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# BRING TO MIND A TROUBLESOME ASSESSEE

• What were problem areas?



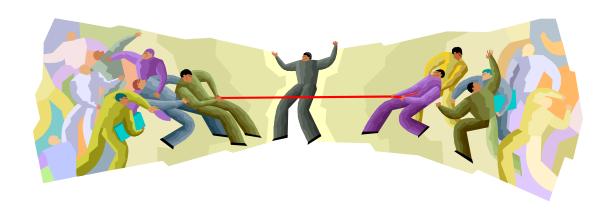
## SUBCOMPETENCIES

- Acute care
- Chronic care
- Undifferentiated signs and symptoms
- Application of knowledge; clinical thinking
- Teamwork
- Self-improvement
- Professional communication



## **OBSERVATION TOOLS**

- Direct observation of care
- Multisource feedback
- Chart audit
- Structured oral interview
- Others



## ACUTE CARE EXAMPLE

- Gathers essential information
- Generates differential diagnoses



- Consistently recognizes common situations that require urgent care
- Stabilizes acutely ill patients appropriately
- Generates appropriate differential diagnoses for any complaint
- Develops appropriate diagnostic and management plans

- Consistently recognizes complex and uncommon situations
- Appropriately prioritizes responses
- Develops appropriate plans for complex and uncommon problems
- Addresses psychosocial implications
- Arranges appropriate transitions of care



 Coordinates care with consultants and community services

 Demonstrates awareness of personal limitations – procedures, knowledge,

experience



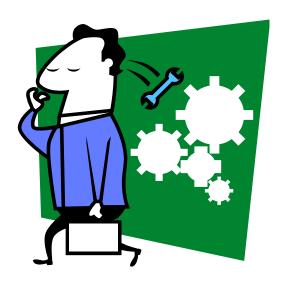
 Provides and coordinates care within local and regional systems



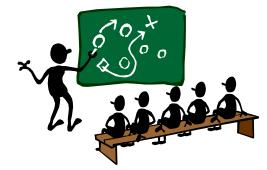
- Systems
- Communication
- Quality improvement



- Understands the importance of team and shows respect for all members
- Understands that quality care requires coordination and participates respectfully



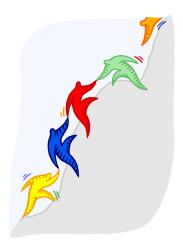
- Understands roles of all team members including patient and family and accepts responsibility for coordinating care
- Demonstrates consultative exchange with clear expectations and timely appropriate information
- Presents and documents patient data clearly, concisely, accurately, and with helpful organization



- Effectively uses the record to exchange information among health team members
- Communicates collaboratively by listening attentively, sharing information, and giving and receiving constructive feedback
- Engages the appropriate team to provide accountable, coordinated care centered on patient needs
- Assumes responsibility for seamless transitions of care
- Sustains a relationship as a personal physician with her or her own patients

- Accepts responsibility for coordination of care and directs appropriate teams to optimize patient health
- Sustains collaborative working relationships during complex and challenging situations
- Effectively negotiates and manages conflict among team members in the best interest of the patient

- Role models effective collaboration with other providers that emphasizes efficient patient-centered care
- Role models leadership, integration, and optimization of care teams to provide quality, individualized patient care



# HOW COULD YOU COACH?

- Remediation
- Goals
- Steps
- Feedback
- Self-reflection
- Measured observation



## **DOCUMENT RESOURCES**

- <a href="http://acgme.org/acgmeweb/Portals/0/PDFs/Miles-tones/FamilyMedicineMilestones.pdf">http://acgme.org/acgmeweb/Portals/0/PDFs/Miles-tones/FamilyMedicineMilestones.pdf</a> the Accreditation Council on Graduate Medical Education and the American Board of Family Medicine
- https://members.aamc.org/eweb/upload/Core%20
  EPA%20Faculty%20and%20Learner%20Guide.p
  df the American Association of Medical Colleges

