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Providing Family Centered Care Within Pediatric Integrated Care Settings

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PROVIDING FAMILY CENTERED CARE WITHIN PEDIATRIC INTEGRATED CARE SETTINGS

by

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ABSTRACT

PROVIDING FAMILY CENTERED CARE WITHIN PEDIATRIC INTEGRATED CARE SETTINGS

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Parent engagement remains critical to pediatric care. Both pediatric medical and mental health care remains dependent upon parent/guardian engagement to support successful outcomes for children and adolescents. Efforts to enhance Family Centered Care (FCC) has been spotlighted within pediatric care since the 1950s and the inclusion of counselors within integrated behavior health (IBH) teams ushers a need for an evolved understanding of the implementation of FCC, including parent/guardian engagement across professional roles. Using an explanatory mixed-method design, I examined team implementation of Family Centered Care (FCC) among different provider types (e.g., physicians, nurses, licensed mental health providers, social workers, technicians) in a pediatric care setting. Results identified shared valuation of FCC and noted differences in delivery by professionals' role type and care setting. Implications offer guidance for healthcare leadership, pediatric professionals, and counselor education programs to recognize strengths of FCC practices within multidisciplinary teams and invest in both program and counselor development within IBH settings.

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CHAPTER 1

INTRODUCTION

In this chapter, I will present background of the problem as I discuss the purpose of this study and identify the associated research questions. Next, I will explore the significance of the study within the context of pediatric care as well as counseling in integrated care settings along with a summary of the theoretical framework guiding this research. I will finalize the chapter as I briefly introduce the proposed methodology and foreseen limitations, as well as identify and define terminology relevant to this study.

Background of the Problem

At a time when suicide is the second leading cause of death for children ages 10 to 14 (CDC, 2020), pediatric mental health services provide critical intervention and prevention to children and families. However, only one in five children experiencing a mental health need are even identified, while only one in three are able to access mental health services when needed (Merikangas et al., 2010). Children in need of mental health services are nearly always dependent upon parent/guardians to be able to access and maintain treatment. For families who are able to access pediatric mental health services, approximately half of pediatric patients terminate services prematurely, often after only a few sessions (Gopalan et al., 2010; Nock & Ferriter, 2005; McKay & Bannon, 2004). Despite concerns about utilization, the rising demand for pediatric mental health care has highlighted accessibility issues and placed parents as key drivers in actualizing the benefits of mental health services for their children.

Positive pediatric treatment outcomes ultimately rely on parents participating in their child’s care. Children depend on parent/guardians to initiate, access, and maintain treatment with providers and to sustain treatment regimens at home, beyond the reach of any provider.

Rocketing needs for pediatric mental health intervention have energized efforts to promote access and collaborative care in many health care settings through integrated approaches (Asarnow et al., 2015; National Institute of Mental Health, 2019; Safety Net, 2014). However, providers in medical settings sometimes have fluctuating skills in implementing family centered care and experience organizational barriers, such as resource limitations, lack of training, and inconsistent communication, which adversely affects parent/guardian participation. The addition of mental health providers (e.g., professional counselors) to integrated care teams has also contributed to role confusion within the treatment team and complicated integrated care provider responsibilities to engage the parent/guardian or family (Alessi et al., 2022; Giresunlu, 2021).

Integrated behavioral health (IBH) models have demonstrated positive outcomes for integrated medical-behavioral pediatric care including enhanced access and treatment outcomes (Apple et al., 2020; Asarnow et al., 2015; Jackson-Triche et al., 2020). As healthcare systems continue to move towards integration, examination of the impact of this shift on family centered care and parent/guardian engagement has lagged. Furthermore, the expanding application of mental health care within integrated care settings has increased access but has inadvertently altered the role of parents and providers within the integrated team setting. For example, a common care pathway of pediatric IBH systems depends more on medical providers to facilitate access to mental health care than on the help-seeking behaviors of parents (Petts & Shahidullah, 2020). As the process for initiating pediatric mental health care shifts from parents to providers, consideration of the systemic impact on parent/guardian engagement is needed (Becker et al., 2017; Hughes, 2007; Varinder et al., 2022).

Family Centered Care (FCC) is a valued, long-standing approach across pediatric healthcare built upon provider-parent/guardian engagement. Based on a number of professional principles (Bruce & Ritchie, 1997; Coyne et al., 2013), FCC focuses on family strengths and parent/guardian participation in care. Under the umbrella of FCC, parent/guardian engagement (PE) remains critical for effective pediatric mental health services and includes seeking help, supporting the child's attendance of sessions (McKay & Bannon, 2004), engaging with mental health providers during sessions, and implementing interventions within the home setting (Becker et al., 2017; Haine-Schlagel & Walsh, 2015; Pereira & Barros, 2019). Although integrated care systems have reduced the need for parents to initiate services as providers often initiate referrals within the health system, the remaining tasks of parent/guardian participation remain firmly within the hands of the parent. Therefore, as pediatric care settings move towards increasingly integrated care models, it becomes paramount to understand challenges of facilitating FCC, especially as additional provider roles, such as professional counselors, join these integrated care teams. Primarily, within researched medical settings, providers often inconsistently implement FCC (Bruce & Ritchie, 1997; King et al., 2003), highlighting a distinct challenge of FCC in many settings. Inconsistent engagement of parents in their child's care then leads to role confusion for parents and providers (Gopalan et al., 2010; Haine-Schlagel & Walsh, 2015). This theme of role confusion (between the parent and provider) also emerges as a problem in IBH teams among providers as task completion and role responsibilities are shared or realigned (Alessi et al., 2022; Giresunlu, 2021).

Researchers have attended to both FCC and PE in mental health services. FCC researchers have focused predominantly on the experiences of nurses in medical settings, but have not often expanded to assess pediatric IBH care contexts. Similarly, pediatric mental health researchers have focused on PE within an outpatient setting but have not often expanded their studies to examine team-based care delivery models. The modernity of the integrated care structure offers ample opportunity to explore the impact of this systemic shift on previously defined roles, care settings, and engagement of parents/guardians. Changes to the system itself have resulted in changes to the providers' and parents' experiences within it (Harveit et al., 2017; Ofonedu et al, 2017; Petts & Shahidullah, 2020). Therefore, additional research is needed to understand the roles and behaviors of providers in integrated settings towards family centered care and promotion of parent/guardian engagement in order to foster desirable outcomes for providers, patients, and families.

Purpose of the Study

In this study, I will examine how healthcare providers perceive and deliver FCC in various integrated care teams roles across a continuum of pediatric care settings. Specifically, I will focus on pediatric doctors, nurses, social workers, licensed mental health providers, and mental health technicians, who practice at pediatric care settings including the Emergency Department, a general pediatric clinic, specialty clinics, and inpatient hospital units. In addition to these traditional medical providers, I will also expand the examination of the IBH treatment team by including the professional counselors and mental health professionals in these settings.

Research Questions

In this study, I will answer the following research questions to identify patterns within provider groups and pediatric IBH services and to better understand role functioning within integrated care teams at various levels of care.

1. Do specific provider practices identified by MPOC-SP subscales of Showing Interpersonal Sensitivity (*SIS*), Communicating Specific Information about the Child (*CSI*), Providing General information (*PGI*), and Treating People Respectfully (*TPR*) vary significantly across provider types?

2. Which professional roles within IBH teams do providers identify as responsible for facilitating family centered care or parent/guardian engagement in pediatric care?
3. Do specific provider practices identified by MPOC-SP subscales of SIS, CSI, PGI, and TPR vary significantly across provider types or care settings?
4. How do providers in IBH settings explain variations in MPOC-SP scores and subscale profiles by provider type and setting?

Significance of the Study

This study will uniquely contribute to the existing research by exploring the implementation of FCC within pediatric IBH care environments. The reach of the study will allow for the comparison of several different IBH settings, such as emergency services, inpatient care, specialty clinics, and primary care. While previous FCC research has traditionally focused on nursing providers, this research extends consideration to mental health providers as valued members of the integrated treatment team. With this enhanced understanding of provider behaviors and experiences, the results may offer an opportunity to identify provider strengths and challenges to foster family participation that ultimately impacts treatment outcomes for young patients.

A richer understanding of the implementation of FCC within IBH settings may also inform programmatic development and guide training efforts to build family-oriented competencies across pediatric settings and providers. Previous researchers suggested that licensed mental health clinicians (e.g., psychologists, professional counselors) do not receive adequate training in integrated behavioral care (Blount & Miller, 2009; O’Donohue et al., 2009). In this study, I will clarify operation gaps regarding the delivery of FCC to support PE. Thus, results of this study may offer guidance for counselor education, clinical programs, and IBH staff development with training opportunities to promote best practices across care teams, to address barriers to staff promotion of PE, and to ultimately bolster pediatric outcomes. For example, results of the study may identify specific gaps in FCC practice for certain care settings or provider types, which would help guide organizational training resources.

Finally, this study will also facilitate an advanced understanding of FCC attitudes and practices within current pediatric integrated care settings and clarify current role negotiation within IBH teams. Identifying role(s) within the IBH team that more consistently implement various FCC tasks may allow for role clarity and a reallocation of responsibilities within the IBH team to facilitate FCC. Such organization within the IBH team may also reduce duplication of tasks and role confusion for providers. Therefore, current study results may foster both guidance for staff development and organized implementation of FCC within evolving pediatric IBH settings.

Theoretical Perspective

The theoretical framework for this study utilizes a pragmatic approach to understand participant experiences in an effort to achieve Dewey’s (1958) quest for “actionable knowledge” (Evans et al., 2011; Subedi, 2016). Actionable knowledge can be applied to training and program improvements to impact the effectiveness of FCC in integrated care settings. While the use of measures reinforces the characteristic concreteness of pragmatism, it does not deny the complexities of integrated care teams or the systems of care and the cultural contexts in which they operate. In fact, the measurement of subjective attitudes and potentially more objective behaviors echoes the dualism of pragmatism in an effort to understand the interaction between inquiry and experience lending itself to a mixed methods approach (Morgan, 2007; Patton, 1990). Using a mixed methods approach, information gained in the quantitative data collection will be further explored for additional application within a subsequent qualitative phase of inquiry.

In this study, I also adopt a social constructivist paradigm noting the historical social context that facilitated the adoption of FCC within the medical setting (Jolly & Shields, 2009) and the evolving dynamics of integrated care. It has been shown that a provider's training along with personal and professional experiences shape their involvement with pediatric patients and their families (Coyne et al., 2013; Letourneau & Elliot, 1996; King et al., 2003). Furthermore, the role of the parent/guardian in health care settings has responded to changing social contexts, previous experiences with their child, and evolving care systems (Bruce & Ritchie, 1997; Campbell et al., 2020; Jolly & Shields, 2009). The inclusion of a focus group in this study will allow for investigation of participants experiences of family focused care relative to their role and setting. These groups will support explanation of resulting FCC score profiles within provider types and care settings based on individual experiences and shared meaning (Creswell & Creswell, 2018).

Methodology

In this study, I will utilize a sequential explanatory mixed-methods design to identify provider behaviors and attitudes towards parent/guardian engagement when providing mental health care in integrated care settings (Creswell & Plano, 2011). The initial phase will obtain quantitative data through a participant survey that includes certain demographic information and the *Measures of Processes of Care for Service Providers* (MPOC-SP), which measures the extent to which providers are implementing FCC based upon individual provider report. The following phase of data collection will involve a follow-up, participant focus group to discuss and elaborate on preliminary results obtained during the initial phase in order to gain an expanded understanding of provider experiences and practices.

Definition of Terms

Parent or Family: Within this study the definitions of "parent" and "family" are generously applied. "Parent" includes any adult individual who provides primary care for the pediatric patient regardless of biological relationship. This role may be fluid and applied to the parent/guardian present during the course of treatment. Similarly, the definition of "family" was adopted from Coyle et al. (2013) identified as "who the member says it is." This definition allows for patient- and parent-identified family systems.

Patient vs. Client: The term "patient" will be used to reference a child or adolescent receiving care regardless of setting because IBH care settings emerged from the medical context. While this term perpetuates the more traditional medical model with a "problem-focus" connotation, the commonality of this term offers a shared terminology within the integrated care team. For the purposes of this study, the shared meaning supports consistencies in survey and focus group question development, thus lending itself to efficiencies of communication. Ultimately, FCC's focus on family strengths and individuality, parent/guardian collaboration, and overall valuation of the family work to counter associated stigma and maintain a strength-based and culturally competent approach for care and mediation of less supported connotations of "patient."

Family Centered Care (FCC) vs. Parent/guardian Engagement (PE): The purpose of this study serves to connect medical contexts of Family Centered Care and mental health context for Parent/guardian Engagement into an integrated approach for providers serving pediatric patients in IBH care settings. While this study will use an FCC-based measure, it is easily accepted that parent/guardian engagement tenets intersect FCC and share similar connotations within pediatric care settings. Therefore, FCC’s valuation of the parent/guardian as well as efforts to promote family decision-making, identify family strengths, and encourage parent/guardian participation in care are viewed holistically within the context of this study as efforts to promote parent/guardian engagement and participation. However, for consistency, this provider approach will default to FCC in recognition of the medical context in which IBH exists and the emerging role of the counselor within this setting.

In summary, in this chapter, I reviewed the purpose of this study within a context of integrated pediatric care settings that include professional counselors and identified the associated research questions of the study. Then, I discussed the significance of the study to expand the understanding of integrated pediatric care to include counselors and summarized the theoretical framework guiding this study. I also briefly introduce the proposed mixed methods design and limitations of the study. Finally, I clarified terminology relevant to this study.

CHAPTER 2

LITERATURE REVIEW

For pediatric healthcare, parent/guardian involvement is essential. Whether it is through help-seeking behaviors, appointment attendance, treatment planning, or implementation of care at home, beyond the reach of providers, efforts to promote parent involvement within a family centered care system have been associated with numerous benefits for the children involved (Becker et al., 2017; Bruce et al., 2002; Dowell & Ogles, 2010; Haine-Schlagel et al., 2016; King et al., 1999; Letourneau & Elliot, 1996; Lindsey et al., 2014; Piotrowska et al., 2017). In this chapter, I will present the study that attends to two frameworks that seek to promote parent/guardian engagement in pediatric care delivery. The first of these frameworks is Family Centered Care (FCC) that is traditionally used within the medical setting. The second is Parent/guardian Engagement (PE) that has been applied across settings and child and adolescent programing both within and beyond mental health care. The context and relevant research for each framework will be discussed. Finally, I will discuss the relevance of the integrated behavioral health setting and the research gap in applying family-oriented care within evolving care settings and the purpose of this study to understand the implementation of FCC within integrated care teams.

Family Centered Care (FCC)

Parent involvement is associated with improved health outcomes and treatment progress for pediatric patients (Bruce et al., 2002; Feeg et al., 2016; King et al., 1999; Letourneau & Elliot, 1996; Smyth et al., 2019). In addition, parent/guardians receive additional education and skill development and report decreased stress when engaged with FCC (Bruce et al., 2002; King et al., 1999; Piotrowska et al., 2017). Despite the significance of these outcomes, FCC was piecemeal in its creation and erratic, at best, in its implementation across pediatric healthcare settings (Jolley & Shields, 2009). To offer more context, I will review the social and historical context as well as research themes associated with FCC. I will also discuss measures used to evaluate FCC with certain provider types.

History of FCC

Prior to World War II, medical care was highly paternalistic and parents, seen as a hinderance to care, were often not allowed into the hospitals caring for their children, regardless of their children's length of admission (Jolley & Shields, 2009). In response to concerns of children being separated from their parents during World War II, evolving social perceptions of pediatric care and intensifying advocacy from parents as well as professional organizations, pediatric health professionals began to adopt the tenants of Family Centered Care (FCC; Jolley & Shields, 2009). According to Shields et al. (2006), FCC became "a way of caring for children and their families within health services which ensures that care is planned around the whole family, not just the individual child/person, and in which all the family members are recognized as care recipients" (p. 1318).

The Association for Care of Children's Health (ACCH) emerged in 1965 to support implementation of FCC in hospital settings and establish eight standard practices for FCC, though their membership did not include parents until 1978 due to board member concerns of maintaining professional authority. ACCH was influential in many improvements in pediatric care until it quietly disbanded prior to 1990, though the exact year is unknown. Following the rise of ACCH, similar organizations appeared across the globe specifically in Europe and Australia resulting in similar impacts on pediatric healthcare (Jolley & Shields, 2009).

One of the founders of ACCH, Johnson, established the Institute for Patient and Family-Centered Care (IPFCC) in 1992 (Jolley & Shields, 2009). To date, in addition to identifying best practices, the IPFCC continues to support major health initiatives in the United States as well as provide resources and educational materials for provider and organizational use (Institute for Patient and Family-Centered Care, 2022). According to the Institute for Patient- and Family-Centered Care (2011), FCC standards echoed those of ACCH: (1) recognizing the family is a constant in the child's life, (2) facilitating parent and professional collaboration, (3) recognizing family strengths and individuality, (4) sharing unbiased and complete information with parents, (5) encouraging parent-to-parent support, (6) understanding incorporating developmental needs of children and families, (7) implementing appropriate policies and programs that are comprehensive, and (8) assuring that the design of the healthcare delivery system is flexible, accessible, and responsive to family needs. More recently, the IPFCC reduced the eight tenants of FCC to four core concepts include maintaining respect and dignity of patients and families, sharing information with patients and families, and allowing them to participate in treatment planning and decision making, and ongoing collaboration (Johnson & Abraham, 2012). The study of FCC continues to drive best practices in medical settings and has been widely accepted across providers as a standard of care as well as a driver for organizational quality improvement efforts.

Research on FCC

Studies of FCC have utilized a mix of both quantitative and qualitative approaches. Across the quantitative studies, researchers traditionally developed measures with nursing participant samples in developmental pediatric and early intervention programs (Alfaro et al., 2019; Hughes, 2007) and sought to identify barriers to consistent FCC implementation (King et al., 1996; U.S. Department of Health and Human Services, 2008).

