This is a list of the activities and actions that your attendings will be observing in continuity clinic to gauge your independence. Use the descriptions of each of these activities that you might do in clinic to solicit specific feedback as you grow towards independence over the three years of residency.

**Coordinate the transition of a recently discharged patient to outpatient care**
Within this context, seek to: Review and follow up on discharge or ED summaries including results of tests that were pending at time of hospital discharge; communicate with the hospital team before the patient is discharged to participate in decisions about changes in care plans, and to provide feedback and updates with the hospital team after the patient is discharged; accurately assess the status of the illness upon activities of daily living, functionality, and safety; reconciles changes in care plan including monitoring for adverse effects of new treatments; and recognizes systems errors and takes steps to prevent future occurrences.

**Effectively manage care and continuity of patients while not in clinic**
Within this context, seek to: Arrange for timely and appropriate patient follow-up; develop and utilize a system for obtaining, reviewing, and responding to test results between visits; communicate with patients and staff in a timely fashion when not in clinic; and appropriately sign-out care of clinic patients to other providers when not available.

**Analyze clinic outcomes data to develop and incorporate a systematic plan for improvement of clinical performance**
Within this context, seek to: Review panel-specific Quality measures and identify solutions for process improvement; understand and practice principles of cost-effective and efficient care; respond to patient satisfaction data and to feedback from the clinic team to improve clinical performance; and participate in coding audits and modify behavior to meet compliance standards.

**Guide a patient to a decision about screening**
Within this context, seek to: Locate and use the most up-to-date guidelines appropriate to each patient; understand the benefits and risks (including patient worry and downstream procedures and testing) of screening; identify appropriate patients for screening; elicit patient preferences about screening in a culturally appropriate manner that includes overall health goals and values; acknowledge the limitations, time required, and direct and indirect costs for screening; and use terms and concepts understandable to the patient while allowing time for questions.

**Manage a patient with chronic joint or musculoskeletal pain**
Within this context, seek to: Incorporate a team-based approach to care including physician subspecialists and non-physician providers, as well as non-traditional providers when applicable; utilize diagnostic testing and imaging appropriately, considering the predictive and cost characteristics of each test; manage, monitor, and document opiate and non-opiate therapies; recognize and treat co-morbid medical conditions including obesity, depression, and substance abuse; and motivate patients to be more physically active within their psychosocial construct and promote goals other than disability.

**Manage the care of a patient with mood disorder**
Within this context, seek to: Take an appropriate psychiatric history, including assessment of risk of harm to self/others; begin or adjust medications appropriately for patients on single psychiatric agents; monitor for adverse side effects of medications; incorporate non-pharmacologic treatments such as cognitive-behavioral therapy from other providers; and refer to psychiatry care as appropriate for more complicated patients.

**Manage the care of patients with diabetes mellitus**
Within this context, seek to: Elicit history-taking that assesses individual patient understanding, preferences and barriers; affect behavioral change including diet, exercise, and medication adherence; manage diabetes medications, including initiating and appropriately adjusting insulin therapy; screen for microvascular complications including retinopathy and nephropathy; manage comorbid conditions such as HTN that increase risk for macrovascular complications including heart disease; incorporate a team-based approach to care that includes non-physician providers including PT, pharmacists, and MA/RN staff.
Assess for alcohol or drug use disorder and begin treatment as appropriate
Within this context, seek to: Screen patients for hazardous drinking and illicit drug use, and assess patients with positive screening tests for alcohol and drug use disorder diagnoses using non-judgmental language and cues; utilize evidence-based brief interventions such as motivational interviewing; initiate appropriate pharmacotherapy when appropriate; help patients access drug and alcohol counseling and make other referrals to treatment.

Manage chronic disease in homeless patients
Within this context, seek to: Provide evidence-based, chronic disease management within the financial and logistical constraints of each patient’s individual housing situation; use history-taking that elicits patient preferences for and barriers to care; incorporate a team-based approach to care including community-based resources to address barriers to adherence and unique needs; demonstrate compassion, empathy and respect to patients and caregivers in all situations.