AMERICAN ACADEMY OF FAMILY PHYSICIANS

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Recommended Curriculum Guidelines for Family Medicine Residents

Practice in Metropolitan, Low-Resourced Areas

This document is endorsed by the American Academy of Family Physicians (AAFP).

Introduction

Each family medicine residency program is responsible for its own curriculum. The AAFP Commission on Education's Subcommittee on Graduate Curriculum has created this guide as an outline for curriculum development, and it should be tailored to the needs of the program.

Through a series of structured and/or longitudinal experiences, the curricula below will support the overall achievement of the core educational competencies defined by the Accreditation Council for Graduate Medical Education (ACGME) and provide guideposts to program requirements specific to family medicine. For updates and details, please refer to the ACGME website at www.acgme.org. Current AAFP Curriculum Guidelines may be found online at www.aafp.org/cg. These guidelines are periodically updated and endorsed by the AAFP and, in many instances, other specialty societies, as indicated on each guideline.

Preamble

Meeting the health needs of metropolitan, underserved communities is a complex phenomenon. It frequently involves working with patients and communities, transforming systems to keep pace with the evolving social contexts of our society, grappling with the effects of urban congestion on health, and undertaking a personal interrogation of what drives attitudes and behaviors in the clinical space.

Underserved patients frequently encounter challenges related to limited resources and face unique barriers in accessing health care and achieving a healthy lifestyle. They are vulnerable to multiple stressors that have a direct impact on their physical and mental health.

The environments in which patients are born, grow, live, work, and are educated have the strongest influence on health outcomes. Poor social conditions produce deleterious health outcomes that are often compounded by systemic inequities and other interlocking systems of oppression. It is also important to highlight that historical insults perpetuated by health care systems are major drivers of patient and community mistrust. All of these factors have been shown to be root causes resulting in health disparities that, in some cases, have persisted for generations.

Although there may be similar disease processes and behaviors in underserved communities and in well-resourced communities, it is well recognized that the aforementioned causative factors result in higher disease prevalence, worse health outcomes, and poorer access to quality health care within underserved communities.

Adequately meeting the needs of underserved communities requires understanding the context in which patients live, identifying systemic inequities that pose barriers to health care access, and delivering high-quality, culturally responsive health care. It requires a broad, comprehensive view of health using a framework built on a foundation that addresses the social and political determinants of health and is rooted in health equity.

In contrast to the challenges they face, underserved communities can manifest strength that supports resilience and ensures connectedness and survival. Since stressors are offset by strengths, the family physician's task is not only to characterize community challenges but also to leverage community strengths as a protective mechanism for health. This balance of challenges and strengths must be thoroughly understood for physicians to successfully work in partnership with patients and communities to help them achieve optimal health and wellness.

The Healthy People 2030 objectives state that "access to comprehensive, quality health care services is important for promoting and maintaining health."[1] This includes patients finding clinicians they feel they can trust and with whom they can communicate. In order to achieve this, health systems need to recruit and train clinicians who have specialized knowledge about equity and provision of high-quality care to diverse populations. Additionally, it is necessary to closely examine how health systems, particularly those located in underserved communities, have contributed to historical insults toward the communities they serve. Working to repair community mistrust and root out internal practices that perpetuate systemic bias is critical in building meaningful individual and community partnerships.

A deeper understanding of how patients' circumstances and environments affect individual and community health can guide physicians' work in a team-centered

approach that augments resilience and strength. Through advocacy, the family physician can contribute to systems change and resource utilization to best meet community needs.

Family physicians must learn and apply methods to the multilevel health needs of individuals and communities. They must hone skills that will help them partner with individuals and communities to address these needs. To best meet the needs of underserved patients and communities, family physicians should also demonstrate and model skills in systems change, advocacy, and leadership.