Additionally, researchers have also explored the dynamics impacting FCC implementation through qualitative frameworks including observations, semi-structured interviews, and focus groups. Although Shields et al. (2006) identified a limited inventory of quality qualitative FCC research, increases in methodological rigor have improved qualitative research offering value towards application beyond the studies themselves (Garrity, et al, 2019). Qualitative FCC studies tend to pursue parent/guardian experiences (Watt et al., 2013), provider perspectives (Trajkovski, et al., 2012), and more recently both (Vetcho et al., 2021). Most often these studies were designed within a nursing context, capturing primarily the complexities of the nurse role in hospital care settings (Grant et al., 2019; Harrison, 2010; Shields et al., 2007), neglecting other involved professionals, such as professional counselors.

Under the charge of FCC, pediatric research tended to focus on provider implementation and experience of FCC in hospital and rehabilitation settings caring for children with complex needs (Bruce et al, 2002; Letourneau & Elliot, 1996; King et al, 1999; Shields et al, 2014; Williams et al, 2021; Woodside, 2001), highlighting variations in perception and implementation of FCC between provider groups. Bailey et al. (1991) reported that nurses had increased FCC type behaviors than physicians, as they also found social workers rating their skills higher than direct care, therapy-oriented providers, such as occupational and speech therapists.

Other studies have found little variation between provider groups noting variation in FCC by practice site instead (Bruce et al 2002; Feeg et al, 2016) and suggesting the contribution of systemic and organizational factors may contribute to effective implementation of FCC; such as staff training and understanding of FCC, scheduling for allowing PE, other demands on staff, and opportunities within treatment for families participation (Mackie et al., 2021; Mirlashari et al., 2020). Research considerations for organizational and cultural factors within international medical settings have led to a richer understanding of cultural components of FCC along with variation in factors that impact its implementation (Alabdulaziz et al., 2017; Coyne et al., 2013; Foster et al., 2010). For example, family's cultural context in Saudi Arabia discouraged effective FCC practices when families were not comfortable engaging with providers or experience inadequate understanding of treatment, thus limiting communication and decisions making opportunities (Alabdulaziz et al., 2017).

Research efforts, most often facilitated within the nursing role, have sought clarity regarding the barriers towards comprehensive and consistent implementation of FCC. Researchers noted inequities within provider motivations to engage with parents and children (Shields; 2014; Smyth et al., 2019). Providers consistently highlighted a decreased motivation to engage with parents when compared with their pediatric patients. This finding suggested that internal provider factors resulted in inconsistencies in the delivery of FCC in pediatric settings due to an aversion to engaging parents.

Studies within the nursing field have acknowledged role conflict and role confusion that can occur when the parent/guardian is invited into the treatment team (Bruce & Ritchie, 1997; Hughes, 2007). Often parent/guardians were unaware of the expectations surrounding their participation (Coyne & Cowley, 2007), resulting in experienced role confusion between parents and providers (Hughes, 2007). Providers may also perceive parent/guardian involvement as a threat to their authority or control over treatment (Brown & Ritchie, 1990), further limiting effective engagement, communication, and application of FCC tasks (Coyne et al., 2013; King et al., 2013).

As treatment teams diversified, additional roles beyond nursing were included in FCC and focused research on nutritionists, pharmacists, physiotherapists, occupational therapists, social workers, and child life specialists (Bruce et al, 2002) as well as applied behavioral analysists (Williams et al., 2021). The research of these professionals' involvement added further complexities to role negotiation both among providers as well as with family members. FCC research on role negotiation recognized the importance of communicating expectations when providers collaborated with family members to help limit role confusion and conflict (Foster et al., 2010; King et al., 2013; Coyne & Cowley, 2007).

Also, the design of the health system continues to emerge as the predominant barrier for providers seeking to implement FCC (Alabdulaziz et al., 2017; Bruce et al., 2002; Coyne et al., 2013; Mirlashari et al., 2020; Shields et al., 2014). Research findings reported organizational factors such as scheduling, reimbursement, and staff orientation and training approaches, that inadvertently create barriers for consistent FCC implementation. Additional organizational issues regarding the lack of prioritization of FCC and limited time to participate on FCC behaviors have also emerged (Bruce & Ritchie, 1997; Smyth et al., 2019).

Within this shared medical context, researchers continued to conclude that variation between FCC practice and ideals exists. Provider understanding of FCC and its benefits typically trump their reported actual performance of FCC behaviors (Coyne et al., 2013; Foster et al., 2010; Harrison, 2010; Letourneau & Elliot, 1996). The role of the provider such as a nurse, physician, or social worker influenced their valuation and implementation of FCC (Bailey, 1991; Woodside et al., 2001).

In addition, provider factors that appeared to bolster implementation of FCC included professional experience, position, and education, indicating mediating factors may impact implementation (Coyne et al., 2013; Letourneau & Elliot, 1996). Providers' individual experiences, such as years of practice or personal parenting experiences or specific pediatric training, were associated with increased FCC implementation (Feeg et al., 2016). Finally, the frequency of both provider and parent observation of FCC behaviors tended to correlate with a provider's sense of self-efficacy in delivering FCC (King et al, 2003). Not only do these findings reinforce the need for effective training and continuing education (Bruce et al., 2002), but also further the growing understanding that internal provider factors including their perceptions significantly influence delivery of FCC (Foster et al., 2016; Harrison, 2010).

Today, FCC has become the prevailing philosophy in pediatric medical care settings (Jolley & Shields, 2009) and a 'gold standard' within pediatric care (Abraham & Moretz, 2012). Quantitative efforts to evaluate the implementation of FCC have produced a variety of tools often with limited scope of application. Meanwhile, qualitative efforts have provided insights into the internal and external dynamics that impact family participation in specific pediatric care settings. FCC studies that utilize a mixed-method design to integrate the benefits of quantitative and qualitative approaches are often limited to a single medical care setting (Foster et al., 2016). Shield et al.'s (2010) empirical call for high-quality FCC research that includes more diversity of participants and care settings highlights this expanding gap in the literature.

The consideration of FCC in IBH settings answers this call and includes a variety of provider types and pediatric care settings while recognizing the impact of evolving care delivery models, care team structures, and organizational factors. Furthermore, the inclusion of IBH settings forces an integration of FCC and PE research that continues to offer a diversity of research towards a shared goal of parent/guardian participation and effective pediatric outcomes.

Parent/Guardian Engagement in Pediatric Mental Health

Within a context of FCC, parent/guardian engagement echoes the inclusion of parents in their child's care. Observable parent/guardian engagement behaviors (i.e., attendance, question asking) can be linked as outcomes of FCC approaches and parent/guardian engagement practices. In pediatric outpatient mental health settings, parent/guardian engagement (PE) has been a key term in studying and assessing FCC and the shared benefits of treatment compliance and clinical outcomes with pediatric clients. For pediatric services, parent/guardians play an essential role in accessing and maintaining care. In fact, collective reviews of PE research recognize the impact of PE on treatment fidelity and provider efficacy further echoing the benefits of FCC (Dowell 2010; Lindsey et al., 2014; Becker et al., 2017; Haine-Schlagel et al., 2016; Morrissey-Kane & Prinz,1999). Dowell and Ogles (2010), for example, noted significantly greater positive effect sizes (58% increase) for treatments that utilized parent/guardian participation.

Ultimately, PE is key for a child to participate in and benefit from services. For families who are able to access pediatric mental health services, about half of them terminate services prematurely, often after only a few sessions (Gopalan, et al., 2010; Nock & Ferriter, 2005; McKay & Bannon, 2004). This brief and limited engagement with mental health providers restricts providers' ability to implement evidence-based treatments (McKay & Bannon, 2004). Despite the growing volume of research identifying the effectiveness of evidence-based programs for improving pediatric mental health outcomes, attendance continues to be a basic and critical step to access and actualize treatment benefits. In this section, I will discuss the evolving definition of PE and associated research.

Defining Parent/Guardian Engagement

The concept of PE incorporates a range of definitions that recognize multiple internal and external factors as well as interactive dynamics. While McKay and Bannon (2004) recognize PE initiating with parental help seeking behaviors, such as requesting a referral or scheduling an appointment, the authors also advocate for an expanded definition of PE to incorporate a rage of PE behaviors such as participating in decision making and treatment. Further differentiation of PE into attitudinal and behavioral elements supports the recognition of interactive factors of PE along a continuum (Staudt, 2007), and offers insights into more opportunities for intervention. As the concept of PE continues to evolve and recognize parental engagement beyond initial help-seeking behaviors, opportunities for interventions to improve PE also expands to include engagement at various stages of treatment in an effort to attain the anticipated benefits of PE and treatment adherence (Becker et al., 2017; Haine-Schlagel & Walsh, 2015; Pereira & Barros, 2019). Considerations for parental engagement have expanded beyond initial help-seeking behaviors and appointment attendance to include participation in treatment, implementation of interventions in the home (Nock & Ferriter, 2005; Staudt, 2007).

The evolution of how PE is defined indicates that PE is dynamic and, therefore, changeable. Efforts to impact PE have traditionally focused on understanding both internal and external parent factors or dynamics that influence PE (Pereira & Barros, 2019; Haine-Schlagel & Walsh, 2015; Gopalan et al., 2010; Jensen, Alyward, & Ric, 2012), rather than a focus on provider behaviors or dynamics.

PE Research

Researchers continued to expand their conceptualization of PE and exploration of factors that influence it. Studies tended to focus on the delivery of programs that promote PE and its associated outcomes as well as barriers to delivery or promoted benefits. As a result, models of PE have emerged and offered a broader understanding of PE dynamics within a shared framework.

PE research has been evaluated within diagnostic specific treatments. Promoting parent/guardian participation has been associated with benefits for individuals with severe mental illness (Giacco et al, 2017; Miklowitz & Chung, 2016), including reduced frequency of hospitalizations and relapse (Norman et al., 2005; Schofield et al, 2001). Also, the improved benefits of PE have been associated with treatments for mental health diagnoses experienced by broader pediatric populations such as anxiety (Gingburg et al., 1995, 2005; Pishva, 2017) and behavior dysregulation (Gopalan et al., 2010; Miller a & Printz, 2003). Results from these studies continue to promote efforts to enhance parent motivation as it plays an important role in treatment utilization (Miller a & Printz, 2003) and outcomes such as symptom reduction, skill development, and improved functioning of pediatric participant (Dowell & Ogles, 2010). Furthermore, Shields et al. (2020) suggests that parent motivation and engagement has the potential to overcome internalized barriers within the child or adolescent participant including stress and presenting symptom severity.

While FCC is linked with specific provider tasks, PE focused research seems to struggle to clearly define measurable elements of PE (Becker et al., 2017; Pereria & Barros, 2019). PE-oriented measures often attend to internal and external parental factors assuming standardization of provider attitudes and motivations to promote family participation (Bloomquist et al., 2011; Haine-Schlagel et al., 2016; Kazdin et al., 1997; Nock & Photos, 2006; Nock et al., 2007). Meanwhile, attendance remains the one simple element of parent/guardian engagement that is easily measured across programs and settings (Becker et al., 2017; Haine-Schlagel & Walsh, 2015; Ingoldsby, 2010) and yet remains fundamental in pediatric outcomes (Piotrowska et al., 2017; Ofonedu, 2017).

Working with identified PE contributors, researchers have investigated specific elements of PE that impact pediatric outcomes. For example, communication efforts such as psychoeducation have been shown to improve PE, helping parents understand what services typically entail (Haine-Schlagel & Walsh, 2015). Here, psychoeducation echoes the FCC tenant of sharing information with the parent(s) including both general information regarding care and specific information about the child. Communication with the parent/guardian also allows them to participate in treatment and decision making. Information shared with parents/guardians also supports understanding of the services themselves and offers role clarity to parent/guardians. As parents continue to express a limited understanding of mental health services (Bone et al., 2015), researchers echo the call for clarity to assist parents in knowing what to expect from care (King et al., 2014) and how to engage in it (Hughes, 2007). For mental health services, parent understanding of pediatric services become a critical component of therapeutic efficacy that should be addressed early in the engagement process (Phoenix, Smart, & King, 2020; Ofonedu et al., 2017).

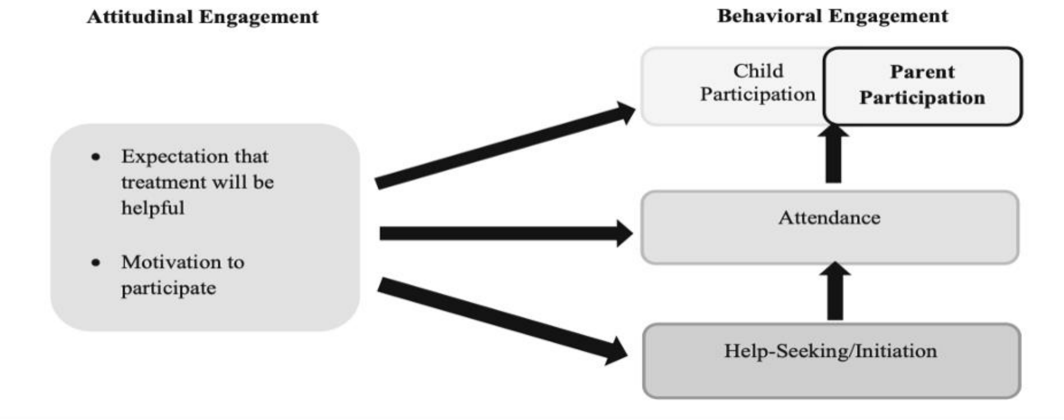
Research has also included exploration of barriers of PE including family factors such as economic resources (Williams et al., 2017), language and cultural background (DeCamp et al., 2016; So et al., 2020), and parent expectations of therapy (Haine-Schlagel et al., 2016; Ingoldsby, 2010; Morrissey-Kane & Prinz, 1999). In addition, according to Pereria and Barros (2019), parent expectations of providers contribute significantly to PE. Navigation of these interpersonal dynamics are also captured in FCC’s call to show interpersonal sensitivity (*SIS*) when working with parent/guardians.

Finally, respect for parent/guardians is evidenced in the recognition of parent/guardian strengths and individuality and is reiterated in both PE and FCC tenants (Johnson & Abraham, 2012; McKay & Bannon, 2004). The focus on treating people respectfully (TPR) includes provider recognition and validation of parent strengths that has been associated with increased engagement and positive outcomes in a variety of care settings (Kemp et al., 2014; Woods-Jaeger, et al., 2020). Likewise, provider validation of parent cultural values are associated with similar benefits (So et al., 2020).

Interval research efforts offered to review, evaluate, and aggregate various elements of PE research through meta-analysis (Gopalan et al., 2010; Hanna & Rodger, 2002; Haine-Schlagel & Walsh, 2015; McKay & Bannon, 2004; King et al., 2014), offer models that guide our understanding of PE. For example, in 2015, Haine-Schlagel and Walsh published a simple model (Figure 1) linking internal parent/guardian attitudes to measurable observational engagement. This model has offered clarity and consistencies around PE definition, contributing factors, and measurable outcomes. Aggregated reviews of PE research have identified common strategies of assessment, accessibility, service promotion, psychoeducation, and modeling to impact parent/guardian engagement (Becker et al., 2017; Lindsey et al., 2014). In addition, these meta-analyses have provided support for PE's impact on treatment outcomes (Dowell & Ogles, 2010), calls for ongoing provider education (King et al., 2014; Maybery et al., 2021), and future research needs. In fact, the foundation of PE research offers future opportunities to explore provider roles in promoting parent/guardian engagement within emerging and complex care systems.

Figure 1

Model of Engagement in Child and Family Mental Health Services



Note. Obtained from Haine-Schlagel & Walsh, 2015.

Studies have also sought evaluation of PE strategies to train providers and operationalize PE efforts through structured models and stepped protocols with a focus on achieving treatment outcomes associated with parent/guardian engagement. (Gopalan et al., 2010; Haine-Schlagel et al., 2020; Lin et al., 2018; Woods-Jaeger, et al., 2020). King et al. (2014) provided a motivational framework based on therapist interpersonal efficacy and directed communication to clarify parental expectations for the therapy process. These studies identified provider behaviors and attitudes that impact the implementation of PE. Moreover, Piotrowska et al.’s (2017) model considered interdependent elements of engagement and systemic context, giving weight to the care environment’s ability to impact PE.

Traditionally, PE research has sought to serve counselors and outpatient-based mental health professionals through a rich understanding of the benefits and barriers of engaging parents in treatment. This research has informed practices for engaging families and identified provider factors that could be incorporated in education and training initiatives. When adopted by other provider types and programs, considerations for PE have extended beyond the counseling office to include other occupational and physical therapists, nutritionists, and parenting programs across a range of settings (Hanna & Rodger, 2002; Lin et al., 2018; So, et al., 2020; Piotrowska, et al., 2017; Phoenix et al., 2020; Williams et al., 2017), including clinic and internet-based care (Ingersoll & Berger, 2015).

More recently, PE research began to spotlight various mental health settings including primary, emergency, and acute care programs. Porras-Javier et al. (2018) found difficulties associated with psychoeducation among primary care physicians when attempting to engage parent/guardians in pre-treatment stages of care. In contrast, service reliability and psychoeducation delivered in emergency care settings positively contributed to PE and desirable outcomes for families (Campbell et al., 2020). Acute inpatient care settings, however, were linked to significant barriers to PE. Caregivers report being excluded from decision making and patient-related information while their child is in care (Bee et al., 2015; Giacco et al., 2017), including limitations surrounding treatment planning due to confidentiality issues and experienced power imbalances (Cree et al., 2015).

Overall, PE research has focused on pediatric mental health care often delivered by a single provider or within segregated program or setting. While these studies have contributed to a shared understanding of factors that impact access and sustained engagement in services, PE research has not stretched beyond the provider-parent dyad to develop parent/guardian engagement models that consider integrated systems of care or incorporate additional provider types within emerging treatment teams.

In review, PE continues to be a critical element of pediatric care outcomes across programs and care settings as well as provider types. Like FCC, PE specific research has not yet extended to integrated care settings or discussed application across a variety of provider types.

Measures of PE remain limited often focused on the parent factors or behaviors such as attendance. Therefore, this study will seek to explore provider application of FCC behaviors and efforts to promote PE within their respective integrated teams and care settings.

