

# Co-located Parent Coaching Services Within Pediatric Primary Care: Feasibility and Acceptability

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## ABSTRACT

**Introduction:** This project assessed the feasibility and acceptability of Parent Connex, a positive parenting program that integrates screening and co-located parent coaching within pediatric primary care.

**Method:** Eleven practices implemented Parent Connex in phases between November 1, 2016, and July 31, 2019. Screening and surveillance for parenting and family psychosocial concerns were performed during patient visits. Providers responded with brief motivational interviewing and referral. Parenting Specialists provided individualized parent coaching to referred caregivers.

**Results:** Screens were completed at 13,346 (65%) targeted visits, with 26% positive for concerns. Parent coaching was provided to 1,301 of 2,711 (48%) referred families (average 2.2 sessions per family). Providers and staff felt significantly more supported, confident, and knowledgeable about addressing parenting and family psychosocial concerns after implementing Parent Connex and felt

the program improved their relationships with families and quality of care.

**Discussion:** Co-located parent coaching was found to be a feasible and worthwhile addition to pediatric primary care. *J Pediatr Health Care.* (2020) XX, 1–11

## KEY WORDS

Adverse childhood experiences, social determinants of health, integrated, collaborative, prevention

## INTRODUCTION

Childhood adversities are stressful, potentially traumatic events that happen during childhood, including being abused, neglected, witnessing domestic violence, living with someone who is mentally ill, suicidal, or using substances, or being separated from a caregiver through incarceration,

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divorce, or death (Felitti et al., 1998). An estimated 62% of the U.S. population has been exposed to one of these experiences, with 16% reporting exposure to four or more (Merrick, Ford, Ports, & Guinn, 2018). Exposure to four or more childhood adversities has been strongly associated with worse physical and mental health outcomes in adulthood (Felitti et al., 1998). Greater exposure to adversity has also been linked with greater odds of having a developmental, physical, or mental health condition in childhood (Bethell, Newacheck, Hawes, & Halfon, 2014; Bright, Knapp, Hinojosa, Alford, & Bonner, 2016).

Given these associations, addressing childhood adversity is highly relevant to the delivery of health care. In particular, the pediatric primary care setting could be a promising environment for addressing childhood adversity because pediatricians have frequent contact, a high level of trust, and continuity of care with families and children. To prevent the effects of childhood adversity, the American Academy of Pediatrics has recommended that pediatricians provide guidance related to child social–emotional development and positive parenting techniques, actively screen for psychosocial risk factors, and participate in innovative service delivery adaptations to support at-risk children (Garner, Shonkoff, Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, & Section on Developmental and Behavioral Pediatrics, 2012).

A 2013 survey of general pediatricians found that most (79% to 81%) agree that screening for family psychosocial risk factors is within the scope of the pediatric medical home and that their advice can influence positive parenting skills (Kerker et al., 2016; Szilagyi et al., 2016). However, about one-third (32%) were not routinely screening for any of the family psychosocial risk factors that they asked about, and 20% were only screening for one—typically maternal depression or divorce (Kerker et al., 2016; Szilagyi et al., 2016). A 2011 survey of primary care physicians found that most (85%) consider patients' psychosocial needs to be as important as medical conditions, but the majority (80%) lack confidence in their capacity to address psychosocial needs (Fenton, 2011). A systematic review of primary care interventions to address childhood adversity found that the majority (9 out of 10 studies) showed a positive impact on outcomes, including reduced child maltreatment rates, improved child behavior, increased referral rates, and enhanced physician competence (Flynn et al., 2015). Positive parenting programs have also been shown to reduce child maltreatment rates (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009).

Parent Connex is a positive parenting and prevention program that was designed within the pediatric primary care setting in response to the American Academy of Pediatrics recommendations above (Lott, 2020). Parent Connex integrates both screening and surveillance for parenting and family psychosocial concerns as well as co-located parent coaching services within pediatric primary care. Pediatricians screen families for parenting and family psychosocial concerns at targeted well-child visits from birth to 6 years of age

and routinely surveil for these concerns at all other patient visits. They use motivational interviewing skills to discuss concerns with families and connect them with resources. A similar screening model has previously been shown to reduce child protective services reports and harsh punishment by parents (Dubowitz, Feigelman, Lane, & Kim, 2009). Parent coaching is a collaborative one-on-one process intended to guide, equip, and empower parents toward achieving their parenting-related goals. Parenting Specialists from a community-based organization with graduate-level education work with parents onsite at the pediatric practice to identify and employ solution-focused strategies for their parenting concerns with the goal of promoting child social–emotional and behavioral health through strengthened positive parenting and family functioning. Parent coaching services are available to all families within the practice, regardless of the child's age. By offering parenting services onsite, parents can receive nearly immediate access to individualized support within a familiar environment. When a referral for more extensive evaluation or intervention is warranted, Parenting Specialists can serve as a bridge to connect parents with other services, such as mental health counseling.

This paper is the first to describe the Parent Connex program and explores the feasibility and acceptability of its integration within 11 pediatric primary care practices. Feasibility was assessed through process measures including screening, referral, and usage rates, and acceptability was assessed through a survey of primary care providers and staff on their attitudes, support, confidence, and knowledge related to addressing parenting and family psychosocial concerns as well as their satisfaction with Parent Connex.

## METHODS

### Setting and Participants

Program staff introduced Parent Connex to 12 pediatric primary care practices within the Cincinnati metropolitan area in the Midwestern United States, and 11 agreed to participate. Four practices began Parent Connex on November 1, 2016. An additional three practices began on January 1, 2018, and another four practices began on January 1, 2019. Two practices that began in 2016 were independently owned solo pediatric primary care practices, and the other nine practices were part of one large multispecialty group medical practice. Table 1 contains more information on these practices. This paper reports results from July 1, 2017, to July 31, 2019 as the screening tool was standardized by July 2017. Process measures were tracked monthly and shared with each practice routinely to assess feasibility and to improve program quality. This project, including a request to waive informed consent, was reviewed by the Institutional Review Board and was determined not to require human subjects approval as it did not meet the regulatory criteria for research involving human subjects. Primary care providers and staff completed the acceptability survey anonymously online, with no identifying private information collected. Providers and staff did not receive compensation for participating.