Patient Care

At the completion of residency, a family medicine resident should be able to:

- Demonstrate an ability to work effectively with racially, ethnically, and culturally diverse and low-income populations, and describe strategies for approaching patients and families who have different health belief models
- Understand the need to develop respectful therapeutic relationships that acknowledge the expertise and strengths of vulnerable patients and families
- Develop and implement a brief health promotion or health education presentation that is appropriate for the patient's level of health literacy
- Define and implement health promotion and risk-/harm-reduction strategies
- Use effective communication methods with cultural humility to harness patient strengths and resilience

Medical Knowledge

In the appropriate setting, a family medicine resident should demonstrate the ability to apply knowledge of the following:

1. How social and political determinants of health contribute to health outcomes
2. How interpersonal, structural, and systemic racism have impacted and contributed to social determinants of health and continue to do so
3. Needs and resources of special populations in the underserved setting
4. The epidemiological, demographic, and historical characteristics of the population served by their practice
5. Environmental and socioeconomic factors that affect the health and safety of patients, such as:
    a. Patterns of employment
    b. Educational opportunities and barriers to learning in school systems
    c. Opportunities for and barriers to physical activity and healthy nutrition
    d. Exposure to violence within family and community

e. Impact of historical violence and disenfranchisement on current social structures
f. Opportunities for and barriers to political and social involvement by community members
g. Crime patterns and safety issues in neighborhoods
h. Patterns of discrimination and oppression
i. History of incarceration of patients or their family members
j. Occupational and environmental health hazards
k. Patterns of substance use and addiction
l. Patterns of housing instability
m. Social service support and inner-city health resources, including elder care and child care, housing, transportation, and employment agencies
n. Local data regarding health disparities in different racial, ethnic, and disadvantaged groups
o. Historical relevance of discriminatory laws and policies that have led to all of the above

6. Identification and treatment of common clinical presentations in underserved settings, such as:
    a. Chronic disease prevention and management in children and adults
    b. Child preventive care and issues related to growth and development
    c. Educational needs assessment and knowledge of resources to address learning disabilities
    d. Recognition of and treatment protocols for child, elder, and partner abuse
    e. Limitations on access to care based on real or perceived stigmatization of certain populations, including, but not limited to:
        i. Patients who have HIV
        ii. Lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA) individuals
        iii. Individuals with substance use
        iv. Recent immigrants to the United States
        v. Individuals experiencing housing instability
    f. Reproductive needs
        i. Effect of and respect for religion and culture on reproductive health care options, health beliefs, and family planning decisions
        ii. Counseling and care of adolescents regarding sexuality, reproductive health, and prevention of sexually transmitted infections (STIs)
        iii. Care of pregnant adolescents and their families
        iv. Impact of legislation on reproductive health care options
        v. Disparities in care based on access to reproductive health counseling and reproductive health care options, including contraception and terminations
        vi. Counseling and care for LGBTQIA and gender nonbinary populations regarding their reproductive health care needs, including gender-affirming care

g. Communicable disease
    i. Prevalence and presentation in special populations
        1. Recent immigrants to the United States
        2. Individuals experiencing homelessness
        3. Men who have sex with men (MSM)
        4. Individuals who use IV drugs
        5. Prison/incarcerated populations
        6. Adolescents
    ii. STI and HIV/AIDS prevention, diagnosis, and treatment
    iii. Common parasitic infections in immigrant populations
    iv. Tuberculosis screening, diagnosis, and treatment
h. How cohabitation in close quarters, often seen in multigenerational households, affects disease
i. Mental health needs in special populations
    i. Individuals experiencing homelessness
    ii. Immigrants/refugees
    iii. Adolescents
    iv. LGBTQIA individuals
    v. Individuals with substance use
j. Posttraumatic stress disorder (PTSD) among immigrant groups related to exposure to violence, immigration experiences, war, and torture

7. Recognition of psychiatric emergencies, including familiarity with available transfer and referral resources
8. Understanding of oral health fundamentals for populations that may not have ready access to dental care, and understanding of what services may be provided in a family medicine office
9. Screening, diagnosis, and treatment for substance use disorders in different population subgroups
10. Practice of safe opioid prescribing for chronic pain, including identifying and addressing substance use disorders in patients who have chronic pain
11. Counseling in behavior change strategies regarding nutrition, physical activity, substance use, and sexual practices/behaviors
12. Recognition of community rates of violence, homicide, gun violence, and accident prevention
13. Identification of occupational hazards and work injuries commonly associated with urban settings (e.g., among restaurant workers, workers in small industries, and service workers)
14. Counseling on motor vehicle and bicycle safety
15. Understanding of family systems and community ecology
16. Recognition of the role of physicians, staff, and the clinic in mass casualty events (e.g., environmental/natural disasters; nuclear, biological, chemical, and other methods of terrorism; civil disturbance)