Integrated Care

Recognizing the intersections and interplay of both of these parent-oriented care frameworks across provider types and care settings, in this study, I seek to incorporate practical elements from previous research, to expand provider types to include mental health professionals (i.e., professional counselors in this study) in integrated behavioral health (IBH) care settings, and to consider treatment team delivery of FCC across settings. As health care systems continue to change, the role of the provider's delivery of FCC must also evolve (Coyne et al., 2013). Expanding the cast of providers to include professional counselors creates an opportunity to revise provider roles in the delivery of family-oriented care and the facilitation of PE. As counselors step into more traditional medical settings with a tool box of culturally competent practices, experience with family systems, and PE techniques, they are well positioned to reinforce FCC practices. However, the addition of this team member forces a shift within the team itself which could confuse the actual delivery of FCC.

Professional counselors are a more recent addition to IBH teams; facilitating assessment, collaborative treatment planning, and timely intervention within a shared setting (Aitken & Curtis, 2004; Blount, 2003; Hudson-Allez, 2000). IBH settings offer efficiencies of treatment and care coordination as providers are often co-located reducing transportation barriers for families and communication barriers for providers (Njoroge et al., 2016; Williams et al., 2006). For pediatric care, embedded mental health providers have been linked with improved treatment outcomes for both psychological and physiological-based presenting concerns (Asarnow, et al., 2005, 2014, 2015; Balasubramanian et al., 2017; Ray-Sannerud et al., 2012). In fact, integrated care has been associated with a 66% increase in positive treatment outcomes for young patients and their families (Rosenbaum et al., 2015). This holistic approach to care has supported de-stigmatization of mental health issues and reduced internalized barriers to access for many families (Insgoldsby, 2010; Miller & Prinz, 2003; Nock & Kazdin, 2001). Furthermore, integrated care systems have been shown to address health care inequities and are helpful for low income and minority populations (Bridges et al., 2014; Jackson-Triche et al., 2020), though inconsistencies in these outcomes have also been identified (DeCamp et al., 2019). For these reasons, IBH teams have continued to expand across inpatient and outpatient treatment settings and outcomes continue to be monitored.

The anticipated benefits of IBH are not without challenges. Provider teams have identified communication issues among providers (Porras-Javier et al., 2018) and role confusion within evolving teams (Alessi et al., 2022; Giresunlu, 2021). Without additional clarity, parents readily experience role confusion within IBH team which ultimately impacts parents' engagement in care (Hughes, 2007). For example, pediatricians have traditionally been responsible for patient referrals, often at the bequest of a parent/guardian. However, automations within the healthcare systems allow for other provider types, such as professional counselors, to refer a child for additional evaluations or services, resulting in a blending of the "referring provider" role. Furthermore, parents are not solely responsible for requesting referrals, as a provider may generate a referral based on the recommendation of another member of the treatment team (Petts & Shahidullah, 2020). In this way, the integrated system may produce a referral for a child that the parent knows nothing about or experiences very little motivation to attend. Williams et al. (2017) found that parents who initiated referrals for their children tended to have a higher level of engagement in those services. Thus, this systematic shift becomes consequential for the parent and provider roles and young patient outcomes (Harveit et al., 2017) as approximately 36% of families referred for pediatric mental health services never attend their first appointment (Ofonedu et al, 2017).

As parents continue to define their role within their child's provider team and likely have it defined for them by the complexities of IBH system itself, providers must do the same. Provider types and care settings must re-evaluate and clarify roles and tasks necessary for FCC and promote PE and FFP to benefit the children and adolescents they serve. In this study, I aspire to conduct a reassessment of provider implementation of FCC within evolving pediatric IBH settings and responds to a call for organizational-level research that reaches beyond individual care practitioners to include integrated health care systems (Phoenix, Smart, & King, 2020; Haine-Schlagel et al., 2016; Harveit, et al., 2017; Flemming et al., 2015).

Echoing the prioritized concerns of FCC, the organizational system for delivery of pediatric health care is often a barrier towards consistent and effective delivery of care that promotes PE. As systems of care move towards integrated care models aimed at promoting collaboration and achieving promised benefits in treatment outcomes for children and adolescents, opportunities emerge to revise traditional structures in order to renegotiate delivery of FCC and augment PE. This study will assess FCC and PE implementation within pediatric IBH teams that include mental health professionals and explain reported and experienced differences in provision of general and child-specific information to parents, communicated respect and valuation of parents, and sensitivity to interpersonal dynamics.

In this literature review I discussed two overlapping frameworks that promote an understanding and evaluation of family-oriented care in variety of contexts and with a variety of provider types. FCC's acceptance in the medical setting offers guidance for provider behaviors and care standards accepted by those in integrated care settings. Meanwhile, PE offers consideration for the promotion of parent/guardian participation in pediatric care and considers a range of settings and programs for application. I also included discussion of prior research and approaches to evaluate FCC and PE. Lastly, I introduced the IBH setting as an emerging care context that seeks to navigate the nuances of FCC and PE practices among its diverse treatment team.

CHAPTER 3

METHODOLOGY

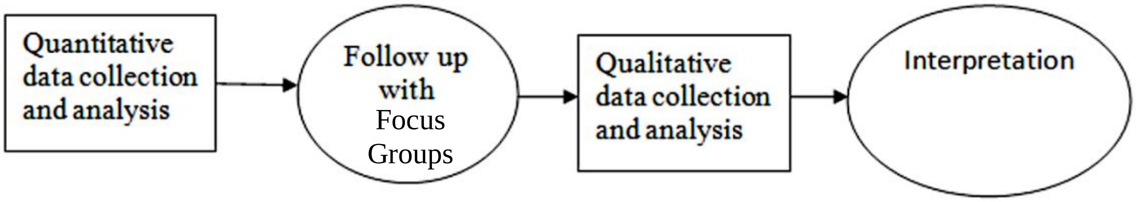
In this chapter, to address the identified research questions, I used a two-phased explanatory mixed-methods research design. First, I discuss the initial phase of the study including participants, data collection instruments, and procedures as well as quantitative data analysis. Next, I describe the qualitative procedures of the second phase of the study, including the participants and procedures for the focus groups and following data analysis. Within each phase of the study, I discuss ethical considerations and explore limitations to validity and trustworthiness as well as highlight efforts to address limitations within the study design. Finally, I review the procedures for data integration and analysis to summarize the results of the study.

Research Design

The purpose of the current study was to identify patterns of family centered care (FCC) behaviors across provider types and integrated behavior health (IBH) care settings. Prior research involving FCC and parent/guardian engagement (PE) has reiterated the complexities of dynamics impacting parent and family engagement in pediatric care. Mixed methods approaches have evolved since the 1980s, offering opportunities for understanding complex phenomena using both qualitative and quantitative models (Creswell & Creswell, 2018) to explore a multi-perspective reality (Subedi, 2016). Therefore, in this study, the use of an explanatory mixed-methods approach provided with aggregation of data collection and statistical analysis as well as an enriched understanding of specific provider experiences. Specifically, quantitative results informed qualitative data collection using a focus group format. Figure 2 provides a visual map for the sequencing of data collection and analysis within this mixed methods study design.

Figure 2

Explanatory Mixed-Methods Design



Note. Steps of research in explanatory mixed methods design (Subedi, 2016, p.573)

Within a pragmatic framework, in this mixed methods study, I explored the complexities and interactions of provider engagement in FCC and PE within IBH settings through two sequential phases of data collection. Aligning with the explanatory format, the initial phase focused on quantitative data collection and analysis. Driven by the descriptive nature of the research questions and considerations regarding the relationship between provider and treatment setting variables, the initial phase incorporated a survey design (Creswell & Creswell, 2018; Subedi, 2016). Involving cross-sectional data collection with a wide reach across the identified health system to include a variety of provider types and IBH settings, the survey (Appendix C) gathered professional demographic information and an established FCC measure, the MPOC-SP (Woodside et al., 2001).

The29econdd phase involved qualitative data collection and analysis using transcription coding from two focus groups. A multidisciplined provider focus group (representing phase one participants) responded to a presentation of the survey results and offered additional insights through shared provider experiences with FCC. The focus group data facilitated a deeper understanding of the empirical findings obtained from phase one.

This explanatory mixed methods design provided the benefits of quantitative survey design and qualitative focus group while countering the limitations of each (Subedi, 2016). For instance, the quantitative approach allowed for a larger sample size and statistical analysis of demographics and score distributions across a range of provider types and settings. Meanwhile, the qualitative focus groups allowed for data collection of provider experience with PE and FCC by means of obtaining responses to the survey results and explanations for impacting variables within IBH teams.

As this study is a dissertation project, I received approval from Old Dominion University's Institutional Review Board (Appendix F, Determination of Exempt Status) and shared agreement from the Children's Hospital of The King's Daughters (Appendix E, Letter of Research Support). Informed consent for participation in the survey was included with the survey (Appendix B) and obtained verbally in the focus group.

Phase One

Participant criteria included providers working in Integrated Behavioral Health (IBH) care settings that offer medical and mental health care services. This study was completed within a regional pediatric healthcare system located in the Mid-Atlantic region of the United States, which currently offers a range of medical and mental health services to children and adolescents in integrated care settings.

Participants

Survey participants included physicians (*n*=10; both pediatricians and psychiatrists), nurses (*n*=35), psychologists (*n*=2), licensed mental health providers (20 LPCs and LCSWs), social workers (*n*=13), medical/mental health technicians (*n*=17), and 17 other professionals that worked with patients and families. Social workers were typically professionals with master's degrees and a focus on social work tasks, while LCSWs and LPCs had additional experiences post-masters and were licensed to provide mental health type services. Represented care settings included a primary care clinic (*n*=4), hospital-based specialty clinics (*n*=26), Emergency Department (*n*=21), and inpatient hospital units (*n*=63).

The sample of the first phase consisted of 14 self-identified males and 100 self-identified females who ranged in age from 21 to 64 years (*M* = 37.1, *SD* =8.3). Participants' years of experience in pediatric care settings spanned four months to 44 years (*M* = 8.7, *SD* =10.3). Race and ethnicity were only reported by a few participants. Regarding level of education, a variable considered in previous FCC research (Letourneau & Elliott, 1996; Bruce & Ritchie, 1997; Foster, et al., 2010; Harrison, et al., 2010), 18.1% of participants had a doctoral degree, 45.0% had a master's degree, 32.4% held a bachelor's degree, and 4.5% reported a high school degree.

Data Collection Instruments

The survey involved questions on demographic and professional information from each participant, prompts identifying assigned FCC responsibilities and the Measure of Processes of Care for Service Providers (MPOC-SP).

Demographic Information Form. The demographics included participant gender, race or ethnicity, highest level of education, professional role, and years of professional experience based on prior research noting the impact of this variable. Participants verified care setting and confirmed IBH and FCC approaches within that setting. In addition, participants were asked to specify the assignment of FCC practices to roles within their care setting. This final question allowed participants to identify which provider types they viewed as responsible for promoting parent/guardian participation in care.

Measure of Process of Care for Service Providers (MPOC-SP; Woodside et al., 2001). The evaluation of provider implementation of FCC through specific behaviors was measured using the MPOC-SP. Woodside et al. (2001) adapted the MPOC-SP from the *Measure of Process of Care* (MPOC), a well-established measure for parents, positively correlated FCC with parent satisfaction and negatively correlated with parent stress (Cunningham & Rosenbaum, 2014; King et al., 1996) and included in settings outside of medical care and traditional nursing providers (Alfaro Diaz et al., 2019; Dyke et al., 2006; Family Voices, 2008; Williams et al., 2021). Prior research and empirical findings supported the content validity of the MPOC regarding parents' expectations for their child's providers and offered sound internal consistency, test-retest reliability, and construct validity (Cunningham & Rosenbaum, 2014; King et al., 1996; Pickering & Busse, 2010; Woodside et al., 2001).

Woodside et al. (2001) designed the MPOC-SP to evaluate pediatric providers' perceptions and reported implementation of family-centered behaviors in treatment settings. The MPOC-SP maintains the empirical validity and theoretical constructs of its parent measure and offers professionals an opportunity to evaluate their implemented FCC practice as opposed to attitudes and beliefs captured by other measures (Cunningham & Rosenbaum, 2014). Exploratory factor analysis indicated four respective subscales accounted for 58% of the variance with factor loadings ranging from 0.50 to 0.86 (Bamm et al, 2015). In addition, utilization of the MPOC-SP noted differences in reported scores between provider roles indicating an ability to identify variance between provider groups (Bamm et al., 2015; Woodside et al., 2001). In this way, the MPOC-SP offers satisfactory construct validity for interpretation and analysis of family-centered practices within the identified population of pediatric providers (Humbley & Zumbo, 1996; Pickering & Busse, 2010; Siebes et al., 2008).

The 27-item measure includes four subscales: Showing Interpersonal Sensitivity (*SIS*), Providing General Information (*PGI*), Communicating Specific Information about the Child (*CSI*), and Treating People Respectfully (*TPR*). Each item is scored on a 7-point Likert scale (1 = not at all and 7 = a very great extent), and the total score is the average of each individual score (King, 2003). The SIS subscale accounts for interpersonal behaviors such providing positive feedback, establishing rapport, discussing expectations, sharing options, and helping the parent to feel competent. The PGI subscale looks at family to family connections and offering of resources to the entire family. The CSI subscale considers the specific communication including testing results, written information, and details about services. Finally, the TPR scale assesses the provider's approach to parents as perceived experts of their child and an individual and equal member of the treatment team.

Woodside et al. (2001) reported internal consistency scores for each subscale in the MPOC-SP ranging from .76 to .88. Reliability of the MPOC-SP's test-retest scores revealed correlations of .81, .99, .79, and .97 for each subscale, indicating good consistency of individual scores over time. Significant social desirability bias was ruled out in validation testing and differences between factors and provider groups also displayed statistically significant results, further supporting the structural validity (p < .001) of this tool for program evaluation and research efforts.

Data Collection Procedures

With the criteria of a medium effect size (.5) and probabilities of Type I errors set at .1 and power at .8, a desired sample size of 120 was determined using power analysis through *G*Power* software (Fowler, 2014; Kang, 2021). Following IRB approval, information regarding the study was sent to leadership within the identified care settings for general awareness and to solicit support from staff.

Surveys including the demographic information form and MPOC-SP were sent to over 550 individuals within the pediatric health systems using a cross-sectional, convenient sampling procedure to directly engage all eligible participants (Creswell & Creswell, 2018; Dillman, 2007). The electronic survey format offered economical and effective distribution of the survey across the pediatric healthcare systems (Berry, 2005; Fogli & Herkenhoff, 2017; Sue & Ritter, 2012; Vogt, 2007). This electronic survey targeted desired departments to capture pediatric providers who are assigned to integrated care settings with little disruption within the respective care settings (Creswell & Creswell, 2018) as providers were able to complete the survey outside of their clinical practice. In order to achieve the desired sample size for grouped analysis, an additional stratified sampling approach was used through targeted emails to promote sufficient representation of provider roles and identified IBH care settings to support analysis. Participants received a cover letter describing the study (Appendix A) with a link to the online survey, which included the informed consent (Appendix B), demographic information questions, and the MPOC-SP measure (Appendix C).

Emailed survey distribution to targeted care settings yielded 141 responses, representing 27.5% response rate. Incomplete surveys (missing more than 5%) were removed from the sample (Field, 2013), yielding 102 complete online surveys. Physical distribution of paper surveys yielded another 12 completed surveys. In total, a sample of 114 care providers within pediatric IBH settings completed all elements of the survey.

Survey results were recorded in *RED*Cap (https://www.project-redcap.org), a data collection platform familiar to the health system, through electronic submission. Participant data was stored on a secured server and participants were assigned identification numbers. Paper surveys were manually entered and verified on the same platform. In addition, variables associated with the MPOC-SP measure were coded to identify the appropriate subscales. Subscales were scored using the average of the subscale scores for each participant. Reported results utilized grouped data sets with restricted demographic information to limit risk of identifying individual participants.

Quantitative Data Analysis

Data from the survey was analyzed prior to the second phase of data collection to allow for initial findings to be included and clarified within the subsequent qualitative phase. This allowed for patterns within provider roles or care settings to be discussed within the focus group. Originally, statistical analysis using MANOVA was proposed, but due to the highly correlated subscales of the MPOC-SP (multicollinearity), this technique was not viable (Field, 2013). Upon further data analysis, normal distribution standards were limited due to the size of each categorical group. The assumption of error variance using Levene’s test was upheld with the CSI and TPR subscales, but were found to be equal for the SIS and PGI subscales. In fact, group differences were potentially difficult to detect due to small sample sizes and larger confidence intervals. Nonetheless, the overall sample size exceeding 100 participants supported the central limit theorem and allowed for robust analysis using two-way Analysis of Variance (ANOVA; Field, 2013). Therefore, after assessing for data adequacy, the two-way ANOVA technique was identified for the purposes of this study. At this step, quantitative data analysis included descriptive statistics and two separate ANOVAs between care settings and provider groups. Survey response rate was noted using *REDCap* and evaluated by respondent groupings.

SPSS Statistics version 29.0 was used for descriptive statistics, ANOVAs, and post hoc analysis. Descriptive statistics served to identify characteristics of the sample and included frequency distribution of scores as well as measures of central tendency. Descriptive statistics also included frequency analysis to address the second research question. Assigned role responsibility was recorded by participant's identified role and distribution of responsibility was assigned using percentages of total responses by that provider type.

Scores for each subscale were grouped by professional role types and then by care setting. Averaged scores and standard deviations were identified by each professional role type (i.e., physician, nurse, psychologist, LPC/LCSW, social worker, and technician/other). Variances of the MPOC-SP subscales were analyzed using Levene's Test to assess homogeneity of variances and two-way ANOVA to assess the significance of the variance between professional role groups (Fogli & Herkenhoff, 2017; Vogt, 2007). ANOVA addressed the categorical variables of provider type while examining additional variance among continuous variables of SIS, CSI, PGI, and TPR. Next, Tukey HSD post hoc analysis was applied to identify significant differences between professional role groupings.

For the second research question, descriptive statistics were used to identify frequency of assigned FCC tasks across professional roles. Responses were recorded using a matrix to display the distribution of FCC responsibility by each professional role. This table was presented to focus group participants for additional explanation in phase two.

