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Cover Page Footnote

This paper and the research behind it would not have been possible without the dedication and efforts of Ashley Zheng. Ashley is responsible for exhausting the research and writing the entirety of the original drafted paper. Her attention to detail and efforts to build understanding around the research goals were exceptional. BobbiJo Pansier conceptualized the work, contributed to the early stages of the research and provided edits to the written work. Kasey Reinhardt offered support, review and suggestions for edits of the written work. We acknowledge and extend our gratitude to Standish Foundation for Children for supporting the research, work and time associated with this paper. We express our gratitude to Catchafire.org for connecting Standish Foundation for Children with invaluable and talented volunteers, like Ashley Zheng, who help to support our mission to transform healthcare for children, families and healthcare professionals. This article is associated with the Staff & Provider Engagement lens of The Beryl Institute Experience Framework (https://www.theberylinstitute.org/ExperienceFramework). You can access other resources related to this lens including additional PXJ articles here: http://bit.ly/PX_StaffProvEngage

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Research

Global child and family-centered care fellowship, education and mentorship for pediatric healthcare professionals: A literature review

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Abstract
Child- and family-centered care (FCC) is increasingly accepted and implemented to optimize the healthcare experience for patients, their families, and healthcare professionals. Standish Foundation for Children, a 501(c)(3) non-profit, has designed and piloted a fellowship to educate pediatric healthcare professionals in FCC & psychosocial care via an inquiry and mentorship model in Tbilisis, Georgia. This review aimed to evaluate and synthesize existing literature on psychosocial and FCC mentorship for pediatric healthcare professionals in four parts: ongoing need, effects on healthcare professionals, effects on children and their families and/or caregivers, and in cross-country healthcare settings. Reviewers searched open-source databases for articles in English published between 2010 and 2021. Opportunities for psychosocial and FCC skills development is both desired and needed by pediatric healthcare professionals, a viewpoint shared by families of pediatric patients. Existing mentorship models varied in design but overall improved provider confidence and ability to provide FCC in clinical settings. Some support for these interventions improving patient and family clinical outcomes is documented, although further research is necessary. In cross-country healthcare settings with varying resource levels, clinical mentorship in general can improve quality and delivery of care without requiring entirely new approaches. This review supports psychosocial mentorship models as an effective tool for child- and family-centered care delivery. Future research into long-term professional and patient outcomes, FCC impact on pediatric patients with non-traditional family units, and in cross-country settings is recommended to gain a more comprehensive understanding of how FCC can improve quality of healthcare.

Keywords
Patient- and family-centered care, patient-centered care, pediatric, pediatric healthcare, healthcare education, quality of care, healthcare, mentorship, patient experience, patient satisfaction, communication

Introduction

The Standish Foundation for Children is a nonprofit organization that aims to transform the child healthcare experience for children, their families, and healthcare providers, spearheading multiple local and global initiatives designed to help foster positive healthcare experiences that lead to long-term wellbeing. One such initiative is the Global Child and Family-Centered Care Fellowship, in which healthcare professionals participate in an inquiry and mentorship based educational exchange at sites in Tbilisi, Georgia. The fellowship's goals are two-fold: 1) to enhance healthcare professionals' knowledge, skills, and confidence in delivering child- and family-centered care (FCC), and 2) promote sustainability and cross-country support for pediatric healthcare worldwide.

FCC is increasingly accepted and implemented as an adaptable and effective model to "optimize the quality of health care for individual patients in any setting"[1] and has documented positive effects on patients, families, and healthcare professionals. The goal of this literature review is to summarize current findings in child and family-centered care education for pediatric healthcare professionals (PHCP), specifically the impacts of mentorship models on providers/professionals and patients, families, and caregivers. An additional area of interest included pediatric healthcare worker mentorship in cross-country healthcare settings with different resource levels.