17. Demonstration of familiarity with treatment guidelines for common medical conditions

Interpersonal and Communication Skills

At the completion of residency, a family medicine resident should be able to:

- Identify and recognize their implicit bias and their colleagues' implicit bias and identify strategies to combat these
- Identify and recognize microaggressions and utilize upstander techniques to combat them
- Demonstrate willingness to identify their own power and privilege and its effect on patient encounters
- Demonstrate the ability to solicit community opinions and engage community members in community-based health improvement efforts
- Reflect on their own personal model of health and illness, and identify ways in which this model may impact clinical decision-making, intentionally or unintentionally
- Demonstrate skill in supporting health-related behavior change that is culturally sensitive
- Demonstrate the ability to work effectively with culturally diverse and low-income populations, and describe strategies for approaching patients and families who have different health belief models
- Demonstrate compassionate care for vulnerable patients and high-risk populations
- Utilize interpretation services appropriately to best meet the communication needs of patients
- Develop respectful therapeutic relationships with vulnerable patients and families
- Engage in motivational interviewing (MI) or similar communication styles and behavior change strategies
- Describe and apply methods to enhance patient self-management/adherence
- Demonstrate the ability to work within an interdisciplinary team
- Describe the role of health coaches and health promoters in an interdisciplinary team, and demonstrate the ability to incorporate their contributions into a patient care plan
- Demonstrate the ability to collaborate with traditional/community healers

Systems-Based Practice

At the completion of residency, a family medicine resident should be able to:

- Explain how social and political determinants of health contribute to health outcomes
- Develop an awareness of the impact of sociocultural and historical factors on patients, health care professionals, the clinical encounter, and interpersonal relationships
- Define the needs and resources of special populations in the urban setting
- Demonstrate compassionate care for vulnerable patients and high-risk populations
- Acknowledge and understand the power dynamics that exist in clinical encounters involving health care professionals and vulnerable patients and families
- Understand the importance of approaching health concerns from a community perspective
- Recognize the importance of community partnerships in addressing health concerns and improving health
- Display openness to learning about the experiences and cultural beliefs of the patients and community being served
- Recognize the importance of improving and adapting systems of care to patients' needs
- Demonstrate willingness to consider and advocate for the role of their own institution in promoting diversity in the workforce through recruitment, retention, mentorship, and support of historically marginalized minorities
- Recognize health systems issues and community engagement in urban settings, such as:
    - Principles and practice of community-oriented primary care (COPC)
    - Principles of authentic community partnerships
    - Components of the chronic care model
    - Models of interprofessional team care
    - Models of health service delivery and sustainability in urban settings, including community health centers and hospital-based ambulatory networks
    - Principles of risk reduction and harm reduction
    - Community epidemiology
    - Principles of community-based participatory research
    - Elements of the patient-centered medical home (PCMH)
    - Political structure and values, and their legislative influence on the community
- Identify obstacles to accessing care for individuals and families, and engage in strategies to overcome these obstacles
- Define elements of a humanistic empowerment model and apply this model to each patient encounter
- Develop an effective advocacy strategy to have an impact and influence change on the organizational and political levels

- Apply elements of the PCMH to an ambulatory health center
- Employ the fundamentals of a community-based needs assessment
- Explain and apply asset-mapping techniques
- Identify key community stakeholders/leaders and establish communication strategies related to patient and community needs
- Describe resources available in the community and how to help patients access them
- Identify environmental and occupational health risks and hazards in a community and ways to overcome them
- Apply COPC strategies
- Advocate for patients' and communities' needs at the local, regional, and national levels

Practice-Based Learning and Improvement

At the completion of residency, a family medicine resident should be able to:

