

Innovations and policies

Implementing a community outreach curriculum in a primary care residency: The creation of ICARE (Integrating Community Agencies in Residency Education) by the WSU School of Medicine's Family Medicine program

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Background

There are thousands of healthcare sites in the United States that provide free medical care and are solely run on physician volunteerism. In parallel, physicians report increasing rates of burnout, just doing the jobs they're paid for. Unfortunately, changes in federal funding, the demands of the healthcare workforce and the cost of medical education put some organizations at risk. Here we explore a method for exposing early-career physicians to community outreach during Family Medicine (FM) residency training as a means to fill gaps in care at the community level and reinvigorate the meaning they find in their profession through direct service. We specifically examined the coverage achieved and gauged the meaning that physician participants gleaned from the experience.

Methods

Across 2 years, residents in an FM program in the suburbs of Detroit participated in a mandatory community outreach curriculum. We drafted a curriculum that began with community partners we worked with previously and used those connections to expand to new organizations. We tracked the number of hours and community members served and residents participated in satisfaction surveys at the end of each year.

Results

Outreach sites provided a total of 888.5 hours of care with 2,734 community members served. Between Year 1 (Y1) and Year 2 (Y2) 5 new community partnerships emerged while 2 were lost due to leadership change. The majority of residents reported finding the curriculum meaningful (Y1 94%, Y2 80%), rewarding (Y1 88%, Y2 95%) and that they were satisfied with it (Y1 82%, Y2 75%).

Conclusion

The development of a community outreach curriculum can be sustainable in an FM residency program. Robust outcomes in terms of both time committed and number of community members served are possible within the constraints of residency education. Such a curriculum can be found to be professionally rewarding and personally meaningful by residents.

INTRODUCTION

Family physicians are facing burnout, and the number of medical students in the United States who are choosing family practice is flatlining despite attempts to combat a workforce shortage.^{1,2} Primary care physicians also report the highest rates of intention to leave the profession, with

Internal Medicine and FM ranked first (39.1%) and second (37.3%) of all specialties.³ A variety of factors are at play: the burdens of EMR, loss of autonomy, time spent on non-clinical tasks and a sense of powerlessness to impact lives.^{4,5}

A review of our own residents' personal statements, written in medical school, tells the story. They write about

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becoming leaders in a community, serving those in need and developing consequential relationships with *humans*. They do not write about finding ways to improve efficiency, integrating AI into their practice, becoming experts in EMR or maximizing RVUs. Put simply, our perceptions of what family practice *should be* are at odds with reality. Family physicians place the highest value on the provider/patient relationships and their role as the healer, but instead spend most of their time trying to navigate a broken system. We explore here a strategy to provide doctors with opportunities to directly serve those in need through a community outreach curriculum in a FM residency as a means to fulfill their passion for healing.

There are 1400 free clinics registered in the United States and a growing number of street medicine programs that run on volunteerism⁶ and although there is limited research in the medical education literature, psychological research shows us that volunteering, altruism, and “giving back” make people feel better about their role.⁷⁻⁹ In 2024, 81% of charitable clinics reported an increase in inquiries for services and the majority of those sites provided primary care (78%).⁶ We hypothesized that a community outreach curriculum in FM training would not only provide care to those in need, but also help to heal the healer. Research has shown that when medical students reflect on service learning opportunities they enhance their grasp of concepts like social responsibility, community orientation and even understanding of something as simple as kindness.⁷ At the graduate medical education (GME) level, service learning not only provides benefit in communication skills and awareness of social determinants of health (both of which are Accreditation Council of GME requirements) it helps close the health care gaps in the underserved.⁸⁻¹⁰ The aim of this project (called ICARE, Integrating Community Agencies in Residency Education) was to create a system of community engagement and measure both the impact on the community as well as the influence it had on the wellness measures of our FM residents.

