The Family Medicine Population Health Milestone-Based Curriculum

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INTRODUCTION

This section of the report highlights the population health content in the existing Family Medicine Milestones, as defined by the ACGME and the Board of Family Medicine. In addition to identifying those milestones, the attached document provides sample materials and assessment tools that can be used in training learners in these competencies

Family Medicine Materials and Assessment Tools for Population Health

MK-2. *Applies critical thinking skills in patient care*

Level	Milestone	Materials	Activities/Assessment Tools
1	Recognizes that an in-depth knowledge of the patient and a broad knowledge of sciences are essential to the work of family physicians. Demonstrates basic decision making capabilities. Demonstrates the capacity to correctly interpret basic clinical tests and images.		
2	Synthesizes information from multiple resources to make clinical decisions. Begins to integrate social and behavioral sciences with biomedical knowledge in patient care. Anticipates expected and unexpected outcomes of the patients' clinical condition and data.		
3	Recognizes and reconciles knowledge of patient and medicine to act in patients' best interest. Recognizes the effect of an individual's condition on families and populations.	**Using a simple registry to improve your chronic disease care** http://www.aafp.org/fpm/2006/0400/p47.html	Preceptor review & discussion of chronic illness patients' characteristics representative of the larger population
4	Integrates and synthesizes knowledge to make decisions in complex clinical situations. Uses experience with patient panels to address population health.	**Patient empanelment: the importance of understanding who is at home in the medical home.** http://www.ncbi.nlm.nih.gov/pubmed/25748755	Preceptor review of common patient panel characteristics related to population health
5	Integrates in-depth medical and personal knowledge of patient, family and community to decide, develop, and implement treatment plans. Collaborates with the participants necessary to address important health problems for both individuals and communities.	Periodic review of materials for Levels 3 and 4	Peer review of relevant cases

PC-2 *Cares for patients with chronic conditions*

Level	Milestone	Materials	Activities/Assessment Tools
1	Recognizes chronic conditions. Accurately documents a clinical encounter on a patient with a chronic condition, and generates a problem list. Recognizes that chronic conditions have a social impact on individual patients.		Chart review/audit
2	Establishes a relationship with the patient as his or her personal physician. Collects, organizes and reviews relevant clinical information Recognizes variability and natural progression of chronic conditions and adapts care accordingly. Develops a management plan that includes appropriate clinical guidelines. Uses quality markers to evaluate the care of patients with chronic conditions. Understands the role of registries in managing patient and population health.	**Improving Chronic Illness Care: Clinical Practice Change** http://www.improvingchroniccare.org/index.php?p=Assessment&s=240 **Using a simple registry to improve your chronic disease care** http://www.aafp.org/fpm/2006/0400/p47.html	**Part 3 of the Assessment of Chronic Illness Care** from http://www.improvingchroniccare.org/index.php?p=ACIC_Survey&s=35
3	Consistently applies appropriate clinical guidelines to the treatment plan of the patient with chronic conditions. Engages the patient in the self-management of his or her chronic condition. Clarifies the goals of care for the patient across the course of the chronic condition and for his or her family and community. Begins to manage the conflicting needs of patients with multiple chronic conditions or multiple co-morbidities.		

PC-2 *Cares for patients with chronic conditions (continued)*

Level	Milestone	Materials	Activities/Assessment Tools
4	Leads care teams to consistently and appropriately manage patients with chronic conditions and co- morbidities. Facilitates patients' and families' efforts at self- management of their chronic conditions, including use of community resources and services	**Clinician-Community Linkages** (connecting clinical providers, community organizations, and public health agencies.) http://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/index.html	Part 2 of the Assessment of Chronic Illness Care from http://www.improvingchroniccare.org/index.php?p=ACIC_Survey&s=35
5	Personalizes the care of complex patients with multiple chronic conditions and co- morbidities to help meet the patients' goals of care. Continually uses experience with patients and evidence-based medicine in population management of chronic condition patients.	Periodic review of materials for levels 2 and 4	**Periodic administration/ review of the Assessment of Chronic Illness care** from http://www.improvingchroniccare.org/index.php?p=ACIC_Survey&s=35

PC-3. *Partners with the patient, family and community to improve health through disease prevention and health promotion*