- Perform systems-level interventions to improve patient services based on patient outcome data and self-assessment
- Understand the importance of the science of population health
- Demonstrate willingness to use interventions that affect the social determinants of health (e.g., empowering communities, functioning as an ally and advocate)
- Perform Plan-Do-Study-Act (PDSA) cycles (i.e., rapid-cycle quality improvement projects) as a continuous quality improvement (CQI) strategy
- Acquire patient/community feedback through various venues (e.g., key informant interviews, focus groups) to be used as needs assessments for services and feedback on health delivery
- Identify and use patient and community epidemiological data, needs assessments, and disease registries that pertain to the target patients and populations

Professionalism

At the completion of residency, a family medicine resident should be able to:

- Reflect on their own personal model of health and illness, and identify ways in which this model may impact clinical decision-making
- Engage in self-care practices that prevent burnout, and identify and reinforce organizational factors that sustain and enhance professional satisfaction in systems with limited resources

- Show dedication to being a lifelong learner
- Understand how implicit bias and stereotypes can lead to assumptions that can limit communication with patients and cause harm
- Recognize the presence of personal bias and how this can affect clinical decision-making and quality of care
- Demonstrate willingness to acknowledge and address their own privilege and biases in clinical encounters with vulnerable patients and families
- Define and assess health literacy
- Elicit patients' health beliefs and model care appropriately for partnership and shared decision-making

Implementation

This curriculum should be taught during both focused and longitudinal experiences throughout the residency program. Physicians who have demonstrated skills and compassion in caring for underserved patients and communities should be available to act as role models and mentors to the residents and should be available to give support and advice to individual residents regarding the management of their own patients. An interdisciplinary approach coordinated by the family physician is an appropriate method for structuring teaching experiences. Individual teaching, observed patient-clinician interactions, in-depth reflection on specific patient encounters, and small-group discussion will help promote appropriate attitudes.

Resources

Social

Berlinger N, Berlinger A. Culture and moral distress: what's the connection and why does it matter?. *AMA J Ethics*. 2017;19(6):608-616.

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Vanjani R, Pitts A, Aurora P. Dismantling structural racism in the academic residency clinic. *N Engl J Med*. 2022;386(21):2054-2058.

Health Care

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Ring JM, Nyquist JG, Mitchell S. *Curriculum for Culturally Responsive Health Care: The Step-by-Step Guide for Cultural Competence Training.* CRC Press; 2008.

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Community

Rhyne R, ed. *Community-Oriented Primary Care: Health Care for the 21st Century*. American Public Health Association; 1998.

World Health Organization (WHO) Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. August 27, 2008. Accessed April 6, 2023. https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1

Website Resources

Social

Family Medicine Residency Curriculum Resource. https://www.fammedrcr.com/

- Common Clinical Problems in Urban Settings
- Environmental and Socioeconomic Health Determinants
- How to Do a Community Needs Assessment
- Social Determinants of Health

Health Care

Agency for Healthcare Research and Quality:

- National Guideline Clearinghouse. www.guidelines.gov/
- National Healthcare Quality and Disparities Reports. www.ahrq.gov/research/findings/nhqrdr/index.html

American Academy of Family Physicians. The Medical Home. www.aafp.org/family-physician/practice-and-career/delivery-payment-models/medical-home.html

Center for Accelerating Care Transformation. Chronic Illness Care. www.act-center.org/our-work/primary-care-transformation/chronic-illness-care

Centers for Disease Control and Prevention:

- Adolescent and School Health. Youth Risk Behavior Surveillance System (YRBSS). www.cdc.gov/HealthyYouth/yrbs/index.htm
- National Center for Health Statistics. www.cdc.gov/nchs

Institute for Healthcare Improvement. www.ihi.org/IHI/

Motivational Interviewing Network of Trainers (MINT). www.motivationalinterviewing.org/

Substance Abuse and Mental Health Services Administration (SAMHSA). Screening, Brief Intervention, and Referral to Treatment (SBIRT). www.samhsa.gov/sbirt

Community

Centers for Disease Control and Prevention. The Guide to Community Preventive Services (The Community Guide). www.thecommunityguide.org/index.html

Office of Disease Prevention and Health Promotion. Healthy People 2030.

www.healthypeople.gov/

University of Kansas (KU) Center for Community Health and Development. Community Tool Box. http://ctb.ku.edu

World Health Organization. Urban Health (fact sheets, data, guidelines). www.who.int/health-topics/urban-health#tab=tab_1

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