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Recommended Curriculum Guidelines for Family Medicine Residents

Patient Education

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

Introduction

This Curriculum Guideline defines a recommended training strategy for family medicine residents. Attitudes, behaviors, knowledge, and skills that are critical to family medicine should be attained through longitudinal experience that promotes educational competencies defined by the Accreditation Council for Graduate Medical Education (ACGME), www.acgme.org. The family medicine curriculum must include structured experience in several specified areas. Much of the resident's knowledge will be gained by caring for ambulatory patients who visit the family medicine center, although additional experience gained in various other settings (e.g., an inpatient setting, a patient's home, a long-term care facility, the emergency department, the community) is critical for well-rounded residency training. The residents should be able to develop a skill set and apply their skills appropriately to all patient care settings.

Structured didactic lectures, conferences, journal clubs, and workshops must be included in the curriculum to supplement experiential learning, with an emphasis on outcomes-oriented, evidence-based studies that delineate common diseases affecting patients of all ages. Patient-centered care, and targeted techniques of health promotion and disease prevention are hallmarks of family medicine and should be integrated in all settings. Appropriate referral patterns, transitions of care, and the provision of cost-effective care should also be part of the curriculum.

Program requirements specific to family medicine residencies may be found on the ACGME website. 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.

Each residency program is responsible for its own curriculum. **This guideline provides a useful strategy to help residency programs form their curricula for educating family physicians.**

Preamble

Effective patient education entails providing patients with health information that will improve their overall health status. The Latin origin of the word “doctor” (“docere”) means “to teach,” and providing education to patients, their families, and communities is the responsibility of all physicians. Family physicians are uniquely suited to take a leadership role in patient education. Patient education is a collaborative effort between family physicians and patients, with a primary goal of improving patient health outcomes. Family physicians build long-term, trusting relationships with patients, providing opportunities to encourage and reinforce changes in health behavior. Therefore, effective and dynamic patient education is an essential component of residency training for family physicians.

As the practice of medicine becomes increasingly patient centered, patient involvement in the medical decision-making process through patient education and partnership is central to improving both overall health outcomes and achievement of patient goals. Providing patients with complete and current information helps create an atmosphere of trust, enhances the physician-patient relationship, and empowers patients to partner in managing their health. The leading causes of death in the United States (i.e., heart disease, cancer, stroke, lung disease, and injuries) are largely preventable and can be reduced through effective patient-physician partnership.

Effective patient-physician partnership and information sharing require mastery of a variety of practical skills. These include ascertaining patients’ health literacy levels, properly identifying patient goals and values, identifying barriers to learning and behavior change, incorporating education into routine office visits, and providing targeted education to enhance patient understanding and empower patient decision making. Providing effective patient education also requires mastery of evaluation and utilization of written, audiovisual, and computer-based patient education materials.

Competencies

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

- Provide effective, patient-centered patient education (Patient Care, Interpersonal and Communication Skills)
- Assess patients’ knowledge deficits related to preventing disease and maintaining health
- Collaborate with the patient to determine goals of care (Patient Care, Interpersonal and Communication Skills)

- Identify attitudinal and motivational barriers preventing healthy patient behavior changes (Interpersonal and Communication Skills)
- Provide patients with complete and current information in order to empower them to be active participants in the health care decision-making process (Medical Knowledge, Interpersonal and Communication Skills, Professionalism)
- Facilitate patient self-management of chronic disease conditions (Patient Care, Systems-based Practice, Interpersonal and Communications Skills)
- Evaluate and select appropriate written, audiovisual, and/or computer-based instructional aids for information sharing and patient decision making, taking into account the patient's background (including educational level, literacy, cultural background, etc.) (Patient Care, Practice-based Learning and Improvement)
- Advocate for patient health by facilitating connections to community support and resources that support optimal health outcomes (Systems-based Practice)
- Incorporate patient education into routine office visits (Patient Care, Interpersonal and Communication Skills)
- Facilitate access to health information and care for populations and communities, especially for minorities and economically underprivileged groups

Attitudes

The resident should demonstrate attitudes that align with the values of patient-centered care:

- Value information sharing as a skill that is essential to the discipline of family medicine and as an integral part of each patient encounter that is essential in the treatment of disease and the maintenance of health
- Prioritize the value of patient autonomy in the decision-making process
- Elicit patient beliefs and values
- Respect patient preferences and goals
- Modify patient education to complement patient health literacy levels
- Target information sharing to the needs, goals, and interests of the individual patient
- Invest in continuous patient-physician partnerships to positively influence health outcomes
- Aspire to understand community and population health needs and intervene to improve health outcomes and reduce disparities
- Follow ethical principles in the provision of patient education

- Respect cultural values and beliefs that influence patient priorities and decisions
- Favor participation of the interdisciplinary team (including nurses, pharmacists, nutritionists, physical therapists, etc.) in patient education and care