Finally, the same statistical analysis noted above was conducted using groupings of care setting. Setting categories included emergency department, primary care pediatric clinic, specialty clinics, and inpatient hospital units. Again, upholding the assumptions and limitations previously mentioned, these care setting groups were analyzed using ANOVA to identify variation between MPOC-SP subscale scores. An overview of the utilized statistical approaches with the respective research questions are outlined in Table 1.

Table 1

Analytic Approach for Quantitative Data Analysis

Research Question	Dependent Variable/s	Independent Variable	Analytical Approach
Do specific provider practices identified by subscales of Showing Interpersonal Sensitivity (*SIS*), Communicating Specific Information about the Child (*CSI*), Providing General information (*PGI*), and Treating People Respectfully (*TPR*) vary significantly across provider types?	MPOC-SP Sub-Scale Scores	Provider Type	ANOVA (two way)
Which professional roles within Integrated Behavioral Health teams do providers see as primarily responsible for facilitating FCC or parent/guardian engagement in care?	Survey Question #11	Provider Type	Descriptive statistics
Do specific provider practices identified by subscales of SIS, CSI, PGI, and TPR vary significantly across care settings?	MPOC-SP Sub-Scale Scores	Care Setting	ANOVA (two way)

Results obtained from phase one were used to inform the focus group protocol used in phase two (Appendix D). Statistically significant variation by provider type and care setting were incorporated into the focus group discussion to help explain the results generated at this phase.

Phase Two

Building on the results of the first phase of the study, the second phase involved a smaller sample of volunteer participants from phase one using thematic analysis to address the final research question. Health care professionals participated in one of the two focus groups to share experiences related to the survey results in an effort to help explain or elaborate on quantitative results. A focus group protocol was used to share results and guide discussions (Appendix D).

Participants

Initial interest in participating in the online focus group was obtained via the survey, including information regarding the interested participants’ role and setting. All interested participants were contacted and invited to the focus group. A purposeful sampling approach was used to promote variety of provider type and setting to achieve a qualitative sample of participants representing each provider type and setting.

Focus group sizes were based on recommendations to promote discussion while limiting repetition or unhelpful transcriptional complexities (Bloor et al., 2001; Stewart & Williams, 2005). A total of seven professionals participated in two focus groups of three and four. Participants represented a diversity of roles and settings with the exception of the mental health technician role and Emergency Department care setting, due to lack of response to invitations to participate. The participants’ years of experience ranged from three to 40 years and only one of the participants was male. Roles represented within the sample included physician, psychiatrist, nurse (RN), LPC, LCSW, and social work. Care setting representation included inpatient units, primary care clinic, and specialty care clinic. The demographic profile of the focus group participants is presented in Table 2.

Table 2

Demographic Profile of Focus Group Participants

Gender	Role	Care Setting	Highest Education	Years of Experience	Ethnicity
Female	Physician	Inpatient	Doctoral	28	White
Female	LCSW	Primary Care	Master	40	African American
Female	Social Work	Specialty Clinic	Master	15	White
Female	Physician	Inpatient	Doctoral	17	White
Female	LPC	Inpatient	Master	10	Latinx
Male	LPC	Inpatient	Master	3	African American
Female	RN	Specialty Clinic	Bachelor	20	White

Note. Demographics of participants in focus groups

The identified research questions drove the qualitative analysis of coded statements to consider variance between professional roles and care settings. To address research question number four, in the focus groups, participants were asked to speak to the factors within roles or settings that help explain consistencies and variation in MPOC-SP subscale score profiles.

Procedures

The qualitative data collection process capitalized on the interactive data the focus group participants provided (Stewart & Williams, 2005). Using a focus group protocol (Appendix D), survey results were presented to each interdisciplinary, synchronous focus group. Participants were encouraged to help explain the results based on their professional roles and experiences in identified care settings. In order to mediate the limitations of the group context, the researcher reinforced the confidentiality of the group, allowed participants to participate without video, or use of the chat function, and offered the use of an alias. Lasting 50 and 58 minutes, the focus groups were held online during off-business hours to allow for audio and visual recording of the group across a variety of locations.

The researcher shared survey findings with each focus group, asked how results were consistent/inconsistent with participant experiences, and encouraged to shared experiences specific to their care setting and role in the delivery of FCC. In response, participants offered explanations for results that provided a deeper understanding and interpretation of the results themselves. In addition, the group structure echoed the dynamics of integrated care teams by promoting dialogue across provider types. This interaction offered insights regarding team dynamics and assigned responsibilities associated with FCC ultimately contributing to the interpretation and analysis of the oral data (Kress & Shoffner, 2007; Stewart & Williams, 2005). The researcher also sought balanced contributions from each represented role and setting and mediated monopolization as needed (Kress & Shoffner, 2007). In this way, the focus groups provided an interactive format to explore provider attitudes, behaviors, and experiences with parent/guardian engagement in conjunction with obtained survey results (Hays & Singh, 2012).

Video recordings of the focus groups were manually transcribed, and participant-specific identifiers were removed. Transcription considered online dynamics of synchronous groups and attended to overlaps in themes as conversations intersected during the groups (Steward & Williams, 2005). Guided by Lapadat (2000), the transcription process included considerations for context, social constructs, and the researcher's role within the setting being studied. The transcription process utilized a denaturalized approach to support critical analysis within the content of the recorded discussion and formalized language (Oliver et al., 2005).

Since unintended alterations can impact the quality of the transcriptions (Hays & Singh, 2012; Oliver et al., 2005; Witcher, 2010), transcribed contributions from each participant were emailed to the respective participant for comment or correction. Through this member checking process, participants had the opportunity to verify and correct any inaccuracies resulting from the transcription and bolster the trustworthiness of the data itself (Hays & Singh, 2012; Oliver et al., 2005; Witcher, 2010). No additional changes were made by the participants.

Qualitative Data Analysis

Once verified by participants, transcriptions were reviewed by the research team for qualitative data analysis. Research team included, one male and three female, four Counselor Education doctoral students, three of whom identified as Caucasian and one as Asian, with an age range of 25 to 46. All research team members had professional experiences with IBH settings. Particularly, two of the members worked within the pediatric health care setting used in this study.

For the qualitative data analysis, we engaged in deductive coding of the units from the verbatim transcripts using a codebook based on established themes identified in the research and subscales of the MPOC-SP’s subscales. In an effort to promote coding reliability, the steps provided by Braun and Clark (2006) guided deductive thematic analysis consistent with the study’s theoretical FCC framework (Clark & Braun, 2018). First, as also recommended by Tesch (1990), after organizing and preparing the data for analysis, the research team reviewed the data and became familiar with it before bracketing information into identified categories or chunks. This process included me, as the primary researcher, conducting the preliminary identification of the units of analysis. I determined a unit of analysis in this qualitative dataset as a statement or coupled statements that were offered as a single response by a single participant. Along with these units of analysis, I also sent the transcripts of the focus groups to each research team member for review. Following the initial review, research team members approved all preliminary units as they also suggested three additional units, leading to a total of 100 units of analysis (statements).

Second, the research team reviewed the pre-defined codes and created additional codes for the coding process. During this process, also utilizing Roberts et al.'s (2019) recommendations, we created a comprehensive codebook to support consistent definitions of codes and rigor of the study itself (Tolley, 2016), leading to six codes. Pre-defined codes were based on independent and dependent variables. Shared examples of behaviors falling within each subscale of the MPOC-SP were coded as *Showing Interpersonal Sensitivity* (*SIS*), *Communicating Specific Information about the Child* (*CSI*), *Providing General information* (*PGI*), and *Treating People Respectfully* (*TPR*). Additional two codes identified the *Setting Factors* and *Role Factors* were also used.

Finally, I aggregated independently assigned codes and the research team discussed the variations to develop consensus. Initially, an average interrater reliability of 76.85% was achieved, exceeding the 70% cutoff (Hays & Singh, 2012). Based on final assigned codes, the frequency of coded units in each theme is identified on Table 3. In this way, the deductive analysis approach helped to identify response to shared data and patterns in provider type and care setting emerging from the focus group data (Carew, 2009; Braun & Clark, 2006; De Clercq et al., 2019).

Table 3

Frequency of Coded Units

Code	Frequency
SIS	34
CSI	9
PGI	12
TPR	13
Setting Factors	12
Role Factors	20

Data Integration and Analysis

As a final step of full data analysis, the results of the quantitative phase were integrated with those of the qualitative phase. For this study, integration included comparison of quantitative results and shared experiences within a single report. Integrating the data from both research phases fostered a richer interpretation and explanation of FCC implementation in pediatric IBH settings (Tashakkori & Teddlie, 2003). Following the qualitative data analysis, a summative narrative noted alignment and divergence of provider reported experience and survey results in response to each research question. This summary included recognized patterns of FCC within provider groups or between IBH care settings explained by shared provider experiences.

Positionality and Trustworthiness

Given my insider status as both an LPC and employee of the selected pediatric health system, there exists a shared bias towards FCC and working in IBH settings. I have been employed within this pediatric health system for a total of five years as a licensed counselor and have worked in a variety of settings including the emergency department, inpatient units, specialty clinics, and an outpatient clinic. During that time, I worked with integrated care teams that included physicians, nurses, social workers, LCSWs, psychologists, other therapeutic staff, and technicians. While these shared contexts offer potential limitations of subjective transcription, they also offer further insights and deeper application of the participants' context (Clark & Braun, 2018; Witcher, 2010), ultimately supporting the dependability and confirmability of the transcriptions (Easton et al., 2000; Lapadat, 2000; Tilley, 2003). As an employee of the identified health system, I remained reflective of biases that may impact data collection and analysis. Efforts to be transparent within the transcription process served to benefit the trustworthiness of the study and included disclosure of the transcription process itself

(Witcher, 2010). Team members used reflective processing within the team to address their insider stance and approach to the data prior to data analysis. Maintaining consultation with research team members during the transcription and coding processes served to support triangulation during analysis (Oliver et al., 2005) and contribute to data confirmability and authenticity (Hays & Singh, 2012).

Organized data was then integrated into the qualitative narrative that includes both extracted examples of participant experience as well as application of those experiences within the survey results (Braun & Clark, 2006; Creswell & Creswell, 2018). The narrative for this study summarized patterns of participant experiences within research question, with attention on provider type and care setting. Ultimately, focus group data analysis supported the explanation of survey results and applied a depth of understanding to reported results.

Chapter Summary

In this methodology chapter, I described the research design and explanatory framework of the study. In addition, I discussed ethical considerations and procedural steps of data collection and analysis for each phase. Efforts to identify and address limitations impacting validity and trustworthiness of the study were also identified within each step of data collection and analysis. Finally, I reviewed procedures for data integration and analysis to summarize the results of the study and limitations.

CHAPTER 4

RESULTS

In this chapter, I will report the results of the current study addressing the respective research questions through two sequential phases. The results for each question will first present quantitative data and follow with qualitative results.

Research Questions

In this study, I sought to answer the following research questions to better understand the role and function of integrated care teams delivering Family Centered Care within pediatric care settings:

1. Do specific provider practices identified by subscales of Showing Interpersonal Sensitivity (*SIS*), Communicating Specific Information about the Child (*CSI*), Providing General information (*PGI*), and Treating People Respectfully (*TPR*) vary significantly across provider types?
2. Which professional roles within Integrated Behavioral Health teams do providers see as primarily responsible for facilitating FCC or parent/guardian/guardian engagement in care?
3. Do specific provider practices identified by subscales SIS, CSI, PGI and TPR vary significantly across care settings?
4. How do providers in IBH settings explain variations in MPOC-SP scores and subscale profiles by provider type and care settings?

While the results for research questions one through three are described below, the results for question four are included in the second phase for each answered question. In this way, the study’s explanatory methodology provides enhanced understanding of the variations reported between professional roles and care settings.

RQ1. Do specific provider practices identified by MPOC-SP's subscales of Showing Interpersonal Sensitivity (SIS), Communicating Specific Information about the Child (CSI), Providing General Information (PGI), and Treating People Respectfully (TPR) vary significantly across provider types?

Phase One. Scores for each subscale were grouped by professional role. Group variances were analyzed using Levene’s Test and two-way ANOVA. Differences between professional roles for SIS (*F* = 4.63, *p* <.001), CSI (*F* = 5.05, *p* <.001), and PGI (*F* = 6.76, *p* <.001) subscales were identified as significant. No significant difference was identified for the subscale TPR. Average scores and standard deviations of MPOC-SP subscales are identified by each professional role type is presented in Table 4.

Table 4

Average MPOC-SP Subscale Scores by Professional Role

		SIS		CSI		PGI		TPR	
Professional Role	*n*	$\overline{M}$	*SD*	$\overline{M}$	*SD*	$\overline{M}$	*SD*	$\overline{\overline{M}}$	*SD*
Physician	10	5.22	1.42	5.90	1.40	3.94	2.05	5.91	1.00
Nurse	35	4.98	1.58	4.57	2.09	3.55	1.97	5.85	1.21
Psychologist	2	4.95	1.20	4.83	1.65	3.10	1.84	5.28	0.71
LPC/LCSW	20	5.96	0.60	5.07	1.74	5.15	1.13	6.16	0.53
Social worker	13	6.02	0.54	2.87	2.46	6.15	0.75	6.48	0.52
Tech/Other	34	4.42	1.57	3.11	2.35	3.25	2.21	5.65	1.08
Total	114	5.12	1.45	4.15	2.29	4.06	2.06	5.91	1.01

Note. n = number of participants, $\overline{M}$ = average score for group, *SD* = standard deviation.

Tukey HSD test for post-hoc analysis was then applied to each subscale and professional role group. Results indicated significant differences in Showing Interpersonal Sensitivity (SIS) between LPC/LCSWs (*p* = .001) and social workers (*p* = .005) when compared with technician roles. Similarly, the difference in Providing General Information (PGI) between LPC/LCSWs when compared to nurses (p =.028) and technician roles (p = .028) was significant. Similarly, social worker average PGI scores differed significantly when compared to nursing (p <.001) and technician roles (p <.001).

For SIS identified behaviors, LPCs and LCSWs and social work roles displayed significant differences (t = 4.04, p <.001; t = 3.65, p <.001) when compared to nurses and technician/other roles. Results for licensed mental health providers, LPCs and LCSWs, showed a higher frequency of SIS type behaviors than those of nurses ($\overline{M}$= .98, p = .011) and technicians ($\overline{M}$= 1.53, p = <.001). Social work roles also indicated an increase in SIS behaviors when compared with nurses ($\overline{M}$= 1.05, p = .019) and technicians ($\overline{M}$ = 1.60, p = <.001). These results indicate that LPCs and LCSWs along with social workers reported an elevated frequency of behaviors related to interpersonal sensitivity when compared to nurses and technician roles.

Considering Communicating Specific Information (CSI) type behaviors, LPCs and LCSWs along with social workers reported lower frequency of behaviors. The differences in the mean scores (Table 4) for the LPC/LCSW group were identified as significantly different (t = 3.29, p =.001) when compared to nurses and physicians (t = 2.88, p =.005; t = 3.67, p <.001). Results for CSI scores displayed a higher frequency of CSI type behaviors for physicians compared to social workers and technician/other positions ($\overline{M}$ = 3.03, p = <.001; $\overline{M}$ = 2.79, p<.001). Similarly, nurses also reported a higher frequency of CSI type behaviors when compared to social work and technician/other positions ($\overline{M}$ = 1.70, p = .015; $\overline{M}$ = 1.46, p = .005). For LPCs and LCSWs, FCC practices of communicating child specific information was also more frequent when compared to technician/other positions ($\overline{M}$ = 1.96, p = .001), but also varied significantly from the social work role. LPCs and LCSWs reported increased frequency of CSI compared to the social work group ($\overline{M} = 2.20$, $p = .004$).

When it came to Providing General Information (PGI) identified behaviors, LPCs and LCSWs and social work roles realigned, echoing significant differences ($t = 3.67$, $p <.001$; $t= 4.84$, $p <.001$) when compared to the majority of other care role types. Results for LPCs and LCSWs showed a higher frequency of PGI type behaviors than those of nurses ($\overline{M}= 1.60$, $p = .002$) and technicians ($\overline{M} = 1.91$, $p <.001$). Social work roles also indicated an overall increase in PGI behaviors when compared with physicians ($\overline{M}= 2.21$, $p =.005$), nurses ($\overline{M}= 2.61$, $p <.001$), psychologists ($\overline{M}= 3.05$, $p =.031$), and technicians and other staff ($M = 2.91$, $p <.001$). These results indicate social work as the primary lead in providing general information and family-based supports to families, often beyond the scope of an admitting diagnosis, and LPC/LCSW role types sharing a similar function.

For Treating People Respectfully (TPR) identified behaviors, no significant variances were noted across professional groups ($p = .054$ and $p = .055$, respectively) and all groups displayed consistently high scores. Therefore, the application of respectful behaviors within the context of FCC appeared to be more consistent across professional roles.

Phase Two. In response to survey results, focus group participants responded regarding the delivery of FCC type behaviors by professional role type. While one participant recognized rapport as a key element of SIS type behaviors that could be built with “a certain nurse or doctor,” (1_21, Physician, Inpatient Unit), the social work role was more frequently associated with maintaining “rapport” and “therapeutic alliance” and with families and helping them “feel heard” (1_11, Physician, Inpatient Unit; 1_48b Social Worker, Specialty Clinic; 2_11 & 2_36, LPC, Inpatient Unit). According to one physician, “The nurses were getting overwhelmed with all these calls from parent/guardians ... so we just assigned all of it to the social worker and it worked out really nicely," (1_11, Inpatient Unit). The assignment of SIS tasks to social work was also echoed by a nurse who stated, "Somebody walks into our clinic and we can tell right away if they're having a bad day or if they need extra help. We'll run and get our social worker to see what we can do to help them." (2_24, Specialty Clinic). Additional SIS elements such as identifying family needs and anticipating concerns were also associated with the social work role and their assessment of "biopsychosocial" factors (1_48a, Social Worker, Specialty Clinic) and asking questions "about the family and their background" (1_45, Physician, Inpatient Unit).