**TABLE 1. Characteristics of 11 pediatric primary care practices that implemented Parent Connex**

Practices	Type	Location	Patient population, <i>n</i>	Percent Medicaid	Targeted visits for screening, months	Targeted visits completed, <i>n</i>	Screens completed, <i>n</i> (%)	Screens reviewed, <i>n</i> (%)	Positive screens, <i>n</i> (%)	Families referred for coaching, <i>n</i>	Families coached, <i>n</i> (%)
Cohort 1											
Practice 1 <sup>a</sup>	Solo	Suburban	19,989	4.2	1, 9, 24, 36	7,781	5,366 (69)	5,223 (97)	1,210 (23)	541	386 (71)
Practice 2	Solo	Suburban	3,300 <sup>b</sup>	4.0	1, 12, 36	416	378 (91)	359 (95)	113 (30)	76	45 (59)
Practice 3	Group	Suburban	10,025	10.8	1, 15, 36, 60	2,956	1,850 (63)	1,804 (98)	498 (27)	447	206 (46)
Practice 4	Group	Urban	6,698	14.3	1, 15, 36, 72	3,014	2,144 (71)	2,075 (97)	556 (26)	686	307 (45)
Cohort 2											
Practice 5	Group	Urban	2,224	19.9	1, 15, 36	964	762 (79)	721 (95)	257 (34)	119	47 (39)
Practice 6	Group	Urban	7,197	19.0	1, 15, 36	1,062	559 (53)	515 (92)	225 (40)	311	94 (30)
Practice 7 <sup>a</sup>	Group	Urban	13,421	6.8	1, 24, 48	2,594	1,392 (54)	1,257 (90)	366 (26)	279	122 (44)
Cohort 3											
Practice 8	Group	Urban	6,252	19.9	1, 15, 36	381	195 (51)	178 (91)	61 (31)	49	9 (18)
Practice 9	Group	Suburban	1,688	33.7	1, 15, 36	274	66 (24)	58 (88)	23 (35)	29	8 (28)
Practice 10	Group	Suburban	5,443	21.8	1, 15, 36	402	163 (41)	154 (94)	56 (34)	45	12 (27)
Practice 11	Group	Suburban	4,924	11.2	1, 15, 36	702	471 (67)	467 (99)	141 (30)	129	65 (50)
Total	—	—	81,161	—	—	20,546	13,346 (65)	12,811 (96)	3,506 (26)	2,711	1,301 (48)

Note. Cohort 1 practices implemented Parent Connex from July 1, 2017, to July 31, 2019 (25 months), Cohort 2 practices implemented Parent Connex from January 1, 2018, to July 31, 2019 (19 months), and Cohort 3 practices implemented Parent Connex from January 1, 2019, to July 31, 2019 (7 months).

<sup>a</sup>Practice 1 had three locations, and practice 7 had two locations.

<sup>b</sup>The size of the patient population and percent Medicaid was estimated for practice 2.

## Intervention

### Screening and surveillance

The Parent Connex Parent Questionnaire (PCPQ), which screens for parenting and family psychosocial concerns, was given to caregivers on paper in English by either front desk registration, nurses, or medical assistants in the examination room at a minimum of three well-child visits from birth to 6 years of age. Each practice selected its targeted well-child visits (Table 1). The PCPQ was developed by combining and modifying two existing surveys based on feedback from parents on a Parent Advisory Council and pediatricians on a Pediatrician Steering Committee related to the items, wording, response scales, and scoring. The first 6-items inquire about parental stress, including parenting confidence, parenting support, parenting effectiveness, child behavior challenges, home or family life stress, and parenting differences, on a 4-point Likert scale (not very, somewhat, quite, very). These items were modified from the 7-item Parenting Experience Survey created by the Triple P—Positive Parenting Program (Turner, Sanders, & Markie-Dadds, 1999). Major parental stress is considered positive if “not very” is selected for any of the items 1–3 or if “quite” or “very” is selected for any of the items 4–6. The next 8-items inquire about family psychosocial concerns, including harsh punishment, parental depression, parental substance abuse, financial insecurity, and domestic violence on a 4-point Likert scale (never, rarely, sometimes, often). Each of these five concerns is considered positive if “sometimes” or “often” is selected on these respective items. These items were modified from the Safe Environment for Every Kid (SEEK) Parent Screening Questionnaire, which has demonstrated good specificity (80% to 95%) and negative predictive value (88% to 98%) across risk factors and more variable sensitivity (29% to 97%) and positive predictive value (17% to 41%) depending on the risk factor (Dubowitz et al., 2007; Dubowitz et al., 2009; Dubowitz, Prescott, Feigelman, Lane, & Kim, 2008; Hager et al., 2010; Lane et al., 2007). Primary care providers reviewed and signed the PCPQ, engaged parents in conversations about any positive responses, and documented any actions or referrals on the PCPQ. Providers also performed routine surveillance for parenting and family psychosocial concerns during patient visits for children of all ages. Before program implementation, 90% (60/67) of providers either completed 2 hrs of in-person training on motivational interviewing adapted for brief encounters (offered on multiple occasions in the evening,  $n = 41$ ) or had already been trained previously by the same trainer ( $n = 19$ ). They were taught core skills of how to ask open questions, deliver affirmations, make reflective statements, and guide and summarize conversations. These communication techniques were intended to help engage parents in supportive conversation and jointly problem-solve and plan for change. Providers’ decision to refer was based on their clinical judgment. Handouts and resource lists related to each positive response were also available for families.