Knowledge

In the appropriate setting, the resident should demonstrate the ability to apply knowledge of:

1. Principles of patient education
   a. Understand that healthy literacy is a set of skills necessary to make appropriate health care decisions and navigate the health care system and is multifactorial

   b. Prioritize patient teaching and use universal health literacy precautions to provide understandable and accessible information to all patients
      i. Avoid medical jargon
      ii. Break down information into small, concrete steps
      iii. Limit patient teaching to three to five key points per visit
      iv. Confirm patient's understanding through teach-back method
      v. Use simple visual aids (e.g., pictures, illustrations, graphs, videos) to reinforce key points
      vi. Ensure that printed information is written at or below a fifth- to sixth-grade reading level
      vii. Use professional medical interpreter services if the preferred language is not one in which the physician is proficient

   c. Adapt teaching to the patient's level of readiness, past experiences, cultural beliefs, and understanding

   d. Create an environment conducive to learning with trust, respect, and acceptance

   e. Involve patients

      i. Encourage self-management and empowerment through a patient-centered approach

      ii. Encourage patients to establish their own goals and evaluate their own progress to enhance self-management

   f. Identify patients' perceptions of health care to improve patient motivation for self-management

   g. Provide opportunities for patients to demonstrate their understanding of information and practice skills

   h. Encourage use of telehealth visits and interdisciplinary teams of nurses, nutritionists, pharmacists, and other ancillary staff to provide a caring environment and help link patients to supportive systems

   i. Utilize tools to help increase communication skills (e.g., the AHRQ Health Literacy Universal Precautions Toolkit, a Health Resources and Services Administration [HRSA] online course, the Ask Me 3 educational program)

2. Barriers to patient learning and adoption of health practices
    a. Physical condition
        i. Age
        ii. Vision or hearing impairment
        iii. Acute pain or illness
        iv. Cognitive impairment
        v. Emotional state
    b. Socioeconomic and environmental considerations
        i. Lack of support systems
        ii. Cost
    c. Misconceptions about disease and treatment
    d. Low literacy and comprehension skills
    e. Cultural and ethnic background and language barriers
    f. Lack of motivation
    g. Negative past experiences
    h. Denial of personal responsibility

3. Selected educational topics*
    a. Health promotion and disease prevention
        i. Chemoprophylaxis (e.g., iron supplementation, folic acid in pregnancy, fluoride)
        ii. Domestic violence
        iii. End-of-life issues
        iv. Evidence-based cancer screening
        v. Family planning and pregnancy
        vi. Immunizations
        vii. Integrative, complementary, and alternative medicine
        viii. Menopause and hormone replacement
        ix. Osteoporosis and fall prevention
        x. Safer sex counseling and sexually transmitted infection (STI) prevention
        xi. Safety and injury prevention
        xii. Screening for prevalent diseases (e.g., blood pressure, cholesterol, diabetes)
        xiii. Substance abuse
        xiv. Therapeutic lifestyle changes (e.g., smoking cessation, weight control, better nutrition, increased exercise, stress reduction)
        xv. Well-child anticipatory guidance
    b. Disease management
        i. Arthritis
        ii. Asthma and chronic obstructive pulmonary disease (COPD)
        iii. Depression and anxiety

iv. Diabetes
v. Headaches
vi. Hyperlipidemia
vii. Hypertension
viii. Obesity
ix. Sports injuries
x. STIs and HIV
xi. Upper respiratory infections and otitis media

**This is not meant to be an exhaustive list of topics. However, it represents core areas in which family medicine residents should have knowledge of specific educational interventions and to which family medicine residents should be exposed during teaching opportunities.*

Skills

In the appropriate setting, the resident should demonstrate the ability to independently perform or appropriately refer the following skills:

1. Basic skills
    a. Identify the educational needs of each patient
    b. Gather information about the patient's daily activities, knowledge, health beliefs, cultural beliefs, and level of understanding
    c. Tailor education to each patient's educational level and cultural beliefs
    d. Inform patients of findings clearly and concisely without use of medical jargon
    e. Discuss treatment plans in terms of specific behaviors
    f. Identify goals of care with the patient
    g. Encourage questions and provide appropriate answers
    h. Utilize appropriate written, audiovisual, and computer-based materials
    i. Utilize interpreters appropriately and effectively to facilitate communication with patients, as needed
2. Short-term plans for acute illness
    a. Prepare the patient for symptoms and effects of the condition, examination, and treatment
    b. Assess the ability of each patient to carry out the treatment plan; identify barriers and individualize the treatment plan accordingly
    c. Assess the patient’s understanding by having them restate the treatment plan
    d. Document educational efforts for acute illness in specific terms in the record
3. Long-term strategies for chronic disease

a. Involve the patient in setting treatment goals and creating a treatment plan
b. Present manageable amounts of information to the patient over time
c. Educate the patient regarding possible long-term health consequences of untreated disease states
d. Provide opportunities for the patient to discuss their feelings
e. Provide the patient with adequate feedback on progress toward goals
f. Assess influence of the patient's background, home, and work environment on the treatment plan and adapt education accordingly
g. Assess the patient's understanding by having them restate the treatment goals and plan
h. Document educational efforts for chronic illness in specific terms in the record
i. Engage surrogate decision makers and family members
j. Create a health care team for a multidisciplinary approach (palliative care, behavioral health specialists, case management, and social work)

