

Early Relational Health

Collaboration and Partnership with Families

A parent-created pediatric resident curriculum

HELLMAN FOUNDATION

UCSF
University of California
San Francisco

PEDIATRICS Supporting PARENTS

STUPSKI FOUNDATION

A parent-created pediatric resident curriculum

Early Relational Health: Collaboration and Partnership with Families

Diane Halberg, MD
Barbara Ivins, PhD
Hope Williams-Burt

Created By Our Family Accountability Board (FAB): Phebe Kemp, Jordyn Lilly, Myrai Mills, Michele Poole, Patricia Rosendo, and Hope Williams-Burt

With additional contributions from Calvanay Nunley, Lashanda Smith, and Angela Venturelli, MD

Audio Interview with Javay Ross, MD; Gena Lewis, MD

Support from:
Maoya Alqassari
Sarah Ismail
Andy Krackov and Hillcrest Advisory
Angela Dumatol

Published October 2026

Table of Contents

03	Introduction and Context to the Curriculum
12	FAB Biographies
18	Module 1: Early Relational Health Introduction - Facilitator Guide
42	Module 2: Authentic Professionalism - Facilitator Guide
62	Module 3: Attuned/Misattuned - Facilitator Guide
80	Module 4: Parent Voices and Case Study - Facilitator Guide
103	Appendix (Slides for All Four Modules, Best Practices Handouts, Pre-Survey, Post-Survey, Case Studies)

Early Relational Health Curriculum Collaboration and Partnership With Families

A parent-created pediatric resident curriculum

Early relational health (ERH) is the foundation of healthy young childhood development, fostering stable and nurturing relationships and leading to increased resilience and positive health outcomes.

We were interested in creating a curriculum for pediatric residents that was both centered on early relational health and co-created with – and informed by – parents. An essential first step was finding a parent leader from within our clinic community who could recruit members for a Family Accountability Board (FAB) and partner with pediatric providers.

We then began sharing with our FAB information about supporting ERH, as well as describing the role of the general pediatrician in fostering these values. We examined already available ERH curricula and reviewed the structure of post-graduate pediatric education. This process was advised and guided by a general pediatrician with experience in post-graduate medical education and an early childhood specialist with experience in implementing behavioral health programs for young children.

Through these sessions, the FAB determined the direction this curriculum should take. Before engaging families in conversations about ERH, the FAB were unanimous in their belief that pediatricians must first establish trusting relationships and develop genuine collaborative partnerships with families. These relationships are essential for authentically incorporating family voices into discussions, fostering meaningful shared decision-making, and ultimately supporting better health outcomes.

From this starting place, the FAB next created a list of core tenets and clinical relational behaviors that they believe residents need to learn and use in encounters with families. This was followed by scripting and filming examples of both mis-attuned and attuned clinical interactions, as well as video testaments to their experiences and desires from encounters with pediatricians. This curriculum will walk residents through these teachings.

The Early Relational Health Best Practices

These best practices were developed by parents on the Family Accountability Board



1) See the Child Through the Family's Eyes

Recognize that parents are experts on their child's needs and development. Listen to and validate parents' concerns without dismissing or minimizing them, even if the child appears well during the visit. Take time to explore concerns, reflect on the family's priorities, and don't assume that issues will resolve on their own.

By trusting families' observations and focusing on what matters most to them, clinicians can build stronger partnerships and provide more responsive, family-centered care.

2) Do With, Not To

Effective family-centered care means partnering with patients and families to make decisions together rather than deciding what is "best" on their behalf. Actively involve families in decisions about their care. Respect their perspectives, goals, and choices. Collaboratively establish shared goals that align with the family's priorities while ensuring the safety and well-being of both the child and the parent.

2a) Understand a Family's Journey and Dynamics

This requires understanding each family's unique journey, including their medical history, current circumstances, and experiences leading up to the visit. Understand who is involved in the child's care and how they are connected. This is what is required to build trust, strengthen relationships, and provide care that reflects the family's needs and perspectives.

2b) Center family values and incorporate partnership in decision-making

Recognize parents as experts on their child. Show respect for their beliefs, preferences, culture, and lived experiences. Tailor recommendations to align with the family's values while providing guidance and support. During examinations, practice informed consent by explaining each step and asking permission before proceeding. Respect the child's autonomy and voice, particularly as they grow older, by involving them in decisions and honoring their preferences whenever it is safe and appropriate.



3) Create a Safe, Trusting Environment

Build an environment where families feel comfortable sharing their experiences without fear of judgment. Give each family your full attention; use open-ended questions to encourage conversation; and approach every interaction with empathy and respect. View families as individuals with unique lives and challenges, seeing them as human, not just another number, or another appointment, or another time slot. Be aware of how power differentials show up during encounters.

Maintain confidentiality, document respectfully (i.e., not weaponizing a family's words against them, such as noting "difficult parent or family." Instead try to recognize different perspectives/beliefs). Be mindful of how past experiences may influence how families view health care and how they respond in an encounter. A welcoming environment and a respectful provider reinforce that families are valued and heard.

3a) Use open-ended, nonjudgmental questions

Encourage meaningful conversation to better understand the family's perspective. Ask questions without judgment. Avoid leading questions, assumptions, or attempts to steer responses. Instead, ask questions that explore the parent's experiences, emotions, and current circumstances, and gain a more holistic understanding of the family's needs to build trust and relationship.

Examples include: “How are you, parent?” “How is the child?” "How has that been for you?" Or "What was it like to be your child's parent this week?"

3b) Practice reflective listening

Give the patient your full attention, listening for both what is said and what may be left unsaid, and reflecting their thoughts and feelings back to confirm understanding. This approach helps patients feel heard, builds trust, and provides insight into their emotional and mental state.

For example, if a parent says, "I've had a hard week," you can respond with, "I HEAR you've had a hard week," which acknowledges their experience and encourages further conversation.

3c) Build trust and obtain permission by approaching families with empathy, honesty, and respect

Ask permission before examinations or procedures; clearly explain what to expect and the purpose of each step; and ensure families feel informed and included in the process. Demonstrate genuine engagement through active listening, eye contact, and thoughtful questions that invite families to share their concerns, emotions, and questions. Especially during stressful situations, take time to explain information clearly and compassionately, recognizing that families may need additional support to process complex decisions.



4) Identify and Navigate System Barriers to Create a Human Experience

Help families navigate healthcare system barriers by recognizing what seems routine to clinicians may feel overwhelming or unfamiliar to patients. Providers should understand common challenges families face, including the impact of past difficult experiences, and serve as advocates by connecting families with appropriate referrals, community resources, and support. Familiarity with available resources and an awareness of one's role within the healthcare system enable clinicians to create a more compassionate, accessible, and human-centered care experience.



5) Recognize That Racial, Cultural, and Other Forms of Trauma Can Shape Families' Experiences with Healthcare

Approach each interaction with empathy; avoid taking mistrust or reluctance personally; and ask families how they would like you to support them.

Avoid labeling parents as "difficult;" instead, understand that their behaviors may reflect concern, past experiences, or difficulty expressing emotions. A trauma-informed approach acknowledges that families may hold the impact of previous healthcare encounters and emphasizes respect, compassion, and individualized care.

A Final Note

Finally, the development of this curriculum modeled a process in which parent voice is not simply included but elevated into a meaningful leadership role in the partnership between families and medical providers. More than any other aspect of this work, this is the message we hope to emphasize: **The voices of parents and caregivers, and the wisdom gained through their lived experiences, must be integral to the design and implementation of programs intended to improve pediatric care.**

Our recommendation is that this curriculum be offered to residents over two days, allowing sufficient time for true reflection on the topics being discussed. We recommend Modules 1 and 2 on the first day, and Modules 3 and 4 on the second day.

Through this work, we identified several practices that can help ensure that parent voice remains central both to the delivery of resident education and to the development of family advisory groups that participate in graduate medical education curriculum design.

1. Identify a Parent Champion

Identifying a parent champion can sometimes feel like searching for a needle in a haystack. Recommendations from providers within the health care system, as well as recruitment through existing projects, family advisory councils, or community advisory boards, can provide valuable starting points. At the same time, recruitment should extend beyond parents who already have experience serving in formal advisory roles. Parents and caregivers who are interested in contributing but have not previously been given the opportunity to participate may bring especially valuable perspectives.

Ideally, parent champions should have direct and recent experience navigating the health care system and be motivated to improve care for other children and families. **Selection should focus on the desire and capacity to contribute, rather than prior advisory or professional experience.** With appropriate support, parents can develop the skills needed to become effective educational partners and leaders.

2. Provide Mentorship and Coaching From Experienced Family Champions

Ongoing mentorship and coaching from an experienced family champion can help parent leaders feel supported and connected rather than isolated in their role. It also reduces the expectation that a new parent leader must immediately understand every aspect of curriculum development, medical education, facilitation, or institutional culture. Regular touch points with an experienced mentor create opportunities to prepare, reflect, troubleshoot challenges, and build confidence over time.

Coaching is particularly valuable when parents are co-facilitating educational sessions. Real-time guidance can help them understand the learning environment they are helping to create and navigate the distinction between **sharing an individual lived experience and drawing upon lived experience as a form of professional expertise.** Recognizing parents as professionals through lived experience acknowledges that their expertise deserves the same seriousness and respect afforded to other members of the educational team.

Mentorship can also help parent leaders determine which experiences are most relevant to share, identify broader themes that extend beyond their individual family's experience, and translate challenges into constructive recommendations without feeling obligated to disclose deeply personal information. This distinction is especially important when a parent leader is representing the perspectives of a broader community of families.