Although numerous articles on mentorship in healthcare settings exist, there is a lack of research discussing short- and long-term effects of FCC mentorship interventions similar to that of Standish Foundation's fellowship program on participating healthcare professionals and their patients. Initial database reviews revealed an ongoing need for psychosocial/FCC mentoring opportunities as our first theme, which we supplemented with a three-part search: 1) psychosocial/FCC PHCP mentorship effects on PHCPs, 2) psychosocial/FCC PHCP mentorship effects on patients, their families, and/or caregivers, and 3) clinical

mentorship for PHCPs between different countries. In total, 25 articles were reviewed.

Persistent need for child- and family-centered care training

There is a persistent need for quality mentorship and psychosocial skills development indicated by healthcare professionals and patients alike. In the United States, the 2008-09 patient-physician ratio in adolescent medicine was 85,000 patients per certified physician and is expected to continue growing.[2] Hergenroeder et al.[2] also found that PHCPs in other fields desire specific training to better deliver care to this patient population. Average employment of U.S. pediatric hospitalists is less than 3 years, with mentorship being the area in which hospitalists were least satisfied irrespective of demographics.[3] Adequate mentorship was associated with greater career satisfaction, which in turn was associated with higher patient satisfaction and better patient care, in addition to higher retention in specialty and employment.[3] Common themes in high quality mentor-mentee relationships include comprehensive focus, clear expectations, and acknowledgment of limitations on the mentor side and preparation, proactivity, continual re-evaluation, willingness to seek mentorship outside of common venues, and building of a mentorship team by the mentee.[4] According to an international survey conducted in 87 countries, emergency department staff saw providing psychosocial care to injured children as part of their job but had only moderate confidence overall in their ability to do so, with low confidence in advanced psychosocial care elements such as educating parents and children about traumatic stress responses.[5] PHCPs feel unable to provide appropriate psychosocial care to patients in emotional distress, showing the need for increased skills development and provider psychosocial support.[6]

In general, health professionals support FCC implementation as beneficial, a perspective shared by parents. Parents of children with congenital heart disease reported needing different forms of formalized psychosocial support at different stages of their child's care that allow them to act as primary caregivers and advocates for their child in both hospital and home.[7]

FCC is widely recognized as "the standard of pediatric healthcare," yet barriers to implementation remain.[8] These include mismatches between perceptions of healthcare professional and patient priorities; healthcare professionals perceive that patients and families prioritized physical care and the medical model of healthcare, whereas patients and families feel they lack opportunity to discuss psychological and social concerns.[6] Coats et al.[9] identified physical hospital layouts and concerns over the effect of parents' presence on nurses' abilities to provide high quality patient care and mentor juniors as additional challenges faced by PHCPs. Separate studies evaluating practices and perceptions in providing FCC and psychosocial support found that PHCPs perceived the necessity of these services and programs to be significantly greater than their availability in practice.[10, 11] In addition, although PHCPs generally believed that they had an important role in providing psychosocial support to siblings and parents, few felt confident in their training and ability to do so.[11]

Impacts of psychosocial and/or FCC education on healthcare professionals

Various interventions have been designed to foster and tailor FCC implementation in specific areas of pediatric healthcare. Between March 2006-07, multi-day retreats held in seven different states in the U.S. with pediatric palliative care providers and parents as equal participants resulted in lasting improvements to participant confidence in catalyzing improvements in care.[12] Providers and parent participants greatly valued the collaborative learning setting, with themes of relational learning across boundaries and leveling of hierarchies between different provider levels and parents as key factors in increasing their confidence in their ability to advocate for pediatric palliative care.[12] Stanford residents participating in the Special Care Optimization for Patients and Education (SCOPE) self-directed intervention were better able to establish FCC goals of care and demonstrated better understanding of the home, social, and systemic challenges faced by children with special healthcare needs and their families.[13] Both 4-hour and 90-minute patient-centered electronic health record (EHR) trainings successfully helped University of Chicago and Cleveland Clinic faculty improve their EHR usage to promote patient-doctor communication instead of detracting from it.[14] Pivoting briefly to emphasize provider wellness, the 18-month Mindful Mentors intervention for pediatric cardiology staff teaches providers to use mindfulness methods with coworkers, patients, and families to reduce stress and burnout and improve wellbeing and was found to be both practical and highly accepted in hospital culture.[15] In neonatal care settings, the unit-wide Close Collaboration with Parents (CCP) training intervention aiming to change values and attitudes and reduce FCC implementation barriers in the NICU was largely well-received by staff.[16] Nurse attitudes towards increased parent presence shifted to viewing parents as resources in caring for infants and overall they perceived the changes to be beneficial to providers, infants, and parents, with key facilitators to adoption of FCC principles being staff motivation to change, commitment across hierarchies, experiential learning, and effective mentors.[16] Addressing healthcare delivery to pediatric refugee and asylee populations, an intervention in the form of a workshop addressing unique challenges and policy barriers in providing care was well-received by participants and significantly increased