### Parent coaching

Parenting Specialists employed by a community-based organization provided complementary parent coaching services onsite at the practices. These services were available to all families within the practice, regardless of the child’s age. Parenting Specialists were hired with graduate-level education in child development, counseling, social work, or a related field and extensive experience ( $\geq 5$  years) working with parents and children. Parenting Specialists were full-time employees with benefits, including paid time off, medical insurance, short- and long-term disability, and malpractice coverage. They were trained in motivational interviewing (Miller, 1983) and Natural Strength Parenting, which is a parent coaching model that was developed by the community-based organization that is centered in positive psychology (e.g., intentionality, strengths, mindfulness) and social cognitive theory (e.g., goal-setting, monitoring, self-efficacy). Natural Strength Parenting training consisted of an 8-hr in-person orientation to the model and toolkit, in-person shadowing of parent coaching sessions, ongoing team case consultation sessions, and regular supervision to ensure high-quality service delivery. Each Parenting Specialist served two practices and had designated, private space within the practice to meet with caregivers (e.g., conference room, examination room). Upon receiving a referral, Parenting Specialists called caregivers to schedule a session. During the first session, caregivers received a copy of their client rights, signed an agreement to participate in parent coaching services, signed an authorization allowing the Parenting Specialist to disclose protected health information to the practice, and completed a demographic form, the PCPQ, and the validated Healthy Families Parenting Inventory to assess the caregiver’s resilience (Krysiak & LeCroy, 2012). During parent coaching, Parenting Specialists facilitated change through a process of (1) eliciting and understanding concerns; (2) envisioning desired goals; (3) providing education on child development, parenting guidance and resources, self-care guidance, resource navigation and referral, and crisis support as appropriate; (4) collaboratively identifying intentional daily actions to support progress; (5) affirming and building on strengths as the foundation for change; and (6) ongoing monitoring. The first session typically lasted 60–90 min, and subsequent sessions lasted up to 60 min. The number of sessions and time between sessions was decided on the basis of the caregiver’s preferences. Parenting Specialists entered brief notes about their sessions in the child’s electronic medical record through the use of a linking software that limited data access to only patients referred to them.

### Data Collection

#### Feasibility

The number and proportion of screens completed, screens reviewed by the provider (as confirmed by their signature on the PCPQ), families referred to the Parenting Specialists, and families who used the parent coaching services were tracked monthly for each practice. These process measures

were also shared and reviewed routinely with each practice to identify opportunities for improvements, and variable small tests of change were implemented by each practice to improve rates (e.g., color-coding, flagging, or having morning huddles to identify patients eligible for the screen; Parenting Specialists returning unsigned screens to providers to ensure parent responses were seen). The demographic characteristics of the caregivers who participated in parent coaching were also collected.

### Acceptability

Primary care providers and staff at the practices that began implementing Parent Connex in 2018 and 2019 were invited to complete an anonymous, online survey immediately before and 1 year after implementation. The survey asked about their position in the practice and 15 questions about their attitudes, support, confidence, and knowledge related to addressing parenting concerns and family psychosocial concerns (e.g., caregiver mental illness or substance use, food or financial insecurity, domestic violence) as part of pediatric health care on a 7-point Likert scale from 1 (strongly disagree) to 7 (strongly agree). The version of the survey given after implementation also asked 15 questions about their perspectives on Parent Connex on a 7-point Likert scale from 1 (strongly disagree) to 7 (strongly agree) as well as “How likely they are to recommend Parent Connex to a colleague” on a scale from 0 (not at all likely) to 10 (extremely likely).

### Data Analysis

Descriptive statistics were used to characterize the caregiver demographics and rates of screening, referral, and use of parent coaching services across practices. Spearman correlations assessed the association between each of these rates and the percentage of the practice population that was receiving Medicaid. Fisher exact tests compared families referred from screening versus surveillance on their usage rates of parent coaching services and their disclosure of parent- and child-related concerns. Primary care provider and staff survey responses were compared from before and 1 year after implementing Parent Connex using Mann-Whitney *U* tests for providers and staff separately. Medians and interquartile ranges are reported instead of means and standard deviations because of the skewness of the survey data.

## RESULTS

### Feasibility

All 11 practices incorporated screening for parenting and family psychosocial concerns at targeted well-child visits and provided parent coaching services onsite. The PCPQ was completed at 65% (13,346/20,546) of targeted well-child visits, ranging widely from 24% to 91% across practices (Table 1). Having a lower percent Medicaid population was significantly correlated with higher PCPQ completion rates ( $r = -0.65, p = .030$ ). Primary care providers reviewed 96% ( $n = 12,811$ ) of completed PCPQs, ranging from 88% to 99% across practices (Table 1). The PCPQ was positive

26% ( $n = 3,506$ ) of the time, ranging from 23% to 40% across practices (Table 1). Having a lower percent Medicaid population was significantly correlated with having fewer positive PCPQs ( $r = 0.75, p = .008$ ). Major parental stress was the most commonly reported concern (16%,  $n = 2,091$ ), followed by parental depression (10%,  $n = 1,356$ ), financial insecurity (6%,  $n = 777$ ), harsh punishment (3%,  $n = 430$ ), parental substance abuse (0.7%,  $n = 100$ ), and domestic violence (0.2%,  $n = 24$ ).

Primary care providers referred 412 (12%) families to the Parenting Specialists and 18 (0.5%) families to external agencies as a result of screening. Referral rates to the Parenting Specialists after screening were highest for the 6-year well-child visit (23%, 24/106), followed by the well-child visits at 12–15 months (16%, 90/562), 3 years (15%, 161/1,044), 5 years (14%, 4/28), 4 years (8%, 7/85), 1–9 months (6%, 69/1,095), and 2 years (6%, 27/437).

An additional 2,299 families were referred to the Parenting Specialists on the basis of routine surveillance. The primary child was aged under 6 years for most of these families (54%, 1,249/2,299), followed by 6–8 years for 418 families, 9–12 years for 348 families, and 13–18 years for 217 families.

Of the total 2,711 families referred to the Parenting Specialists, 1,301 (48%) families engaged in parent coaching, including 1,874 caregivers (more than one caregiver could participate per family). Table 2 contains the demographic characteristics of caregivers. The average age of caregivers was 38 years (standard deviation = 7, range = 18–75 years). Usage rates for referred families ranged broadly from 18% to 71% across practices (Table 1). Having a lower percent Medicaid population was significantly correlated with a higher usage rate ( $r = -0.87, p < .001$ ). Families that were referred from surveillance were more likely to engage in parent coaching than families referred from screening (52% [1,189/2,299] vs. 27% [112/412],  $p < .001$ ). Overall, families participated in 2,924 parent coaching sessions, with 664 (51%) families having one session, 298 (23%) families having two sessions, and 339 (26%) families having three or more sessions. The average number of sessions per family was 2.2 (standard deviation = 2.3, range = 1–24 sessions). Table 3 contains the main concerns discussed, supports provided, and referrals made during sessions. Families that were referred from screening were significantly more likely to disclose parent-related concerns (54% [61/112] vs. 24% [282/1,189],  $p < .001$ ) and less likely to disclose child-related concerns (82% [92/112] vs. 91% [1,086/1,189],  $p = .003$ ) during sessions than families that were referred from surveillance.

