Recommended curriculum guidelines for family medicine residents

Physician leadership in team-based primary care

This document was 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 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

In 2007, the *Joint Principles of the Patient-Centered Medical Home* emphasized the need for comprehensive and coordinated care, quality and safety, access and a personal physician. The concept of a patient-centered medical home (PCMH) to provide high-quality primary care supports these ideals. Organizations such as the Primary Care Collaborative were formed to promote progression of this concept.

Residency graduates face an increasingly demanding and complex health care environment, and care delivery models are evolving to meet patient needs. Family

physicians are presented with various job opportunities—including group practice, direct primary care and telemedicine—and opportunities to lead expanded care teams. Within each practice setting, physicians may encounter accreditation and regulatory requirements, personnel decisions, quality metrics and access standards. Accordingly, new physicians need to possess the skills, adaptive capacity and knowledge to help create and lead a comprehensive health care team that embodies the underlying concepts of the PCMH. An engaged physician leader remains central to the success of the team.

PATIENT CARE

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

1. Understand the components of empanelment, including:
    a. Determination of proper panel sizes
    b. Models of risk assessment used to determine patient complexity
    c. Chronic and preventive population health management through scheduled appointments and outreach initiatives
2. Demonstrate proficiency in creating patient-team partnerships to advance patient care, maintain continuity and deliver timely services
3. Understand the importance of prompt access to care, including template management that involves:
    a. Identifying appointment types and the ratio of appointment types
    b. Matching access to and demand for care through various appointment types, open scheduling and same-day visits, including digital and asynchronous options
    c. Determining the equity of access to address health care disparities
    d. Optimizing the care team to provide access to needed services
4. Understand the importance of familiarity with the communities and cultures one serves in order to meet their needs
5. Make a holistic assessment of patients and their environment
    a. Collect and evaluate information on social determinants of health to identify gaps and barriers in care
    b. Use the community health needs assessment (CHNA) to allocate appropriate resources to the community
    c. Assess the impact of mental health and substance use, especially in relation to trauma-informed care

MEDICAL KNOWLEDGE

At the completion of residency training, a family medicine resident should have the following baseline knowledge:

1. Population management strategies to assess and achieve quality care metrics, along with their benefits in patient-centered care
2. Patient-specific preventive health recommendations and how to counsel patients regarding them
3. Utilization of a multidisciplinary team in complex care management

a. Determination of patients who are high utilizers
b. Referral and test tracking
c. Care coordination and transitions of care
d. Behavioral component in the patient plan, including trauma-informed care
4. Proper utilization of medical tools, analytics and references, including ethical use of artificial intelligence (AI)
5. Adverse outcomes and how to lead a root cause analysis with the multidisciplinary team

INTERPERSONAL COMMUNICATION

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

1. Model excellent communication with support staff, colleagues and all members of the care team
2. Communicate a vision for the medical practice and empower the development of team models that promote trust, growth and engagement in the practice
   a. Foster meaningful connections with support staff and patients
   b. Facilitate a culture of safety by empowering team members to speak up and give feedback
3. Demonstrate the ability to independently prioritize and perform or appropriately delegate tasks to other individuals within the team
4. Include the "voice of the patient" by using patient focus groups or advisory councils and routinely practicing shared decision-making
5. Utilize health IT and new innovative approaches to health care delivery (See the AAFP curriculum guideline on medical informatics.)
   a. EHR options and impact on practice
   b. Meaningful use measures
   c. E-prescribing, virtual patient care, practice website design and online patient education for two-way electronic communication
   d. AI scribe and inbox technologies
6. Help patients and others involved in their care locate reputable medical information on the internet and from other sources
7. Discuss internet safety and protection of health information
8. Discuss risks and benefits of social media use for a medical practice and for a health care professional

SYSTEMS-BASED PRACTICE

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

1. Demonstrate a basic understanding of PCMH concepts, including the Institute for Healthcare Improvement's (IHI's) Triple Aim
2. Demonstrate the ability to foster patient-centered care using a holistic approach within the framework of the individual, family and community
3. Demonstrate an understanding of optimal staffing requirements, full-time equivalent (FTE) measurements, empanelment methods and metrics for