comfort with asking about social and behavioral health of refugee patients.[17]

Impacts of psychosocial and/or FCC healthcare professional education on patients, families, and caregivers

Fewer studies have been done on the effects of PHCP education on their patients and families and those we found focused on changes in perception or immediate clinical outcomes. Parents in the relationship learning retreat intervention, similar to clinicians, had increased confidence in their ability to advocate for pediatric palliative care improvements and felt they learned to better understand the care and commitment clinicians have for their patients.[12] Families of children with special healthcare needs who participated in the SCOPE intervention reported high satisfaction with SCOPE care teams, and nearly half of participants stated that their SCOPE resident was the only contact in the medical system that helped them coordinate care for their child, an element they perceive as an essential part of their child's healthcare.[13] In two hospitals where NICU nurses underwent a 2-month training in delivering Family Integrated Care (FIC), infants with Bronchopulmonary Dysplasia in the FIC intervention group had significantly better clinical measures in several areas.[18] FIC encouraged nurses to facilitate increased parent presence with their infant through education and support, which is thought to have positive impacts on infant health outcomes.[18] CCP, another NICU-focused intervention, decreased maternal postpartum depression, with the biggest effects in mothers of infants born between 28-31 gestational weeks, and increased parent-infant closeness.[19, 20]

Mentorship between Countries

The studies discussed so far have taken place in higher resource countries, which many of the original authors have noted as potential limitations to generalization. Different facilitators and barriers to clinical mentorship likely exist in different countries, cultures and resources levels, with an added importance of long-term sustainability to encourage continued participation and development. In countries with high child mortality, Integrated Management of Childhood Illness (IMCI) aims to improve pediatric care, but carries several implementation challenges such as poor post-didactic training supervision and gaps in support systems for healthcare professionals.[21] In rural Rwanda, an intervention designed to address these barriers through mentoring and enhanced supervision (MESH) is perceived by mentors, mentees, and clinical leadership as an accepted and effective capacity-building strategy for addressing gaps in provider ability and improving clinical outcomes.[21] In a similarly styled intervention in the Jigawa State of Nigeria, clinical mentoring significantly improved healthcare workers' capacity to deliver better maternal, newborn, and child health services and increased emphasis on the need for better quality health services to government health officials.[22] Mentors in Bihar, India identified mentee resistance to change as a barrier to mentorship; physical resources, doctor-nurse hierarchy, and corruption and fear as barriers to care provision; and facility layout, human resources, nurse-nurse hierarchy, cultural issues, and low baseline skill levels as barriers to both mentorship and care provision.[23] They saw establishment of strong mentor-mentee relationships, administrative support, increased training frequency, improved healthcare professional skills and confidence, and inclusion of doctors in training as facilitators to providing higher quality obstetric and neonatal emergency care.[23]