This collaborative approach builds parents' knowledge and confidence while helping Family Leads better understand and respond to the needs of residents in the room. At the same time, it supports them in elevating the perspectives of the families they represent. Thoughtful mentorship is essential to maintaining the delicate balance required to create a learning environment that is safe, open, transparent, and respectful for families, residents, and faculty alike.

3. Compensate Parents for Their Time and Expertise

Parents know their children in ways that clinicians cannot. They understand their child's personality, strengths, needs, challenges, preferences, and the realities of managing care in everyday life. This expertise is essential to humanizing the clinical experience and helping health care professionals understand how medical care affects children and families beyond the clinical encounter.

Parents and caregivers also contribute substantial amounts of **invisible labor** when participating in educational and advisory work. Their contributions should therefore be recognized as professional expertise and compensated accordingly. Compensation should reflect a livable professional consultation rate and account for the full time required to participate, including preparation, team meetings, review of educational materials, facilitation, and follow-up. Programs should also address practical costs and barriers associated with participation, including travel, time away from paid work, meals, technology access, and childcare.

Removing financial and logistical barriers to participation communicates an important principle: **parents' time, experiences, and ideas have value.** Equitable compensation makes meaningful participation possible for a broader range of families rather than limiting these opportunities to those who can afford to volunteer their time.

4. Make Scheduling Accessible and Family-Centered

Scheduling should prioritize the availability of the Family Lead, particularly when their presence is essential to co-facilitation. Whenever possible, teams should reserve five to ten minutes at the end of planning meetings to coordinate upcoming dates and responsibilities. Families should receive **at least three weeks'** notice for educational sessions whenever feasible, and schedule changes should be made in consultation with—and with the agreement of—the participating parent or caregiver.

Parents and caregivers already devote considerable time and energy to supporting their children and navigating health care. Participation in medical education should not create unnecessary additional burdens. Thoughtful scheduling, adequate notice, flexibility, and respect for family commitments are practical ways to create an environment in which parent partners feel welcomed and valued.

Ultimately, building this type of partnership does more than help families feel heard and respected. It creates opportunities for parents to develop professional skills and leadership experience while strengthening trust, communication, and relationship-centered care. Most importantly, it moves parent engagement beyond consultation toward **genuine partnership and shared leadership,** ensuring that pediatric education is shaped not only by those who provide care, but also by the families who experience it.

Family Accountability Board (FAB)



Hope Williams-Burt, Family Lead

Hope Williams-Burt is a dedicated community leader with over 30 years of experience in education, advocacy, and amplifying community voices. Her personal journey as a mother of five and grandmother fuels her passion for serving others and driving meaningful change.

Currently, Hope serves as a Community Relations Consultant supporting the Family Accountability Board (FAB) for the Ready! Resilient! Rising! (R3!) Network in California. Previously, she served as a Family Liaison in San Francisco for over 14 years, demonstrating her enduring commitment to family and community partnerships

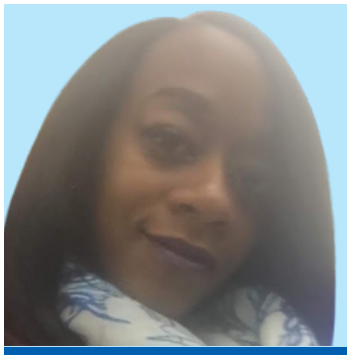
Hope's leadership extends across multiple sector initiatives. For nine years, she served on the board of the UCSF Preterm Birth Initiative, contributing to strategic policy and community development planning. In 2020, she launched her consulting business and founded Residents Supporting Community (RSC), a neighborhood action group in San Francisco. Under her guidance, RSC collaborated with key stakeholders—including the SF District 6 Supervisor's office, DPH, SFFD, housing partners, and SFUSD—to develop a community-led COVID Response Action Model that was later adopted citywide and statewide. Nationally, Hope has collaborated with over 50 advisory councils across the United States to lead transformative care initiatives.

As a full-time consultant, Hope focuses her work on family education and relational health partnerships. She actively mentors communities and organizations to reexamine power distribution, build shared vision, and to create safe spaces for collaboration. Her commitment to service continues through her active participation in local and national forums addressing critical issues such as housing, education, and the Black maternal health crisis. Hope's career remains a testament to her dedication to family, community, and transformative leadership.



Myrai Mills

Myrai Mills is a mother, student, and maternal health advocate passionate about uplifting the voices and experiences of Black mothers and families. Her own journey through motherhood has strengthened her commitment to ensuring mothers feel heard, respected, informed, and supported throughout pregnancy, birth, and beyond. She brings lived experience, community advocacy, and a deep belief in the power of mothers advocating for themselves and one another. Myrai is committed to continue creating spaces where families are not only included in conversations about maternal health, but are valued as partners in creating meaningful change.



Phebe Kemp

Phebe Kemp is a proud new mother and a devoted stepmother to three amazing daughters. Inspired by her children, she has embraced an active role in her community, striving to create a better future for them. Phebe is involved in supporting community intervention initiatives, such as the local food bank, and she facilitates empowerment programs that uplift families in need.

Through her work with the Family Accountability Board (FAB), Phebe supports the medical system and fosters positive connections within her community. In her spare time, she enjoys mother-daughter hikes around the beautiful Bay Area, cherishing the moments spent in nature with her girls.



Michele Poole

Michele Poole is a dedicated parent of four children. Her parenting journey has taught her invaluable lessons about not sweating the small things, advocating for herself and her children, having faith in her creator, and trusting her instincts to make the right decisions while being open to learning from mistakes.

Before joining the Family Accountability Board (FAB), Michele was involved in the Preterm Birth Initiative through UCSF and BreastFriends Lactation Support Services. She is passionate about working within her community and values the opportunity to contribute tangibly by sharing her unique lived experiences with FAB.

Michele is particularly committed to ensuring that she gets the best care for her children and believes that parents are the experts on their own families. She is also dedicated to disrupting anti-Blackness and Islamophobia within the healthcare system. In her role at FAB, she aims to deepen her understanding of the resident program and process, learn from the expertise of other parents, and explore collaborative approaches to holistic community care for families in Oakland.
A personal goal for Michele in this project is to bring a fresh perspective to family-centered care, especially for Black families.



Jordyn Lily

Jordyn Lilly is a mother, dedicated Community Health Worker, birth worker, and aspiring midwife. Her work is deeply rooted in supporting, connecting, and uplifting her community, with a special focus on Black pregnant and postpartum women and families.

Having proudly served with the FAB Collective for nearly two years, Jordyn continues to create spaces centered on connection, care, and collective wellness. She believes that community is crucial to our survival and views community care as more than just a profession—it is a way of life.

Jordyn is passionate about the idea that when we care for one another, share resources, hold space, and build genuine relationships, we create the conditions for our communities to heal, thrive, and flourish.



Patricia Rosendo

Patricia holds herself as a strong single parent and dedicated student. She is the proud mother of an intelligent 4-year-old daughter, Sarah Rosendo. Being a parent has taught Patricia that she is a primary role model for her child and that her voice matters in advocating for her daughter's needs. She believes in the importance of diversity and inclusion, ensuring that all voices are heard.

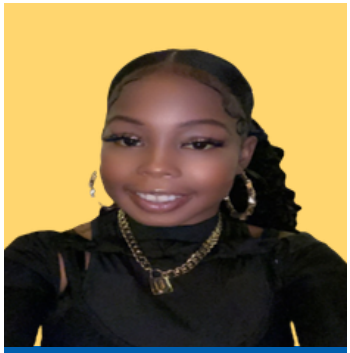
Before joining the Family Accountability Board (FAB), Patricia volunteered and worked at The Primary School East Bay, actively participating in the Parent Program to enhance the educational experiences of future children. She is also a part-time accountant, with a passion for math, and is currently a student at Chabot College after previously attending the University of California, Santa Cruz.

Patricia joined FAB due to her positive and negative experiences within the medical system. Living with Type 1 diabetes and Multiple Sclerosis, she understands the importance of advocating for herself and her daughter. She is well-versed in navigating the healthcare system and is committed to ensuring that families receive the care they deserve.

One of Patricia's key beliefs in child and family care is persistence; if one visit to a healthcare provider is unsuccessful, she will continue to seek out alternatives and do her research. In her role at FAB, she hopes to enlighten and inspire future doctors to be open-minded, kind, and direct. She emphasizes that mistakes are part of the learning process and that it's okay to be imperfect.

A personal goal for Patricia in this project is to eliminate negative experiences within the healthcare system. She values her time at FAB, recognizing it as a supportive group with whom she can collaborate.

An interesting fact about Patricia is her aspiration to graduate with a degree in Business, Accounting, and Taxation as a single mother. She credits her parents as her rock, providing the motivation to keep going.

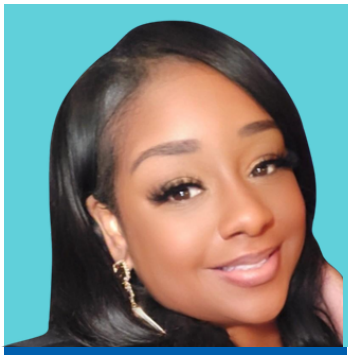


Calvanay Nunley

Calvanay Nunley, a vibrant individual that proudly identifies her greatest accomplishment as becoming a mother. This journey has taught her invaluable lessons in patience and endurance, contributing significantly to her personal growth.

As the Founder and CEO of The Pull Up, Calvanay leads a support group for adolescents living with Sickle Cell Disease. Her organization fosters a community where members are recognized for more than their illness, empowering youth to take charge of their health and well-being.

