## Goals and Objectives

**The PCMH Ambulatory Care Curricular Competency Based *Goals* are:**

- **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.**

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

| **Residency PCMH Longitudinal Curriculum<br>Competency Based Goals and Objectives**<br><br>***ACGME Core Competencies***<br>**PC=Patient Care**<br>**MK=Medical Knowledge**<br>**PBL-Practice Based Learning**<br>**IPCS=Interpersonal Communication Skills**<br>**Prof=Professionalism**<br>**SBL=System Based Learning** | | | | | | |
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| **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 through asynchronous communications | **X** | | | **X** | | **X** |
| Demonstrate ability to effectively communicate | | | | **X** | | **X** |

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| with patients both during and between office visits, including ability to participate in E-Visits and Telephone Appointment Visits (TAVs) | | | | | | |
| Demonstrate ability to facilitate Group Medical Visits | **X** | | **X** | **X** | **X** | |
| Demonstrate ability to assess practice's capacity and demand based on characteristics of patient panel, to effectively design schedule, office flow and creative solutions to meet *advanced/open access* targets (eg, third next available visit, direct booking, new patient intake) | **X** | | **X** | | | **X** |
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| **Quality Improvement** | | | | | | |
| Utilize patient and practice data to improve patient care, demonstrated by use of data and improvement in patient care of at least one of the practice's clinically important conditions. | | | **X** | | | **X** |
| Participate actively in practice improvement meetings and PDSA cycles | | | **X** | | | **X** |
| Demonstrate the ability to access, evaluate, and act on patient safety and quality data | | | **X** | **X** | | **X** |
| Recognize and understand team behaviors that strengthen or weaken patient safety and quality of care | | | **X** | **X** | **X** | **X** |
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| **Population Management/Panel Management** | | | | | | |
| Demonstrate the ability to identify continuity patients, both as a group and as sub-populations with specific conditions. | | | | | | **X** |
| Demonstrate effective care management for patients that includes proactive outreach for preventive services and chronic disease management | **X** | **X** | | **X** | | **X** |
| Utilize registries and/or IT tools to identify and manage populations of patients within the practice | | | **X** | | | **X** |
| Demonstrate ability to measure if patient outcomes are improving and to target those patients whose outcomes are not improving (*as measured by practice quality metrics provided by DOPE)* | | | **X** | | | **X** |
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| **Personal Care Physician (PCP)** | | | | | | |
| Serve as their patients' advocate and as a steward of their health care resources within the practice and health care system | **X** | | **X** | | **X** | **X** |
| Demonstrates the ability to establish and maintain personal relationships with patients as demonstrated by developing measurable | **X** | | | **X** | **X** | **X** |

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| continuity in their patient population (Patient Panel) | | | | | | |
| Demonstrate the 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** | |
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| **Team Based Care** | | | | | | |
| Demonstrate ability to practically apply a multi-disciplinary team approach to the care of patients | **X** | | | **X** | | **X** |
| Provide Care Management for patients utilizing a collaborative team approach (Chronic Care Model) | **X** | | | **X** | **X** | **X** |
| Demonstrate the ability 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** | |
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| **Integrated and Coordinated Care** | | | | | | |
| Demonstrate the ability 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** |
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| **Patient Centeredness** | | | | | | |
| Ability to maintain high levels of patient satisfaction (as measured by reliable surveys | **X** | | **X** | **X** | **X** | **X** |

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| and other feedback) | | | | | | |
| Demonstrate the ability to manage patients and families with sensitivity to patient's beliefs, customs, culture, and community (cultural mindfulness). | **X** | | | **X** | **X** | |
| Demonstrate 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 use of Motivational Interviewing, readiness for change, the 5As, Four Habits Model, and/or other appropriate communication skills with patients considering health behavior change. | **X** | | | **X** | | |
| Assist patients with developing effective action plans for health behavior change and other self-management activities | **X** | | | **X** | | |
| Provide appropriate disclosure to patients when errors occur | **X** | | | **X** | **X** | |
| Experience having patient provide perspective on at least one clinical practice team (know how to obtain patient "voice" to be "patient centered") | **X** | | **X** | | | **X** |
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| **Medical Informatics to Support the Medical Home** | | | | | | |
| Demonstrate ability 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** |
| Demonstrate ability to improve patient outcomes by utilization of information systems in patient care. | **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* | **X** | | | | **X** | |

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| *7 business days)* | | | | | | |
| Demonstrate ability to leverage IT to improve access, continuity, coordination and quality of care with virtual visits (email/secure messaging) and telemedicine/electronic specialty consultation | **X** | | **X** | | **X** | **X** |
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| **Leadership Skills** | | | | | | |
| Demonstrate ability to actively engage in and provide leadership for practice's change and improvement process. | | | **X** | **X** | **X** | **X** |
| 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** |
| Ability to assess and effectively utilize practice finances and other economic drivers that effect delivery of PCMH services | | | **X** | | **X** | **X** |