### Acceptability

Twenty-one primary care providers, including medical doctors, physician assistants, and advanced registered nurse practitioners, completed the survey before implementing Parent Connex, and 16 providers completed the survey 1 year after implementation. Thirty-six primary care staff (six registered nurses, nine licensed practical nurses, 12 medical



**TABLE 2. Demographic characteristics of caregivers (N = 1,874) who participated in parent coaching services as part of Parent Connex**

Characteristic	n (%)
Sex	1,755 (94)
Male	583 (33)
Female	1,172 (67)
Race	1,664 (89)
White or Caucasian	1,546 (93)
African American or black	50 (3)
Asian	38 (2)
Mixed race	16 (1)
Other	14 (1)
Ethnicity	1,619 (86)
Not Hispanic or Latino	1,568 (97)
Hispanic or Latino	51 (3)
Parenting role	1,751 (93)
Biological parent	1,705 (97)
Grandparent	20 (1)
Stepparent	16 (1)
Legal guardian or dedicated adult	6 (< 1)
Foster parent	4 (< 1)
Marital status	1,703 (91)
Married	1,429 (84)
Single	135 (8)
Divorced	84 (5)
Separated	50 (3)
Widowed	5 (< 1)
Educational attainment	1,645 (88)
Graduate or professional degree	491 (30)
Bachelor degree	630 (38)
Some college or associate degree	327 (20)
High school graduate or GED	187 (11)
Some high school	10 (1)
Employment status	1,602 (85)
Full-time	1,113 (69)
Part-time	200 (12)
Stay-at-home parent	231 (14)
Unemployed	42 (3)
Retired	16 (1)
Annual household income	1,586 (85)
≤ \$15,000	27 (2)
\$15,001–\$30,000	52 (3)
\$30,001–\$50,000	129 (8)
\$50,001–\$75,000	253 (16)
> \$75,000	1,125 (71)

Note. GED, General educational development.

assistants, and nine administrative staff) completed the survey before implementing Parent Connex, and 14 staff (one registered nurse, four licensed practical nurses, seven medical assistants, and two administrative staff) completed the survey 1 year after implementation.

Both primary care providers and staff showed a significant increase from before to 1 year after implementing Parent Connex in their belief that there was sufficient support within their practice for addressing parenting and family psychosocial concerns, in their confidence in their ability to address them, and in their knowledge of resources for them (Table 4). Providers also showed significantly greater

**TABLE 3. Most common concerns discussed by families (N = 1,301) and supports provided by Parenting Specialists during parent coaching sessions as part of Parent Connex**

Characteristic	% (n)
Child-related concerns	91 (1,178)
Behavior	55 (722)
Emotion or mood	31 (405)
Anxiousness	18 (235)
Attention	15 (201)
Sleep	12 (156)
School	7 (85)
Sibling rivalry	6 (72)
Sensory processing	5 (61)
Development	4 (49)
Toilet training	3 (42)
Parent-related concerns	26 (343)
Stress	20 (262)
Divorce	7 (85)
Mental health	4 (56)
Parenting guidance provided	85 (1,106)
Conveying empathy	47 (615)
Delivering labeled praise	33 (430)
Regulating emotions	25 (323)
Setting limits	25 (320)
Spending quality “time in”	24 (315)
Acceptance of child	24 (310)
Mindfulness techniques	16 (209)
Creating routines or schedules	15 (193)
Sleep hygiene	12 (156)
Sibling guidance	6 (72)
Sensory processing strategies	5 (61)
Toilet training strategies	3 (42)
Parenting resources provided <sup>a</sup>	16 (205)
Child development education provided	49 (635)
Self-care guidance provided	11 (148)
Resource referrals provided <sup>b</sup>	8 (106)
Crisis support provided	1 (19)

<sup>a</sup>Includes books, videos, and Web sites.

<sup>b</sup>Includes referrals to mental health services (n = 70), medical specialties (n = 26), basic needs assistance (n = 6), support groups (n = 5), divorce services (n = 1), addiction services (n = 1), domestic violence services (n = 1), bereavement services (n = 1), legal assistance (n = 1), and child care resources (n = 1).

endorsement that their practice was equipped to address the mental and behavioral health needs of their patients following 1 year of Parent Connex (Table 4). Providers and staff strongly endorsed both before and 1 year after Parent Connex that pediatric practices should inquire about parenting and family psychosocial concerns, that referring caregivers to resources for these concerns is within the scope of a pediatric practice, and that their practice was providing patients with the care that they needed to thrive and leading the way in patient care (Table 4).

Providers gave an average rating of 9.4 (median = 10, interquartile range = 1) on a 10-point scale for how likely they would be to recommend Parent Connex to a colleague. All providers endorsed being satisfied with Parent Connex, that Parent Connex improved the quality of their patient care, their ability to address parenting concerns, and was

**TABLE 4. Primary care provider and staff attitudes and perceived knowledge, confidence, and support related to addressing parenting and family psychosocial concerns before and 1 year after implementing Parent Connex at six pediatric practices**