In her professional life, Calvanay works as a per diem Certified Nursing Assistant (CNA), driven by her passion for helping others and giving back to the community. This commitment led her to join the Family Accountability Board (FAB), where she focuses on educating medical professionals about cultural competence. Her goal is to ensure that families from all backgrounds feel supported and heard without judgment



Lashanda Smith

Lashanda Smith is a Mental Health Family Partner/Case Manager in Early Intervention Services at UCSF Benioff Children's Hospital Oakland. Her work is rooted in compassion, relationship-building, and a commitment to helping children and families feel supported during important stages of their lives.

Lashanda brings extensive experience working directly with families facing a variety of challenges. She is skilled in connecting families to community resources, supporting educational needs, coordinating services, and helping parents understand the different systems involved in their child's care. She approaches each family individually, recognizing that every family has its own strengths, circumstances, and goals.

Lashanda's contribution to the Family Accountability Board (FAB) reflects her desire to bring the everyday experiences of families into conversations about programs and services. She values open communication between families and professionals and believes meaningful change begins with listening to the people most impacted by the services being provided. Her personal goal is to continue using her voice and experience to create opportunities for families to feel respected, included, and confident when making decisions for themselves and their children.

Advisors to this project:



Diane Halberg, MD

Diane is a clinical professor of pediatrics at UCSF Benioff Oakland Children's Hospital Primary Care department. She has a special interest in post-graduate medical education, the mental and behavioral health of children, and in ensuring good access to care for all patients.



Barbara Ivins, PhD

Barbara is a clinical psychologist and Early Childhood Mental Health (ECMH) specialist who manages multiple early childhood development and mental health service programs within the Division of Child and Adolescent Mental Health at UCSF Benioff Children's Hospital Oakland. She has a particular interest in integrating ECMH into child serving systems, including pediatric care, and in elevating parent voice in clinical services and training.

Module 1: Intro to Early Relational Health

This session and the sessions that will follow were built alongside families – not just for them. Through video, reflection, and role play, you will learn about and practice the relational skills that support Early Relational Health (ERH) in your everyday clinical interactions.



Facilitator Guide: Module 1, Intro to ERH

Module 1: Intro to Early Relational Health

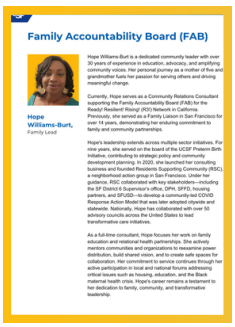
1. Slides:
Parent Voices and Case Study (pg. 103)



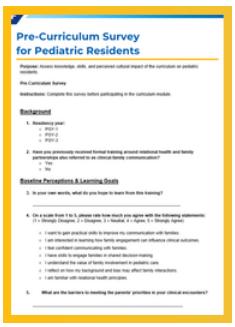
2) Handout:
FAB Best Practices (pg. 104-107)



3) Handout:
FAB member biographies (pg. 12-17)



4) Survey:
Pre-survey (pg. 108)



Orienting This Session

This module is recommended to be the first module in the training.

This module provides learners with the broader context for the training by introducing the purpose of the curriculum and the collaborative process through which it was developed. Learners are introduced to the Family Advisory Board (FAB) and the central role that parents played in creating the curriculum. The module also introduces the concept of early relational health (ERH), explores its importance to child and family well-being, and considers the pediatrician's role in fostering ERH.

Facilitator Guide: Module 1, Intro to ERH

Orienting This Session

Early in the curriculum-development process, the FAB recognized that meaningful conversations about parent-child relationships depend on the quality of the relationship between the clinician and the family. Before clinicians can effectively engage families in these personal and sometimes intimate discussions, there must first be a foundation of genuine partnership, trust, and collaboration.

This module therefore introduces five tenets of clinician behavior identified by the FAB as essential to fostering strong clinician-family relationships. Residents should receive a handout describing these five tenets at the beginning of the training. Facilitators should refer to the tenets at relevant points throughout the curriculum, reinforcing them as foundational principles that inform the skills and approaches explored in subsequent modules.

Orienting This Session

The resident reflection for this module should invite residents to consider each of the five tenets and identify which behaviors already feel natural or are areas of strength in their work with families, as well as which are more challenging to put into practice. Encourage them to reflect on the specific barriers that may make it difficult to engage in these behaviors and to consider how those barriers might be addressed throughout the training.

Facilitator Guide: Module 1, Intro to ERH

Slide 3: Who We Are: Project Advisors, Parent Lead and Facilitators

This curriculum was created by community parents, the Family Accountability Board, and a parent lead, alongside advising from a general pediatrician and a psychologist that specializes in early child development. The Parent Lead serves as the primary liaison between the FAB and the clinical team, ensuring family perspectives remain central throughout



Slide 4: Who We Are: FAB Curriculum Content Creators

The Family Advisory Board (FAB) is a group of parents from our community who shaped this curriculum based on their lived experiences as caregivers navigating the pediatric health system. The UCSF Claremont clinic is a FQHC with a tremendously diverse patient population with a wealth of lived experiences.



Facilitator Guide: Module 1, Intro to ERH

Slide 5: Early Relational Health

The goal of these slides is to help the learners understand the meaning of the term early relational health and recognize that as pediatricians we play a role in educating parents about how significant this part of their relationship with their children can be.



Slide 5: Early Relational Health

Before the ERH content is introduced, ask residents: Is the term Early Relational Health familiar to you?

This is meant to be a brief, honest invitation to understand where residents are starting from and to create a reference point they can return to at the end of the session, when we'll reflect on what was taught. Expect a range of responses. Some residents will have prior exposure to ERH concepts, but many will not.

Facilitator tip: Resist the urge to correct or teach during this discussion. Your role here is to listen and validate, not instruct. What residents say in this moment gives you useful information about what to emphasize as the session unfolds.

Facilitator Guide: Module 1, Intro to ERH

Slide 6: What Is Early Relational Health?

Early Relational Health describes the positive, nurturing relationships that build and protect the interpersonal connections and emotional security of young children.



Positive reciprocal interactions between a child and their caregiver(s) are the building blocks for safe, stable, nurturing relationships.

Slide 6: What Is Early Relational Health?

These types of interactions happen all the time between children and their caregivers. Pediatricians can play an important role in highlighting the immense importance these activities have for young children and can learn to notice them when with families in the clinical setting and reflect them back to families in real time.

Decades of research show that adverse experiences and stress can be buffered – meaning harmful effects can be reduced or offset – by strong foundational childhood relationships and positive experiences.

Facilitator tip: Residents often have some familiarity with adverse childhood experiences (ACEs) but less with the protective side of the equation. Frame ERH as the counterweight: if ACEs represent risk, ERH represents resilience.

Facilitator Guide: Module 1, Intro to ERH

Slide 7: What Does Early Relational Health Look Like?

Ask the residents to describe the activities that they think constitute opportunities for parents and children that support ERH.

Discuss playtime, reading, shared meals, etc.

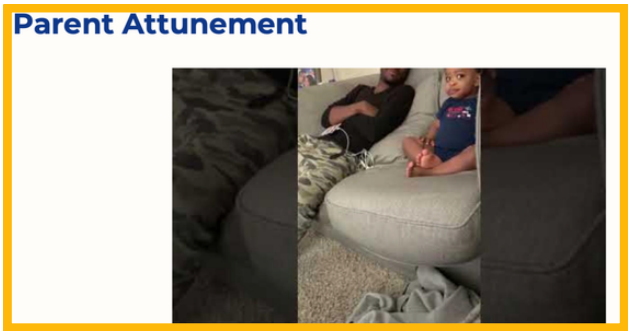


Slide 8: VIDEO Illustrating Attunement

Discuss what the residents see in this video and what they predict it offers this young child.

A feeling of being seen and listened to

A sense of their importance in the relationship



Facilitator Guide: Module 1, Intro to ERH

Slide 9: Why Partnership Matters

Partnership with families is not simply a value. It has direct clinical consequences. When pediatricians build authentic, trusting relationships with parents, families are more likely to share concerns openly, follow through on care plans, and engage meaningfully with screening conversations. All of which leads to better outcomes for children.



Slide 9: Why Partnership Matters

For residents, learning to build these relationships early is foundational to the kind of care this curriculum is designed to support.

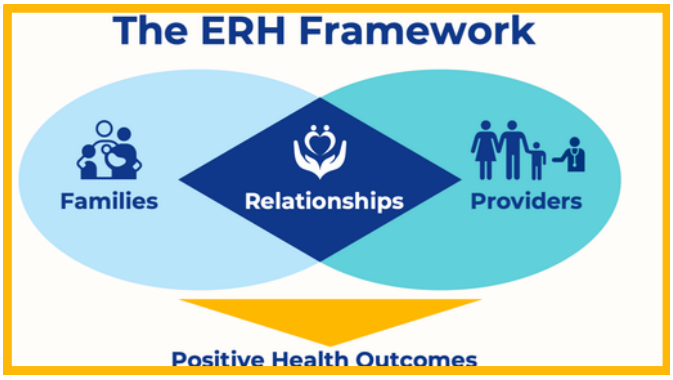
Screening tools and conversations around ERH, and all clinical decisions, should be implemented in the context of authentic, trusting partnerships with families.

Collaboration and partnership with families allows for authentic conversations about their relational strengths, resources, and vulnerabilities.

Facilitator Guide: Module 1, Intro to ERH

Slide 10: The Early Relational Health Framework

This slide is an illustration of what the FAB wants residents to understand regarding the importance of learning to create true collaboration and partnership with families.



Slide 10: The Early Relational Health Framework

The FAB created a set of **best practices** of behaviors that residents can learn to use when interacting with families in the clinical setting. The following slides describe these tenets. The residents should also have a handout that contains these 5 tenets in detail and that can be referred to here as well as during future portions of this training.

The next slide present the 5 Best Practices that the FAB created to describe what ideally is required for pediatricians to create true partnerships with families. The residents should have these in a handout that they can refer to during the training.