METHODS

Residents in the Wayne State University School of Medicine (WSUSOM) FM program during the 2023-2024 (n=23) and 2024-2025 (n=28) academic years were enrolled in the curriculum as part of required training. These experiences were scheduled by the program during protected time on low-demand outpatient rotations. Since the service was direct patient care, albeit “free”, we counted this time as patient care time for our faculty. This was crucial in keeping faculty motivated as opposed to taking time away from important administrative tasks or expecting faculty to volunteer in their free time. In Y1, outreach sites included WSUSOM’s Student-Run Free Clinic and Street Medicine Detroit in downtown Detroit and Samaritas Senior Living and the Older Person’s Commission in Rochester, Michigan. We subsequently added Neighborhood House in Rochester, the Gary Burnstein Free Clinic in Pontiac and a wider network of sports physicals offered to the local public schools.

In the flagship year of ICARE we revised the existing curriculum to encompass the new learning experiences, revisited community partners to look for additional opportunities, and started measuring our outreach. This began with formalizing relationships with community organizations with whom we already had a partnership:

- The Robert R. Frank Student Run Free Clinic (SRFC) in Detroit functions under the leadership of a board of WSUSOM students along with their attending physician/Medical Director. The SRFC requires 1-3 licensed physicians to oversee the care the medical students provide to their patients. They provide non-pregnancy related care to children and adults who are uninsured. Since our faculty and residents had volunteered for SRFC in the past, we were able to identify three faculty champions who together could provide the support necessary to run the clinic once per month. Dates were selected 6 months in advance and 2 residents were assigned to attend each session with the faculty champions.
- Samaritas Senior Living (SAL) in Rochester, Michigan, is an affordable housing development for those 62 years or older who meet income requirements. Our program committed to having 1 resident provide blood pressure screening for 2 hours each week year-round.
- The Older Person’s Commission (OPC), also in Rochester, is a community center that runs free year-round programming in three local zip codes free of charge for adults over 50 years old. Like SAL, our program committed to having residents provide blood pressure screenings for 2 hours each week.
- Street Medicine Detroit (SMD) is a non-profit founded by WSU medical students whose mission is “to ensure access to quality medical care for Detroit’s unreached houseless population.” Like SRFC, SMD needs volunteer preceptors for their street “runs” which may involve providing medical services in areas occupied by those experiencing homelessness or a pop-up clinic in a shelter (referred to as a “shelter-based run.”) FM faculty and residents attended 1-3 runs per month.
- Neighborhood House (NH) was founded in 1968 by community members in the Rochester area to provide referrals for citizens in need of resources. Today NH provides meals, clothes, job-support, bike drives and more to hundreds of local families. Our partnership with NH started with providing free back-to-school physicals.
- The Orion Center (OC), founded by the community of Lake Orion, functions similarly to the OPC. We provided blood pressure screenings weekly for 2 hours.

In the second year of ICARE, we strengthened our measurement strategy from only tracking hours in the community, to also tracking patient encounters, and we also began expanding our reach to other organizations as well as refine the curriculum based on what we learned in Y1.

- The Gary Burnstein Community Health Center (GBCHC) was identified by one of our residents as a potential partner and in Y2 we set up an arrangement similar to SRFC. Once a month, 1 of our faculty along with 2 residents hosted a free clinic at GBCHC in Pontiac.
- The Golden Opportunity Club (GOC) is a community organization in Pontiac that advocates for the older adult population. Our local Community Health Coordinator, who had helped us make connections at SAL and NH, introduced us to GOC. Our residents hosted educational events at GOC on blood pressure and healthy lifestyle choices and conducted blood pressure screenings.
- The Salvation Army (SA) of Pontiac requested a similar outreach event to that held at the GOC, and our residents provided education at this site as well in Y2.
- Innovations Park (IP) in Rochester Hills is a popular recreation area supported by a donation from our hospital (Ascension Providence Rochester at the time, now Henry Ford Rochester). In collaboration with the staff at IP we hosted educational sessions that were usually geared toward children and included a story-time and “healthy hike” through the forest. Some sessions were for adults (for example, learning about the Mediterranean diet) while others had a health focus for kids (“Bones of the Body”).
- One of our clinic patients invited us to her workplace, Pontiac High School (PHS), where 4 of our resident physicians met with students interested in health-related fields.
- The OC invited us to host sport physicals for students in Lake Orion and any neighboring school district.
- At the end of Y2, we expanded our services at NH by starting monthly blood pressure screenings and providing educational materials at their food pantry in addition to the back-to-school physical exams planned for the fall.