efficient and high-quality care

4. Demonstrate basic understanding of productivity and financial management, including:
    a. Billing, coding and documentation for medical necessity requirements
    b. Relative value unit (RVU) generation
    c. Physician compensation models
    d. Pay for performance and CMS
    e. Payor capitation and subcapitation models, including value-based care
    f. Cash flow management, including payments, reimbursement and expenditures
    g. Scheduling
5. Understand team-based care
    a. Definition, clarification and expansion of each team member's roles and responsibilities, including non-physician clinicians, mental health professionals and support staff
    b. Utilization of team members to the top of their abilities, education and licenses
    c. Establishment of staff involvement in quality improvement (QI) procedures
    d. Evaluation of team members and feedback from team members
    e. Facilitation of routine meetings and daily huddles
    f. Establishment of a foundation for office workflow based on team members' expertise
6. Apply knowledge of guidelines and resources critical to clinic operations and accreditation
    a. PCMH resources
    b. American College of Physicians PCMH resource website
    c. DNV, Joint Commission or other hospital-based PCMH accreditation standards
    d. IHI Triple Aim
    e. Agency for Healthcare Research and Quality patient-centered medical neighborhood
    f. CHNA
7. Have routine exposure to quality metrics
    a. Access, continuity, outcomes and patient experience measures
    b. Healthcare Effectiveness Data and Information Set (HEDIS) measures
    c. Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (AAPM)
8. Have exposure to legal and personnel management topics (See the AAFP curriculum guideline on risk management and medical liability.)
    a. Quality assurance and risk management
    b. Employment contracts, to include performance expectations, compensation, benefits and liability coverage
    c. Estimation of staffing requirements
    d. How to work with learners in a medical practice setting
    e. Strategic planning
    f. Recruitment, motivation, retention and termination
9. Apply education regarding facilities management
    a. Rent, lease or own
    b. Location and marketing
    c. Inventory and supplies
    d. Special services: office-based procedures, vaccine storage, radiology, lab,

financial counselors and social workers
    e. Medical records
        i. HIPAA
        ii. Chart audits
        iii. Patient portals
10. Understand finances
    a. Cash flow, to include billing, accounting and overhead management

PRACTICE-BASED LEARNING

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

1. Recognize the importance of lifelong learning and the pursuit of improved quality care with evidence-based best practice standards that are continuously evolving
2. Understand how to innovate in an increasingly complex health care environment
3. Utilize data and the care team to create concrete goals and objectives
4. Lead improvement initiatives in quality and patient experience metrics
    a. Develop methods for performance measurement, including care outcomes and patient experience
    b. Engage clinicians and staff in QI activities
    c. Use validated tools and evidence-based medicine to improve patient care
5. Foster innovative approaches to health IT and clinical care
6. Analyze current practice
    a. Documentation, coding and RVUs
    b. Collaboration with the practice's patient advisory committee to assess and address community health needs

PROFESSIONALISM

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

1. Model professionalism in leading the collaboration of support staff and the clinical care team
2. Demonstrate an understanding of basic physician leadership attributes and skills necessary to effectively lead a comprehensive care team
    a. Conflict resolution
    b. Mentorship
    c. Self-awareness
    d. Ability to give and receive feedback
    e. Adaptability
    f. Growth mindset
3. Demonstrate foundational knowledge of the administrative, legal and financial processes involved in clinic operations
4. Demonstrate awareness of implicit bias, particularly in relation to race and ethnicity

IMPLEMENTATION

This curriculum guideline should be taught through both focused and longitudinal experiences, with increasing emphasis during the latter half of residency. Integration into conferences, group discussions, case studies and community projects is recommended. Residents should gain hands-on experience by being involved in on-site practice management in the family medicine practice. Additionally, residents should be involved in practice transformation policies and workflows as a way of implementing what they learn and integrating it with experience.

Residencies with clinical activities that are limited to only one model of practice should make special effort to expose residents to other practice types. Each family medicine resident should be able to demonstrate the ability to work with various individuals involved in practice management, including demonstrating an understanding of their relationships to practice needs, office personnel, practice management systems, consultants and various other resources available in the community.

RESOURCES

Altschuler J, Margolius D, Bodenheimer T, et al. Estimating a reasonable patient panel size for primary care physicians with team-based task delegation. *Ann Fam Med.* 2012;10(5):396-400.

American Academy of Family Physicians. Curriculum guideline: Medical informatics. Revised October 2022. Accessed August 14, 2025. https://www.aafp.org/dam/AAFP/documents/medical_education_residency/program_directors/reprint288-medical-informatics-2023.pdf

American Academy of Family Physicians. Curriculum guideline: Risk management and medical liability. Revised October 2022. Accessed August 14, 2025. https://www.aafp.org/dam/AAFP/documents/medical_education_residency/program_directors/reprint281-risk-management-medical-liablity-2023.pdf

American Academy of Family Physicians, Rock Health. The Starfield Signal: a shared vision and roadmap for AI in primary care. August 2025. Accessed August 15, 2025. https://www.aafp.org/news/practice-professional-issues/ai-starfield-signal-report.html

Bitton A, Schwartz GR, Stewart EE, et al. Off the hamster wheel? Qualitative evaluation of a payment-linked patient-centered medical home (PCMH) pilot. *Milbank Q.* 2012;90(3):484–515.