Discuss the details of each of these tenets while showing the slides.

Facilitator Guide: Module 1, Intro to ERH

Slide 11: FAB Best Practices



Slide 11: See the Child Through the Family's Eyes

Recognize that parents are experts on their child's needs, and development. Listen to and validate parents' concerns without dismissing or minimizing them, even if the child appears well during the visit. Take time to explore concerns, reflect on the family's priorities, and don't assume that issues will resolve on their own.

By trusting families' observations and focusing on what matters most to them, clinicians can build stronger partnerships and provide more responsive, family-centered care.

Facilitator Guide: Module 1, Intro to ERH

Slide 11: Do With, Not To and Create a Safe, Trusting Environment

Effective family-centered care means partnering with patients and families to make decisions together rather than deciding what is "best" on their behalf. Actively involve families in decisions about their care. Respect their perspectives, goals, and choices. Collaboratively establish shared goals that align with the family's priorities while ensuring the safety and well-being of both the child and the parent.

This includes thinking about a family's journey and dynamics and how to center family values and incorporate partnership in decision-making

Slide 11: Create a Safe, Trusting Environment

Build an environment where families feel comfortable sharing their experiences without fear of judgment. Give each family your full attention; use open-ended questions to encourage conversation; and approach every interaction with empathy and respect. View families as individuals with unique lives and challenges; seeing them as human, not just another number, or another appointment, or another time slot. Be aware of how power differentials show up during encounters.

Maintain confidentiality, document respectfully (i.e., not weaponizing a family's words against them, such as noting "difficult parent or family." Instead, try to recognize different perspectives/beliefs. Be mindful of how past experiences may influence how families view health care and how they respond in an encounter. A welcoming environment and a respectful provider reinforce that families are valued and heard.

This includes prioritizing learning how to use open-ended, nonjudgmental questions, practice reflective listening and build trust and obtain permissions by approaching families with empathy, honesty, and respect

Slide 11: Identify and Navigate System Barriers to Create a Human Experience

Help families navigate healthcare system barriers by recognizing what seems routine to clinicians may feel overwhelming or unfamiliar to patients. Providers should understand common challenges families face, including the impact of past difficult experiences, and serve as advocates by connecting families with appropriate referrals, community resources, and support. Familiarity with available resources and an awareness of one's role within the healthcare system enable clinicians to create a more compassionate, accessible, and human-centered care experience.

Slide 11: Recognize That Racial, Cultural, and Other Forms of Trauma Can Shape Families' Experiences with Healthcare

Approach each interaction with empathy; avoid taking mistrust or reluctance personally; and ask families how they would like you to support them. Avoid labeling parents as "difficult;" instead, understand that their behaviors may reflect concern, past experiences, or difficulty expressing emotions. A trauma-informed approach acknowledges that families may hold the impact of previous healthcare encounters and emphasizes respect, compassion, and individualized care.

Facilitator Guide: Module 1, Intro to ERH

Slide 12: Reflection

Here is an opportunity to discuss with the residents their understanding of the best practices described in the previous slides.

Are there any of these that stand out to the residents?

Are there any of the above practices that are hard to follow or that they feel they focus on well already?



Module 2: Authentic Professionalism

This module was built alongside families – not just for them. Through video, reflection, and role play, you will learn about and practice the relational skills that support Early Relational Health (ERH) in your everyday clinical interactions.

The facilitator guide is organized slide by slide, so you can move through it in parallel with the deck. Each slide entry includes context, facilitation guidance, and tips where relevant.

This session is designed so that any facilitator can lead it. Where the guide suggests a personal story or example, you are encouraged to draw on your own experience.

Facilitator's Guide: Module 2, Authentic Professionalism

Materials

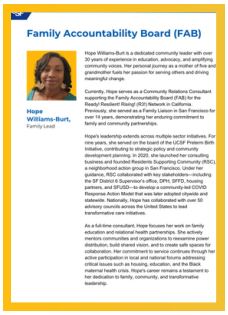
1) Slides: Authentic Professionalism (pg. 103)



2) Handout: FAB Best Practices (pg. 104-107)



3) Handout: FAB member biographies (pg. 12)



Orienting the Session

This module is recommended to be the second module in this training. It provides background on key concepts, suggested language for navigating discussion moments, and notes on where to spend time.

This module focuses on residents' professional journeys as they develop their own voices and learn to maintain their values throughout training. It builds on the FAB's emphasis on the importance of relationship-building and collaboration with families, while asking residents to consider how these principles intersect with their evolving identities as physicians.

The module explicitly explores the concepts of authenticity and professionalism. Residents will hear an audio interview with an attending physician reflecting on their own experiences and evolution in these areas, providing an opportunity to consider how authenticity and professionalism can develop over the course of a medical career.

UCSF
Facilitator's Guide: Module 2, Authentic Professionalism

Orienting the Session

During the development of this curriculum, the FAB also recognized the particularly vulnerable position residents may occupy as they navigate multiple, and sometimes competing, perspectives. Residents are learning to respond to the values and priorities of patients and families which, may, at times, conflict with the expectations of attending physicians, clinical teams, and larger medical systems. This tension provides an important opportunity to introduce the concept of professional identity formation (PIF) and to invite residents to reflect on where they are in their own professional journeys. Reflection during this module might explore questions such as: Where do residents notice tensions between their own values and the expectations of others? How do they navigate these moments? How might these experiences be shaping their developing professional identities?

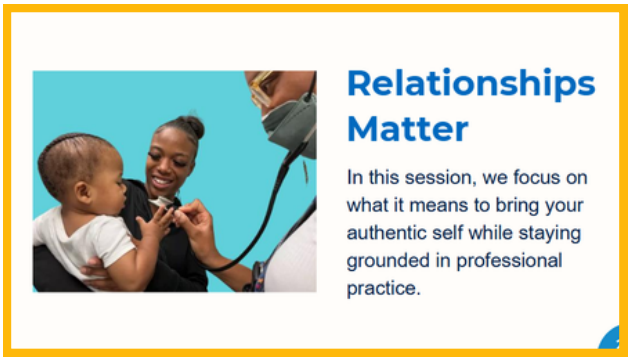
Orienting the Session

At the conclusion of the module, the facilitator should return to the FAB's five tenets and highlight two that are particularly relevant to the discussion of authenticity, professionalism, and professional identity formation: "Create a Safe and Trusting Environment" and "Identify and Navigate Systems Barriers." Residents can consider how these tenets might help them remain authentic to their values while navigating the expectations and constraints of clinical training and, ultimately, building collaborative and trusting relationships with families.

Facilitator's Guide: Module 2, Authentic Professionalism

Slide 2: Relationships Matter

Discuss the two paired relationships that we are focusing on: one between a child and caregiver as well as the parallel relationship that this training focuses on which is the relationship between a clinician and family/patient.

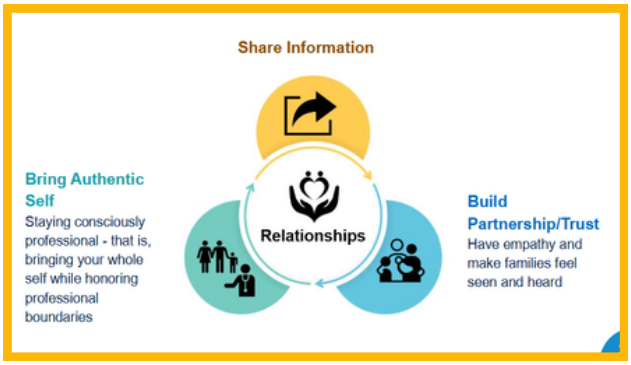


The framework being described here anchors all the following sections of this training:

- Mis-attunement/Attunement
- Parent Voice/role play

Slide 3: Relationships Framework

Our FAB created an image that described the context in which a truly collaborative discussion with a clinician could take place. This slide shows the crucial components as described by our FAB. One component was having a clinician that was both authentic and professional.



What does it mean to be Authentic?

What does it mean to be professional?

Facilitator's Guide: Module 2, Authentic Professionalism

Slide 4: Professionalism: Safety and Structure

What is the purpose of "being professional?"
Professionalism is often experienced by residents as a set of constraints – things they cannot do or say. This slide reframes it as a structure that creates safety for both clinician and family.



Slide 5: Boundaries, Competence, Respect, and Ethical Behavior

The four elements – boundaries, competence, respect, and ethical behavior – are not limitations. They are the conditions under which authentic relationships become possible.

- Boundaries - knowing where your role ends and another's begins
- Competence - delivering care that meets professional standards
- Respect - treating every family with dignity regardless of differences
- Ethical behavior - making decisions guided by patient welfare, not convenience



Facilitator's Guide: Module 2, Authentic Professionalism

Slide 6: Authenticity

Authenticity in a clinical context does not mean self-disclosure or informality. It means letting genuine values - curiosity, warmth, care - show up in interactions with families while maintaining appropriate professional boundaries.

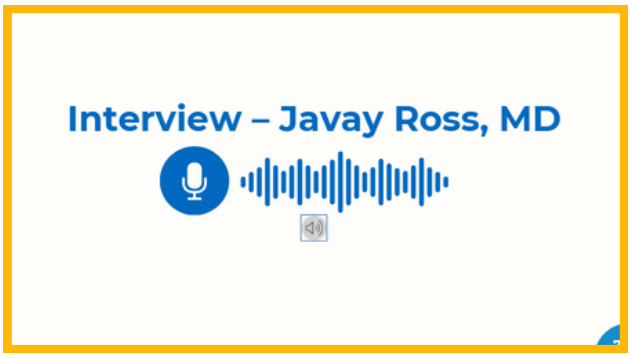
What are some of the components of being authentic?