Despite the elevated attention to the role of social work and LPCs and LCSWs in facilitating interpersonal elements of FCC, physician role types also identified efforts to build "rapport." One physician reported efforts to find "some area [to] create an attachment or bond with them, because I know how tough this work is going to be." (1_31, Inpatient Unit). The extension of SIS behaviors to physician roles was also experienced by a LCSW who shared seeing physicians with families who "were doing this [FCC] all day long" instead of "deferring" to social work. (1_62, Primary Care Clinic).

Focus group participants confirmed the role of physicians and nurses in sharing specific information about the child (CSI) such as communicating with families about "the diagnosis and … treatment plans," (2_15, Nurse, Specialty Clinic). Other participants noted in the midst of providing CSI that they defer certain treatment questions to the physician role (2_12, LPC, Inpatient Clinic). Explanation of CSI results were shared with participant experiences as social work was not associated with CSI behaviors which were more commonly discussed by nurse and physician participants.

In addition, a few shared LPC/LCSW experiences helped explain the distinction of the LPC/LCSW role in facilitating CSI. These LPCs and LCSWs experienced communicating "in depth about what happened, why they're here" (2_11, LPC, Inpatient Unit) along with providing "updates if there are any changes in regards to treatment and following up if there are any significant events that occurred," (2_9, LPC, Inpatient Unit). Here, the LPC/LCSW role in communicating specific information seems differ from that of a social worker.

Whereas CSI scores were lower for social workers compared to physicians, nurses, and LPC/LCSWs, PGI scores displayed inverted results highlighting social work's facilitation of PGI behaviors over physicians, nurses, psychologists, and technicians. Similarly, participants noted a shared value "for the family to get what they need" (2_22, Physician, Inpatient Unit), but also highlighted the social work role as most frequently associated with PGI. Social work continued to be identified as the role called on to get families "connected" (2_13, Nurse, Specialty Clinic) and provide community resources (2_14, Nurse, Specialty Clinic). In fact, PGI tasks were associated with a significant investment of time and effort including "applying for Medicaid, getting financial support, helping out with cabs," etc. (2_32, Physician, Inpatient Unit). One nurse explained the various PGI type tasks associated with social workers in the clinic stating, "They're doing a ton trying to get [patient] make-a-wishes granted, all this other stuff" (2_29, Nurse, Specialty Clinic). Social work was most frequently identified as a key role to support families with different concerns and resources to cope. At times this included mental health services.

While survey results indicated elevated levels of TPR without significant differences in frequency of TPR behaviors, two focus group participants shared experiences of inconsistencies in the delivery of TPR. One LPC/LCSW type professional stated, "[There have been] so many times when I did not feel like they were honoring and respecting the dignity – or worth of patients and their families," (1_4, LCSW, Primary Care Clinic). Instances of disrespect or "cultural in-humility" were associated with social work or licensed mental health staff being called to "clean it up," leaving this participant wondering, "How come you couldn't be as respectful in your role and think about the entire family?" (1_5&17, LCSW, Primary Care Clinic). Despite experiences contrary to the survey results, all focus group participants endorsed frequent efforts to display respectful behaviors, supporting survey results.

RQ2. Which professional roles within Integrated Behavioral Health teams do providers see as primarily responsible for facilitating FCC or parent/guardian engagement in care?

Phase One. Per the distribution of results, participants tended to identify their own professional role as primarily responsible for FCC, except for psychologists who tended to agree on the physician role of primary responsibility while denying their own (0%). Physicians identified themselves primarily responsible (90%) for FCC with lesser responsibility falling to nurses, LPC/LCSWs, and social workers. Nurses tended to hold the primary FCC charge (91%) while sharing the responsibility with more traditional roles of physicians (54%) and social work (51%). Interestingly, social work and LPC/LCSWs noted similar distribution of obligation with physicians (46%; 45%) and nurses (38%, 35%) while upholding their primary responsibility most consistently (100%, 90%). Medical and Mental Health Technicians deviated from this observed pattern, recognizing the majority of FCC care to be the responsibility of physicians (76%), LPC/LCSWs (82%), and other staff (82%) while also noting a shared responsibility across the remaining provider types. Frequency distribution analysis of roles responsible for FCC is identified in Table 5.

Table 5

Distribution of FCC Responsibility by Professional Role Type

Assigning Professional	Physician	Nurse	Psychologist	LPC/ LCSW	Social Worker	Technician	Other
Physician	70%	60%	10%	50%	50%	10%	0%
Nurse	54%	91%	14%	31%	51%	17%	3%
Psychologist	100%	0%	0%	50%	50%	0%	50%
LPC/LCSW	45%	35%	20%	90%	25%	30%	0%
Social Worker	46%	38%	8%	38%	100%	8%	8%
Technician	76%	47%	47%	82%	65%	59%	82%
Other	47%	12%	6%	18%	18%	6%	71%

Note. Percent based on number of responses by identified professional role.

Phase Two. Focus group participants responded to survey results that highlighted assigned roles for implementing FCC. As observed in the previous results, focus group discussions tended to center around roles most commonly identified as responsible for FCC. For example, social work role types were most frequently compared with nurses and physicians rather than medical or mental health technicians or LPC/LCSWs. Participants echoed their own responsibility in implementing FCC, but differed in their experiences of an integrated versus assigned role.

Several focus group participants appreciated the responsibility survey participants assigned to themselves to provide FCC and echoed the collaborative approach to FCC.

> "*I'm glad to see -, that everyone sees themselves as responsible. I think that has the makings of a successful family centered care area,"* (2_5a, Physician, Inpatient Unit).
>
> "*Family centered care should be shared by everyone that touches that family. It should not be just a physician that drives that train. It should be the physician, the psychiatrist, nursing, social worker, and everyone who touches that family should be, you know, incorporating the principles of family centered care"* (1_6, LCSW, Primary Care Clinic).

> "*I've worked on teams where they were very family centered.... That it really was oriented toward the family and the patient so that we got better outcomes."* (1_63, Social Worker, Specialty clinic).

Still others shared experiences delivering family centered care that was "*inclusive*" and "*includes everybody*"(2_10, LPC, Inpatient Unit; 2_15, Nurse, Specialty Clinic). These experiences underline a shared ownership of FCC with an integrated team approach alongside an individual responsibility for its implementation.

Meanwhile, other participants noted the value of assigning SIS and communication type responsibilities for FCC to a particular provider type. Typical experiences included assigning the social worker as the "family delegate" and associated this assignment with better FCC and care outcomes (1_13a, Physician, Inpatient Unit).

> *"The nurses were getting overwhelmed with all these calls from parents ... so we just assigned all of it the social worker, and it worked out really nicely. Like she handled the families and like maintained that rapport and it just worked really well."* (Statement 1_10, Physician, Inpatient Unit)
>
> "*And I think it really helps the therapeutic alliance to have a person designated who could give extra time to the family to talk about things that are important.*" (1_13b, Physician, Inpatient Unit)
>
> *"If you're going to affect healthcare outcomes, you've got to have someone who can take the time to discover the family. Also complement the work the medical provider is doing. ...the more successful teams that I've seen in here they do have a social worker does that."* (1_50, Social Worker, Specialty Clinic)

In contrast, some professional participants opposed assigning responsibility of FCC to a single team member. While one participant resisted social work as the "only lifeline" (1_18&59, LCSW, Primary Care Clinic), another reinforced the need for shared ownership stating, "If you don't consider yourself responsible for that [FCC] and you're always relying on someone else then it may or may not happen," (2_5b, Physician, Inpatient Unit).

LPC/LCSW versus Social Work. Focus group participants often defaulted to the term "social work" when referencing both social work and LPC/LCSW type roles (1_58, LCSW, Primary Care Clinic). Several participants noted the "interchangeable" use of social work and counseling across settings (2_28, LPC, Inpatient Unit, 1_40, Social worker, Specialty Clinic). A social worker explained, "It is just easier to reduce it down to social work, I think. … Or maybe it's just our culture" (1_56, Specialty Clinic). Another participant confirmed this shared definition stating, "I know in some settings social worker and therapist are two different things, but in our setting, they primarily have the same responsibilities," (2_26, LPC, Inpatient Unit).

However, a nurse from a specialty clinic observed a clearer distinction between LPCs and LCSWs and social work roles but noted a limited awareness of professional qualifications for the licensed mental health provider role. "In our area the social workers do just social work. Some of them have gone and gotten their counseling certificate or whatever it's called. But they don't do that with our patients. They just stick to the social work," (2_27). A specialty clinic-based social worker echoed that the licensed qualifications of an LPC or LCSW are "not well understood," (1_57).

RQ3. Do specific provider practices identified by subscales SIS, CSI, PGI and TPR vary significantly across care settings?

Phase One. Variances of the MPOC-SP subscales were analyzed using Levene's Test and two-way ANOVA analysis across care setting groups. Statistical differences between care settings for SIS ($F = 4.44$, $p = .005$), CSI ($F = 5.49$, $p = .001$) and PGI ($F = 4.57$, $p = .005$) subscales were identified as significant. Scores for each subscale were then grouped by care setting. Averaged scores and standard deviations are identified by each care setting in Table 6.

Table 6

Average MPOC-SP Subscale Scores by Care Setting

		SIS		CSI		PGI		TPR	
Care Setting	*N*	$\overline{M}$	SD	$\overline{M}$	SD	$\overline{M}$	SD	$\overline{M}$	SD
Primary Care Clinic	4	6.25	0.48	5.25	2.36	6.45	0.55	6.78	0.24
Specialty Clinic	26	5.67	0.94	5.17	2.04	4.67	1.70	6.15	0.85
Emergency Department	21	5.45	1.30	4.89	1.88	4.45	2.04	6.01	0.82
Inpatient Unit	63	4.71	1.58	3.41	2.29	3.53	2.09	5.73	1.11
Total	114	5.12	1.45	4.15	2.29	4.06	2.06	5.91	1.01

Note. *N* = number of participants, $\overline{M}$ = average score for group, *SD* = standard deviation.

Post-hoc analysis with Tukey HSD indicated significant differences in SIS between specialty clinics ($p = .019$) and inpatient units. Using the same analysis, the difference in PGI between primary care pediatric clinic when compared to inpatient units ($p = .025$) was significant.

For SIS type behaviors, primary care clinic ($t = 2.14$, $p = .034$), specialty clinics ($t = 2.96$, $p = .004$), and emergency settings ($t = 2.11$, $p = .037$) displayed significant differences when compared to inpatient settings. Results from inpatient settings displayed significantly lower SIS type behaviors when compared to primary care clinic ($\overline{M} = -1.54$, $p = .034$), specialty clinics ($\overline{M} = -.96$, $p = .004$), and the Emergency Department ($\overline{M} = -.74$, $p = .037$). For professionals providing care in inpatient settings, interpersonal sensitivities are less frequently implemented with families compared to other settings within the pediatric health care system.

Scores for CSI behaviors indicated a similar distinction between care settings. Inpatient units varied significantly in specific communication when compared with specialty clinics (t = 3.47, p <.001) and emergency department staff (t = 2.70, p =.008). Moreover, inpatient units reported a significantly lower average score than specialty clinics and emergency care ($\overline{M}$ = -1.75, p<.001; $\overline{M}$ = -1.48, p=.008). When it came to child specific information, specialized hospital settings tended to have more frequent CSI behaviors than generalized inpatient care.

For PGI identified behaviors, primary care clinic and specialty clinic settings displayed significant differences (t = 2.87, p =.005; t = 2.47, p =.015) when compared to other care settings. Results from inpatient settings displayed significantly lower PGI type behaviors when compared to primary care clinic ($\overline{M}$ = -2.92, p = .005) and specialty clinics ($\overline{M}$= -1.14, p = .015). Therefore, these results suggest staff in the primary care clinic and specialty clinics provide general information including resources and supports for families, on average, more often than staff in inpatient clinics.

For TPR identified behaviors, no significance variances were noted across groups (F = 2.32, p = .079). Similar to professional role-based groupings, respectful behaviors toward patients and families were consistently reported across care settings.

Phase Two. Focus group participants shared experiences of variation in FCC delivery across care settings. Setting-based staffing structures that included treatment teams were seen as more effective in FCC care delivery as opposed to the Emergency Department (ED) that " *has no main treatment team. … It's just a completely different environment, like apples and oranges*" (1_26 Physician, Inpatient Unit). Participants response to survey results frequently focused on factors impacting SIS type behaviors. For example, staffing rotations that were characteristic of certain care settings were seen to adversely impacted engagement with families.

> *"I mean [in ED] you have a different doctor every 12 hours whereas on my unit I am the doctor for six months, if the patient is there that long,"* (1_27 Physician, Inpatient Unit).

In response to survey data that identified the SIS scores of inpatient units to be significantly lower compared to other settings, participants identified a care setting's ability to maintain longer term relationships with patients and families as beneficial to providing FCC. An LPC from an inpatient setting agreed, "I feel like sometimes we're not reaching the family as much as we would love to," (2_36). Similarly, there was an expectation of primary care settings to have longer term relationships and "deeper understanding" of patients and families (1_33 Physician, Inpatient Unit; 1_47 LCSW, Primary Care; 2_3, LPC, Inpatient Unit). In this way, the duration of care was often determined by the care settings, thus impacting the expectations and delivery of FCC.

> "*I feel like with [primary care clinic] and specialty clinics I think they have more opportunities and more time to establish that long term rapport with the families whereas if you're coming in inpatient and emergency department, I feel like that's a little more rushed, which is unfortunate because I really, I think, we would love nothing more than to make the families as a whole feel included*." (2_2, LPC/LCSW, Inpatient Unit).

While the data did not suggest significant variation of SIS behaviors between ED and other care settings, participants shared concerns of the pace of care within a setting, such as the ED, as adversely impacting motivation for SIS type behaviors such as build rapport or explore concerns and expectations (1_30 & 1_46 Physician, Inpatient Unit; 1_52, Social Worker, Specialty Clinic). When compared with "general pediatrics" (2_37&39 LPC/LCSW, Inpatient Unit), ED care roles were not seen as worrying "so much about maybe maintaining that rapport," (1_32 Physician, Inpatient Unit).

> *"... in the Emergency Room or those very quick settings, where building the rapport with the family isn't quite as necessary or important because you're not going to have that long-term relationship, you're just going to see them for this hour and you're not going to see them again,"* (1_30 Physician, Inpatient Unit).

However, other participants challenged these assumptions. One inpatient physician noted the intentionality of staff applying information previously learned about patients and families when they return to the inpatient unit and the need to "jump start" this understanding with new patients and families. In addition, an LCSW challenged the perceived limitation of the duration of care or number of contacts with a family required to provide effective FCC.

> "*That whether my relationship with this patient is going to be five minutes or five years, I should still be able to do exactly what you do, which is think about and be deliberate and intentional. Because that initial interface with that patient and that family is going to matter for years to come or days to come, you know. I get emotional just thinking about it,"* (1_34, Primary Care Clinic).

CSI scores indicated a significant variation between specialty clinics and inpatient units which was inconsistent with lived experiences of participants. In fact, several inpatient-based participants felt they provided CSI type behaviors "non-stop" to an extent that may "overload" parents (1_1, Physician, Inpatient Unit; 2_1, Physician, Inpatient Unit; 2_38 &40 LPC/LCSW, Inpatient Unit). Specialty clinic participants did explain the elevated CSI scores through shared communication of information with families, consistent team structures "where everybody knows everybody" and frequently discusses patient specific information with the families (2_15, 18 & 19, Nurse, Specialty Clinic). The identified variable of the treatment team's knowledge of one another potentially impacting FCC later emerged when considering PGI type behaviors.

Participants from specialty clinics most often discussed the consideration of PGI type behaviors associated with social workers when explaining survey results. These behaviors included providing additional information and resources as well as addressing extenuating stressors in an effort to help the family cope (2_29 &32, Nurse, Specialty Clinic; 1_48, Social Worker, Specialty Clinic). A specialty clinic nurse stated "Whether those families want us in their lives or not, we're in their lives. …we help them out a ton with medical stuff, financial stuff…" (2_25a). While the size of specialty clinics was associated with their ability to "do more" (2_25b, Nurse, Specialty Clinic), limitations of PGI in inpatient units were associated with dispersed patients and treatment team members (2_17 Physician, Inpatient Unit) and a lack of consistent team membership that impacted communication of family needs and response (2_19, Nurse, Specialty Clinic).

> *"I may or may not know the nurse, so I may or may not share …whether this family is having a hard time or not."* (2_20, Physician, Inpatient Unit)
>
> *"We don't know who is going to be responding to us. And so, I don't know what that person's strengths, particular strengths are … So I think it could impact…"* (2_34, Physician, Inpatient Unit)
>
> *"…if I have an idea of something that they [the family] may need or if I hear of a need and I'm not quite sure how to solve it and I don't talk to it about anybody, then that need is not going to get solved or attended to or heard."* (2_22, Physician, Inpatient Unit)

When it came to TPR, participants expressed a shared sense of respect for families and efforts to engage with patients and families as part of treatment (1_23&27, Physician, Inpatient Unit; 2_16, Nurse, Specialty Clinic). However, results were not consistent with experiences of FCC in primary care settings. One LCSW said, "I did not feel like there was an honoring and respecting of the dignity … and worth of patients and their families," (1_4, Primary Care Clinic) and questioned if cultural considerations were captured in the survey results (1_5, Primary Care Clinic).

Overall, participants explained differences in the MPOC-SP sub score profiles across settings as associated with variations in frequency of contacts associated with the setting, setting-based staffing structures, and knowledge of other team members. Reported results of CSI-type behaviors in inpatient settings were inconsistent with participant experiences, potentially warranting further investigation.

Repeatedly, explanations for variation MPOC-SP scores across settings were associated with interactions among care team members and often linked to organizational factors within each setting. Collaborative and consistent communication among team members emerged as an explanatory factor for elevated scores for CSI and PGI. Participants reported increased communication among known team members and decreases in communication when team members where not known (1_32 & 34, Physician, Inpatient Unit). Recent increases in the use of "travelers" or temporary contracted staff in inpatient settings were associated with changes in team members and barriers to communication (2_17, Physician, Inpatient Unit).

