Goals and Objectives for PGY 3

The PCMH Ambulatory Care Curricular Competency Based *Goals* are to train PGY 3 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 3 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 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 through asynchronous communications	**X**			**X**		**X**
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 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**
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**
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**

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 continuity in their patient population (Patient Panel)	**X**			**X**	**X**	**X**
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**	
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**	
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**
Patient Centeredness						
Ability to maintain high levels of patient satisfaction (as measured by reliable surveys and other feedback)	**X**		**X**	**X**	**X**	**X**
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**
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 during 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**	
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**
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**