- Let your values guide you
- Show up as human – warmth, genuine curiosity
- Allow appropriate vulnerability - This should be highlighted, as this can be a common pitfall- knowing the boundaries here
  - *Facilitator tip: The bullet on 'appropriate vulnerability' is worth unpacking with residents. It means allowing families see that you are human – without making the clinical encounter about you. That distinction matters*.
- Being grounded in your identity and strengths – Staying true to yourself.



Slide 7: Interview - Javay Ross, MD

Introduce this Audio clip as an interview with an attending pediatrician discussing her journey and thoughts around interacting and being a clinician for her patients and families.



Slide 8: What Did You Hear?

Allow time for the residents to comment and reflect on the Audio interview

Ask:

- What resonated with you?
- What challenges do you have, or anticipate having, incorporating these qualities into your patient/clinician relationships?



Slide 9: FAB Reflections

Present to the resident these reflections that the FAB had when listening to the same attending audio interview. Stress that these ideas are important components to making the relationship work.

- Bridge the gap between training and practice – Families experience how you apply what you know, not just what you know
- Make relationship the work – Warmth, curiosity, and seeing each patient as an individual aren't extras; they're the encounter itself
- Bring yourself, not your assumptions – Authentic presence means knowing where your experience ends and the family's begins

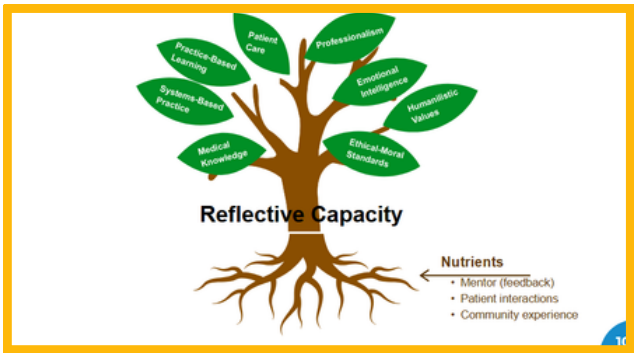
Note: Highlight Bring yourself, not your assumptions-to remind the residents to be careful not to assume that the clinicians' experience is the same as the patients.



Slide 10: Professional Identity Formation

Professional Identity Formation (PIF) is the gradual transformation that occurs in the process of becoming a doctor, as professional values, beliefs, behaviors, relationships, roles, and responsibilities become integrated.

There is a predictable evolution of PIF: Discuss some of the characteristics of the different stages as described here:



Slide 10 (continued):

Early: foundational education (premedical students and early medical students)

- follow social roles and rules
- appreciate others' viewpoints, yet self-views predominate;

Middle: training and/or supervised practice (later medical students and residents)

- view medical practice through multiple perspectives
- subordinate self-interests more effectively
- feel a sense of belonging but not yet "professional"
- **may still have trouble reconciling competing expectations;**

Facilitator's Guide: Module 2, Authentic Professionalism

Slide 10 (continued):

Later: practicing professional (practicing physicians)

- understand differing values and perspectives
- own and embody expectations of the profession
- begin to internalize the external values of the profession
- **reconcile challenges between personal and professional expectations more effectively.**

Facilitator tip: the 2 bullets bolded here – both these ideas and the evolution from one to the next – is specifically important here.

Over time, your professional values, roles, and responsibilities become part of how you see yourself – layered onto, not replacing, who you already are.

Slide 11:

This slide is to acknowledge the specifically challenging role of a pediatric resident; often being pulled in multiple directions.

Residents often are caught between the values and desires of the families and the expectation of the attendings/medical system without having the power to independently negotiate a solution. Surfacing this as a structural reality – not a personal failing – is the point.

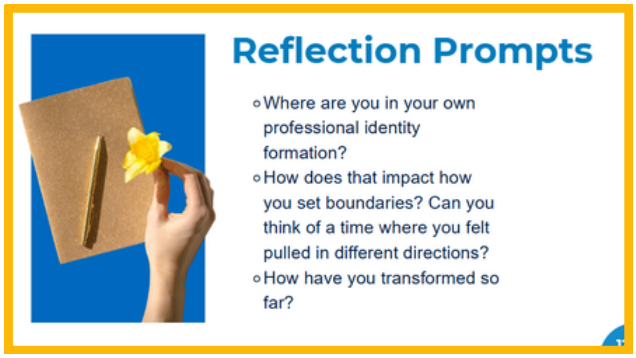


Facilitator's Guide: Module 2, Authentic Professionalism

Slide 12: Reflection Prompts

Take some time here to have the residents reflect on the ideas discussed in this portion of the training.

Consider first sharing a brief personal example – a moment in your own professional formation where you felt the tension between authenticity and professionalism, and how you navigated it. The story doesn't need to be polished; its purpose is to model the kind of reflection you're asking of residents.



Slide 12 (continued):

Consider tailoring the reflection prompts to match the experience of the residents in the training (ie interns vs 2nd or 3rd year residents)

Many residents can relate to the example of delayed comfort in being called or calling oneself "doctor". This is a good example to explore with the trainees.

Some possible prompts:

- Where are you in your own professional identity formation?
- How does this impact how you set boundaries?
- Can you discuss a time where you were pulled in different directions regarding the family's values, your own values, your attendings values? How did you resolve this?
- How have you transformed in your own PIF so far?

Facilitator's Guide: Module 2, Authentic Professionalism

Slide 13 and 14: FAB Best Practices

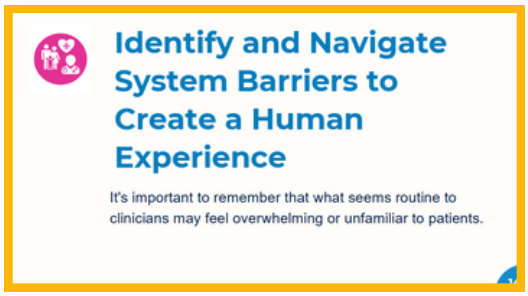
Returning to the FAB Best Practices:
Create a Safe and Trusting Environment
and Identify and Navigate Systems Barriers

Have the residents take a moment to look at the handout with the FAB best practices.

Reflect that this portion of the training is particularly relevant regarding the ideas of:

- Create a Safe and Trusting Environment
- Identify and Navigate Systems Barriers





Module 3: Attuned - Misattuned

This session was built alongside families – not just for them. Through video, reflection, and role play, you will learn about and practice the relational skills that support Early Relational Health (ERH) in your everyday clinical interactions.



This facilitator guide supports facilitators leading the Attuned-Misattuned module. It provides context for the key concepts, slide-by-slide facilitation guidance, suggested language, and notes on timing and tone. The guide is organized slide by slide. Each entry includes context, facilitation notes, and tips where relevant.

Facilitator's Guide: Module 3, Attuned - Misattuned

Materials

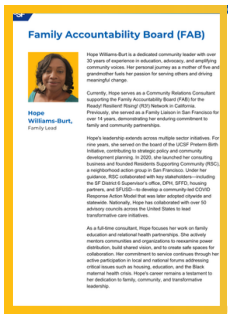
1) Slides:
Attuned-Misattuned
(pg. 103)



2) Handout:
FAB Best Practices
(pg. 104-107)



3) Handout:
FAB member biographies
(pg. 12)



Orienting the Session

This is recommended to be the third module in this training.

This module sits at the heart of the curriculum. While the Authentic Professionalism module asks residents to reflect on their professional identity, and the Parent Voices module asks them to hear directly from families, this module asks residents to look closely at what clinical encounters actually look like—moment to moment—and to identify what is working and what is not.

The central concept is **attunement:** a provider's ability to recognize and respond to a family's emotional state, needs, and cultural context in each moment. **Misattunement** occurs when there is a mismatch between what a family needs and what the provider offers. This mismatch is usually unintentional, but it is felt by the family, nonetheless.

Facilitator's Guide: Module 3, Attuned - Misattuned

Orienting the Session

Two points are worth emphasizing at the outset of the session:

- **Misattunement is not a character flaw.** It is a structural reality of time-pressured—and sometimes high-stakes—clinical environments.

- **A strong relationship is defined not by the absence of misattunement, but by the willingness to repair it.** A critical component of this portion of the training is therefore a discussion of **repair:** recognizing when a disconnect has occurred and intentionally re-engaging with families through communication.

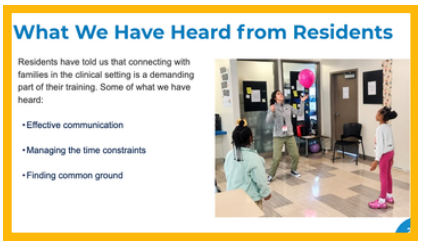
Please note that the video vignettes illustrating both mis-attuned and attuned interactions were written and role-played by FAB parents. The vignettes are based on their own experiences in clinical environments.

Slide 2: What We Have Heard from Residents

This slide opens the module with resident voice by naming the challenges residents face before asking them to engage with family perspectives. The aim is to create a sense of shared acknowledgment that this ERH work is genuinely hard. What we have heard from residents specifically is that:

- It's challenging to maintain a balance between being emotionally supportive and adhering to medical protocols, especially in sensitive or high-stress situations.
- These goals of having truly effective communication, managing time constraints and achieving common ground and perspective are truly challenging.
- Some practical strategies – like specific phrasing and ways to build rapport – can be more useful early in training than generic advice.