> *I feel like there's less sharing when you don't have as much of a relationship, even of the things that one should be sharing, like the family is having a hard time* (2_21, Physician, Inpatient Unit).

Focus groups considered three additional factors such as time, cultural biases, and training needs that may impact the delivery of FCC. First, time was seen as a necessary element of providing effective FCC. Typically, the role of the social worker was seen as "having time" (1_11 & 45, Physician, Inpatient) while other roles (nurses and physicians) were associated with a “lack of time” (1_12, Physician, Inpatient, 1_50 Social worker, Specialty Clinic). Others viewed the social worker’s time as limited and unable to facilitate every element of FCC (1_42, Social worker, Specialty clinic; 2_29, Nurse, Specialty Clinic). Specialty Clinics were viewed as having more time with families when compared to other settings (1_46, Physician, Inpatient; 2_24, Nurse, Specialty Clinic). Second, cultural biases were experienced as impacting each MPOC-SP subscale. One LCSW participant highlighted that “biases about patients and families also affects - the application of family centered care,” (1_28, Primary Care Clinic). Consideration of family’s preferred language, cultural values, and cultural humility approaches were discussed. Third, participants noted potential variable of training and experience providing FCC. Inpatient settings endorsed more frequent use of “learners” that may be coming from different clinical contexts, requiring specific instruction to provide FCC in the inpatient setting.

RQ4. How do providers in IBH settings explain variations in MPOC-SP scores and subscale profiles by provider type and care settings?

The discussions from the focus groups were analyzed through Thematic Analysis (Clark & Braun, 2018). In addition to the predefined groups from MPOC-SP (i.e., SIS, CSI, PGI, and TRP), research team also observed two other themes specifically focusing on the independent variables of the study, *Role Factors* and *Setting Factors.* Theme 1, SIS, included discussion points on interpersonal sensitivities that addressed establishing rapport, discussing expectations, exploring feelings, anticipating concerns, choosing how information is shared, adjusting to family needs/lifestyle, and establishing a relationship with the provider. Theme 2, CSI, described communication of test results, treatment planning, and details about the services. Theme 3, PGI, included family resources to support coping during treatment, information for the entire family, and addressing different family concerns. Theme 4, TPR, focused on treating the parents as experts, offering a nonjudgmental approach to families, and engaging with parents as partners in their child’s care. Finally, themes 5 and 6 for Role Factors involved statements referencing specific roles within the treatment team that fell outside of the definitions for each subscale but were considered influential delivering FCC. Meanwhile Setting Factors included statements that were associated with a certain care setting, again, beyond the definitions of specific MPOC-SP subscales. Coded statements were applied to each research question previously discussed.

Chapter Summary

This chapter reviewed results of both phases of the study. The quantitative results were reviewed across professional roles with consideration of roles primarily responsible for FCC along with comparisons across settings. Survey results were further explained by focus group participants who shared experiences to help clarify variations and describe the complexities of FCC within their various roles and settings. Qualitative results provided enhanced understanding of survey results and offered additional considerations impacting FCC and the interpretation of results.

CHAPTER 5

DISCUSSION

In this chapter, I will discuss the results, practical and research implications, and the limitations of the study. This study responded to Shield et al.'s (2010) call for high-quality FCC research that includes both a diversity of participants and care settings to address the gap in the literature alongside a need to consider the evolution of integrated pediatric care. The purpose of the study was to expand the consideration of FCC and PE based activities beyond traditional roles of nurses, physicians, and social workers to consider the emerging presence of the LPC/LCSW in integrated pediatric care settings, in addition to exploring variations in the delivery of FCC by both professional role and care setting.

Identified Roles

In this study, each professional role tended to identify themselves as primarily responsible for the delivery of Family Centered Care (FCC). This finding supports the call for FCC as the gold standard for pediatric care and recognizes the awareness of FCC responsibilities across professional roles (Abraham & Moretz, 2012; Williams et al., 2021). In addition, responsibilities of FCC implementation were also preferably shared, rather than the sole responsibility of one provider type. Whereas this finding supports the professionals' personal engagement with FCC, the MPOC-SP subscales and qualitative data offer further insights into the coordinated delivery of FCC in integrated care settings.

FCC Across Professional Roles

Within the integrated teams in this pediatric health care setting, I found variations in FCC delivery between role types. The MPOC-SP subscales offered insights into variations within the delivery of FCC across professional roles. The blended understanding and implementation of the role of the social worker and the LPC/LCSW may help explain the aligned MPOC-SP TPR (Treating People Respectfully) and SIS (Showing Interpersonal Sensitivities) scores. TPR and SIS behaviors focus on interpersonal interactions with families and tasks, which the focus group participants applied to the broader definition of “social work” that includes both roles. Professionals seemed to struggle to identify the differences in licensed staff qualifications when compared to the traditional social work role. Given this shared nomenclature, responsibilities for each professional type also seemed to be shared. The focus groups’ collective expectations of SIS and TPR type behaviors for social workers and LPCs/LCSWs helped explain the lack of significant differences between these subscales. Meanwhile, the diverging scores for CSI and PGI may explain an emerging distinction as LPCs and LCSWs participate in more child specific communications with families and social workers maintain their elevated PGI role in supporting family needs during a child’s treatment.

Regarding interpersonal sensitives with patients and families, social work and LPC/LCSW roles were identified as facilitating SIS type behaviors more frequently than nurse, technician, or other direct-care roles. While historically, Bailey et al. (1991) identified variation between roles, this study confirms differences in FCC delivery and suggests the evolution of FCC within team-based care. As teams are expanded to include LPC/LCSW type staff, these team members offer SIS type behaviors more often within this setting than the previously upheld nurse role. Lower SIS scores for nursing may also be related to the lack of prioritization of interpersonal dynamics identified by Bruce et al. (2002), whose study consisted of mostly nurses. Therefore, this may suggest that the responsibility for building rapport and discussing expectations and concerns is assigned to social work and counseling roles coupled with a prioritization of interpersonal dynamics among these professional groups.

While social work and LPC/LCSWs were more frequently associated with SIS type behaviors, nurse and physician type roles showed an increase in CSI (Communicating Specific Information) type behaviors often focused on sharing diagnostic and treatment information. The variations of CSI behaviors between professional groups reinforces roles of physicians and nurses in relaying specific information, such as test results and treatment plans to patient and families. However, the role of the LPC/LCSW is also seen to communicate specific information beyond the frequency of social work. Previous research also supports this distinction from social work and associated CSI-type tasks with LPC/LCSW professionals working in IBH settings (Aitken & Curtis, 2004; Blount, 2003; Hudson-Allez, 2000). Here, the LPC/LCSW role seems to differentiate itself from the social worker role as counselors provide additional diagnostic information and treatment planning with families specific to their child’s care.

In addition, PGI score profiles offer further role distinction and highlight the social work role supporting the family. While LPC/LCSW roles reported increased PGI (Providing General Information) type behaviors when compared to nurses and technician roles, social workers reported a consistently elevated PGI score compared across role types. Social work appears to be frequently associated with support for families and accessing additional resources to help the family cope. The social worker role was identified as the point of contact if families were having a hard time and actively seeking resources for families. Therefore, within these integrated settings, social work remains central in addressing ancillary family needs while nursing and physicians (and even counselors) offer treatment focused communications.

Finally, while survey results did not identify significant differences in delivery of TPR (Treating People Respectfully), focus group participants challenged these results sharing experiences of inconsistencies in the delivery of TPR by provider type. Here the limitations of the MPOC-SP to capture observable behaviors may result in a professional's individual assessment of effective TPR behaviors that varies, in reality, from the observed implementation of TPR (Woodside et al., 2001). Therefore, this study supports Pickering and Busse's (2010) suggested application of the MPOC-SP as an evaluative tool alongside other data-collection efforts for provider or program evaluation.

As observed in this study, the counselor role (LPC/LCSW) shares a blended identity with social work, occasionally sharing responsibilities in some settings. Social workers have a long history in pediatric healthcare settings and the tendency to apply historical context to current experiences has blurred the role of counselors. Furthermore, the qualifications of an LPC or LCSW that differentiate them from their social work colleagues are often not clear to other professionals which would support role clarity. However, the differentiation of counselors and social workers in regards to MPOC-SP score profiles (CSI and PGI) help to clarify the application of each role within the team. Armed with the awareness of ongoing role confusion, counselors are better prepared to further role differentiation within their respective care setting.

FCC Across Care Settings

Although previous mixed-method FCC and PE research were often limited to a single care setting (Bruce et al, 2002; Foster et al., 2016; Ingersoll & Berger, 2015; King et al, 1999; Letourneau & Elliot, 1996; Shields et al, 2014; Williams et al, 2021; Woodside, 2001), this study considered a range of care settings and found variations by site similarly noted by previous researchers (e.g., Bruce et al., 2002; Feeg et al., 2016).

Results from this study echo the limitations of FCC behaviors in inpatient settings including reduced frequencies of interpersonal sensitivities (SIS) compared to other settings and lower CSI (specific communications about the child) compared with specialty clinics. In previous research, inpatient care settings have been linked to internalized barriers in the delivery of PE and FCC based on caregiver-focused studies (Bee et al., 2015; Cree et al., 2015; Giacco et al., 2017). These barriers for caregivers include uncertainty regarding caregiver expectations, inconsistencies in care, and feelings of incompetence to engage in child's care. This study offers additional considerations from providers who noted organizational barriers for inpatient settings such as not having collocated teams, shorter durations of care, limited staff availability, and recent increases in staffing turnover.

Within this health system, care setting variations in the delivery of FCC are associated with limited resources or time to implement family engagement practices. Consistent with previous studies, time constraints impact the frequency of FCC type tasks (Bruce & Ritchie, 1997; Smyth et al., 2019). Inpatient admissions were associated with shorter durations of care that may limit FCC implementation. However, the Emergency Department (ED) setting, which tends to have shorter durations of care did not vary significantly in their implementation of FCC. According to Campbell et al. (2020), the service reliability and psychoeducation provided by emergency care setting may help to mediate the parent/caregiver engagement and FCC families experience. These organizational norms may preemptively bolster the rapport and engagement with families in the ED. From the service provider vantage point, providers' efforts to implement FCC do not significantly vary from other pediatric care settings despite the shorter duration of care.

Meanwhile, specialty clinics that boasted consistent team structures within a shared location seem to benefit from improved communication practices and interpersonal practices with families. A similarly structured setting, primary care clinics also noted higher PGI scores associated with the implementation of psychoeducation and family-focused resources. Alongside

Porras-Javier et al. (2018), results from the current study elevate team communication issues within care settings and offer explanation for elevated scores for CSI and PGI. Established teams, with clearly identified team members who are known among one another, are associated with increased communication and supports for families (Safety Net Medical Home Initiative, 2014). Specialty clinics reported lower turnover of staff, colocation of staff, and efforts to build team cohesion while inpatient clinics report the use of temporary staff, wider distribution of team members across the hospital, and the use of LPC/LCSW types that were not often "known." These setting-based cultural components identified in previous studies offer a richer understanding of variations of FCC delivery (Alabdulaziz et al., 2017; Coyne et al., 2013).

As evidenced by the variation across subscale profiles, implementation of FCC does not occur within the isolation of a single professional role; but is the integration of the roles themselves that may offer consistency of FCC. Therefore, strategic considerations to promote FCC type behaviors must consider the roles involved. Pediatric health care settings should consider the strengths and deficits of care teams to strategically invest training or staffing resources to reinforce the identified elements of FCC. For example, rather than Gao's (2021) universal call to focus on PGI behaviors across treatment providers, targeted approaches to empower the social worker role and maximize current PGI functions may offer greater and more immediate value to families.

Ultimately, the individually assumed responsibility of most professional roles to implement FCC practices highlights a critical element of integrated care; the shared ownership of patient care and its outcomes (Foster et al, 2016; 2010) Nonetheless, navigating role definition within these teams remains critical to the delivery of FCC and parent engagement efforts. The pursuit of improved outcomes drives both the integration of care and the elevation of FCC and PE practices.

Implications

This study has implications for health care organizations, pediatric care teams, and counselor education programs to promote the implementation of FCC competencies within integrated care settings and prepare counselors to promote FCC and, with it, PE to improve patient outcomes.

Organizational efforts to promote consistent FCC delivery across provider roles benefit from an understanding of complementary MPOC-SP subscale profiles. Understanding how FCC varies across professional roles and care settings allows for tailored quality improvement efforts within nuanced healthcare settings. Variations in MPOC-SP score profiles offer visibility to strengths within current professionals and settings as well as opportunities for growth, thus identifying competencies across teams. As noted by Sieves et al. (2008), the MPOC-SP allows for evaluation of family-centered care and quality improvement efforts. Therefore, organizational leadership may more intentionally apply training, staffing, and clinical programming resources within their organization to amplify strengths and address barriers to consistent FCC and PE practices. This enhanced understanding offers advanced strategies for organizations to address pervasive inconsistencies in FCC and PE (Bruce & Ritchie, 1997; Gao, 2021; King et al., 2003).

This study also contributes to the growing efforts to shape integrated care and maximize its benefits (Apple et al., 2020; Asarnow et al., 2015; Jackson-Triche et al., 2020). When pediatric integrated care teams gain clarity and accountability around their respective roles, they are likely to experience a reduction in task duplication and role confusion (Foster et al., 2010). The addition of mental health counselors to these historically medical settings has contributed to role confusion (Alessi et al., 2022; Giresunlu, 2021), but may bring with them additional strengths within FCC and PE practices. Therefore, this study offers guidance for counselors alongside nurses, physicians, and social workers to better orient their role within IBH settings and coordinate tasks with their pediatric care team. Specifically, understanding of FCC practices in different care settings and role types provides an opportunity for counselors and other medical professionals to coordinate specific functions to bolster the implementation of FCC through certain tasks. Understanding of differences in care delivery aids the counselor's ability to navigate FCC practices and compliment the work already being done.

While this study offers clarity around the organizational and team-based coordination of FCC practices, it also provides role guidance for counseling supervisors within IBH teams to prepare new counselors to better understand and navigate the nuances therein. Armed with a better understanding of the perceived similarities and differences of the counseling role relative to other team roles (such as social work), new counselors and their supervisors would be better prepared to navigate IBH team dynamics and more readily implement strengths within their role. In this way, counseling supervisors are better equipped to recognize FCC tasks, reinforce the counselor's role in promoting FCC, and support role clarity within the team.

Finally, this study highlights strengths and opportunities for Counselor Education (CE) programs to respond to evolving pediatric care settings. Results of this study highlight success in current academic programs to develop strengths within the counselor role that readily contribute to FCC delivery when compared to other professional roles. CE attends to individualized care and person-centered approaches that parallel FCC values. In addition, CE programs that include culturally competent practices, experience with family systems, and engagement techniques may potentially exceed SIS, CSI, and TPR type tasks and expand consideration of FCC behaviors. In fact, CE programs that promote cultural competencies and multicultural ethical practices may serve to improve care delivery beyond tasks identified by the MPOC-SP. In addition, findings of the current study also offers opportunities for CE programs to further prepare counselors to work in pediatric integrated care settings through shared vocabulary, specific family-focused considerations, and role clarification. CE programs have an opportunity to offer course curriculum to address the counselor role within IBH settings and integrate FCC terminology and practices in medical settings. This intentional education will prepare counselors to “speak the same language” as their IBH team members and help navigate roles and responsibilities within the team. Since CE programs tend to focus on individual care and offer little in terms of pediatric counseling training, this study offers an opportunity for the programs to develop curriculum to address pediatric care consider the needs and resources for families of pediatric patients. While some of the programs may briefly address family systems, education regarding community resources is often left to on-the-job training. Therefore, CE programs may benefit from the pro-active inclusion of PGI guided curriculum to support a richer understanding of this element of FCC. This additional education would better prepare counselors to provide family-focused care in IBH settings.

Limitations

The scope of this study to a single healthcare system and limited sample offer considerations but limit the generalizability of the results. The limitations of this study are discussed within both phases of the study. Limitations within the quantitative phase include participant bias, adequacy of the sample size, and limitations of the selected measure. Participant and social bias are potential limitations of this study offering an overestimation of FCC behaviors when compared with the larger population despite research claims that the MPOC-SP has been demonstrated to reduce the impact of social bias. Furthermore, though anonymity of online surveys tends to increase authentic response (Fogli & Herkenhoff, 2017), the distribution of the survey within the professional setting may have fostered concerns for confidentiality and influenced reporting that aligned with the health system's expectations (Sax et al, 2003). Next, sampling efforts failed to achieve the recommended sample size of 120 participants or provide equal representation of categorical groupings, thus limiting the statistical power of the analysis as well as available statistical techniques (Balkin & Sheperis, 2011). For the purposes of this study the robust ANOVA technique allowed for data analysis to help guide focus group discussions regarding FCC functionality within care teams. Furthermore, the MPOC-SP has not been previously applied to counseling professionals or intentionally applied within IBH settings. Nevertheless, the shared acceptance of the MPOC-SP to assess FCC behaviors for various provider types, and previous efforts to validate this measure have supported its use in similar settings with pediatric patients (Woodside et al., 2001).

Within the qualitative phase limitations include sample representation, researcher biases, and coding limitations that may impact result interpretation. For example, focus groups did not include representation of the emergency settings or technician roles. Despite recruitment efforts, feedback from these participant types were unavailable to support the explanatory function of the focus groups. Also, while the research design sought to support confidentiality, the professional context of each online group was not truly a "neutral venue," thus, potentially impacting disclosures that diverge from the expectations of their peers or their employer (Bloor et al., 2001; Carew, 2009; DeClercq et al., 2019; Kiesler & Sproull, 1992; Steward & Williams, 2005). Next, researcher bias inherent in my role as an LPC within the pediatric health system, along with another member of the research team, may have influenced the engagement of focus group participants. While my membership in the pediatric health system, allowed for shared understanding of setting-based terminology (Clark & Braun, 2018), it may have influenced focus group facilitations and limited alternative exploration of FCC delivery. Finally, the use of a research team aided coding reliability and trustworthiness (Oliver, Serovich, & Mason, 2005), however, the team's familiarity with the MPOC-SP and pediatric healthcare setting potentially impacted the descriptive coding process within the predefined framework, limiting flexibility and generation of new insights (Braun & Clark, 2006).