Level	Milestone	Materials	Activities/Assessment Tools
1	Collects family, social, and behavioral history. Demonstrates awareness of recommendations for health maintenance and screening guidelines developed by various organizations.		
2	Identifies the roles of behavior, social determinants of health, and genetics as factors in health promotion and disease prevention. Incorporates disease prevention and health promotion into practice. Reconciles recommendations for health maintenance and screening guidelines developed by various organizations.	**Materials pertinent to your state on social determinants of health** http://www.cdc.gov/socialdeterminants/Resources.html **Healthy People 2020: Genomics** https://www.healthypeople.gov/2020/topics-objectives/topic/genomics **USPSTF Guide to Clinical Preventive Services** http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/	Portfolio: list recommended preventive measures for a patient with particular characteristics
3	Explains the basis of health promotion and disease prevention recommendations to patients with the goal of shared decision making. Describes risks, benefits, costs, and alternatives related to health promotion and disease prevention activities. Partners with the patient and family to overcome barriers to disease prevention and health promotion. Mobilizes team members and links patients with community resources to achieve health promotion and disease prevention goals.	**Clinician-Community Linkages** (connecting clinical providers, community organizations, and public health agencies.) from http://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/index.html **Choosing Wisely: *15 Things Physicians and Patients Should Question*** http://www.choosingwisely.org/doctor-patient-lists/american-academy-of-family-physicians/	Portfolio: describe one or more patients referred to community resources
4	Tracks and monitors disease prevention and health promotion for the practice population. Integrates disease prevention and health promotion seamlessly in the ongoing care of all patients.	**Using a simple registry to improve your chronic disease care** http://www.aafp.org/fpm/2006/0400/p47.html	Record review: compare outcomes for those in the same clinical setting

PC-3. *Partners with the patient, family and community to improve health through disease prevention and health promotion*
(continued)

Level	Milestone	Materials	Activities/Assessment Tools
5	Integrates practice and community data to improve population health. Partners with the community to improve population health.	**A Guide for Assessing Primary Care and Public Health Resources** https://practicalplaybook.org/further-guidance/guide-assessing-primary-care-and-public-health-resources	Completion of a project as outlined in the above guide

PC-5 *Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients' care*

Level	Milestone	Materials	Activities/Assessment Tools
1	Identifies procedures that family physicians perform. Demonstrates sterile technique.		
2	Performs procedures under supervision, and knows the indications of, contraindications of, complications of, how to obtain informed consent for, procedural technique for, post- procedure management of, and interpretation of results of the procedures they perform . Begins the process of identifying additional procedural skills he or she may need or desire to have for future practice.		
3	Uses appropriate resources to counsel the patient on the indications, contraindications, and complications of procedures. Identifies and actively seeks opportunities to assist with or independently perform additional procedures he or she will need for future practice.		
4	Independently performs all procedures required for graduation. Counsels the patient regarding indications, contraindications, and complications of procedures commonly performed by other specialties. Identifies a plan to acquire additional procedural skills as needed for practice.		
5	Seeks additional opportunities to perform or assist with procedures identified as areas of need within the community.	**Resources for Implementing the Community Health Needs Assessment** http://www.cdc.gov/policy/chna/	Portfolio: list of specialty procedures identified as needed in community, annotated with experience

C-2. *Communicates effectively with patients, families, and the public*

Level	Milestone	Materials	Activities/Assessment Tools
1	Recognizes that respectful communication is important to quality care. Identifies physical, cultural, psychological, and social barriers to communication. Uses the medical interview to establish rapport and facilitate patient-centered information exchange.		
2	Matches modality of communication to patient needs, health literacy, and context. Organizes information to be shared with patients and families. Participates in end-of-life discussions and delivery of bad news.		
3	Negotiates a visit agenda with the patient, and uses active and reflective listening to guide the visit. Engages patients' perspectives in shared decision making. Recognizes non-verbal cues and uses non-verbal communication skills in patient encounters.		
4	Educates and counsels patients and families in disease management and health promotion skills. Effectively communicates difficult information, such as end-of-life discussions, delivery of bad news, acknowledgement of errors, and during episodes of crisis. Maintains a focus on patient-centeredness and integrates all aspects of patient care to meet patients' needs .		
5	Role models effective communication with patients, families, and the public. Engages community partners to educate the public.	**Principles of Community Engagement (CDC)** http://www.cdc.gov/phppo/pce	Peer review of work with community partners and public education efforts

C-3 *Develops relationships and effectively communicates with physicians, other health professionals, and care teams.*