Survey items	Providers					Staff				
	Before (n = 21)		After (n = 16)		Difference z (p Value)	Before (n = 36)		After (n = 14)		Difference z (p value)
	% (n) Agree	Median (IQR)	% (n) Agree	Median (IQR)		% (n) Agree	Median (IQR)	% (n) Agree	Median (IQR)	
How strongly do you agree or disagree with the following statements? <sup>a</sup>										
1. Pediatric practices should inquire about parenting.	100 (21)	7 (1.0)	100 (16)	6.0 (1.0)	0.15 (.88)	92 (33)	6.0 (1.0)	93 (13)	6.0 (1.0)	0.24 (.81)
2. Referring caregivers to resources for parenting support is within the scope of a pediatric practice.	95 (20)	6.0 (1.0)	100 (16)	7.0 (1.0)	-0.89 (.37)	97 (35)	7.0 (1.0)	93 (13)	6.0 (1.0)	0.86 (.39)
3. There is sufficient time for assessing parenting during well-child visits.	33 (7)	3.0 (3.0)	56 (9)	5.0 (2.2)	-0.86 (.39)	53 (19)	5.0 (2.0)	64 (9)	5.0 (2.0)	-1.17 (.24)
4. There is sufficient support within our practice for addressing parenting concerns.	29 (6)	3.0 (3.0)	88 (14)	6.0 (1.0)	-3.39 (< .001)*	56 (20)	5.0 (2.0)	93 (13)	6.0 (0.0)	-2.46 (.014)*
5. I am confident in my ability to address parenting concerns with families.	76 (16)	5.0 (1.0)	94 (15)	6.0 (1.0)	-2.02 (.043)*	39 (14)	4.0 (1.0)	71 (10)	6.0 (2.0)	-2.27 (.023)*
6. I am knowledgeable of resources for parenting.	43 (9)	4.0 (1.0)	88 (14)	5.5 (1.0)	-2.94 (.003)*	36 (13)	4.0 (2.0)	85 (11) <sup>b</sup>	6.0 (1.0)	-2.43 (.015)*
7. Pediatric practices should inquire about the family's psychosocial history.	90 (19)	6.0 (1.0)	94 (15)	6.0 (0.3)	-1.61 (.11)	89 (32)	6.0 (1.0)	86 (12)	6.0 (1.0)	0.35 (.73)
8. Referring caregivers to resources for psychosocial concerns is within the scope of a pediatric practice.	76 (16)	6.0 (1.0)	88 (14)	6.0 (2.0)	-1.67 (.095)	89 (32)	6.0 (1.0)	93 (13)	6.0 (1.0)	-0.42 (.67)
9. There is sufficient time for assessing the family's psychosocial history during well-child visits.	14 (3)	2.0 (1.0)	38 (6)	3.0 (3.0)	-1.47 (.14)	42 (15)	4.0 (2.0)	57 (8)	5.0 (2.0)	-1.10 (.27)
10. There is sufficient support within our practice for addressing family psychosocial concerns.	5 (1)	2.0 (1.0)	50 (8)	4.5 (3.0)	-3.40 (< .001)*	56 (20)	5.0 (2.0)	93 (13)	6.0 (1.0)	-2.61 (.009)*
11. I am confident in my ability to address psychosocial concerns with families.	19 (4)	4.0 (2.0)	75 (12)	5.0 (1.2)	-2.88 (.004)*	28 (10)	4.0 (2.0)	71 (10)	6.0 (2.0)	-2.54 (.011)*
12. I am knowledgeable of resources for families with psychosocial concerns.	24 (5)	3.0 (2.0)	56 (9)	5.0 (2.2)	-2.50 (.012)*	31 (11)	4.0 (3.0)	79 (11)	6.0 (1.0)	-2.67 (.008)*
13. Our practice is equipped to address the mental and behavioral health needs of our patients.	52 (11)	5.0 (1.0)	81 (13)	6.0 (1.0)	-2.62 (.009)*	64 (23)	5.0 (2.0)	86 (12)	6.0 (2.0)	-1.90 (.057)
14. Our practice is providing patients with the care that they need to thrive.	86 (18)	6.0 (1.0)	94 (15)	6.0 (0.0)	-1.76 (.078)	89 (32)	6.0 (1.0)	93 (13)	6.0 (1.0)	-0.35 (.73)
15. Our practice is leading the way in patient care.	76 (16)	6.0 (1.0)	88 (14)	6.0 (0.0)	-1.59 (.11)	92 (33)	6.0 (1.0)	93 (13)	6.0 (1.0)	0.18 (.86)

Note. IQR, interquartile range.  
<sup>a</sup>Scores from 1 (strongly disagree) to 7 (strongly agree).  
<sup>b</sup>Completed by 13 staff.  
 \*p < .05

**TABLE 5. Primary care provider and staff feedback on Parent Connex after 1 year of implementation at six pediatric practices**

Survey items	Providers (n = 16)		Staff (n = 12)	
	% (n) Agree	Median (IQR)	% (n) Agree	Median (IQR)
How strongly do you agree or disagree with the following statements? <sup>a</sup>				
1. I am satisfied with Parent Connex.	100 (16)	7.0 (1.0)	83 (10)	7.0 (1.0)
2. Parent Connex has improved the quality of our patient care.	100 (16)	7.0 (1.0)	92 (11)	7.0 (1.0)
3. Parent Connex has improved our relationships with our families.	75 (12)	6.0 (1.0)	83 (10)	7.0 (1.0)
4. Parent Connex has improved our ability to address parenting concerns.	100 (16)	7.0 (1.0)	92 (11)	7.0 (1.0)
5. Parent Connex has helped clinic to stay on schedule.	44 (7)	4.0 (2.0)	50 (6)	5.0 (2.0)
6. Parent Connex has reduced the length of well-child visits.	31 (5)	4.0 (3.0)	33 (4)	4.0 (4.0)
7. Parent Connex has decreased the workload of our health care team.	56 (9)	5.0 (2.0)	33 (4)	4.0 (2.0)
8. Parent Connex has made my job less stressful.	63 (10)	5.0 (3.0)	17 (2)	4.0 (0.0)
9. Parent Connex has helped me to do my job better.	88 (14)	6.0 (1.0)	42 (5)	4.0 (2.0)
10. Parent Connex has been worth the time and effort.	100 (16)	7.0 (1.0)	75 (9)	6.0 (2.0)
11. The Parenting Specialist is a valuable addition to our health care team.	100 (16)	7.0 (1.0)	92 (11)	6.5 (1.2)
12. The Parenting Specialist works and communicates well with our health care team.	100 (15) <sup>b</sup>	6.0 (1.0)	92 (11)	6.5 (1.0)
13. The Parenting Specialist is effective at addressing our families' needs.	100 (16)	6.0 (1.0)	83 (10)	6.5 (1.0)
14. I hope our practice can continue Parent Connex after the grant period is over.	94 (15)	7.0 (1.0)	92 (11)	6.5 (1.0)
15. I would advocate to a health network or insurance company to cover the cost of Parent Connex.	94 (15)	7.0 (1.0)	83 (10)	6.5 (1.0)

Note. IQR, interquartile range.  
<sup>a</sup>Scores from 1 (strongly disagree) to 7 (strongly agree).  
<sup>b</sup>Completed by 15 providers.

worth the time and effort, and that the Parenting Specialist was a valuable addition to their health care team, who worked and communicated well with their health care team, and was effective at addressing their families' needs (Table 5). In general, providers felt that Parent Connex helped them to do their jobs better and improved their relationships with their families but did not help the clinic to stay on schedule or reduce the length of well-child visits (Table 5). Staff responses were similar to providers, although a much smaller proportion endorsed that Parent Connex helped them to do their jobs better or made their jobs less stressful (Table 5). The staff gave an average rating of 8.8 (median = 10, interquartile range = 1.5) on a 10-point scale for how likely they would be to recommend Parent Connex to a colleague.