Future Research

As counselors integrate into medical settings, they must understand the culture, context, and language of this new (and evolving) care setting. The integration of mental health within medical settings must similarly understand the context within which it is merging as well as the enhancements it provides. In the same way, research tied to pediatric mental health and medical care must also navigate this same integration. Therefore, future research should continue to respond to the evolution of care and guide evidenced based practices for its delivery.

Future research efforts to include a larger sample size would allow for more complex statistical procedures and the consideration of additional variables such as education, race, and ethnicity. Larger sample sizes would also support the inclusion of covariates in data analysis, such as years of professional experience. Furthermore, study replication in other pediatric healthcare settings would offer additional understanding of the evolving delivery of team-based FCC.

Future research may also consider PE practices that fall outside of the MPOC-SP and explore revisions to this measure that reflect additional tasks such as cultural responsiveness and team collaboration that have been identified as provider behaviors contributing to FCC.

Deductive coding practices within this study limit the expanded consideration of additional practices that contribute to FCC or PE efforts. Therefore, this study issues a call for research to consider further integration of FCC and PE factors and expand the scope of these practices across provider roles and care settings.

Finally, additional research efforts may consider the use of the MPOC-SP for program evaluation and quality improvement efforts to monitor trends and staff awareness of FCC practices within specific pediatric care settings and teams. Although widely adopted for use in pediatric settings, the application of the MPOC-SP as an evaluative tool for trend analysis has been recommended in conjunction with other data collection efforts (Pickering & Busse, 2010; Woodside et al., 2001).

Conclusion

FCC is a gold standard for pediatric providers in medical settings. As counselors join pediatric care teams, they must do so with a rich understanding of FCC practices and their responsibility to uphold this standard of care. In many ways, counselors are well prepared to implement elements of Family Centered Care, including child specific information, and interpersonal sensitivities offering strengths to IBH teams and organizations. However, counselor considerations for families and specific FCC practices may be an opportunity for growth in Counseling Education programs in both didactic learning and associated field experiences. This study offers role clarification for counselors and equips counselors, counselor supervisors, and IBH professionals to navigate team-based care and offer further role clarity within these evolving settings.

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APPENDICES

Appendix A

Invitational Email

You are invited to participate in a research study about family centered care in pediatric care settings. The goal of this research study is to understand differences in provider implementation of family centered care practices within treatment teams and across various treatment settings.

This study is being conducted by Emily Bebber, LPC as part of a Counselor Education Doctoral Program at Old Dominion University under the supervision of Dr. Gulsah Kemer, PhD. The Children's Hospital of The King's Daughters has also provided additional approval for this study.

There are **2 qualifications** to participate in this study:

1. Your current position **must** allow you to provide direct care to pediatric patients and their families.
2. You **must** work in a setting that provides integrated care.

Participation in this study is voluntary. If you agree to participate in the study, you will be asked to complete a brief survey (5 -7 minutes) about your practices providing care with families. At the end of the survey, you will also have the option to present interest in a follow up focus group to further elaborate on your experiences and engage in dialogues with other professionals.

Participating in this study presents limited risks and may not benefit you directly, while it will aid the understanding of variations in family care approaches across settings and provider groups. Through the survey as well as participating in the focus group, you may also have an opportunity to reflect on your experiences and learn from other professionals to enhance your practices.

To support **confidentiality,** participant information will be secured and identification numbers will be assigned. Names will not be included in the data collection and only identified if participants opt to be included in the drawing.

At the end of the survey, you can opt to be entered into a drawing for a gift card.

If you choose to participate in this study, the information you share with me will be kept confidential.

Thank you!
Emily
Ebebb001@odu.edu

Appendix B

Informed Consent Document

OLD DOMINION UNIVERSITY

PROJECT TITLE: Providing Family Centered Care Within Pediatric Integrated Care Settings

INTRODUCTION

The purposes of this form are to give you information that may affect your decision whether to say YES or NO to participation in this research, and to record the consent of those who say YES. The Study "Providing Family Centered Care Within Pediatric Integrated Care Settings" will consist of an online survey and optional focus group.

RESEARCHERS

Dr. Gulsah Kemer PhD NCC, Doctoral Advisor, and Emily Bebber MEd, LPC, Doctoral Student
Old Dominion University
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DESCRIPTION OF RESEARCH STUDY

Several studies have been conducted looking into the subject of family centered-care in various settings with a variety of providers. However, these studies have not considered the diversity of providers in integrated care setting. Therefore, this study will incorporate both medical and mental health professionals providing care across a range of integrated care settings.

If you decide to participate, then you will join a study involving research of pediatric care providers through a survey and optional focus group. If you say YES, then your participation will last for 10 to 15 minutes to complete the survey. Participants who agree to participate in a focus group will be asked to select a date and time for a 45-minute online focus group via WebEx.

INCLUSIONARY CRITERIA

Participants will be pediatric providers working in integrated care settings.

RISKS AND BENEFITS

RISKS: If you decide to participate in this study, then you may face a risk of disclosing your experiences within your work setting. For the survey part of the study, the researcher tried to reduce these risks by utilizing a secure data management platform, assigning participant identification numbers, and reporting results using grouped data sets with restricted demographic data. Focus group participants may experience increased risks of self-disclosure among colleagues and relaying experiences that are counter to policy or organizational standards or values. Recorded focus groups will be encrypted and secured. Recordings will not be shared and transcripts will remain secured. And, as with any research, there is some possibility that you may be subject to risks that have not yet been identified.

BENEFITS: Your participation will primarily aid the understanding of variations in family care approaches across settings and provider groups. Through your participation with the survey and the focus group, you may have an opportunity to reflect on your experiences and learn from other professionals to enhance your practices.

COSTS AND PAYMENTS

The researchers want your decision about participating in this study to be absolutely voluntary. Yet they recognize that your participation may pose some cost of time. To thank you for your participation, you can choose to be entered in a raffle for a gift card.

NEW INFORMATION

If the researchers find new information during this study that would reasonably change your decision about participating, then they will give it to you.

CONFIDENTIALITY

The researchers will take reasonable steps to keep private information, such as limiting required disclosure of personal information and keep disclosures confidential. The researcher will remove identifiers from all identifiable private information collected and maintain grouped data for reporting. Data will be stored in a secured platform, information will be deidentified, and recordings will be destroyed following the completion of the study. The results of this study may be used in reports, presentations, and publications; but the researcher will not identify you. Of course, your records may be subpoenaed by court order or inspected by government bodies with oversight authority.

WITHDRAWAL PRIVILEGE

It is OK for you to say NO. Even if you say YES now, you are free to say NO later, and withdraw from the study at any time. Your decision will not affect your relationship with Old Dominion University or the Children's Hospital of The King's Daughters or otherwise cause a loss of benefits to which you might otherwise be entitled.

COMPENSATION FOR ILLNESS AND INJURY

If you say YES, then your consent in this document does not waive any of your legal rights. However, in the event of harm arising from this study, neither Old Dominion University nor the researchers are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in any research project, you may contact Dr. Gulsah Kemer at 757-683-3225, Dr. John Baaki the current IRB chair at 757-683-5491 at Old Dominion University, or the Old Dominion University Office of Research at 757-683-3460 who will be glad to review the matter with you.

VOLUNTARY CONSENT

By signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researchers should have answered any questions you may have had about the research. Please send any additional questions via email to: Emily Bebber at Ebebb001@ODU.edu

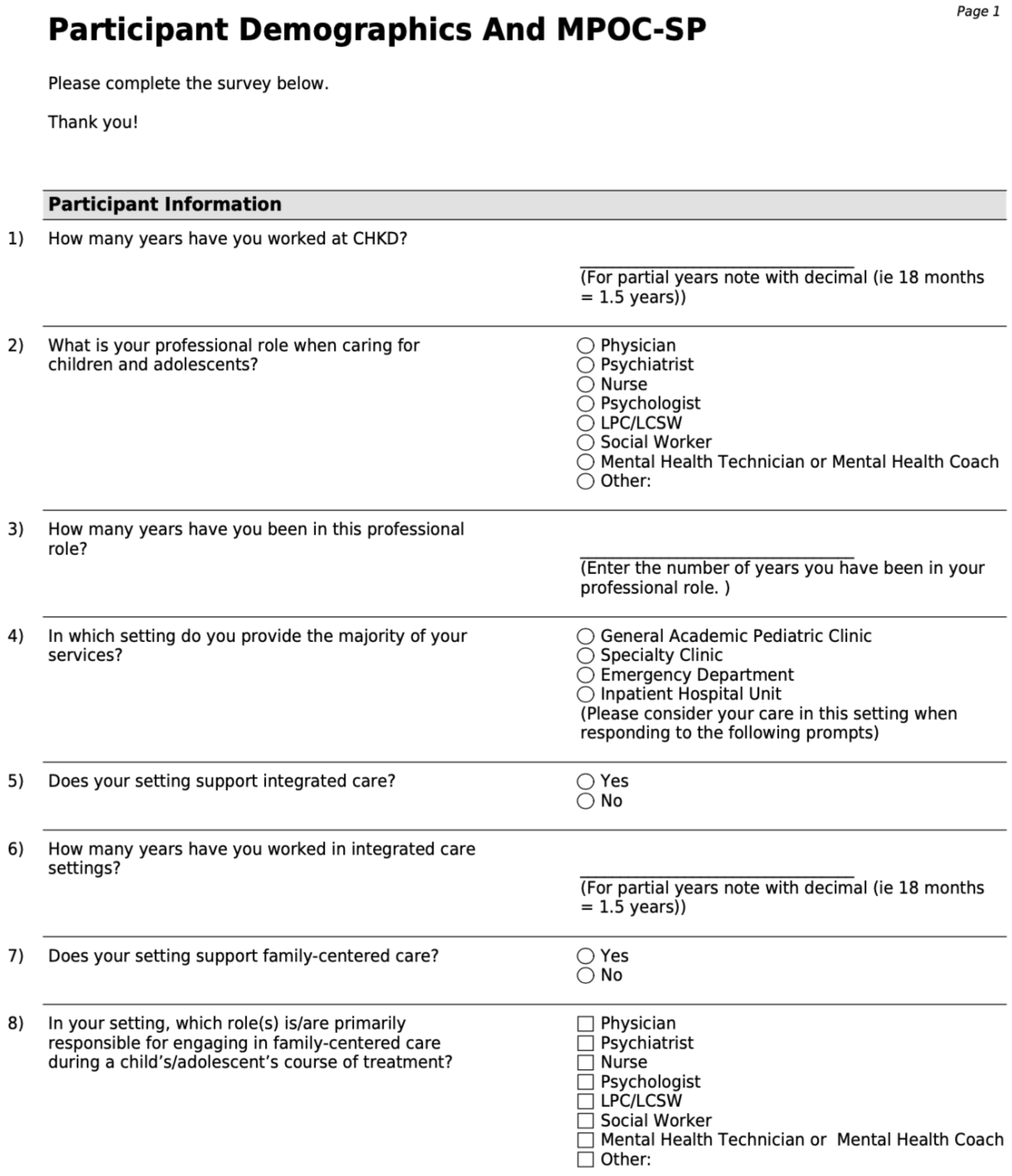
If at any time you feel pressured to participate, or if you have any questions about your rights or this form, then you should call Dr. John Baaki, the current IRB chair, at 757-683-5491, or the Old Dominion University Office of Research, at 757-683-3460.

And importantly, by selecting the check box below, you are telling the researchers YES, that you agree to participate in this study.

☐ Yes I have read the information above and agree to participate in the study

Appendix C

Sample Survey with Measure of Process of Care –Service Provider



Page 1

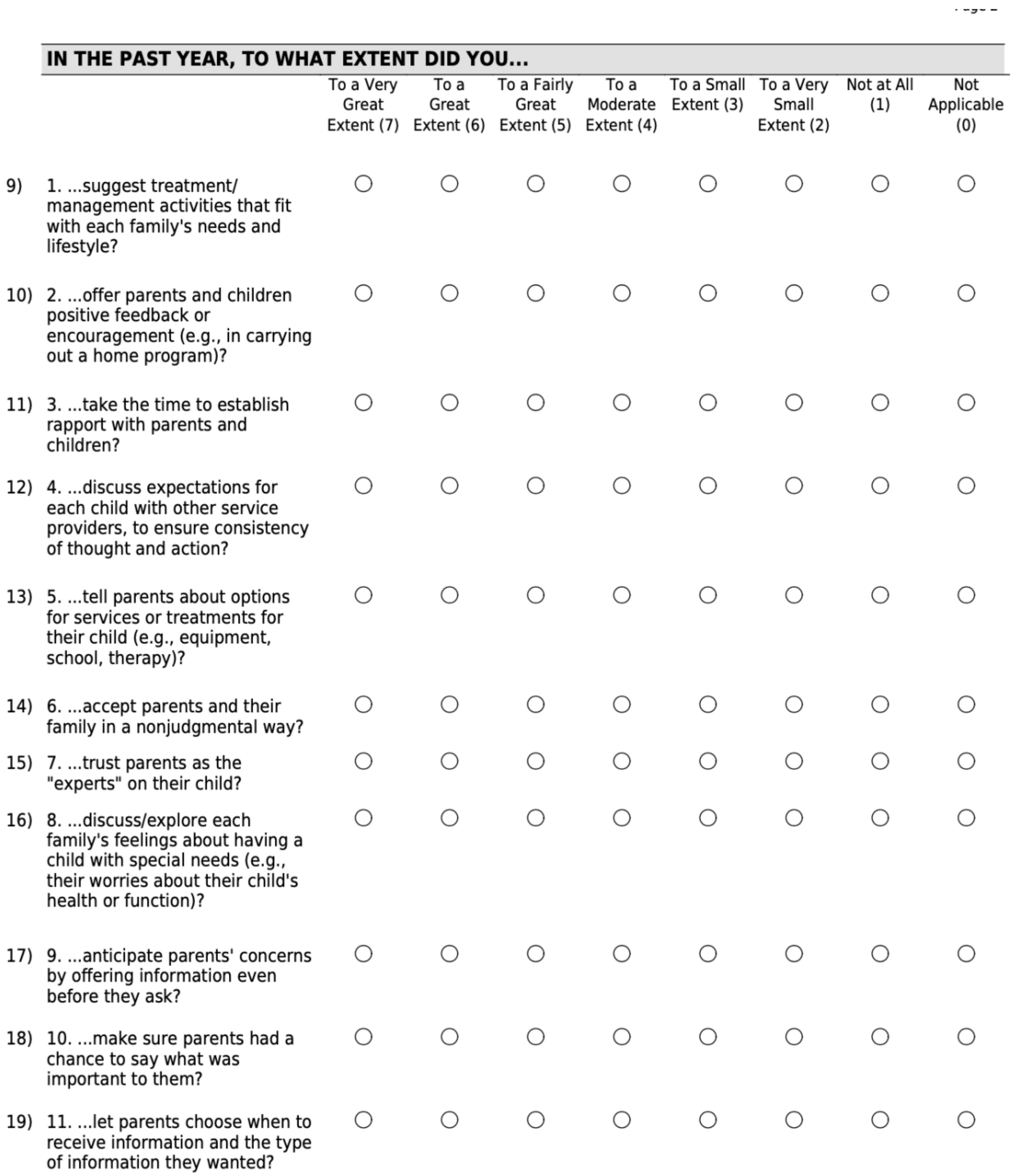
Participant Demographics And MPOC-SP

Please complete the survey below.

Thank you!

Participant Information

1)	How many years have you worked at CHKD?	______________________________ (For partial years note with decimal (ie 18 months = 1.5 years))
2)	What is your professional role when caring for children and adolescents?	○ Physician ○ Psychiatrist ○ Nurse ○ Psychologist ○ LPC/LCSW ○ Social Worker ○ Mental Health Technician or Mental Health Coach ○ Other:
3)	How many years have you been in this professional role?	______________________________ (Enter the number of years you have been in your professional role.)
4)	In which setting do you provide the majority of your services?	○ General Academic Pediatric Clinic ○ Specialty Clinic ○ Emergency Department ○ Inpatient Hospital Unit (Please consider your care in this setting when responding to the following prompts)
5)	Does your setting support integrated care?	○ Yes ○ No
6)	How many years have you worked in integrated care settings?	______________________________ (For partial years note with decimal (ie 18 months = 1.5 years))
7)	Does your setting support family-centered care?	○ Yes ○ No
8)	In your setting, which role(s) is/are primarily responsible for engaging in family-centered care during a child's/adolescent's course of treatment?	☐ Physician ☐ Psychiatrist ☐ Nurse ☐ Psychologist ☐ LPC/LCSW ☐ Social Worker ☐ Mental Health Technician or Mental Health Coach ☐ Other:



IN THE PAST YEAR, TO WHAT EXTENT DID YOU...

