Goals and Objectives for PGY 1

The PCMH Ambulatory Care Curricular Competency Based *Goals* are to train PGY 1 Learners developmentally appropriate skills, knowledge and attitudes in the following domains:

- **Access to Care**
- **Quality Improvement**
- **Population Management**
- **Team Based Care**
- **Integrated and Coordinated Care**
- **Personal Care Physician (PCP)**
- **Patient Centeredness (Service)**
- **Medical Informatics to Support the Medical Home**
- **Leadership Skills**

Objectives have been linked to the ACGME Core Competencies for each Learning Goal.

PGY 1 Residents will be able to achieve the following Core Competencies prior to promotion to PGY 2 as part of the PCMH Longitudinal Curriculum. The curriculum is longitudinal starting in PGY1 and completed by PGY3 graduation.

Residency PCMH Longitudinal Curriculum Competency Based Goals and Objectives ***ACGME Core Competencies*** **PC=Patient Care** **MK=Medical Knowledge** **PBL-Practice Based Learning** **IPCS=Interpersonal Communication Skills** **Prof=Professionalism** **SBL=System Based Learning**						
Goals and Objectives/Competencies	**PC**	**MK**	**PBL**	**IPCS**	**Prof**	**SBL**
Access to Care						
Demonstrate willingness to do what is necessary to facilitate continuity of care to meet patients' needs in *timely, agreeable* manner (eg, timely appts, alternative flexible access)	**X**				**X**	
Demonstrate ability to manage patient problems	**X**			**X**		**X**

through asynchronous communications						
Demonstrate ability to effectively communicate with patients both during and between office visits, including ability to participate in E-Visits and Telephone Appointment Visits (TAVs)				**X**		**X**
Demonstrate knowledge of potential uses in patient care of Group Medical Visits	**X**		**X**	**X**	**X**	
Quality Improvement						
Demonstrate knowledge of Improvement Module (PDSA cycles)			**X**			**X**
Experience being on Care Team with discussions of patient safety and quality of care			**X**	**X**	**X**	**X**
Population Management/Panel Management						
Experience continuity patients, both as a group and as sub-populations with specific conditions.						**X**
Be exposed to examples of effective care management for patients that include proactive outreach for preventive services and chronic disease management	**X**	**X**		**X**		**X**
Discuss with Wing Leadership the clinic IT System (eCW) current tools to identify registries and manage populations of patients within the practice			**X**			**X**
Experience review of personal Performance Report Card for Panel Mangement			**X**			**X**
Personal Care Physician (PCP)						
Experience being patients' advocate as a steward of their health care resources within the practice and health care system	**X**		**X**		**X**	**X**
Demonstrate the ability to establish and maintain personal relationships with patients as demonstrated by developing measurable continuity in their patient population (Patient Panel)	**X**			**X**	**X**	**X**
Demonstrate the early ability to utilize therapeutic, ethical physician-patient relationship, patient interviewing and counseling skills in developing collaborative, caring relationships with a panel of patients	**X**			**X**	**X**	
Team Based Care						
Attend Care Team Meetings to learn multi-disciplinary team approach to the care of	**X**			**X**		**X**

patients						
Experience Care Management for patients utilizing a collaborative team approach (Chronic Care Model) for at least one patient	**X**			**X**	**X**	**X**
Start to participate as a team member in practice improvement, including evaluation of the practice and performance of PDSA cycles	**X**		**X**			**X**
Demonstrate collaborative, respectful and effective communication with office staff during patient care and practice meetings				**X**	**X**	
Integrated and Coordinated Care						
Start to integrate and coordinate patient care across the complex health care system, the practice, and patient's family and community. This includes the following:						
Track and appropriately follow-up on referrals, labs, xrays, and other patient services	**X**	**X**		**X**		**X**
Manage bi-directional communications with consultants, community agencies (hospital, home health, SNFs, etc), and other parts of the health care system				**X**		**X**
Identify and manage mental and behavioral health issues for patients in collaboration with mental/behavioral health providers in the practice and/or community	**X**	**X**		**X**		**X**
Assure the patient's personal care plan is communicated to all people involved in the patient's care and used to guide care across the health care system.	**X**			**X**		**X**
Assist patients and/or families in connecting with peer support groups or other appropriate resources in the community	**X**					**X**
Patient Centeredness						
Start to learn the art and science of delivering care that maintains high levels of patient satisfaction (as measured by reliable surveys and other feedback)	**X**		**X**	**X**	**X**	**X**
Begin to manage patients and families with sensitivity to patient's beliefs, customs, culture, and community (cultural mindfulness).	**X**			**X**	**X**	
Learn whole person, comprehensive, coordinated care using an evidence-based personal care plan, with goals prioritized by the patient	**X**			**X**		**X**
Routinely assess the self-management needs of patients with chronic illness	**X**		**X**	**X**		**X**
Demonstrate the knowledge and start to use Motivational Interviewing, readiness for	**X**			**X**		

change, the 5As, Four Habits Model, and/or other appropriate communication skills with patients considering health behavior change.						
Assist patients with developing effective action plans for health behavior change and other self-management activities	**X**			**X**		
Know model of appropriate disclosure to patients when errors occur	**X**			**X**	**X**	
Experience having patient provide perspective on at least one clinical practice team (start to know how to obtain patient "voice" to be "patient centered")	**X**		**X**			**X**
Medical Informatics to Support the Medical Home						
Learn how to utilize information systems within the Residency Practice, such as patient registries, to support PCMH			**X**			**X**
Use evidence-based approach for chronic disease management, as demonstrated by the use of flow sheets for chronic diseases and preventive health care.	**X**	**X**	**X**			**X**
Demonstrate ability to use evidence-based decision support tools at the point of care in real time during patient visits	**X**	**X**	**X**			**X**
Use the electronic chart <u>during</u> patient visit to enhance quality of patient experience while in the exam room	**X**			**X**	**X**	
Demonstrate ability to chart/document patient care in effective, timely manner (*as measured by practice metrics, eg, closing charts in 2 business*) including in-box ("jelly beans") management (*eg, reviewing non-critical labs within 2 business days and closing labs within 7 business days)*	**X**				**X**	
Leadership Skills						
Demonstrate a reflective approach to practice with the ability to identify opportunities for improvement in patient care on both the personal and practice levels			**X**		**X**	**X**