4. Health promotion
   a. Determine the patient's health-risk behaviors through interview and health-risk appraisals
   b. Introduce health promotion topics during "teachable moments"
   c. Assess the patient's priorities and readiness to change health-related behaviors
   d. Respond to the patient's interest in health promotion with specific suggestions for behavior change (e.g., exercise prescription)
   e. Employ educational messages appropriate for various stages of behavior change
   f. Enlist assistance of other health care professionals (e.g., case managers, social workers, behavioral health specialists, nurses, health educators, dietitians, certified fitness instructors) to create a patient-centered health care team
   g. Incorporate use of appropriate community resources

5. Incorporation of patient education into practice
   a. Develop evidence-based patient education resources and protocols directed to the most common educational levels and primary languages of patients in the practice
   b. Evaluate commercial patient education resources (e.g., brochures, books, audiotapes, videotapes, Internet materials, phone- or web-based applications)
   c. Select instructional materials appropriate for the patient's readiness to learn and level of understanding
   d. Develop systems to facilitate use of patient education materials in office practice
   e. Develop systems to involve office staff in assisting with patient education
   f. Utilize family conferences, when appropriate
   g. Participate in health education presentations to community groups

h. Adapt and incorporate emerging technologies
i. Guide patients to evaluate and select reliable websites for medical information

Implementation

Instruction on physician communication skills should be incorporated longitudinally throughout the entire residency curriculum. Each residency program should ensure that preceptors who provide direct patient care include patient education as an integral part of patient encounters to facilitate development of this skill in residents. Faculty should demonstrate a commitment to physician communication and patient education by teaching and molding these skills in resident education. Questions regarding patient education or communication issues should be included in discussions of individual cases during rounds and precepting on an ongoing basis.

The residency's behavioral sciences faculty can play a key role in development, instruction, and competency-based assessments for a communication curriculum. Often, they have specific training in and exposure to best-practice communication techniques. It is helpful to employ teaching modalities of role modeling (i.e., resident watches faculty communicate well) and direct observation (i.e., faculty observe residents and offer constructive feedback) in sessions focused on enhancing resident communication skills.

Each residency is encouraged to form a patient education committee comprising residents, faculty, staff, and—if possible—patients and members of the community. This committee may participate in the patient education curriculum for the residency. Continual research and evaluation should be encouraged by the committee to determine the effectiveness of patient education resources, methods, and materials. The patient education committee may also help design systems that incorporate patient education activities into a model office practice (e.g., disease-specific patient education classes) so that residents can transfer this knowledge to their own practice situations after graduation. If a committee is unavailable, identifying a faculty patient education champion is recommended.

Each residency is encouraged to maintain ready access to patient education materials of all types, including written, audiovisual, and computer-based materials. Patient education materials should cover the common health problems in the community, as well as frequently requested health promotion and disease-related topics. The materials should be appropriate for the health literacy levels and the cultural and ethnic diversity of the patient population. Each residency should maintain a current list of resources available in the community to supplement the patient education provided in the family medicine center and should promote residents' familiarity with these resources.

There is an increasing need for comprehensive residency telemedicine curricula to improve the delivery of quality virtual health care. Each residency is encouraged to maintain a variety of e-health patient education materials that can be utilized in the telehealth setting. Residents should receive formal education on implementation of these resources.

In addition to didactic hours on patient education, residents should attend patient

education conferences and participate in community education projects.

Resources

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Website Resources

Agency for Healthcare Research and Quality. The SHARE Approach. www.ahrq.gov/health-literacy/curriculum-tools/shareddecisionmaking/index.html

American Academy of Family Physicians. familydoctor.org. https://familydoctor.org

American Academy of Pediatrics. Bright Futures. https://brightfutures.aap.org/families/Pages/Resources-for-Families.aspx

Centers for Disease Control and Prevention. www.cdc.gov

Health Literacy Online: A Guide for Simplifying the User Experience. https://health.gov/healthliteracyonline

Mayo Clinic Shared Decision Making National Resource Center. https://shareddecisions.mayoclinic.org

Nemours Foundation. KidsHealth. www.kidshealth.org

Tufts University Hirsh Health Sciences Library. Selected Patient Information Resources in Asian Languages (SPIRAL). http://spiral.tufts.edu/index.html

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