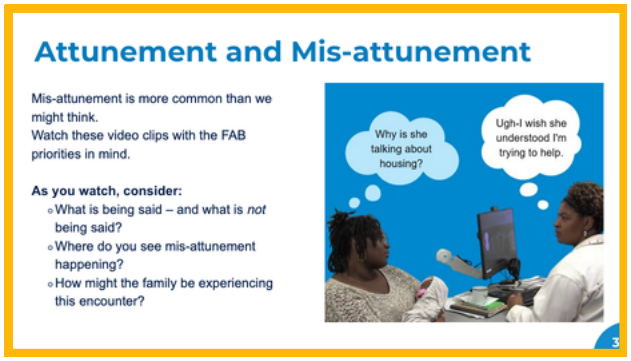
Facilitator tip: This slide is an invitation, not a presentation. Keep it brief and conversational. The goal is to signal that residents' real experiences are seen and taken seriously before the curriculum asks anything of them.



Facilitator's Guide: Module 3, Attuned - Misattuned

Slide 3: Attunement and Mis-attunement

Facilitator tip: *Open by asking residents what they understand attunement to mean before offering a definition. Their initial responses may provide an indication of where you can spend your time teaching.*



Slide 3: Attunement and Mis-attunement Key Definitions

Attunement: A provider's ability to recognize and respond to a family's emotional state, needs, and cultural context in a given moment, thus creating a sense of being seen, heard, and understood.

Mis-attunement: A mismatch between what a family needs emotionally and what the provider offers – often unintentional, but felt by the family, nonetheless. Mis-attunement can occur through tone, pacing, language, assumptions, or simply failing to follow the family's lead.

As you watch the following video vignettes, consider these questions:

- What is being said – and what is not being said?
- Where do you see mis-attunement happening?
- How might the family be experiencing this encounter?

Facilitator's Guide: Module 3, Attuned - Misattuned

Slides 4-6 The Vignettes

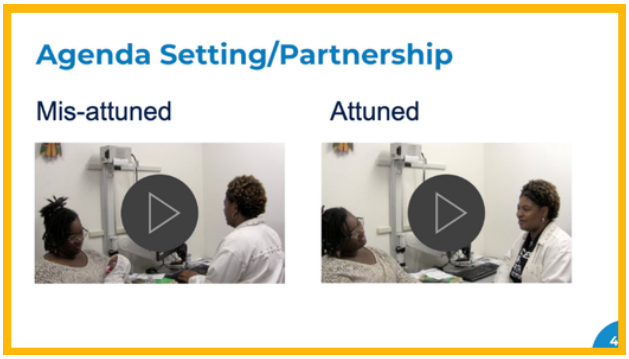
These next 3 slides offer examples of mis-attuned and attuned interactions side by side.

- "Watch this encounter with the FAB priorities in mind, paying attention to how the parent is responding."

Note: Take some time before starting your training to think about whether you want to use all 3 of these examples of one or another will be more appropriate for the specific training you are doing based on timing and level of training of the residents participating.

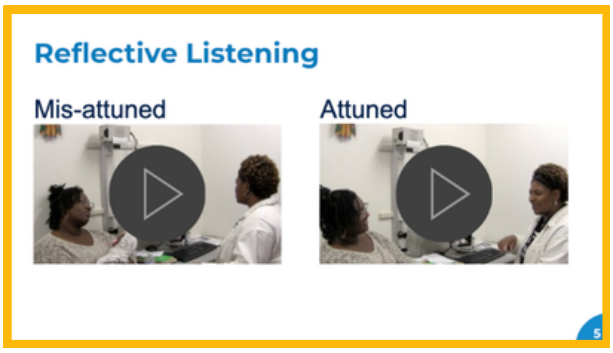
Slide 4: Agenda Setting / Partnership

Here, we compare examples of the initial agenda setting in a clinical interaction and examine how genuine partnership with a family is, or is not, established.



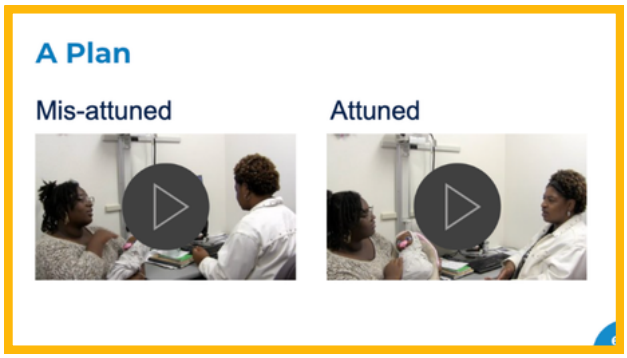
Slide 5: Reflective Listening

Here, we explore how both verbal and nonverbal communication are essential to creating an environment in which families and clinicians can engage collaboratively around a patient's health.



Slide 6: A Plan

Here, we contrast interactions in which a clinician is, or is not, open to a parent's perspectives and experiences, and examine how this openness—or lack thereof—affects collaboration in developing a plan to support the patient's health.



Slide 7: FAB Best Practices Revisited

At this point, the goal is to have the FAB Best Practices at the forefront during the following reflections.

Remind the residents to look at the handout where the 5 best practices are defined and to use them as they consider the reflection prompts.



Slide 8: Let's Reflect

Here is an opportunity to discuss the video(s) that the residents have just watched.

Facilitator tip: Avoid rushing to the reflection prompts immediately after the video. A simple "What did you notice?" is often enough to open a rich discussion before moving to the structured prompts on Slide 7.



- "Remind residents as they reflect on the FAB best practices. They reflect what families have actually experienced in clinical settings and what they want from their providers. As you reflect on the videos, keep these in mind. Notice where you saw them – or didn't see them – in the vignettes."

Slide 8 (continued): Let's Reflect

Have the residents highlight the components of the vignettes that created an attuned or misattuned interaction. Ideally have them relate these back to the FAB best practices list.

Consider using the reflection prompts on the slide. Not all prompts need to be used; you can select based on the level of training and the energy in the room.

- In what ways can you relate to the physician in the vignette?
- Can you describe a mis-attuned clinical experience that the vignette reminds you of?
- What tools and strategies did you use to repair and move forward, and what did you learn through those experiences?
- What tools and strategies do you use to navigate system barriers in order to build trust and relationships?

Slide 8 (continued): Let's Reflect

Note: For some groups, the personal prompts – "can you think of a time when you felt mis-attuned in any relationship?" – tend to open discussions more safely than asking them to name clinical mis-attunement directly.

For others, the clinical prompts – "describe a mis-attuned clinical experience" – will generate more specific and actionable discussions.

The repair question – "How did you repair and re-attune?" – is an important one. It shifts the frame from deficit to agency and sets up the attuned video that follows.

Slide 9: Let's Reflect

This is an opportunity to reflect on the Attuned vignettes

- Where did you see the provider attuning?
- How did the family's responses change?

In your own experience, can you think of an encounter with families where you successfully made a true connection and demonstrated belief in family expertise?



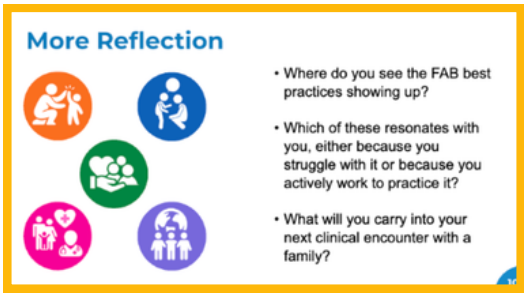
Facilitator tip: Resist the urge to work through all five priorities in detail here – that conversation happens more productively after the videos, on Slide 6. At this stage, the goal is orientation, not analysis.

Slide 10: More Reflection

FAB Best Practices – As a Reflection Tool

This distinction is worth naming explicitly:

- "You saw this list before the videos. Now that you've watched the videos, look at it again. What lands differently?"



The two closing prompts are designed to move residents from reflection to intention:

- Which of the best practices resonates with you – because you struggle with it or because you actively work to practice it? – is meant to invite self-assessment without judgment.
- The other prompt – what will you carry into your next clinical encounter – anchors the session in forward action rather than leaving it as a theoretical exercise.

Facilitator's Guide: Module 3, Attuned - Misattuned

Closing the Session

As residents prepare to leave the session, consider offering one brief closing thought that names the central reframe of the session:

- "Remember that mis-attunement is not a failure. What defines the relationship is what you do next. For example, that skill of repair is one important thing you can develop as a clinician."

Module 4: Parent Voices and Case Study

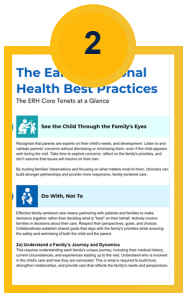
This session was built alongside families – not just for them. Through video, reflection, and role play, you will learn about and practice the relational skills that support Early Relational Health (ERH) in your everyday clinical interactions.

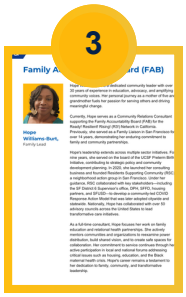


Materials

1) Slides: Parent Voices and Case Study (pg. 103)
2) Handout: FAB Best Practices (pg. 104-107)
3) Handout: FAB member biographies (pg. 12)
4) Handout: Clinician role-play instructions (pg. 108)
5) Handout: Caregiver/parent role-play instructions (pg. 109)
6) Survey: Post-survey (pg.111-112)

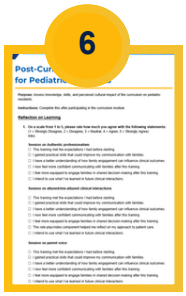












Orienting the Session

This module comes at the end of the curriculum sequence, which means residents arrive having already engaged with the ERH introduction, attunement/mis-attunement content, and the authentic professionalism material.

This module serves as a bridge between the resident trainees and the parents who created this curriculum. It provides residents with an opportunity to hear directly from FAB members reflecting on their own experiences in building relationships with families, and practice applying the FAB best practices in a challenging clinical conversation.