Bodenheimer T, Ghorob A, Willard-Grace R, et al. The 10 building blocks of high-performing primary care. *Ann Fam Med*. 2014;12(2):166-171.

Buljac-Samardzic M, Doekhie KD, van Wijngaarden JDH. Interventions to improve team effectiveness within health care: a systematic review of the past decade. *Hum Resour Health*. 2020;18(1):2.

Dai M, Ingham RC, Peterson LE. Scope of practice and patient panel size of family physicians who work with nurse practitioners or physician assistants. *Fam Med.* 2019;51(4):311-318.

Dine CJ, Kahn JM, Abella BS, et al. Key elements of clinical physician leadership at an academic medical center. *J Grad Med Educ.* 2011;3(1):31-36.

Epperly T, Bechtel C, Sweeney R, et al. The shared principles of primary care: A multistakeholder initiative to find a common voice. *Fam Med*. 2019;51(2):179-184.

Franks AM, Clements C, Bannister T, et al. Optimization of electronic health record usability through a department-led quality improvement process. *Ann Fam Med.* 2024;22(2):81-88.

Goren L. Five steps for building physician leadership skills. *Fam Pract Manag.* 2014;21(5):40.

Hernandez N. Five ways physicians can better communicate with staff. *Physicians Practice* blog. December 17, 2014. Accessed August 14, 2025. www.physicianspractice.com/view/five-ways-physicians-can-better-communicate-staff

Hopkins K, Sinksy CA. Taking team-based care to the next level. *Fam Pract Manag.* 2022;29(3):25–31.

Kong M, Bodenheimer T, Willard-Grace R. Making a business case for team-based care. *Fam Pract Manag.* 2023;30(4):31–37.

Loeb DF, Kline DM, Kroenke K, et al. Designing the relational team development intervention to improve management of mental health in primary care using iterative stakeholder engagement. *BMC Fam Practice*. 2019;20(1):124.

Mahoney MR, Damrose E, Shanafelt T. Empowering family physicians in medical staff leadership to foster physician well-being. *J Am Board Fam Med*. 2025;38(1);168-171.

Markova T, Mateo M, Roth LM. Implementing teams in a patient-centered medical home residency practice: lessons learned. *J Am Board Fam Med.* 2012;25(2):224-231.

Markuns JF, Fraser B, Orlander JD. The path to physician leadership in community health centers: implications for training. *Fam Med.* 2012;42(6):403-407.

National Academies of Sciences, Engineering, and Medicine. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care.* The National Academies Press; 2021.

Naughton D, Adelman AM, Bricker P, et al. Envisioning new roles for medical assistants: strategies from patient-centered medical homes. *Fam Pract Manag.* 2013;20(2):7-12.

Patel MS, Arron MJ, Sinsky TA, et al. Estimating the staffing infrastructure for a patient-centered medical home. *Am J Manag Care.* 2013;19(6);509-516.

Safford BH, Manning C. Six characteristics of effective practice teams. *Fam Pract Manag*. 2012;19(3):26-30.

Sinksy CA, Willard-Grace R, Schutzbank AM, et al. In search of joy in practice: a report of 23 high-functioning primary care practices. *Ann Fam Med.* 2013;11(3):272-278.

Teisberg E, Wallace S, O'Hara S. Defining and implementing value-based health care: a strategic framework. *Acad Med*. 2020;95(5):682-685.

Warde CM, Giannitrapani KF, Pearson ML. Teaching primary care teamwork: a conceptual model of primary care team performance. *Clin Teach*. 2020;17(3):249-254.

Weber R, Murray M. The right-sized patient panel: a practical way to make adjustments for acuity and complexity. *Fam Pract Manag*. 2019;26(6):23-29.

Working Party Group on Integrated Behavioral Healthcare, Baird M, Blount A, et al. Joint principles: integrating behavioral health care into the patient-centered medical home. *Ann Fam Med.* 2014;12(2):183-185.

WEBSITE RESOURCES

Agency for Healthcare Research and Quality (AHRQ). TeamSTEPPS. www.ahrq.gov/teamstepps

American Academy of Family Physicians (AAFP). aafp.org

American College of Physicians (ACP). Delivery and payment models. www.acponline.org/practice-career/business-resources/payment/delivery-and-payment-models

Centers for Medicare & Medicaid Services (CMS). Promoting Interoperability Programs. www.cms.gov/medicare/regulations-guidance/promoting-interoperability-programs

Institute for Healthcare Improvement (IHI). Triple Aim. www.ihi.org/library/topics/triple-aim

Joint Commission. www.jointcommission.org

National Committee for Quality Assurance (NCQA). www.ncqa.org

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People 2030. health.gov/healthypeople

REVISIONS

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