with my child or in the office, then it would have been a good opportunity for me to say, oh, yes, another word for gun, you know, to have the child also be familiar with a variety of words that mean the same thing." (FG 4)*
	"It depends on the household because a lot of urban households just say gun…so, if a kid hears firearm, they might not know exactly what you're talking about." (FG 6)
(4) Consider sharing local and national data on pediatric gun violence	*"If you gave me statistics about children being harmed by guns, and that's why we want to know if we can better help you store or something your gun." (FG 5)*
	"Say like what's just in the news. The police officer, security guard, whoever, they just got locked up because he had his gun laying out, and his girlfriend's son picked it up and shot himself." (FG 6)
II. Share information on safe firearm storage	*"I think it is a good way to bring up…referring to research, so it's not feeling like its coming directly from the doctor, maybe more like this is a best practice, and so someone might not even know that." (FG 2)*
	"I also think the presumptive teaching helps to avoid sort of that opt-out option we were talking about before, whereas if you ask, is there guns in the homes, people might say no, whether that's true or not. And we'd never know. But that kind of ends your conversation right there and gets you in a tough point, that this way, you've at least gotten a little tidbit of information in there, even if you do face some resistance later on." (FG 4)
	"It's the literature, something that's real straight to the point. So, you know how some had those like for CPR, stop, drop, and roll...for locking it up, lock, store, put, you get what I'm saying. So, something simple that they can read, and then also, yeah, and then also like a resource." (FG 6)
Recommendations:	
(1) Discuss specific safe storage devices	*"I think for doctors, it's like why would I need to know all these different storage devices? At least at a basic level, to be able to relate to that patient that does have a gun...maybe you don't know everything...but the three typical things that families might have to safely store." (FG 1)*
	"...I don't think parents know the difference between the three [storage devices—cable lock, trigger lock, and lock box]…And being able to point and say, this is a trigger lock, and this is a cable lock, and this works better on pistols, or this works better on etc." (FG 3)
(2) Consider offering a visual aid or handout	*"...there's lots of posters in the pediatrician's office. I mean, I feel like locked, unloaded, stored separately, is pretty succinct. And if you just have a graphic next to each one, I feel like that could stick in your brain." (FG 1)*
	"Something that they can be like, okay, I heard about, she told me about this gun safety, because everybody can relate, one way or another. But if they got their resource, right there on that paper, that goes a long way, because you could tell somebody some information. When they leave out the door, they could forget it…but if they know like, okay, I can learn right here..." (FG 6)
(3) Have safe storage devices available in clinics or be able to offer information on where patient families can find the devices at low or no cost	*"I agree because I know there are, in some cases, where they, some people qualify for free car seats because they can't afford them. Their child still deserves to be safe. And same with a gun, if they're interested in protecting their child and can't afford it, I think there should at least be some sort of resource to help them." (FG 1)*
	"… Maybe if they can have a video training, or just say, look at this on your own time on how, if someone has a gun, this is, they got a lock box. They got this, this, this, and pretty much where they could probably get it for free if they really need it." (FG 5)

(*Continued*)

Table II. Continued

Themes and recommendations	Exemplary quotes*
III. Screen for safe storage strategies rather than gun ownership	*"I just wanted to say that I like, in this question, how you don't ask, do you have firearms? But you just say, for all the firearms." (FG 1)*
	"I do think that piece about what's the safest way to have a gun in the home so that they know what to look for, rather than just asking, do you have a gun in your house." (FG 2)
	"I agree wholeheartedly that this needs to be two questions because I think, for one, substantively, its two very different situations, to know what's happening in your own home versus a play date." (FG 3)
	"We barely controlling what's going on in our own home…And then it's like…and then you asking us about somebody else's." (FG 5)

CPR, cardiopulmonary resuscitation.
*To protect study participants, exemplary quotes have been deidentified and labeled at the Focus Group (FG) level (eg, FG 1).

safe storage strategies rather than gun ownership. Similar to previous studies, caregivers were receptive and supportive of pediatricians asking about firearm safety[16]; however, this did not differ between firearm and nonfirearm owners.