RESULTS

Thus far, we have identified and tracked 3 metrics: the number of hours at outreach sites and the patients/community members encountered, shown in [Table 1](#) below, and resident satisfaction ratings regarding the program and curriculum, shown in [Table 2](#).

From July 1, 2023 to June 30, 2025, ICARE provided a total of 892.5 hours of service with 2,733 community members. Between Y1 and Y2, 5 sites were added (GBHC, GOC, SA, IP and PHS), while 2 were lost (SAL and OC) due to leadership changes at these locations. At the end of Y2, 2 more sites were added: Pope Francis Center, a homeless shelter in Detroit, and a rebranded center at the former OC called Great Lakes Athletic Club. In Y3, we will be tracking

Table 1. Hours and volume of care in Y1 and Y2

Organization	Demographic (Location)	Y1		Y2	
		Hours	Patients	Hours	Patients
Student Run Free Clinic (SRFC)	Uninsured M/F, all ages (Detroit)	60	20	60	95
Street Medicine (SM)	Homeless M/F 18+ (Detroit)	96	49	70	140
Neighborhood House (NH)	Children age 4-18, food pantry participants (Rochester)	4.5	26	12	16
Older Persons Commission (OPC)	50+ M/F, must live in Rochester, Rochester Hills or Charter Township of Oakland (Rochester)	100	260	134	409
Samaritas Affordable Living (SAL)	62+ M/F, must meet HUD income requirements (Rochester Hills)	75	237	50	625
Gary Burnstein Community Health Center (GBCHC)	Uninsured M/F, all ages (Pontiac)	0	0	36	53
Golden Opportunity Club (GOC)	Senior citizens of Pontiac M/F (Pontiac)	0	0	8	117
Salvation Army (SA)	Citizens of Pontiac, M/F, predominantly F seniors (Pontiac)	0	0	8	52
Innovations Park Story Time (IP)	Children all ages from Oakland County (Rochester Hills)	2	30	2	26
Orion Center (OC)	Seniors, mostly from Lake Orion, Oakland Township (Lake Orion)	100	217	69	253
"	All school-aged kids, any nearby municipality	0	0	4	68
Pontiac High School (PHS)	9-12th grade Pontiac students interested in health careers (Pontiac)	0	0	2	40
TOTALS		437.5	839	455	1894

Table 2. Resident impressions of curriculum in Y1 and Y2

2024-2025			
	Meaningful	Rewarding	Satisfied
Extremely not	0	0	0
Moderately not	2	1	
Neutral	2	5	5
Moderately	6	6	6
Extremely	10	8	9
Did not partake	1	1	1
	21	21	21

2023-2024			
	Meaningful	Rewarding	Satisfied
Extremely not	0 (0%)	0 (0%)	0 (0%)
Moderately not	0 (0%)	1 (6%)	0 (0%)
Neutral	1 (6%)	1 (6%)	3 (18%)
Moderately	6 (35%)	8 (47%)	3 (18%)
Extremely	10 (59%)	7 (41%)	11 (64%)
	17 (100%)	17 (100%)	17 (100%)

the number of hours and number of community members served at these sites as well.

Using a survey instrument with Likert scales, we asked residents the extent to which they found the community outreach activities personally meaningful or rewarding and whether they were satisfied or dissatisfied with the revised curriculum in both Y1 and Y2. In Y1, 17 residents responded to the survey (a response rate of 71%) and in Y2 that number grew to 21 (a 75% response rate), although one of the respondents in Y2 had not yet engaged in the curriculum and was removed from the respondents' total. The majority found the curriculum meaningful (Y1 94%, Y2 80%), rewarding (Y1 88%, Y2 95%), and were satisfied with it (Y1 82%, Y2 75%). These findings were reflected in their comments as well. Below is a sample from a PGY2 participant.

"One of the reasons I chose this program was its emphasis on community outreach. Serving the communities I grew up in is meaningful to me, and it's something that truly sets this program apart and why I chose it in the first place."