		To a Very Great Extent (7)	To a Great Extent (6)	To a Fairly Great Extent (5)	To a Moderate Extent (4)	To a Small Extent (3)	To a Very Small Extent (2)	Not at All (1)	Not Applicable (0)
9)	1. ...suggest treatment/ management activities that fit with each family's needs and lifestyle?	○	○	○	○	○	○	○	○
10)	2. ...offer parents and children positive feedback or encouragement (e.g., in carrying out a home program)?	○	○	○	○	○	○	○	○
11)	3. ...take the time to establish rapport with parents and children?	○	○	○	○	○	○	○	○
12)	4. ...discuss expectations for each child with other service providers, to ensure consistency of thought and action?	○	○	○	○	○	○	○	○
13)	5. ...tell parents about options for services or treatments for their child (e.g., equipment, school, therapy)?	○	○	○	○	○	○	○	○
14)	6. ...accept parents and their family in a nonjudgmental way?	○	○	○	○	○	○	○	○
15)	7. ...trust parents as the "experts" on their child?	○	○	○	○	○	○	○	○
16)	8. ...discuss/explore each family's feelings about having a child with special needs (e.g., their worries about their child's health or function)?	○	○	○	○	○	○	○	○
17)	9. ...anticipate parents' concerns by offering information even before they ask?	○	○	○	○	○	○	○	○
18)	10. ...make sure parents had a chance to say what was important to them?	○	○	○	○	○	○	○	○
19)	11. ...let parents choose when to receive information and the type of information they wanted?	○	○	○	○	○	○	○	○

	12. ...help each family to secure a stable relationship with at least one service provider who works with the child and parents over a long period of time?	○	○	○	○	○	○	○	○
21)	13. ...answer parents' questions completely?	○	○	○	○	○	○	○	○
22)	14. ...tell parents about the results from tests and/or assessments?	○	○	○	○	○	○	○	○
23)	15. ...provide parents with written information about their child's condition, progress, or treatment?	○	○	○	○	○	○	○	○
24)	16. ...tell parents details about their child's services, such as the types, reasons for, and durations of treatment/ management?	○	○	○	○	○	○	○	○
25)	17. ...treat each parent as an individual rather than as a "typical" parent of a child with a "problem"?	○	○	○	○	○	○	○	○
26)	18. ...treat parents as equals rather than just as the parent of a patient (e.g., by not referring to them as "Mom" or "Dad")?	○	○	○	○	○	○	○	○
27)	19. ...make sure parents had opportunities to explain their treatment goals and needs (e.g., for services or equipment)?	○	○	○	○	○	○	○	○
28)	20. ...help parents feel like a partner in their child's care?	○	○	○	○	○	○	○	○
29)	21. ...help parents to feel competent in their roles as parents?	○	○	○	○	○	○	○	○
30)	22. ...treat children and their families as people rather than as a "cases" (e.g., by not referring to the child and families by diagnosis)?	○	○	○	○	○	○	○	○

	23. ... promote family-to-family "connections" for social, informational or shared experiences?	○	○	○	○	○	○	○	○
32)	24. ... provide support to help families cope with the impact of their child's condition (e.g., informing parents of assistance programs, or counselling how to work with other service providers)?	○	○	○	○	○	○	○	○
33)	25. ... provide advice on how to get information or to contact other parents (e.g., through a community's resource library, support groups, or the Internet)?	○	○	○	○	○	○	○	○
34)	26. ... provide opportunities for the entire family, including siblings, to obtain information?	○	○	○	○	○	○	○	○
35)	27. ... have general information available about different concerns (e.g., financial costs or assistance, genetic counselling, respite care, dating and sexuality)?	○	○	○	○	○	○	○	○

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36) Gender

○ Male
○ Female
○ Non-Binary
○ Other

---

37) Race

○ American Indian/Alaska Native
○ Asian
○ Native Hawaiian or Other Pacific Islander
○ Black or African American
○ White
○ More Than One Race
○ Unknown / Not Reported

---

38) Ethnicity

○ Hispanic or Latino ○ NOT Hispanic or Latino ○ Middle Eastern/Arab ○ South Asian
○ East Asian ○ Other ○ Unknown/ Not Reported

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39) Age (years) ______________________________

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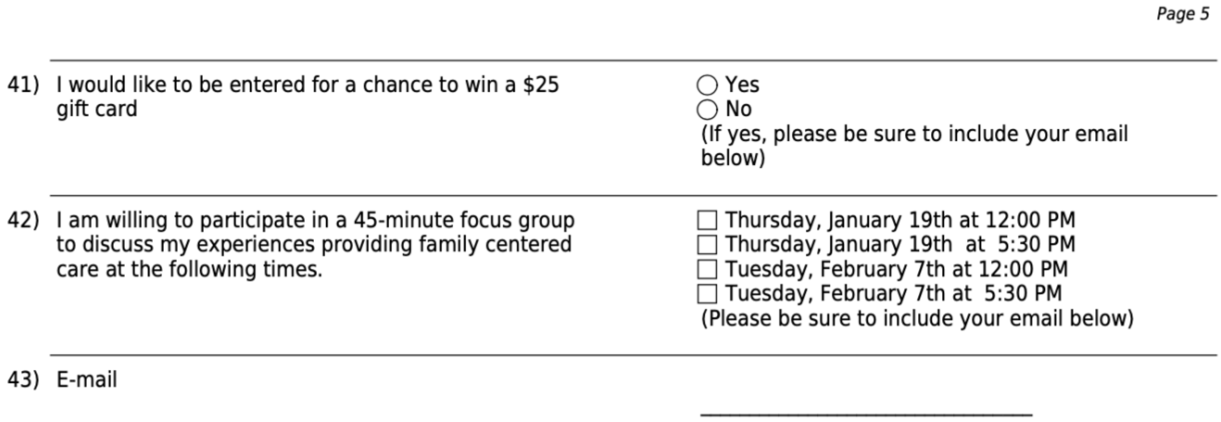
40) Highest Level of Education

○ Doctoral Degree
○ Master's Degree
○ Bachelor's Degree
○ High School Degree
○ Other



Page 5

41)	I would like to be entered for a chance to win a $25 gift card	○ Yes ○ No (If yes, please be sure to include your email below)
42)	I am willing to participate in a 45-minute focus group to discuss my experiences providing family centered care at the following times.	☐ Thursday, January 19th at 12:00 PM ☐ Thursday, January 19th at 5:30 PM ☐ Tuesday, February 7th at 12:00 PM ☐ Tuesday, February 7th at 5:30 PM (Please be sure to include your email below)
43)	E-mail	______________________________

Thank you for sharing your experiences and your time.

Appendix D

Focus Group Protocol

Welcome – *Thank you for making time to be here today. This conversation is part of a larger, independent research effort to understand provider engagement in family focused care across our health care system.*

Duration: 45 minutes

Please put your name/alias, care setting, and provider or staff role in the chat.

Purpose Statement

- The purpose of the focus group is to further understand provider specific implementation of family centered care (FCC).
- Providers will be asked to comment on results of survey and MPOC-SP score profiles by provider type and care settings
- Providers will share their experiences with parent engagement within their respective integrated care settings.
- Information is intended to support role definition with integrated teams and guide training and programmatic practices within pediatric integrated care settings.

Rules

- Please support confidentiality of the group
- It's important to hear everyone's ideas and opinions. Please share the space with other participants.
- There are no right or wrong answers – just ideas, experiences and opinions, which are all valuable.
- It's important to hear all sides– both positive and negative.
- It's important for us all to be equally represented and respected.

I will be video recording our session for transcription purposes only. I want to capture your exact words and still stay engaged with our conversation. Is anyone opposed to being recorded?

Begin Recording

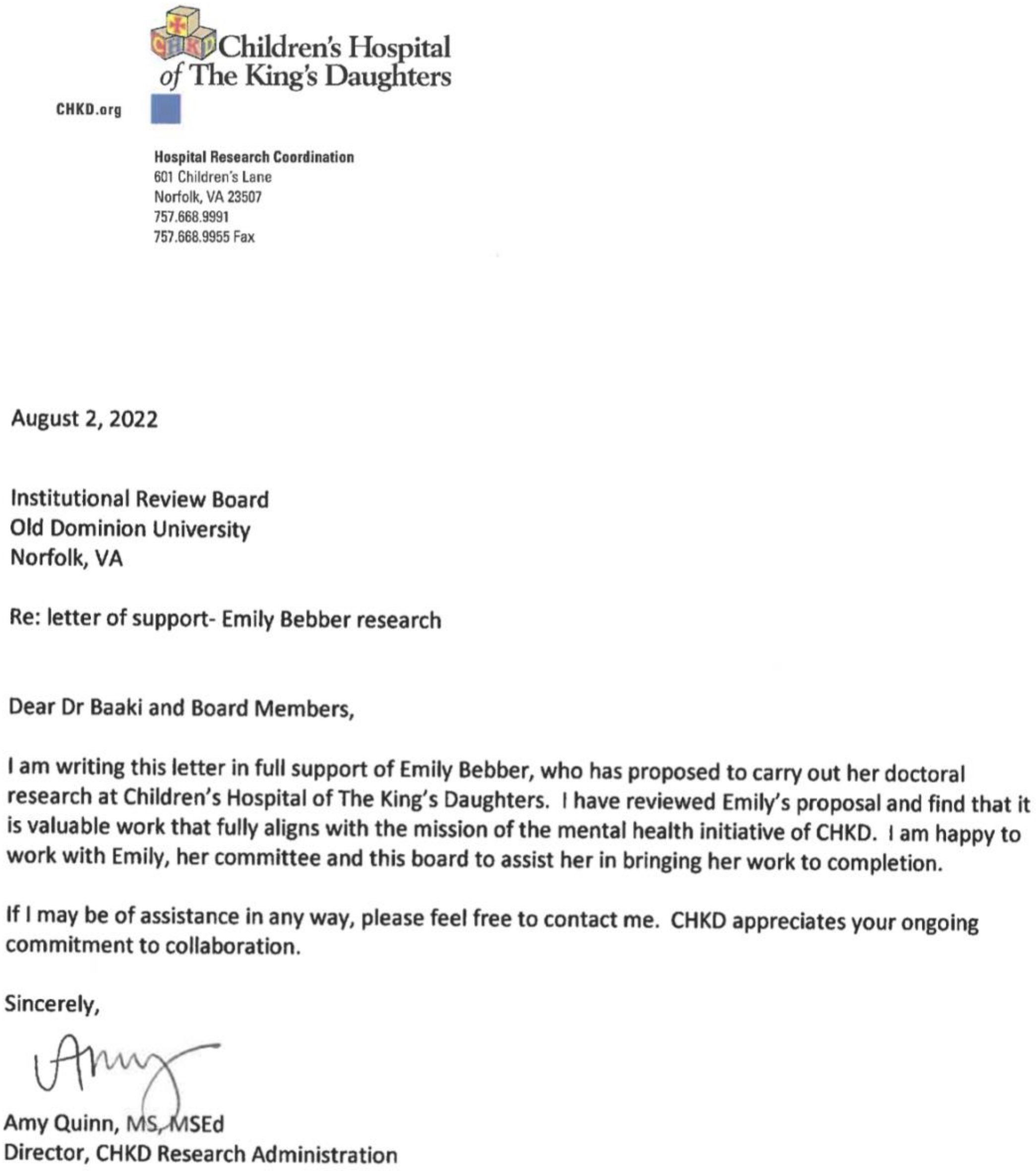
- Tell us what your role in FCC looks like in your setting.
- The results of the survey showed subscale score distributions that…. [Summary of provider score profiles and setting score profiles]. How would you explain these results?
- How are these results consistent or inconsistent with your experiences?
- What, specific to your care setting, supports or limits parent engagement or participation?

Thank you for sharing your time and experiences with me. I will provide a transcription of your individual contributions today for you to review. Please let me know if there are any corrections, additions, or clarifications needed at that time. Thank you!

End Recording

Appendix E

Letter of Research Support



Children's Hospital
of The King's Daughters
CHKD.org

Hospital Research Coordination
601 Children's Lane
Norfolk, VA 23507
757.668.9991
757.668.9955 Fax

August 2, 2022

Institutional Review Board
Old Dominion University
Norfolk, VA

Re: letter of support- Emily Bebber research

Dear Dr Baaki and Board Members,

I am writing this letter in full support of Emily Bebber, who has proposed to carry out her doctoral research at Children's Hospital of The King's Daughters. I have reviewed Emily's proposal and find that it is valuable work that fully aligns with the mission of the mental health initiative of CHKD. I am happy to work with Emily, her committee and this board to assist her in bringing her work to completion.

If I may be of assistance in any way, please feel free to contact me. CHKD appreciates your ongoing commitment to collaboration.

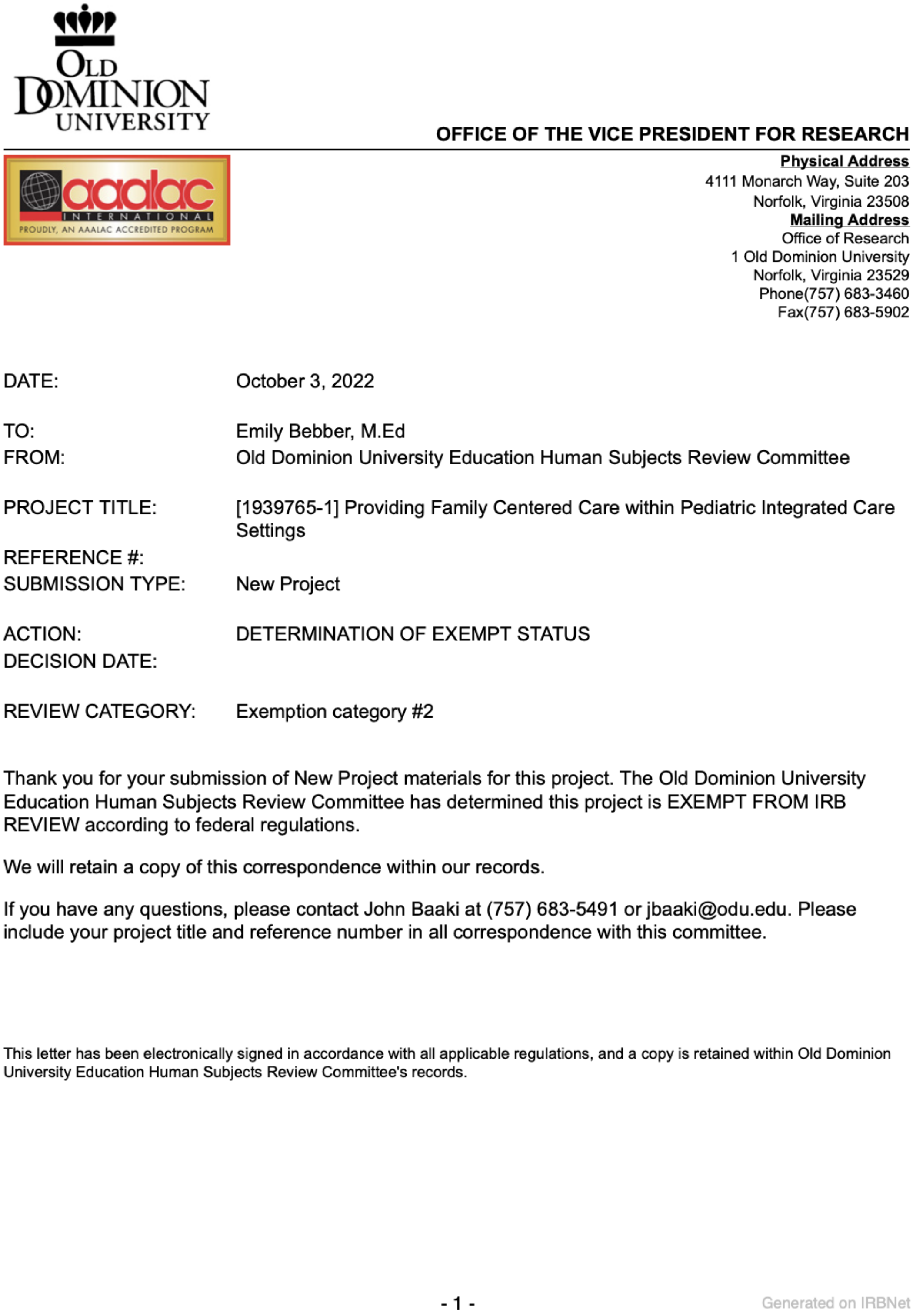
Sincerely,

Amy

Amy Quinn, MS, MSEd
Director, CHKD Research Administration

Appendix F

Determination of Exempt Status



OLD DOMINION UNIVERSITY

OFFICE OF THE VICE PRESIDENT FOR RESEARCH

Physical Address
4111 Monarch Way, Suite 203
Norfolk, Virginia 23508
Mailing Address
Office of Research
1 Old Dominion University
Norfolk, Virginia 23529
Phone(757) 683-3460
Fax(757) 683-5902

DATE: October 3, 2022

TO: Emily Bebber, M.Ed
FROM: Old Dominion University Education Human Subjects Review Committee

PROJECT TITLE: [1939765-1] Providing Family Centered Care within Pediatric Integrated Care Settings
REFERENCE #:
SUBMISSION TYPE: New Project

ACTION: DETERMINATION OF EXEMPT STATUS
DECISION DATE:

REVIEW CATEGORY: Exemption category #2

Thank you for your submission of New Project materials for this project. The Old Dominion University Education Human Subjects Review Committee has determined this project is EXEMPT FROM IRB REVIEW according to federal regulations.

We will retain a copy of this correspondence within our records.

If you have any questions, please contact John Baaki at (757) 683-5491 or jbaaki@odu.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Old Dominion University Education Human Subjects Review Committee's records.

Appendix G

VITA

Emily D. Bebber, M.Ed., LPC

Education

Doctorate in Counselor Education, Old Dominion University, June 2023
Darden College of Education and Professional Services
1226 W. 43rd St., Norfolk, VA 23508
M. Ed, Clinical Mental Health Counseling, Clemson University, December 2011
B.A. Finance and Marketing, Texas Christian University, May 2002

Licensure

Licensed Professional Counselor: Issue date: August 5, 2015, Virginia License #0701006268
Residency Supervisor for LPC: Issue date: August 7, 2017, Virginia

Professional Experience

Manager of Acute Mental Health Services and Operations, Children's Hospital of The King's Daughters.
Director of Community Relations for Compass Services, Lucid Management Solutions.
Licensed Outpatient Therapist, Community Psychological Resources.
Mental Health Therapist, Mental Health Service Line, Children's Hospital of the Kings Daughters.
Director of Crisis Intervention Services and Supervisor for Intensive In-Home Services, Compass Youth and Family Services.
Coordinator of Academic Success.
Area Director, Young Life.
Financial Analyst, Raytheon Missile Systems.

Conference and Community Presentations:

Childhood Anxiety, Virginia Beach City School District, September 2021.
Functions of Behavior, UP Center Therapeutic Foster Care Program, July 2020.
Preparing Future Counselors for Integrated Behavioral Health Care in Pediatrics: Recommendations for Counselor Education and Supervision, Association for Counselor Education and Supervision, October 2019.
Engaging Parents in Treatment Success, Sentara Autism Roundtable, September 2019.
Understanding Depression and Anxiety in Youth, November 2017 and February 2018.

Awards, Grants, and Honors:

Outstanding Doctoral Candidate – Old Dominion University 2023
Darden College of Education Dean's Graduate Travel Award 2019