

The Family Discipline and a Parent Led Curriculum: Measuring Training Outcomes Using an MCH Leadership Competency

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ABSTRACT

While the *MCH Leadership Competencies* and the family discipline have been required elements of Leadership Education in Neurodevelopmental and related Disabilities (LEND) programs for over a decade, little research has been published on the efficacy of either programmatic component in the development of the next generation of leaders who can advocate and care for MCH populations.

Objective: Using an MCH leadership competency as an outcome measure, the effectiveness of family faculty and a parent led curriculum on trainees' content knowledge, skills and leadership development in family-centered care was analyzed.

Method: One hundred and two long-term LEND trainees completed a clinical and leadership training program which featured intensive involvement by a full-time family faculty member and a parent led curriculum. Trainees rated themselves on the basic and advanced skill items that comprise *MCH Leadership Competency 8: Family-centered Care* (ver. 3.0) at the beginning and conclusion of their LEND traineeship.

Results: When compared to their initial scores, trainees rated themselves as significantly higher across all family-centered leadership competency items at the completion of their LEND traineeship.

Conclusion: The intentional engagement of a full-time family faculty member and a parent led curriculum that includes didactic and experiential components leads to greater identification and adoption by trainees of family-centered attitudes, skills, and practices. In addition, the use of the *MCH Leadership Competencies* as a quantifiable measure of program evaluation, particularly leadership development, is supported.

Significance: This study represents a first effort using an MCH leadership competency to directly measure the effectiveness of LEND family faculty and a parent led curriculum in facilitating trainee leadership development in family-center care.

FAMILY AS A LEND DISCIPLINE

MCHB mandated the inclusion of family as a formal discipline within LEND programs in 2005 [1]. This was, in part, in response to the lack of emphasis on family-centered care across many allied health education programs [2-3]. The Boling Center for Developmental Disabilities has continuously employed a full-time family member as part of the interdisciplinary LEND faculty since 2001. The Family Faculty Coordinator has a variety of roles with long-term LEND trainees, including consultation during diagnostic and evaluation clinics, assessment of the family's resource needs, and provision of family-centered and culturally competent approaches to patient care. Trainees are invited to attend support / information groups and local disability board meetings with family faculty as learning experiences. Periodic noon didactics, training panels, and discipline-specific seminars include family faculty and other family representatives.

Most notably, the Family Faculty Coordinator oversees a didactic and experiential Family Mentorship program for LEND trainees. There are several components to this experience, including 8-12 hours with the mentoring family, journaling those experiences, and participating in six interdisciplinary meetings, facilitated by the Family Faculty Coordinator, on a variety of current issues in disability.

Evaluation of the family discipline and parent led curricula in developmental disabilities has been very limited. No research has examined the efficacy of including family faculty with long-term allied health trainees in a LEND Program. There is, however, a limited amount of research that supports the use of parent led curricula with medium-term (40-299 program hours) trainees in such programs [4-5].



| MCH Leadership Competencies: LEND Trainee Rating Scale | | |
|--|---|---|
| Demonstrates a lack of leadership competency | 1 | Lacks strength / competency in this area. Learning experiences are needed. |
| Demonstrates marginal leadership competency | 2 | Emerging skill and awareness of issues. Marginal competency in this area. Continuing to need learning experiences. |
| Demonstrates some leadership competency | 3 | Able to contribute to own profession and related disciplines in this area. Has basic knowledge of issues, demonstrates clinical skills and resources to continue professional growth. Effective with patients and colleagues with some guidance. |
| Demonstrates leadership competency intermittently | 4 | Strong knowledge base in intellectual and developmental disabilities. Competency consistently demonstrated. Able to professionally act and contribute both collaboratively and individually. Expertise demonstrated working with individuals of all ages and their families. Learning is put into practice independently. |
| Demonstrates leadership competency consistently | 5 | Extensive working knowledge, networking, and resourcefulness demonstrated. Demonstrates leadership in advocacy, program development, implementation, and evaluation to enhance the lives of persons with intellectual and developmental disabilities and their families. Engages in research. |

Pre/Post Ratings of MCH Competency 8 - Family-centered Care: **Basic** Skills^a

| Through participation in this program, a participant will: | Type of Ranks | N | Mean Rank | Sum of Ranks | Z | p-value (2-tail) |
|--|---|----------------------|---------------|-----------------|---------------------|------------------|
| Solicit and use family input in a meaningful way in the design or delivery of clinical services, program planning, and evaluation. | Negative Ranks Positive Ranks Ties Total | 0 87 15 102 | 0.00 44.00 | 0.00 3828.00 | -8.316 ^b | < .001 |
| Operationalize the "family-centered care" philosophical constructs (e.g., families and professionals share decision making; professionals use a strengths-based approach when working with families) and use these constructs to critique and strengthen practices, programs, or policies that affect MCH population groups. | Negative Ranks Positive Ranks Ties Total | 0 94 8 102 | 0.00 47.50 | 0.00 4465.00 | -8.623 ^b | < .001 |