Level	Milestone	Materials	Activities/Assessment Tools
1	Understands the importance of the health care team and shows respect for the skills and contributions of others.	Leasure EL, Jones RR, Meade LB, Sanger MI, Thomas KG, Tilden VP, et al. **There is no "i" in teamwork in the patient-centered medical home: defining teamwork competencies for academic practice.** Acad Med. 2013 May;88(5):585–92.	Portfolio, preceptor review, 360° review
2	Demonstrates consultative exchange that includes clear expectations and timely, appropriate exchange of information. Presents and documents patient data in a clear, concise, and organized manner.		
3	Effectively uses Electronic Health Record (EHR) to exchange information among the health care team. Communicates collaboratively with the health care team by listening attentively, sharing information, and giving and receiving constructive feedback.	**Practical Playbook: Using EHRs for population health.** https://practicalplaybook.org/further-guidance/electronic-health-records-meaningful-use-and-integration *Core Competencies for Interprofessional Collaborative Practice.* Interprofessional Education Collaborative Expert Panel. Washington DC 2011. From http://www.aacn.nche.edu/education-resources/ipecreport.pdf	Portfolio: preceptor record review, 360°/multisource evaluation
4	Sustains collaborative working relationships during complex and challenging situations, including transitions of care. Effectively negotiates and manages conflict among members of the health care team in the best interest of the patient.	Core Competencies for Interprofessional Collaborative Practice. Interprofessional Education Collaborative Expert Panel. Washington DC 2011. From http://www.aacn.nche.edu/education-resources/ipecreport.pdf	Portfolio: preceptor, record review; 360°/multisource evaluation
5	Role models effective collaboration with other providers that emphasizes efficient patient-centered care.		

C-4 *Utilizes technology to optimize communication*

Level	Milestone	Materials	Activities/Assessment Tools
1	Recognizes effects of technology on information exchange and the physician/patient relationship. Recognizes the ethical and legal implications of using technology to communicate in health care.		
2	Ensures that clinical and administrative documentation is timely, complete, and accurate. Maintains key patient-specific databases, such as problem lists, medications, health maintenance, chronic disease registries. Uses technology in a manner which enhances communication and does not interfere with the appropriate interaction with the patient.	***Using a simple registry to improve your chronic disease care*** http://www.aafp.org/fpm/2006/0400/p47.html	Preceptor/resident record review of chronic illness patients
3	Ensures transitions of care are accurately documented, and optimizes communication across systems and continuums of care.	**How-to Guide: Improving transitions from hospital to home health care to reduce avoidable rehospitalizations.** http://www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingTransitionsfromHospitaltoHomeHealthCareReduceAvoidableHospitalizations.aspx	• Portfolio: case examples of 30-day readmissions • Preceptor record review
4	Effectively and ethically uses all forms of communication, such as face-to-face, telephonic, electronic, and social media. Uses technology to optimize continuity care of patients and transitions of care.		
5	Stays current with technology and adapts systems to improve communication with patients, other providers, and systems.	Periodic review/update of materials for Levels 2 & 3	Peer review

SBP-1 *Provides cost-conscious medical care*

Level	Milestone	Materials	Activities/Assessment Tools
1	Understands that health care resources and costs impact patients and the health care system.	IHI Open School QCV 100 Introduction to Quality Cost and Value in Healthcare http://app.ihi.org/lms/onlinelearning.aspx	Portfolio: Documented completion of QCV 100
2	Knows and considers costs and risks/benefits of different treatment options in common situations.	IHI Open School QCV 101 **Achieving Breakthrough Quality Access and Affordability** http://app.ihi.org/lms/onlinelearning.aspx USPSTF ***Guide to Clinical Preventive Services*** http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/	Portfolio: • Documented completion of QCV 101 • List of common preventive services & associated costs
3	Coordinates individual patient care in a way that is sensitive to resource use, efficiency, and effectiveness.		
4	Partners with patients to consistently use resources efficiently and cost effectively in even the most complex and challenging cases.		
5	Role models and promotes efficient and cost-effective use of resources in the care of patients in all settings.	Periodic review of Level 1, 2 materials IHI Open School L 101: ***Becoming a Leader in Healthcare*** http://app.ihi.org/lms/onlinelearning.aspx	Peer review