Facilitator's Guide: Module 4, Parent Voices and Case Study

Orienting the Session

The first part of this module centers the voices of FAB members as they share their experiences with clinicians and describe what they want and need from their healthcare providers. Several videos featuring FAB parents are included. Depending on the specific goals of the session and available time, facilitators may choose to show one or all of these videos. It is important to emphasize that the FAB members are not describing aspirational ideals. Their perspectives are grounded in what families in this clinical context have experienced and what they genuinely want from their relationships with clinicians.

Orienting the Session

Following the videos, use the reflection questions to invite residents to think about their own interactions with families.

Ask them to identify experiences in which they felt they were able to establish meaningful connection and collaboration. Explore what contributed to those interactions:

- What did the resident do?
- What did the family do?
- What aspects of the interaction helped create trust, connection, or a sense of partnership?

Orienting the Session

The second part of the module gives residents an opportunity to put these ideas into practice through a role-play centered on co-sleeping. Conversations about infant sleep provide a particularly rich opportunity to practice the skills reflected in the FAB best practices guidelines. Families' beliefs and practices around sleep may be deeply influenced by culture, family traditions, living circumstances, and psychosocial realities. At the same time, residents are taught to counsel families about safe infant sleep and the risks associated with co-sleeping. Navigating these conversations therefore requires residents to communicate important health and safety information while also seeking to understand the family's perspective, priorities, and circumstances.

Orienting the Session

For the role-play, each participant is provided with background information that shapes their character's perspective on co-sleeping. Importantly, the other participant does not know this information at the beginning of the interaction. This structure encourages residents to practice eliciting the family's perspective rather than making assumptions about the beliefs, experiences, or circumstances underlying a particular parenting practice.

Following the role-play, use the reflection questions to engage both the participants and observers in discussing the interaction. Encourage them to identify moments when the clinician demonstrated curiosity, connection, or collaboration, as well as moments when additional opportunities for partnership may have been possible. Consider not only what was communicated, but how the clinician approached the conversation and how that approach may have influenced the family's willingness to engage.

Facilitator's Guide: Module 4, Parent Voices and Case Study

Orienting the Session

During the discussion, return explicitly to the FAB best practices guidelines , particularly **"See the Child Through the Family's Eyes"** and **"Identify and Navigate Systems Barriers to Create a Human Experience."**

Invite residents to consider how these principles apply to conversations about co-sleeping.

- What might become visible when a clinician seeks to understand why a family has chosen a particular sleep practice?
- How might structural or systems-level barriers shape the options realistically available to a family?
- How can clinicians provide evidence-based guidance while maintaining curiosity, respect, and partnership?

Orienting the Session

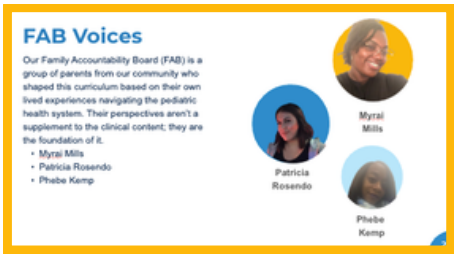
Following this discussion, residents will hear an audio reflection from a pediatric attending describing how she approaches and navigates conversations about co-sleeping with families. This provides an opportunity to hear how an experienced clinician works to integrate safe-sleep counseling with the relationship-building and collaborative practices emphasized throughout the chapter.

Finally, the residents can watch a video and hear again from one of the FAB participants discussing the importance of the specific FAB best practices guidelines.

Slide 2: FAB Voices

This slide introduces the members of the FAB who created the FAB videos and case study.
Suggested language:

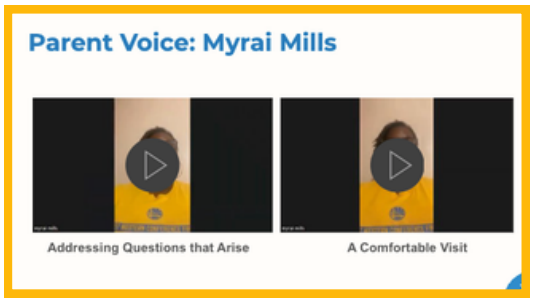
- "The FAB – our Family Accountability Board – is a group of parents from this community. They didn't advise this curriculum from the outside; they built it. The videos you're about to watch and the case you're about to work through came directly from their lived experiences."

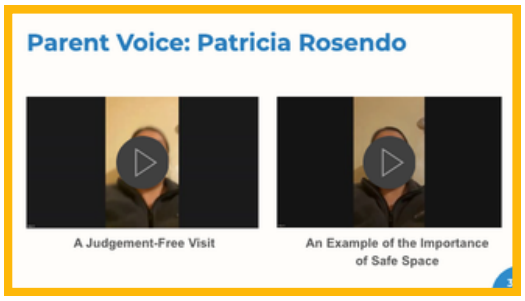


Consider reading one or two of the FAB members bio's aloud before playing the videos. It helps residents see FAB members as individuals, not just collective.
Note: These bio's are on a separate document available to the facilitator

Slides 3 and 4: Parent Voice Videos (Myrai Mills and Patricia Rosendo)

Play and watch the following videos





Slide 5: Reflection

This slide opens the module with a positive prompt – asking residents to recall an interaction that went well before they engage with the more complex material that follows. This is intentional: It anchors the session with competence rather than deficit, and it gives residents something concrete to compare against as the module unfolds.



Read out the three questions on the slide and ask 1 or 2 residents to share

If residents struggle to identify a positive example, you might offer: "Think about a moment when you felt like a family really heard you – or when you felt like you really heard them. What made that possible?

Slide 5: Reflection

Here are a few follow-up questions that can support a group understanding of the videos:

- What stood out to you from what you heard?
- Did anything surprise you or confirm something you already sensed?
- Where did you hear the FAB best practices showing up in what families shared?

Slide 6: FAB Best Practices for Building Provider-Family Relationships

This slide again presents the FAB's list of 5 best practices – what families in this community want from their pediatric providers. These best practices were developed by FAB members and represent their collective experience navigating the healthcare system.



Note: Remind residents that they have these best practices in more detail in a handout in front of them.

Slides 7-8: Clinical Case: Co-sleeping

These slides present the clinical scenario residents will role-play on the following slide. Give residents a moment to read it before moving on – or ask a volunteer to read it aloud to the group.



The case is carefully constructed. The family is NOT non-compliant. They tried the recommendation, it didn't work for their household, and they made a considered decision. They are pleased with the outcome. This means the resident cannot default to correction; they have to actually partner.



Facilitator's Guide: Module 4, Parent Voices and Case Study

Slides 7-8: Clinical Case: Co-sleeping

A few things worth noting before the role play begins:

- Co-sleeping carries cultural weight that varies significantly across communities. What reads as a safety risk in one context may be a deeply embedded family practice in another.
- The previous clinician's advice was clinically sound. The tension here is not about right versus wrong. It's about how to hold clinical guidance and family autonomy at the same time.

Slide 9: Co-Sleeping Role Play

The goal of this exercise is to practice all that has been learned today. That is, the clinician will need to sit with the fact that the caregiver's choice is uncomfortable to them as a clinician – that there is a risk, but that this will always be the parent's reality and lived experiences and choice. Recognizing this is in service of a continued relationship. They will need to apply the skills they learned, such as reflective listening and open-ended questions.



Recruit two volunteers: one to play the clinician, one to play the parent. Provide each with their character background privately before the role play begins. (Important: Make sure that neither will be familiar with the other's background information.)

Slide 9: Co-sleeping Role Play

The participants will only know the background of their own character Character background – Clinician: A first-year resident who recently cared for a family in the ED whose infant died from SIDS. That experience is still something the resident thinks about frequently and is very much on their mind as they enter this visit.



(Have a pdf to be handed out to the participant playing this role)

Slide 9: Co-sleeping Role Play

Character background – Parent:

- Mother of a 4-month-old infant living in a multigenerational household. She grew up with a family bed tradition. She tried the bassinet as recommended by the previous clinician; the infant's crying disrupted the whole household, including her mother-in-law, causing family tension. Has returned to co-sleeping. Her relationship with both her mother-in-law and her partner has since improved, and she is able to more fully attend to her infant's needs.

(Have a pdf to be handed out to the participant playing this role)



Slide 10: Reflections on the role play

Following the role play, discuss with the full group:

- How did the clinician choose to communicate and partner with the parent?
- For the doctor to answer: As the clinician, what did you feel during this conversation? What was challenging for you?
- For the patient to answer: How did this conversation go for you? How did you feel about the doctor's questions and suggestions?
- How else might the clinician have responded?
- Did you notice the clinician drawing on any of the FAB best practices?



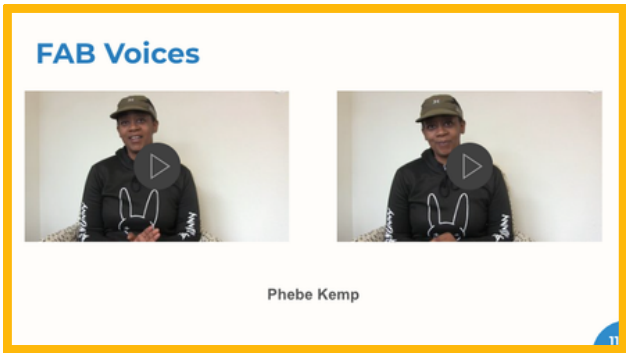
Slide 11: An Attending's Thoughts on the Co-Sleeping Conversation

Here is an opportunity to hear again from the attending her thoughts on the co-sleeping conversation with families.