Support exists for international partnerships as well. Countries that participate in global health initiatives benefit in turn. Seven Harvard-affiliated institutions (Harvard Medical School, Brigham and Women's Hospital, Harvard School of Dental Medicine, Boston Children's Hospital, Beth Israel Deaconess Medical Center, Massachusetts General Hospital, and Massachusetts Eye and Ear Infirmary) partnered with Rwanda to help increase numbers of healthcare professionals through the Rwanda Human Resources of Health Program (HRH), in which Harvard faculty are sent abroad and then gradually replaced with Rwandan faculty to build capacity and achieve sustainability.[24] While the benefit to Rwanda is clearly stated, U.S. institutions have also seen positive outcomes directly resulting from this partnership: obtaining funding directly catalyzed by HRH involvement, establishment of long-term partnerships with Rwandan institutions, and greater opportunity for U.S. faculty and trainees to pursue global health beyond HRH through increased administrative and mentorship capacity. Some examples include the creation of Harvard School of Dental Medicine's global health research track for students in 2012 and Boston Children's Hospital's Department of Anesthesiology's integration of HRH participation into its formal global health fellowship program.[24] A shorter workshop intervention presented at the 2019 Pediatric Academic Societies and North American Refugee Health Conferences addressing common challenges in providing pediatric refugee and asylee FCC was well-received by participating clinicians, policy makers, and public health professionals and increased their confidence in providing care to this patient population, although the increase was not statistically significant.[17]

Though challenges to sustainability remain, mentorship interventions can be tailored to specific local cultural and resource contexts without loss of effect. A systematic review of mentoring programs in Africa found that regardless of specific form, mentorship in general was effective in improving clinical management of infectious diseases and maternal, neonatal, and childhood illnesses, as

well as having positive effects on managerial performance.[25] The variability for intervention length is less robustly supported. Shorter interventions such as the educational workshop on pediatric refugee care produced smaller results; however, such formats are easily adaptable for different settings, do not require specially trained facilitators, and can potentially work well when time and resources are limited.[17]

Conclusion

The goal of this literature review was to probe and synthesize current findings in child- and family-centered care education and mentorship for healthcare professionals with elements shared with Standish Foundation for Children's Child- and Family-Centered Care Fellowship. Four themes emerged: need, effects on healthcare professionals, effects on patients, families, and caregivers, and mentorship between different countries, cultures and resources levels. Need for additional psychosocial skills development for healthcare professionals was consistently recognized throughout to improve a wide range of topics in healthcare, both for the transition from non-FCC models to FCC and for quality improvement of FCC provision. In high resource settings, FCC education was positively perceived by healthcare professionals and believed to improve care for patients and families. Fewer studies document the impact on patient outcomes, but those we found showed some improvement in short-term clinical outcomes. Clinical mentorship is effective in improving pediatric healthcare quality in a variety of different countries, and although low-resource settings face some distinct challenges, many are shared in high-income settings and generally do not necessitate entirely new approaches.

Questions remain about the effectiveness of FCC healthcare professional interventions on long-term healthcare professional and patient outcomes. Current research has focused on specific groups of pediatric healthcare professionals and recipients, and publications describing outcomes are notably fewer than those indicating need. Further research is needed to evaluate FCC education across all pediatric healthcare. In addition, patient and family outcomes were largely limited to nuclear, heterosexual families. Future studies can fill this gap by looking at FCC education with regards to single-parent, same-sex couples, adoption and foster families, multiple primary caregivers, unrelated caregivers, and other non-traditional family structures. More research is also needed on specific FCC education between countries, cultural contexts and long-term outcomes.

Some limitations noted by Park et al.[1] apply to this literature review as well: we searched only for publications in English, resulting in possible missed research especially on mentorship between different countries, cultures and resource levels, and were constrained by the quality of included papers, which we did not evaluate. In addition, while we attempted to obtain full papers of all identified relevant publications, limiting our search to open-source articles may have caused us to exclude evidence documented in paid publications.

Healthcare professional mentorship to foster psychosocial support and FCC implementation is a powerful and adaptable tool for improving healthcare for providers and care recipients alike. Existing research provides strong support and rationale for key elements facilitating positive change in a diverse range of settings. As FCC continues to be implemented in institutions across the world, it is important for adaptations to be informed by both existing research and local contexts in future iterations, in pursuit of the ultimate goal of making a better healthcare experience for all.

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