AMERICAN ACADEMY OF FAMILY PHYSICIANS

AAFP Reprint No. 289B

Recommended Curriculum Guidelines for Family Medicine Residents

Urban Practice Curriculum

This document is 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 skillset 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.

Please note that the term “manage” occurs frequently in AAFP Curriculum Guidelines. “Manage” is used in a broad sense to indicate that the family physician takes responsibility for ensuring that optimal, complete care is provided to the patient. This does not necessarily mean that all aspects of care need to be directly delivered personally by the family physician. Management may include appropriate referral to other health care providers, including other specialists, for evaluation and treatment.

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

Addressing the health needs of urban communities frequently involves working with patients who have limited resources, sometimes called the “urban underserved.” Urban underserved individuals and communities may lack necessities for survival and face unique challenges in accessing health care or achieving a healthy lifestyle. They are uniquely vulnerable to multiple stressors that have a direct impact on their health.

Although there may be similar disease processes and behaviors in many communities, it is well recognized that disease prevalence, health outcomes, and access to health care are worse in communities of need. Addressing these issues requires understanding of the patient’s context, which includes social, political, cultural, economic, and physical environments, and delivering culturally responsive health care. It requires a broad view of health. In addition, because the root causes of illness and poor health are often traceable to difficulty accessing fundamental resources such as time, employment, money, housing, food, or control over one’s situation, the framework of health care must include a foundation that addresses the social and political determinants of health.

In contrast to the challenges urban underserved patients face, individuals and communities manifest strengths that support resilience and ensure connectedness and survival. Realizing that stressors are offset by strengths, the family physician’s task is not only to characterize the challenges that individuals in resource-poor communities face, but also to understand their strengths and how these strengths help protect them. This balance of challenges and strengths must be understood to better work in partnership with patients and communities to help them achieve optimal health and wellness.

The Healthy People 2020 objectives state that access to health services is important in “promoting and maintaining health.” This includes patients finding clinicians they feel they can trust with whom they can communicate. Not addressing barriers to health care services may lead to many adverse outcomes, including unmet health needs, inability to access preventive services, and failure to prevent hospitalizations. Access to care is often disproportionately varied based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location.

In the context of understanding the social and political determinants of health, physicians must be committed to addressing patients' needs (including acute and chronic health needs) at all levels, as well as understanding the conditions and policies that create and contribute to those needs. 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 strengths. Through advocacy, the family physician can contribute to systems change and resource utilization to best meet a community's needs.

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

Competencies

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

- Explain how social and political determinants of health contribute to health outcomes (Medical Knowledge, Systems-based Practice)
- Describe how systematic racism and historical racism have impacted and contributed to social determinants of health and continue to do so (Medical Knowledge, Systems-based Practice)
- Identify and recognize implicit bias in oneself and one's colleagues and identify strategies to combat it (Systems-based Practice)
- Define the needs and resources of special populations in the urban setting (Medical Knowledge, Systems-based Practice)
- Describe the epidemiological/demographic and historical characteristics of the population served by his or her practice (Medical Knowledge)
- Demonstrate the ability to solicit community opinions and to engage community members in community-based health improvement efforts (Interpersonal and Communication Skills, Practice-based Learning and Improvement)
- Describe strategies for adapting the health delivery organization to the culture and needs of the patients and community served by her or his practice (Practice-based Learning and Improvement, Systems-based Practice)
- Reflect on his or her own personal model of health and illness, and identify ways in which this model may impact clinical decision-making (Interpersonal and Communication Skills, Professionalism)
- Demonstrate an 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 (Patient Care, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, Systems-based Practice)

- Demonstrate skill in supporting health-related behavior change that is culturally sensitive (Medical Knowledge, Interpersonal and Communication Skills)
- Perform systems-level interventions to improve patient services based on patient outcome data and self-assessment (Practice-based Learning and Improvement, Systems-based Practice)
- 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 (Professionalism)

Attitudes and Behaviors

The resident should develop attitudes and behaviors that encompass:

- Dedication to being a lifelong learner
- Understanding of the need to develop respectful therapeutic relationships that acknowledge the expertise and strengths of vulnerable patients and families
- Awareness of the impact of sociocultural and historical factors on patients, health care professionals, the clinical encounter, and interpersonal relationships
- Understanding of how implicit bias and stereotypes can lead to assumptions that can limit communication with patients and harm them
- Recognition of the presence of personal bias and how this can affect clinical decision-making and quality of care
- Demonstration of compassionate care for vulnerable patients and high-risk populations
- Acknowledgement and understanding of the power dynamics that exist in clinical encounters involving health care professionals and vulnerable patients and families
- Willingness to acknowledge and address one’s own privilege and biases in clinical encounters with vulnerable patients and families
- Openness to learning about the experiences and cultural beliefs of the patients and community being served
- Understanding of the importance of approaching health concerns from a community perspective
- Recognition of the importance of community partnerships in addressing health concerns and improving health
- Understanding of the importance of the science of population health
- Recognition of the importance of improving and adapting systems of care to patients’ needs
- Willingness to use interventions that affect the social determinants of health (e.g., empowering communities, functioning as an ally and advocate)

- Willingness to consider and advocate for the role of one's own institution in promoting diversity in the workforce through recruitment, retention, mentorship, and support of underrepresented minorities
- Willingness to utilize interpretation services to best meet the needs of patients

Knowledge

In addition to the core clinical and health systems knowledge required of all family medicine residents, in the appropriate setting, the resident should demonstrate the ability to apply knowledge of the following:

1. Environmental and socioeconomic factors that affect the health and safety of patients
    a. Patterns of employment
    b. Educational opportunities and barriers to learning in urban 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
    i. History of incarceration of patients or family members
    j. Occupational and environmental health hazards
    k. Patterns of substance use and addiction
    l. Social service support and inner city health resources, including elder care and childcare, housing, transportation, and employment agencies
    m. Local data regarding health disparities in different racial, ethnic, and disadvantaged groups
    n. Historical relevance of discriminatory laws and policies that have led to all of the above
2. Common clinical presentations in urban settings
    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, or partner abuse
    e. Limitations of access to care based on real or perceived stigmatization of certain populations (including but not limited to patients who have HIV; lesbian, gay,

bisexual, and transgender [LGBT] individuals; individuals who use intravenous [IV] drugs)

f. Reproductive needs
    i. Effect of culture on women's health/reproductive health care options
    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 women's health and reproductive health care options
    v. Disparities in care based on access to options

g. Communicable disease
    i. Prevalence and presentation in special populations: recent immigrants, individuals who are homeless, men who have sex with men (MSM), individuals who use IV drugs, adolescents, and prison populations
    ii. STI and HIV/AIDS prevention, diagnosis, and treatment
    iii. Common parasitic infections in immigrant populations
    iv. Tuberculosis screening, diagnosis, and treatment

h. Mental health needs in special populations
    i. Individuals who are homeless; immigrants/refugees; adolescents; LGBT individuals; individuals who use substances
    ii. Posttraumatic stress disorder (PTSD) related to exposure to violence, immigration experiences, war, and torture among immigrant groups

i. Psychiatric emergencies, including familiarity with available transfer and referral resources

j. Understanding of oral health fundamentals in a population that may not have ready access to dental care and what services may be provided in a family medicine office

k. Screening, diagnosis, and treatment for substance use disorders in different population subgroups

l. Practice of safe opioid prescribing for chronic pain, including identifying and addressing substance use disorders in patients who have chronic pain

m. Counseling in behavior change strategies regarding nutrition, physical activity, substance use, and sexual practices/behaviors

n. Violence, homicide, gun violence, and accident prevention

o. Occupational hazards and work injuries commonly associated with urban settings (e.g., among restaurant workers, small industries, and service workers)

p. Motor vehicle and bicycle safety

q. Family systems and community ecology

r. Role of physician, staff, and clinic in mass casualty events (e.g., environmental/natural disasters; nuclear, biological, chemical, and other methods of terrorism; civil disturbance)

3. Health systems issues and community engagement in urban settings

    a. Principles and practice of community-oriented primary care (COPC)

b. Principles of authentic community partnerships
c. Components of the chronic care model
d. Models of interprofessional team care
e. Models of health service delivery and sustainability in urban settings, including community health centers and hospital-based ambulatory networks
f. Principles of risk reduction and harm reduction
g. Community epidemiology
h. Principles of community-based participatory research
i. Elements of the patient-centered medical home (PCMH)
j. Political structure and values, and their legislative influence on the community

Skills

In the appropriate setting, the resident should demonstrate the ability to:

1. Identify obstacles to accessing care for individuals and families, and engage in strategies to overcome these obstacles
2. Define elements of a humanistic empowerment model and apply this model to each patient encounter
3. Develop respectful therapeutic relationships with vulnerable patients and families
4. Define and assess health literacy
5. Use an interpreter effectively
6. Elicit patients' health beliefs
7. Engage in motivational interviewing (MI) or similar communication styles and behavior change strategies
8. Describe and apply methods to enhance patient self-management/adherence
9. Develop and implement a brief health promotion or health education presentation that is appropriate to the patient's health literacy
10. Define and implement health promotion and risk-/harm-reduction strategies
11. Demonstrate familiarity with treatment guidelines for common medical conditions
12. Perform plan, do, study, act (PDSA) cycles (i.e., rapid-cycle quality improvement projects) as a continuous quality improvement (CQI) strategy
13. Develop an effective advocacy strategy to have an impact and influence change on the organizational and political levels

14. Apply elements of the PCMH to an ambulatory health center

15. Demonstrate ability to work within an interdisciplinary team

16. Describe the role of health coaches and health promoters in an interdisciplinary team and demonstrate ability to incorporate their contributions into a patient care plan

17. Demonstrate ability to collaborate with traditional/community healers

18. Employ the fundamentals of community-based needs assessment

19. Explain and apply asset-mapping techniques

20. Identify key community stakeholders/leaders and establish communication strategies related to patient and community needs

21. 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

22. Describe resources available in the community and how to help patients access them

23. Identify and use patient and community epidemiological data, needs assessments, and disease registries that pertain to the target patients and populations

24. Identify environmental and occupational health risks and hazards in a community and ways to overcome them

25. Apply COPC strategies

26. Advocate for patients' and communities' needs at the local, regional, and national levels

27. Engage in self-care practices that prevent burnout and in organizational activities that sustain and enhance professional satisfaction

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-provider interactions, in-depth reflection on specific patient encounters, and small-group discussion will help promote appropriate attitudes.

Resources

Social

Levy BS, Sidel VW. *Social Injustice and Public Health*. 2nd ed. Oxford, UK: Oxford University Press; 2013.

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

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

United Nations (UN). Universal Declaration of Human Rights. UN General Assembly Resolution 217A (III) of 10 December 1948. http://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf.

Health Care

Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Board on Health Sciences Policy. Smedley BD, Stith AY, Nelson AR, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press; 2003.

Doak CC, Doak LG, Root JH. *Teaching Patients with Low Literacy Skills.* 2nd ed. Philadelphia, Pa.: Lippincott Williams & Wilkins; 1995.

King TE Jr, Wheeler MB, Bindman AB, et al. *Medical Management of Vulnerable and Underserved Patients: Principles, Practice, and Populations.* 2nd ed. New York, NY: McGraw-Hill Education; 2016.

National Cancer Institute. *Theory at a Glance: A Guide for Health Promotion Practice*. 2nd ed. Washington, DC: National Institutes of Health; 2005. NIH publication no. 05-3896.

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

Community

Rhyne R, ed. *Community-Oriented Primary Care: Health Care for the 21st Century*. Washington, DC: 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*. Geneva, Switzerland: WHO; 2008. www.who.int/social_determinants/thecommission/finalreport/en/index.html.

Website Resources

Health Care

Agency for Healthcare Research and Quality. 2016 National Healthcare Quality and Disparities Report. https://www.ahrq.gov/research/findings/nhqrdr/nhqdr16/index.html

Agency for Healthcare Research and Quality. National Guideline Clearinghouse. www.guidelines.gov/

American Academy of Family Physicians. Patient-Centered Medical Home (PCMH). www.aafp.org/online/en/home/membership/initiatives/pcmh.html

Centers for Disease Control and Prevention:

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

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

MacColl Center for Health Care Innovation. Improving Chronic Illness Care. www.improvingchroniccare.org/

Motivational Interviewing Network of Trainers. http://www.motivationalinterviewing.org/

Substance Abuse and Mental Health Services Administration (SAMHSA). Screening, Brief Intervention, and Referral to Treatment (SBIRT). https://www.samhsa.gov/programs-campaigns/screening-brief-intervention-referral-treatment

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 2020. www.healthypeople.gov/

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

Developed 08/2011 by Los Angeles County/Harbor-UCLA Medical Center Program
Revised 09/2013 by University of California, San Francisco/San Francisco General Hospital (UCSF/SFGH) Family and Community Medicine Residency Program
Revised 07/2017 by Northwestern McGaw Family Medicine Residency Program, Humboldt Park, IL