## DISCUSSION

This project explored the feasibility and acceptability of the Parent Connex positive parenting and prevention program, including screening and surveillance and co-located parent coaching services, within 11 pediatric primary care practices. Screening for parenting and family psychosocial concerns was implemented within all practices, with over 13,000 screens completed in 2 years (an overall screening rate of 65%) and varying success with screening across practices

(24% to 91%). Onsite parent coaching was provided at all practices, with 1,301 families participating (an overall usage rate of 48%) and varying degrees of use across practices (18% to 71%). Greater feasibility, as indicated by higher screening rates and usage rates, was found within those practices that served fewer low-income families. All surveyed primary care providers were satisfied with Parent Connex, as they felt it improved their quality of care, their ability to address parenting concerns, and their relationships with families.

Routine screening resulted in many parents disclosing parenting stress and depressive symptoms to their pediatricians. However, few parents reported substance use or domestic violence. This finding is similar to other studies (Eismann, Theuerling, Maguire, Hente, & Shapiro, 2019; Gottlieb, Hessler, Long, Amaya, & Adler, 2014), suggesting that screening may not be the most effective way to identify these concerns. Referrals were made for 12% of families with a positive screen, with 412 referrals to the onsite Parenting Specialists and only 18 referrals to offsite resources. Referrals were provided at the discretion of the pediatrician. Pediatricians addressed many concerns without a referral through conversation, anticipatory guidance, and support. Some families were already managing or receiving supports for concerns, and some were not interested in guidance or



referral. Connection to offsite resources was not tracked, which is similar to most studies assessing screening for family psychosocial concerns (Gottlieb, Wing, & Adler, 2017). When assessed, mixed results have been found on the uptake of community referrals (Gottlieb et al., 2017). Additional provider training and linkage with offsite resources could increase this referral rate. Routine surveillance for parenting and family psychosocial concerns resulted in substantially more referrals to the Parenting Specialists than formal screening ( $n = 2,299$ ), suggesting that screening may not be the most effective way to promote connection to supportive services within this primarily privately insured population. However, screening may still be worthwhile for identifying parenting and mental health concerns and initiating related conversations with families (Eismann et al., 2019).

Parent coaching was co-located onsite and mostly integrated within the pediatric primary care practices, such that the service was available to all families and Parenting Specialists attended regular practice meetings and documented their sessions within the patient medical record. Scheduling was the only nonintegrated feature, being coordinated by the community-based organization and routinely communicated to practice staff. The usage rate of 48% for onsite parent coaching was comparable to offsite behavioral health services (Kolko, Campo, Kelleher, & Cheng, 2010; Kolko et al., 2014). A greater usage rate may not have been found with this onsite service because parent coaching is intended to be preventive, serving families who have not reached the threshold for needing more intensive behavioral health services. This usage rate is slightly higher than that of other positive parenting programs that have been provided onsite at pediatric primary care practices, such as Incredible Years (42% to 44%; McMenamy, Sheldrick, & Perrin, 2011; Perrin, Sheldrick, McMenamy, Henson, & Carter, 2014), Child Adult Relationship Enhancement in Primary Care (41%; Schilling et al., 2017), and Primary Care Triple P (18%; Spijkers, Jansen, & Reijneveld, 2013). These programs provide parenting guidance through a set number of group sessions, whereas Parent Connex provides individual sessions using a coaching model with the intensity of services on the basis of parent preference. Co-location and individualized coaching allow for greater flexibility in seeing families and the ability to provide open-ended services as needed (Stancin & Perrin, 2014). Evidence from meta-analyses demonstrates that coaching is an effective intervention for improving well-being, coping, self-regulation, changing attitudes and behaviors, and attaining goals (Sonesh et al., 2015; Theeboom, Beersma, & van Vianen, 2014).

Other integrative pediatric primary care models have recently been developed and shown to be effective in improving preventive health care and reducing costly emergency care for children (Coker et al., 2016; Johnston, Huebner, Anderson, Tyll, & Thompson, 2006; Sege et al., 2015). These integrative care models include the Parent-focused Redesign for Encounters, Newborns to Toddlers program, in which master's degree level parent coaches

provide anticipatory guidance, psychosocial and developmental screening, and referral to community agencies during well-child visits for children aged up to 2 years for low-income families (Coker et al., 2016), the Healthy Steps for Young Children program, in which master's degree level Healthy Steps specialists provide developmental screening and anticipatory guidance to parents with infants through team-based well-child visits and follow-up home visits and parenting classes (Johnston et al., 2006), and the Developmental Understanding and Legal Collaboration for Everyone program, in which family specialists participate in well-child visits in children aged up to 6 months, initiate consults with medical-legal partners, and provide home visitation to low-income families (Sege et al., 2015). Parent Connex differs from these programs by providing support to parents with any age child rather than only infants and by targeting services to parents specifically seeking support rather than providing services universally. Future research is needed to understand better the comparative and cost-effectiveness of these programs within different populations.

After 1 year of Parent Connex, primary care providers and staff showed significant improvement in how supported, confident, and knowledgeable they felt about addressing parenting and family psychosocial concerns. These findings are similar to previous research on the SEEK model, which also involves screening at early well-child visits, that found increased comfort and perceived competence among providers in addressing family psychosocial risk factors after implementing SEEK (Dubowitz et al., 2011). However, providers who implemented SEEK did not show a change in their knowledge of how to address psychosocial risk factors (Dubowitz et al., 2011). A study evaluating the integration of care managers into pediatric primary care to provide behavioral health interventions also showed increased perceived competence and effectiveness among primary care providers in addressing behavioral health concerns (Kolko et al., 2014). Primary care providers who received training in the Triple P—Positive Parenting Program also reported greater confidence, use of skills, and satisfaction with the outcomes of their parent consultations (Sanders, Tully, Turner, Maher, & McAuliffe, 2003; Turner, Nicholson, & Sanders, 2011). This evidence suggests that screening, parenting, and behavioral health interventions have the potential to help overcome some of the perceived provider barriers to addressing psychosocial concerns within pediatric health care, such as lack of confidence, skills, and specific resources (Szilagyi et al., 2016).