Pre/Post Ratings of MCH Competency 8 - Family-centered Care: **Advanced** Skills^a

| With more experience and building on the basic skills, MCH leaders will: | Type of Ranks | N | Mean Rank | Sum of Ranks | Z | p-value (2-tail) |
|---|---|----------------------|---------------|-----------------|---------------------|------------------|
| Ensure that family perspectives play a pivotal role in MCH research, clinical practice, programs, or policy (e.g., in community needs assessments, processes to establish priorities for new initiatives or research agendas, or the development of clinical guidelines). | Negative Ranks Positive Ranks Ties Total | 0 90 12 102 | 0.00 45.50 | 0.00 4095.00 | -8.426 ^b | < .001 |
| Assist primary care providers, organizations, and/or health plans to develop, implement, and/or evaluate models of family-centered care. | Negative Ranks Positive Ranks Ties Total | 0 82 20 102 | 0.00 41.50 | 0.00 3403.00 | -8.043 ^b | < .001 |
| Incorporate family-centered and medical home models of health care delivery into health professions and continuing education curricula and assess the effect of this training on professional skills, health programs, or policies. | Negative Ranks Positive Ranks Ties Total | 0 86 16 102 | 0.00 43.50 | 0.00 3741.00 | -8.245 ^b | < .001 |

^aWilcoxon Signed Ranks Test
^bBased on negative ranks

MCH LEADERSHIP COMPETENCIES

Prior to 2000, there was no uniform definition or metric to measure leadership development within MCH programs, including LENDs. By 2004, MCHB, in collaboration with MCH training programs and practitioners, codified important elements of leadership development by creating and publishing the *MCH Leadership Competencies*. The current version (3.0) encompasses 72 items clustered into 12 competency domains, one of which is Family-Centered Care. Each competency includes a definition of the competency, knowledge areas and basic and advanced skills for that competency. While recent retrospective analysis [6] of cross-sectional data show that a majority of former long-term trainees affirm leadership roles in the field with MCH populations (84.4%), there is no available research that evaluates the sensitivity of specific MCH Leadership Competencies as a measure of specific knowledge, skills or leadership development.

HYPOTHESIS

It was hypothesized that trainees would rate their own knowledge, skills and leadership development in family-centered care as significantly higher after completion of a LEND program which prominently featured high interdisciplinary involvement with family faculty and a parent led curriculum.

METHODS / PARTICIPANTS

At the outset and completion of their LEND experience, trainees were asked to voluntarily rate themselves on the 12 MCH leadership competencies using a 5-point Likert scale. A pre-test / post-test item analysis was conducted to determine the degree of perceived change within a group of trainees for *MCH Leadership Competency 8: Family-centered Care*.

Trainees who completed 300 or more contact hours in the LEND program at the Boling Center for Developmental Disabilities between 2009 and 2015 were eligible participants for the study. One hundred and two trainees (80.3%) completed the *MCH Leadership Competencies* (version 3.0) as a pre- and post-test measure. Disciplines included psychology (46.1%), speech-language pathology (19.6%), audiology (8.8%), nutrition (11.8%), social work (4.9%), nursing (4.9%), and family (2.9%). Forty-seven (46.1%) of the trainees reported having a personal relationship with disability in their life.

RESULTS

As is common with ordinal scales of measurement, the distribution of pre/post test scores was not normally distributed; as such, the nonparametric Wilcoxon Paired Signed-Rank Test was used to evaluate score differences. Trainees uniformly rated themselves as more knowledgeable about what constitutes family-centered care and more supportive of a family-professional partnership at the conclusion of their LEND traineeship. While all post-program ratings of Family-Centered Care (Basic and Advanced skills) were statistically significant, a slightly higher number of trainees rated themselves as unchanged (i.e., tied) across Advanced items of the competency measure.

LIMITATIONS

The *MCH Leadership Competencies* have been criticized as being limited in its validity as an outcome measure [7]. The need to update the competencies to include concepts such as quality improvement and health equity has been noted [6].

Obtained data are based on trainee self-report, which is subject to response bias and may not necessarily reflect changes in observable practice [8]. In addition, one cannot firmly conclude that the self-reported gains in family-centered care in leadership development reported by the trainees derived exclusively from their interdisciplinary interactions with family faculty or participation in a parent led curriculum or were the result of some other aspects of clinical or didactic experience within the LEND Program.

The validity of trainees' ratings on the Family-centered Care competency could be improved upon with a multi-informant assessment system; for example, asking supervisors to separately rate the trainee on the same measure for the purpose of comparison. In addition, this sample was only drawn from one LEND program over a period of six years; establishing a standardized means to use the *MCH Leadership Competencies* as an assessment measure across the network of LEND programs would yield even more robust and generalizable findings.

While these limitations are worth considering, the data in this study provides the first empirical support through the conceptual framework of the *MCH Leadership Competencies* for the effectiveness of the LEND family discipline and a parent led curriculum.

REFERENCES

Available upon request