SBP-2 *Emphasizes patient safety*

Level	Milestone	Materials	Activities/Assessment Tools
1	Understands that medical errors affect patient health and safety, and that their occurrence varies across settings and between providers. Understands that effective team-based care plays a role in patient safety.	IHI Open School PS 101 ***Fundamentals of Patient Safety*** IHI Open School PS 103 ***Teamwork and Communication*** http://app.ihi.org/lms/onlinelearning.aspx	Portfolio: Documented completion of PS 101 and PS 103
2	Recognizes medical errors when they occur, including those that do not have adverse outcomes. Understands the mechanisms that cause medical errors. Understands and follows protocols to promote patient safety and prevent medical errors. Participates in effective and safe hand-offs and transitions of care.		
3	Uses current methods of analysis to identify individual and system causes of medical errors common to family medicine. Develops individual improvement plan and participates in system improvement plans that promote patient safety and prevent medical errors.	IHI Open School PS 104 ***Root Cause and System Analysis*** IHI Open School QI 201 ***Guide to the IHI Open School Quality Improvement Practicum*** http://app.ihi.org/lms/onlinelearning.aspx	Portfolio: documented completion of PS 104 and QI 201
4	Consistently engages in self-directed and practice improvement activities that seek to identify and address medical errors and patient safety in daily practice. Fosters adherence to patient care protocols amongst team members that enhance patient safety and prevent medical errors.	Periodic review of materials for Levels 1 and 3 IHI Open School QI 202 ***Quality Improvement in Action*** http://app.ihi.org/lms/onlinelearning.aspx	Portfolio: • Documentation of ongoing work to identify & address systematic error • Documented completion of QI 202
5	Role models self-directed and system improvement activities that seek to continuously anticipate, identify and prevent medical errors to improve patient safety in all practice settings including the development, use and promotion of patient care protocols and other tools.	Periodic review of materials for Levels 1, 3, and 4 IHI Open School L 101 ***Becoming a Leader in Healthcare*** http://app.ihi.org/lms/onlinelearning.aspx	Peer review

SBP-3 *Advocates for individual and community health*

Level	Milestone	Materials	Activities/Assessment Tools
1	Recognizes social context and environment, and how a community's public policy decisions affect individual and community health.	**APTR Learning Module 3: Social Determinants of Health: A Lens for Public Health** https://www.mededportal.org/icollaborative/resource/939 **CDC Social Determinants of Health** http://www.cdc.gov/socialdeterminants/Resources.html Meurer LN, et al. **The urban and community health pathway: preparing socially responsive physicians through community-engaged learning.** Am J Prev Med. 2011 Oct;41(4 Suppl 3):S228–36. http://www.ncbi.nlm.nih.gov/pubmed/?term=The+Urban+and+Community+Health+Pathway%3A+Preparing+Socially+Responsive+Physicians+Through+Community-Engaged+Learning	Portfolio: Identify a community policy and describe its potential effects on public and/or individual health
2	Recognizes that family physicians can impact community health. Lists ways in which community characteristics and resources affect the health of patients and communities.	**Resources for Implementing the Community Health Needs Assessment Process** http://www.cdc.gov/policy/chna	Portfolio: List ways in which characteristics of the local community may affect the health of patients and the community
3	Identifies specific community characteristics that impact specific patients' health. Understands the process of conducting a community strengths and needs assessment.	**Resources for Implementing the Community Health Needs Assessment Process** http://www.cdc.gov/policy/chna/	Portfolio: • Explain the process of conducting a community needs assessment. • Describe a patient whose health is affected by community characteristics
4	Collaborates with other practices, public health, and community-based organizations to educate the public, guide policies, and implement and evaluate community initiatives. Seeks to improve the health care systems in which he or she practices.	**Principles of Community Engagement (CDC)** http://www.cdc.gov/phppo/pce	Portfolio: case examples of policies, evaluations of community initiatives
5	Role-models active involvement in community education and policy change to improve the health of patients and communities.		Peer review