CONCLUSION

Our pilot project, ICARE, demonstrates that the development of a community outreach curriculum can be sustainable in an FM residency program. Our initiative demonstrates that achieving impressive measures of hours and patients served is possible within the constraints of residency education and that residents perceive the experience as professionally rewarding and personally meaningful. The biggest two barriers we encountered included scheduling residents in the chaotic matrix of GME assignments and consistently tracking all encounters. Some data was obtained from resident logs (which we suspect are underre-

ported) and others are from sign-in sheets at events, which are probably more accurate.

A limitation that we identified and would like to address in upcoming years is the simplicity of our measurements of resident interpretation of the curriculum. In a separate curriculum in our program we have residents engage in reflective writing and are considering using those entries for a thematic analysis about their impressions of the community outreach curriculum.

In Y3, we will continue measuring the volume of community members served, and resident impressions of the curriculum. We would also like to increase the number of sites and survey our community partners on their levels of satisfaction with the program. An even more exciting development, in Y3, we have started our own street medicine outreach to serve even more sites, bypassing some of the scheduling constraints of formally working with SMD, although we will continue in our partnership with this stalwart organization.

Despite some increases in public funding for healthcare and volume of federally qualified health centers, one-third of Americans still lack access to primary care.¹⁰ In our current political climate, access to federal or even state funded programs is unlikely to grow. Encouraging young physicians to value and apply volunteerism in their careers, while it may be a "drop in the bucket," can still help everyday Americans who lack access to healthcare. Further, planting the seed of good Samaritanism during residency may inspire physicians' future behaviors and mitigate burnout as the burden and moral injury of the profession may increase.

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Writing – original draft: Eleanor King (Lead). Writing – review & editing: Heidi Kenaga (Supporting). Project administration: Kathryn Cox (Supporting). Resources: Ralph Williams (Supporting).

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REFERENCES

1. American Academy of Family Physicians. 2025 Match® Results for Family Medicine. 2025. Accessed February 6, 2025. <https://www.aafp.org/students-residents/residency-program-directors/national-resident-matching-program-results.html#:~:text=Only%208.3%25%20of%20matched%20U.S.,sharply%20than%20the%20historical%20trend>
2. Doe S, Coutinho AJ, Weidner A, et al. Prevalence and Predictors of Burnout Among Resident Family Physicians. *Fam Med*. 2024;56(3):148-155. doi:[10.22454/FamMed.2024.875388](https://doi.org/10.22454/FamMed.2024.875388)
3. Garvey G. In 6 specialties, desire to step away or scale back is common. American Medical Association. July 23, 2024. Accessed April 1, 2025. <https://www.ama-assn.org/practice-management/physician-health/6-specialties-desire-step-away-or-scale-back-common>
4. Fred HL, Scheid MS. Physician Burnout: Causes, Consequences, and (?) Cures. *Tex Heart Inst J*. 2018;45(4):198-202. doi:[10.14503/THIJ-18-6842](https://doi.org/10.14503/THIJ-18-6842)
5. Yates SW. Physician Stress and Burnout. *Amer J Med*. 2019;133(2):160-164. doi:[10.1016/j.amjmed.2019.08.034](https://doi.org/10.1016/j.amjmed.2019.08.034)
6. National Association of Free and Charitable Clinics. *NAFC Member Data Report 2025*.; 2025.
7. Demirören M, Atılgan B. Impacts of service learning-based social responsibility training on medical students. *Advances in Physiology Education*. 2023;47(2):166-174. doi:[10.1152/advan.00049.2022D](https://doi.org/10.1152/advan.00049.2022D)
8. Humphrey VS. The Importance of Service Learning in Dermatology Residency: An Actionable Approach to Improve Resident Education and Skin Health Equity. *Cutis*. 2021;107(3). doi:[10.12788/cutis.0199](https://doi.org/10.12788/cutis.0199)
9. Geftter L, Merrell SB, Rosas LG, Morioka-Douglas N, Rodriguez E. Service-Based Learning for Residents: a Success for Communities and Medical Education. *Family medicine*. 2015;47(10):803-806. <https://pubmed.ncbi.nlm.nih.gov/26545059/>
10. Young S, Bates T, Wolff M, Maurana CA. Service-Learning in Healthy Aging for Medical Students and Family Medicine Residents. *Education for Health: Change in Learning & Practice*. 2002;15(3):353-361. doi:[10.1080/1357628021000012796](https://doi.org/10.1080/1357628021000012796)