The primary care providers unanimously agreed that the Parenting Specialist was a valuable addition to their health care team and effective at addressing family needs. After implementing Parent Connex, providers felt like their practice was better equipped to address the mental and behavioral health needs of their patients. However, the majority did not endorse that Parent Connex saved time during visits or helped keep clinic on schedule. In a previous study evaluating part-time co-location of a psychologist within primary

care, practice staff also reported quicker identification of behavioral health concerns, improved quality of patient care, and enhanced referrals to community resources, but providers did endorse spending less unscheduled time discussing behavioral health concerns with families (Ward-Zimmerman & Cannata, 2012). The impact of Parent Connex on the unscheduled time of providers was not evaluated. A previous study that combined psychosocial screening during 2–3-year well-child visits with an onsite 10-week group parenting education program using the Incredible Years curriculum found that most of the primary care providers (90% to 100%) felt the program had little to no negative impact on their unscheduled workload, clinic flow, or office space, and 70% felt it improved their overall care by offering a needed service for parents (McMenamy et al., 2011).

### Limitations

This project has limitations. First, the screening tool used by the practices has not been validated, although one of the surveys that it was adapted from has some evidence of validity. Lack of validation is a limitation of many screening tools for family psychosocial concerns (Sokol et al., 2019). This screening tool was intended to initiate conversations, not to diagnose or formally evaluate. Second, demographic information was not collected on families who completed the screen, only on those who participated in parent coaching, and the only practice level measure collected and evaluated was the percentage of the practice population receiving Medicaid. Future studies should evaluate demographic and additional practice level measures to understand better the characteristics of families who disclose concerns and receive referrals. Third, most of the families who participated in parent coaching had annual household incomes greater than \$75,000, limiting the generalizability of these findings to low-income families who may experience additional barriers to the use of services. There was also a greater proportion of white or Caucasian participants (93%) in this cohort when compared with the general population of this metropolitan area (79%) and a smaller proportion of black or African American participants (3% vs. 12%, respectively), suggesting disparity in the use of either this service or these practices (U.S. Census Bureau, 2018). Fourth, the survey given to primary care providers and staff has not been validated. It was also completed anonymously, so it was not possible to link up each participant's pre- and postsurvey responses. Observational changes in behavior and competence were also not evaluated. Fifth, survey completion may have been subject to self-selection bias and may, therefore, not be representative of the perspectives of all providers and staff who participated. The statistical significance of these survey results must be interpreted with caution because of the limited sample size of providers and staff who completed it.

In summary, the Parent Connex positive parenting program, including screening and co-location of parent coaching services, was implemented within 11 pediatric primary

care practices with varying results. Early screening provided an opportunity for providers to routinely assess and discuss parent-related stresses and concerns early in the child's life but did not result in substantial referrals or connections to supports for families. Surveillance resulted in many more referrals and greater connection of parents to the conveniently located, onsite parent coaching services. Parenting Specialists from the community-based organization provided parents with individualized support to strengthen positive parenting and family functioning in an effort to foster healthy child development and prevent childhood adversity and/or the need for behavioral health services later in life. Nearly all primary care providers and staff surveyed found the co-location of parent coaching services within pediatric primary care to be worthwhile and beneficial for improving patient care. Further research is needed to understand better the effectiveness of this program on improving child development and health.

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### REFERENCES

- Bethell, C. D., Newacheck, P., Hawes, E., & Halfon, N. (2014). Adverse childhood experiences: Assessing the impact on health and school engagement and the mitigating role of resilience. *Health Affairs*, *33*, 2106–2115.
- Bright, M. A., Knapp, C., Hinojosa, M. S., Alford, S., & Bonner, B. (2016). The comorbidity of physical, mental, and developmental conditions associated with childhood adversity: A population based study. *Maternal and Child Health Journal*, *20*, 843–853.
- Coker, T. R., Chacon, S., Elliott, M. N., Bruno, Y., Chavis, T., Biely, C., . . . Chung, P. J. (2016). A parent coach model for well-child care among low-income children: A randomized controlled trial. *Pediatrics*, *137*, e20153013.
- Dubowitz, H., Feigelman, S., Lane, W., & Kim, J. (2009). Pediatric primary care to help prevent child maltreatment: The Safe Environment for Every Kid (SEEK) model. *Pediatrics*, *123*, 858–864.
- Dubowitz, H., Feigelman, S., Lane, W., Prescott, L., Blackman, K., Grube, L., . . . Tracy, J. K. (2007). Screening for depression in an urban pediatric primary care clinic. *Pediatrics*, *119*, 435–443.
- Dubowitz, H., Lane, W. G., Semiatin, J. N., Magder, L. S., Venepally, M., & Jans, M. (2011). The Safe Environment for Every Kid model: Impact on pediatric primary care professionals. *Pediatrics*, *127*, e962–e970.
- Dubowitz, H., Prescott, L., Feigelman, S., Lane, W., & Kim, J. (2008). Screening for intimate partner violence in a pediatric primary care clinic. *Pediatrics*, *121*, e85–e91.
- Eismann, E. A., Theuerling, J., Maguire, S., Hente, E. A., & Shapiro, R. A. (2019). Integration of the Safe Environment for Every Kid (SEEK) model across primary care settings. *Clinical Pediatrics*, *58*, 166–176.

- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*, 245–258.
- Flynn, A. B., Fothergill, K. E., Wilcox, H. C., Coleclough, E., Horwitz, R., Ruble, A., . . . Wissow, L. S. (2015). Primary care interventions to prevent or treat traumatic stress in childhood: A systematic review. *Academic Pediatrics, 15*, 480–492.
- Garner, A. S., Shonkoff, J. P., & Committee on Psychosocial Aspects of Child and Family Health. (2012). Committee on Early Childhood, Adoption, and Dependent Care, & Section on Developmental and Behavioral Pediatrics. (2012). Early childhood adversity, toxic stress, and the role of the pediatrician: Translating developmental science into lifelong health. *Pediatrics, 129*, e224–e231.
- Gottlieb, L. M., Wing, H., & Adler, N. E. (2017). A systematic review of interventions on patients' social and economic needs. *American Journal of Preventive Medicine, 53*, 719–729.
- Gottlieb, L., Hessler, D., Long, D., Amaya, A., & Adler, N. (2014). A randomized trial on screening for social determinants of health: The iScreen study. *Pediatrics, 134*, e1611–e1618.
- Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., . . . Frank, D. A. (2010). Development and validity of a 2-item screen to identify families at risk for food insecurity. *Pediatrics, 126*, e26–e32.
- Johnston, B. D., Huebner, C. E., Anderson, M. L., Tyll, L. T., & Thompson, R. S. (2006). Healthy Steps in an integrated delivery system: Child and parent outcomes at 30 months. *Archives of Pediatrics and Adolescent Medicine, 160*, 793–800.
- Kerker, B. D., Storfer-Isser, A., Szilagyi, M., Stein, R. E. K., Garner, A. S., O'Connor, K. G., . . . Horwitz, S. M. (2016). Do pediatricians ask about adverse childhood experiences in pediatric primary care? *Academic Pediatrics, 16*, 154–160.
- Kolko, D. J., Campo, J. V., Kelleher, K. J., & Cheng, Y. (2010). Improving access to care and clinical outcome for pediatric behavioral problems: A randomized trial of a nurse-administered intervention in primary care. *Journal of Developmental and Behavioral Pediatrics, 31*, 393–404.
- Kolko, D. J., Campo, J., Kilbourne, A. M., Hart, J., Sakolsky, D., & Wisniewski, S. (2014). Collaborative care outcomes for pediatric behavioral health problems: A cluster randomized trial. *Pediatrics, 133*, e981–e992.
- Krysiak, J., & LeCroy, C. W. (2012). Development and initial validation of an outcome measure for home visitation: The healthy families parenting inventory. *Infant Mental Health Journal, 33*, 496–505.
- Lane, W. G., Dubowitz, H., Feigelman, S., Kim, J., Prescott, L., Meyer, W., & Tracy, J. K. (2007). Screening for parental substance abuse in pediatric primary care. *Ambulatory Pediatrics, 7*, 458–462.
- Lott, R. (2020). Treating children, coaching their parents. *Health Affairs, 39*, 562–566.
- McMenamy, J., Sheldrick, R. C., & Perrin, E. C. (2011). Early intervention in pediatric offices for emerging disruptive behavior in toddlers. *Journal of Pediatric Health Care, 25*, 77–86.
- Merrick, M. T., Ford, D. C., Ports, K. A., & Guinn, A. S. (2018). Prevalence of adverse childhood experiences from the 2011–2014 Behavioral Risk Factor Surveillance System in 23 states. *JAMA Pediatrics, 172*, 1038–1044.
- Miller, W. R. (1983). Motivational interviewing with problem drinkers. *Behavioural Psychotherapy, 11*, 147–172.
- Perrin, E. C., Sheldrick, R. C., McMenamy, J. M., Henson, B. S., & Carter, A. S. (2014). Improving parenting skills for families of young children in pediatric settings: A randomized clinical trial. *JAMA Pediatrics, 168*, 16–24.
- Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-based prevention of child maltreatment: The U.S. Triple P system population trial. *Prevention Science, 10*, 1–12.
- Fenton, M (2011). *Health Care's Blind Side: The Overlooked Connection between Social Needs and Good Health*. Princeton, NJ: Robert Wood Johnson Foundation.
- Sanders, M. R., Tully, L. A., Turner, K. M. T., Maher, C., & McAuliffe, C. (2003). Training GPs in parent consultation skills. An evaluation of training for the Triple P-Positive Parenting Program. *Australian Family Physician, 32*, 763–768.
- Schilling, S., French, B., Berkowitz, S. J., Dougherty, S. L., Scribano, P. V., & Wood, J. N. (2017). Child-Adult Relationship Enhancement in Primary Care (PriCARE): A randomized trial of a parent training for child behavior problems. *Academic Pediatrics, 17*, 53–60.
- Sege, R., Preer, G., Morton, S. J., Cabral, H., Morakinyo, O., Lee, V., . . . Kaplan-Sanoff, M. (2015). Medical-legal strategies to improve infant health care: A randomized trial. *Pediatrics, 136*, 97–106.
- Sokol, R., Austin, A., Chandler, C., Byrum, E., Bousquette, J., Lancaster, C., . . . Shanahan, M. (2019). Screening children for social determinants of health: A systematic review. *Pediatrics, 144*, e20191622.
- Sonesh, S. C., Coultas, C. W., Lacerenza, C. N., Marlow, S. L., Benishek, L. E., & Salas, E. (2015). The power of coaching: A meta-analytic investigation. *Coaching: An International Journal of Theory, Research and Practice, 8*, 73–95.
- Spijkers, W., Jansen, D. E., & Reijneveld, S. A. (2013). Effectiveness of Primary Care Triple P on child psychosocial problems in preventive child healthcare: A randomized controlled trial. *BMC Medicine, 11*, 240.
- Stancin, T., & Perrin, E. C. (2014). Psychologists and pediatricians: Opportunities for collaboration in primary care. *American Psychologist, 69*, 332–343.
- Szilagyi, M., Kerker, B. D., Storfer-Isser, A., Stein, R. E. K., Garner, A., O'Connor, K. G., . . . McCue Horwitz, S. (2016). Factors associated with whether pediatricians inquire about parents' adverse childhood experiences. *Academic Pediatrics, 16*, 668–675.
- Theeboom, T., Beersma, B., & van Vianen, A. E. M. (2014). Does coaching work? A meta-analysis on the effects of coaching on individual level outcomes in an organizational context. *The Journal of Positive Psychology, 9*, 1–18.
- Turner, K. M. T., Nicholson, J. M., & Sanders, M. R. (2011). The role of practitioner self-efficacy, training, program and workplace factors on the implementation of an evidence-based parenting intervention in primary care. *Journal of Primary Prevention, 32*, 95–112.
- Turner, K. M. T., Sanders, M. R., & Markie-Dadds, C. (1999). *Practitioner's Manual for Primary Care Triple P*. Brisbane, Australia: Families International Publishing.
- U.S. Census Bureau. (2018). *American Community Survey 1-year estimates*. Retrieved from <https://censusreporter.org/profiles/31000US17140-cincinnati-oh-ky-in-metro-area/>
- Ward-Zimmerman, B., & Cannata, E. (2012). Partnering with pediatric primary care: Lessons learned through collaborative colocation. *Professional Psychology: Research and Practice, 43*, 596–605.