SBP-4 *Coordinates team-based care*

Level	Milestone	Materials	Activities/Assessment Tools
1	Understands that quality patient care requires coordination and teamwork, and participates as a respectful and effective team member.	Leasure EL, Jones RR, Meade LB, Sanger MI, Thomas KG, Tilden VP, et al. T**here is no "i" in teamwork in the patient-centered medical home: defining teamwork competencies for academic practice.** Acad Med. 2013 May;88(5):585–92.	Portfolio, preceptor review, 360° review
2	Understands the roles and responsibilities on oneself, patients, families, consultants, and interprofessional team members needed to optimize care, and accepts responsibility for coordination of care.	***Core Competencies for Interprofessional Collaborative Practice.*** Interprofessional Education Collaborative Expert Panel. Washington DC 2011. http://www.aacn.nche.edu/education-resources/ipecreport.pdf	See Figure 7, p31 in *Core Competencies for Interprofessional Collaborative Practice* for an outline of knowl- edge, attitudes, and skills appro- priate for levels of interprofession- al competencies from exposure to competence.
3	Engages the appropriate care team to provide accountable, team-based, coordinated care centered on individual patient needs. Assumes responsibility for seamless transitions of care. Sustains a relationship as a personal physician to his or her own patients.		
4	Accepts responsibility for the coordination of care, and directs appropriate teams to optimize the health of patients.		
5	Role models leadership, integration, and optimization of care teams to provide quality, individualized patient care.		

PROF-1 *Completes a process of professionalization*

Level	Milestone	Materials	Activities/Assessment Tools
1	Defines professionalism Knows the basic principles of medical ethics. Recognizes that conflicting personal and professional values exist. Demonstrates honest, integrity, and respect to patients and team members.		
2	Recognizes own conflicting personal and professional values. Knows institutional and governmental regulations for the practice of medicine.		
3	Recognizes that physicians have an obligation to self-discipline and to self-regulate. Engages in self-initiated pursuit of excellence.		
4	Embraces the professional responsibilities of being a family physician.		
5	Demonstrates leadership and mentorship in applying shared standards and ethical principles, including the priority of responsiveness to patient needs above self-interest across the health care team. Develops institutional and organizational strategies to protect and maintain these principles.	Markakis KM et al. **The Path to professionalism: cultivating humanistic values and attitudes in residency training.** *Acad. Med* 2000 Feb;75(2):141-50. http://www.ncbi.nlm.nih.gov/pubmed/10693844	Peer review

PROF-3 *Demonstrates humanism and cultural proficiency*

Level	Milestone	Materials	Activities/Assessment Tools
1	Consistently demonstrates compassion, respect, and empathy. Recognizes impact of culture on health and health behaviors.		
2	Displays a consistent attitude and behavior that conveys acceptance of diverse individuals and groups, including diversity in gender, age, culture, race, religion, disabilities, sexual orientation, and gender identity. Elicits cultural factors from patients and families that impact health and health behaviors in the context of the biopsychosocial model. Identifies own cultural framework that may impact patient interactions and decision-making.		
3	Incorporates patient's beliefs, values, and cultural practices in patient care plans. Identifies health inequities and social determinants of health and their impact on individual and family health.	**Healthy People 2020: Social determinants of health** http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health **Materials pertinent to your state on social determinants of health** http://www.cdc.gov/socialdeterminants/Resources.html	Portfolio: case review of patients whose health was impacted by social determinants
4	Anticipates and develops a shared understanding of needs and desires with patients and families; works in partnership to meet those needs.		
5	Demonstrates leadership in a cultural proficiency, understanding of health disparities, and social determinants of health. Develops organizational policies and education to support the application of these principles in the practice of medicine.	**The Relative Contribution of Multiple Determinants to Health** http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=123	Peer review of individual's leadership role in developing education and policies to promote cultural proficiency in her/his practice

PLBI-3 *Improves systems in which the physician provides care*

Level	Milestone	Materials	Activities/Assessment Tools
1	Recognizes inefficiencies, inequities, variation, and quality gaps in health care delivery.	**IHI Open School: Quality, Cost and Value** http://www.ihi.org/education/IHIOpenSchool/courses/Pages/default.aspx	Portfolio: documented completion of IHI Quality, Cost, and Value course
2	Compares care provided by self and practice to external standards and identifies areas for improvement.		
3	Uses a systematic improvement method (e.g., Plan-Do-Study-Act [PDSA] cycle) to address an identified area of improvement. Uses an organized method, such as a registry, to assess and manage population health.	IHI Open School: ***Improvement Capability*** http://www.ihi.org/education/IHIOpenSchool/courses/Pages/default.aspx ***Using a simple registry to improve your chronic disease care*** http://www.aafp.org/fpm/2006/0400/p47.html	Portfolio: documented completion of IHI *Improvement Capability* course
4	Establishes protocols for continuous review and comparison of practice procedures and outcomes and implementing changes to address areas needing improvement.		
5	Role Models continuous quality improvement of personal practice, as well as larger health systems or complex projects, using advanced methodologies and skill sets.		

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