Soliciting guidance from caregivers and community members on provider communication strategies to support effective guidance around firearm safety is critical to inform curricula. Similar to previous research studies, our participants also found it undesirable for pediatricians to ask direct questions about firearm ownership and preferred for pediatricians to engage in conversations around safe firearm storage with all families to facilitate dialogue.[16,19] Our study adds to the current literature by demonstrating consensus between 2 diverse community organizations on the desire for firearm safety discussions to occur in pediatric primary care visits, the need to introduce the discussion of firearms within routine injury prevention counseling, the benefits of disseminating actionable information on safe firearm storage, and the importance of screening for safe storage strategies. Our findings further align with 2 previous publications emphasizing a need for a shared common language among health care providers when discussing firearm injury prevention with caregivers and community members.[18,19]

We used a rapid qualitative approach, the RADaR technique,[25] that could have applicability to other researchers refining educational interventions through community partnerships. This approach was advantageous, as it allowed for efficient, rigorous procedures. Based on our findings, the REACH Firearm Safety intervention was modified to suggest the inclusion of statistics on pediatric-firearm related injury or recent community events as segue ways for pediatricians to introduce firearm safety. We also incorporated a focus on the primary residence, added in considering alternating the words "gun" and "firearm" in conversation, and encouraged pediatricians to provide a handout or additional resource (eg, safe storage device) to patient families when feasible.

This study had limitations. First, self-selection bias may have contributed to the findings, as individuals with increased interest in firearm safety might have chosen to participate. To overcome this, we conducted purposeful sampling to include a variety of perspectives. Second, social desirability bias may have influenced the findings, as participants might have wanted to align their responses with what is perceived to be socially acceptable. We did not obtain quantitative data on firearm safety discussions requiring participants to verbalize individual opinions within the focus group setting. To minimize social desirability bias, we tried to establish rapport with participants before starting focus groups, emphasized anonymity and confidentiality, and used neutral questions. Third, the difference in focus group settings, video teleconferencing vs in-person, could have affected the dynamic of the interactions. To minimize this, all focus groups were led by the same team members, followed a standardized interview guide, and mirrored the format of each organization's typical member meetings. Fourth, the possibility of confirmation bias could have affected study results as the same authors led the focus groups and data analysis. To address this, co-authors reviewed data tables individually and collectively until consensus was achieved. Fifth, this study occurred in one city among 2 community groups engaged in firearm injury prevention, which may limit transferability. Certain findings, such as the desire for firearm safety to be discussed at all visits, may be biased toward those more comfortable engaging in conversations around firearms and may not represent the perspectives of the broader population or account for differences by geographic region. Despite this, the study provides a framework and themes for exploring perspectives among other populations.

Conclusions

Caregivers and community members are supportive of pediatricians engaging with families on firearm safety. Embedding the discussion in injury prevention counseling, sharing information on safe storage, and screening for safe storage strategies not firearms were identified as crucial components. Next steps include exploring these themes with different populations, including those who may be less comfortable engaging in conversations around firearms, assessing the acceptability of this communication framework among pediatric providers, and evaluating the impact of exposure to REACH Firearm Safety on counseling behaviors. ■

CRediT authorship contribution statement

Michelle L. March: Writing – review & editing, Writing – original draft, Project administration, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Andrea R. Meisman:** Writing – review & editing, Project administration, Investigation, Formal analysis, Data curation. **Matthew W. Zackoff:** Writing – review & editing, Resources, Methodology, Investigation, Formal analysis. **Melissa D. Klein:** Writing – review & editing, Methodology, Investigation, Formal analysis, Conceptualization. **Francis J. Real:** Writing – review & editing, Writing – original draft, Supervision, Resources, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization.