Slide 12: FAB Voices Video

Here's another opportunity to hear a FAB member discuss their experiences as it relates to the FAB best practices and collaborating with clinicians



Slide 13: "See the Child through the Family's Eyes" and "Identify and Navigate Systems Barriers to Create a Human Experience"

- Discuss how these two FAB best practices relate to the co-sleeping conversation.
- Discuss if they were apparent in the role play

- If time allows, close with a brief reflection. One prompt that works well:
  - **"What is one thing from this training you want to carry into your next clinical interaction with a family?"**



PowerPoint Slides

All PowerPoint Slides and optional additional resources for the four modules of the ERH Toolkit can be found on the website at the ERH Toolkit Page readyresilientrising.ucsf.edu/resources

Alternatively, you may download them from the following Box folder: https://tiny.ucsf.edu/eGAmQ1



The Early Relational Health Best Practices

These best practices were developed by parents on the Family Accountability Board



1) See the Child Through the Family's Eyes

Recognize that parents are experts on their child's needs and development. Listen to and validate parents' concerns without dismissing or minimizing them, even if the child appears well during the visit. Take time to explore concerns, reflect on the family's priorities, and don't assume that issues will resolve on their own.

By trusting families' observations and focusing on what matters most to them, clinicians can build stronger partnerships and provide more responsive, family-centered care.

2) Do With, Not To

Effective family-centered care means partnering with patients and families to make decisions together rather than deciding what is "best" on their behalf. Actively involve families in decisions about their care. Respect their perspectives, goals, and choices. Collaboratively establish shared goals that align with the family's priorities while ensuring the safety and well-being of both the child and the parent.

2a) Understand a Family's Journey and Dynamics

This requires understanding each family's unique journey, including their medical history, current circumstances, and experiences leading up to the visit. Understand who is involved in the child's care and how they are connected. This is what is required to build trust, strengthen relationships, and provide care that reflects the family's needs and perspectives.

2b) Center family values and incorporate partnership in decision-making

Recognize parents as experts on their child. Show respect for their beliefs, preferences, culture, and lived experiences. Tailor recommendations to align with the family's values while providing guidance and support. During examinations, practice informed consent by explaining each step and asking permission before proceeding. Respect the child's autonomy and voice, particularly as they grow older, by involving them in decisions and honoring their preferences whenever it is safe and appropriate.



3) Create a Safe, Trusting Environment

Build an environment where families feel comfortable sharing their experiences without fear of judgment. Give each family your full attention; use open-ended questions to encourage conversation; and approach every interaction with empathy and respect. View families as individuals with unique lives and challenges; seeing them as human, not just another number, or another appointment, or another time slot. Be aware of how power differentials show up during encounters.

Maintain confidentiality, document respectfully (i.e., not weaponizing a family's words against them, such as noting "difficult parent or family." Instead try to recognize different perspectives/beliefs). Be mindful of how past experiences may influence how families view health care and how they respond in an encounter. A welcoming environment and a respectful provider reinforce that families are valued and heard.

3a) Use open-ended, nonjudgmental questions

Encourage meaningful conversation to better understand the family's perspective. Ask questions without judgment. Avoid leading questions, assumptions, or attempts to steer responses. Instead, ask questions that explore the parent's experiences, emotions, and current circumstances and gain a more holistic understanding of the family's needs to build trust and relationship.

Examples include, “How are you, parent?” “How is the child?” "How has that been for you?", or "What was it like to be your child's parent this week?"

3b) Practice reflective listening

Give the patient your full attention, listening for both what is said and what may be left unsaid, and reflecting their thoughts and feelings back to confirm understanding. This approach helps patients feel heard, builds trust, and provides insight into their emotional and mental state.

For example, if a parent says, "I've had a hard week," you can respond with, "I HEAR you've had a hard week," which acknowledges their experience and encourages further conversation.

3c) Build trust and obtain permission by approaching families with empathy, honesty, and respect

Ask permission before examinations or procedures; clearly explain what to expect and the purpose of each step; and ensure families feel informed and included in the process. Demonstrate genuine engagement through active listening, eye contact, and thoughtful questions that invite families to share their concerns, emotions, and questions. Especially during stressful situations, take time to explain information clearly and compassionately, recognizing that families may need additional support to process complex decisions.



4) Identify and Navigate System Barriers to Create a Human Experience

Help families navigate healthcare system barriers by recognizing what seems routine to clinicians may feel overwhelming or unfamiliar to patients. Providers should understand common challenges families face, including the impact of past difficult experiences, and serve as advocates by connecting families with appropriate referrals, community resources, and support. Familiarity with available resources and an awareness of one's role within the healthcare system enable clinicians to create a more compassionate, accessible, and human-centered care experience.



5) Recognize That Racial, Cultural, and Other Forms of Trauma Can Shape Families' Experiences with Healthcare

Approach each interaction with empathy; avoid taking mistrust or reluctance personally; and ask families how they would like you to support them.

Avoid labeling parents as "difficult;" instead, understand that their behaviors may reflect concern, past experiences, or difficulty expressing emotions. A trauma-informed approach acknowledges that families may hold the impact of previous healthcare encounters and emphasizes respect, compassion, and individualized care.

Role-Play Scenario for Doctor

This page is given to the resident that has volunteered to role play the CLINICIAN in our role play scenario:

Character background

– Clinician: You are a pediatric resident who recently cared for a family in the ED whose infant died from SIDS.

That experience is still something that you, the resident, think about frequently and is very much on your mind as you enter this visit.

You are the ONLY trainee in the room that is aware of this background information. In particular, the volunteer role-playing the patient's parent does not know this information.

Role-Play Scenario for Patient

This page is given to the resident that has volunteered to role play the PARENT in our role play scenario:

Character background

Parent: You are the parent of a 4-month-old infant living in a multigenerational household. You grew up with a family bed tradition.

You have tried the bassinet as recommended by the previous clinician; the infant's crying disrupted the whole household, including your in-law's, causing family tension.

You have returned to co-sleeping. Your relationship with both your in-laws and her partner has since improved, and you feel that you are more able to fully attend to your infant's needs.

You are the ONLY trainee in the room that is aware of this background information. In particular, the volunteer role-playing the patient's parent does not know this information.

Pre-Curriculum Survey for Pediatric Residents

Purpose: Assess knowledge, skills, and perceived cultural impact of the curriculum on pediatric residents.

Pre-Curriculum Survey

Instructions: Complete this survey before participating in the curriculum module.

Background

1. **Residency year:**
   - PGY-1
   - PGY-2
   - PGY-3

2. **Have you previously received formal training around relational health and family partnerships also referred to as clinical-family communication?**
   - Yes
   - No

Baseline Perceptions & Learning Goals

3. **In your own words, what do you hope to learn from this training?**

   _____

4. **On a scale from 1 to 5, please rate how much you agree with the following statements:**
   (1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree)

   - I want to gain practical skills to improve my communication with families.
   - I am interested in learning how family engagement can influence clinical outcomes.
   - I feel confident communicating with families.
   - I have skills to engage families in shared decision-making.
   - I understand the value of family involvement in pediatric care.
   - I reflect on how my background and bias may affect family interactions.
   - I am familiar with relational health principles.

5. **What are the barriers to meeting the parents' priorities in your clinical encounters?**

   _____

Post-Curriculum Survey for Pediatric Residents

Purpose: Assess knowledge, skills, and perceived cultural impact of the curriculum on pediatric residents.

Instructions: Complete this after participating in the curriculum module.

Reflection on Learning

1. **On a scale from 1 to 5, please rate how much you agree with the following statements:**
   (1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree)
   Intro

   Session on Authentic professionalism
   - ☐ This training met the expectations I had before starting.
   - ☐ I gained practical skills that could improve my communication with families.
   - ☐ I have a better understanding of how family engagement can influence clinical outcomes.
   - ☐ I now feel more confident communicating with families after this training.
   - ☐ I feel more equipped to engage families in shared decision-making after this training.
   - ☐ I intend to use what I've learned in future clinical interactions.

   Session on attuned/mis-attuned clinical interactions

   - ☐ This training met the expectations I had before starting.
   - ☐ I gained practical skills that could improve my communication with families.
   - ☐ I have a better understanding of how family engagement can influence clinical outcomes.
   - ☐ I now feel more confident communicating with families after this training.
   - ☐ I feel more equipped to engage families in shared decision-making after this training.
   - ☐ The role-play/video component helped me reflect on my approach to patient care.
   - ☐ I intend to use what I've learned in future clinical interactions.

   Session on parent voice

   - ☐ This training met the expectations I had before starting.
   - ☐ I gained practical skills that could improve my communication with families.
   - ☐ I have a better understanding of how family engagement can influence clinical outcomes.
   - ☐ I now feel more confident communicating with families after this training.
   - ☐ I feel more equipped to engage families in shared decision-making after this training.
   - ☐ I intend to use what I've learned in future clinical interactions

2. **If anything, what would you improve or change?**

_____

Cultural Shift & Sustainability

3. **On a scale from 1 to 5, please rate how much you agree with the following statements:**
(1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree)

- ☐ This training has influenced how I think about family involvement in pediatric care.
- ☐ This curriculum challenged my assumptions about clinician-family dynamics.
- ☐ This training reinforced the value of family involvement in pediatric care.
- ☐ This curriculum encouraged me to reflect on how my background and bias may affect family interactions.

4. **In your opinion, how might this kind of training impact pediatric care in the long term?**

Broader Adaptation

5. **Do you think this curriculum should be used in other residency programs?**
   - ☐ Yes
   - ☐ No
   - ☐ Not Sure

6. **What advice would you give to improve or adapt this training for other clinics or settings?**

Additional Feedback & Testimonial

7. **Do you have any additional thoughts or reflections about your experience with the curriculum?**