Declaration of Competing Interest

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References

1. Cunningham RM, Walton MA, Carter PM. The major causes of death in children and adolescents in the United States. N Engl J Med 2018;379:2468-75.
2. Children's Defense Fund. The state of America's children in 2023 - gun violence. Accessed April 1, 2024. https://www.childrensdefense.org/tools-and-resources/the-state-of-americas-children/soac-gun-violence/
3. Goldstick JE, Cunningham RM, Carter PM. Current causes of death in children and adolescents in the United States. N Engl J Med 2022;386:1955-6.
4. Lee LK, Fleegler EW, Goyal MK, Doh KF, Laraque-Arena D, Hoffman BD. Firearm-related injuries and deaths in children and youth: injury prevention and harm reduction. Pediatrics 2022;150:e2022060070.
5. Azrael D, Cohen J, Salhi C, Miller M. Firearm storage in gun-owning households with children: results of a 2015 national survey. J Urban Health 2018;95:295-304.
6. Grossman DC, Mueller BA, Riedy C, Dowd MD, Villaveces A, Prodzinski J, et al. Gun storage practices and risk of youth suicide and unintentional firearm injuries. JAMA 2005;293:707-14.
7. Monuteaux MC, Azrael D, Miller M. Association of increased safe household firearm storage with firearm suicide and unintentional death among US youths. JAMA Pediatr 2019;173:657.
8. Hoops K, Crifasi C. Pediatric resident firearm-related anticipatory guidance: why are we still not talking about guns? Prev Med 2019;124:29-32.
9. Juang DD, McDonald DL, Johnson-Young EA, Burrell TD, Silver DL, Wang Y, et al. Assessment of pediatric residents' attitudes toward anticipatory counseling on gun safety. Children (Basel) 2019;6:122.
10. Monroe KK, Fried SQ, Rubin A, Markman LR, Shefler A, McCaffery H, et al. Firearms screening in the pediatric inpatient setting. Hosp Pediatr 2020;10:37-42.
11. Naureckas Li C, Sacks CA, McGregor KA, Masiakos PT, Flaherty MR. Screening for access to firearms by pediatric trainees in high-risk patients. Acad Pediatr 2019;19:659-64.
12. Olson LM, Christoffel KK, O'Connor KG. Pediatricians' involvement in gun injury prevention. Inj Prev 2007;13:99-104.
13. Pallin R, Teasdale S, Agnoli A, Spitzer S, Asif-Sattar R, Wintemute GJ, et al. Talking about firearm injury prevention with patients: a survey of medical residents. BMC Med Educ 2022;22:14.
14. Solomon BS, Duggan AK, Webster D, Serwint JR. Pediatric residents' attitudes and behaviors related to counseling adolescents and their parents about firearm safety. Arch Pediatr Adolesc Med 2002;156:769-75.
15. Webster DW, Wilson ME, Duggan AK, Pakula LC. Firearm injury prevention counseling: a study of pediatricians' beliefs and practices. Pediatrics 1992;89:902-7.
16. Garbutt JM, Bobenhouse N, Dodd S, Sterkel R, Strunk RC. What are parents willing to discuss with their pediatrician about firearm safety? A parental survey. J Pediatr 2016;179:166-71.
17. Aitken ME, Minster SD, Mullins SH, Hirsch HM, Unni P, Monroe K, et al. Parents' perspectives on safe storage of firearms. J Community Health 2020;45:469-77.
18. Betz ME, Harkavy-Friedman J, Dreier FL, Pincus R, Ranney ML. Talking about "firearm injury" and "gun violence": words matter. Am J Public Health 2021;111:2105-10.
19. Hinnant A, Boman CD, Hu S, Ashley RR, Lee S, Dodd S, et al. The third rail of pediatric communication: discussing firearm risk and safety in well-child exams. Health Commun 2021;36:508.
20. Azallion A. West End community leaders, advocates work to expand anti-gun violence work: WCPO News Cincinnati. 2023. Accessed January 1, 2024. https://www.wcpo.com/news/local-news/hamilton-county/cincinnati/west-end/west-end-community-leaders-advocates-work-to-expand-anti-gun-violence-work
21. Cincy Insights. Reported shootings city of Cincinnati. Accessed January 1, 2024. https://insights.cincinnati-oh.gov/stories/s/Reported-Shootings/xw7t-5phj/
22. Everytown for Gun Safety. Unload, lock, and separate—secure storage practices to reduce gun violence. 2019. Accessed January 1, 2024. https://everytownresearch.org/report/unload-lock-and-separate-secure-storage-practices-to-reduce-gun-violence/
23. Ohio Chapter of the American Academy of Pediatrics. Store it safe program 2015. Accessed January 1, 2024. https://ohioaap.org/storeitsafe
24. Petty J, Henry M, Nance M, Ford H , the American Pediatric Surgical Association Board of Governors. Firearm injuries and children Position Statement of the American Pediatric Surgical Association [Position Statement]. 2019. Accessed January 1, 2024. https://apsapedsurg.org/wp-content/uploads/2020/10/APSA-Position-Statement-on-Firearm-Injuries-and-Children-2019.pdf
25. Watkins DC. Rapid and rigorous qualitative data analysis: the "RADaR" technique for applied research. Int J Qual Methods 2017;16:1609406917712131.
26. Vindrola-Padros C, Johnson GA. Rapid techniques in qualitative research: a critical review of the literature. Qual Health Res 2020;30:1596-604.
27. Nevedal AL, Reardon CM, Opra Widerquist MA, Jackson GL, Cutrona SL, White BS, et al. Rapid versus traditional qualitative analysis using the Consolidated Framework for Implementation Research (CFIR). Implement Sci 2021;16:67.