CDPM Learning Objectives

Patient self-care management	1. Elicit and articulate patient identified barriers to and strategies for health promoting behaviors. 2. Demonstrate communication strategies (i.e., motivational interviewing) to activate patients for self-care management
Decision support	3. Utilize appropriate tools (i.e., expanded social history, chronic disease history and physical) to obtain patient-centered values, goals, and socio-behavioral-economic factors that influence chronic disease screening, prevention, and management decisions. 4. Utilize evidence-based clinical practice guidelines or tools (e.g., rubrics, calculators, risk screeners) to obtain patient-centric and population-based risk assessment screening. 5. Apply the information gathered to co-create a comprehensive chronic disease management plan with the patient.
Clinical information system	6. Utilize electronic health record to review, guide, and document patient-centered chronic disease prevention and management. 7. Utilize electronic health record tools to identify population level burden, disparities, trends, and outcomes in chronic disease screening, prevention, and management.
Community resources	8. Recognize community resource availability for chronic disease screening, prevention, and management.
Delivery systems & teams	9. Describe the function of interprofessional teams and health care systems in chronic disease care delivery to include care coordination and transitions of care.
Health system practice & improvement	10. Describe the role of health care finance systems in promoting (or limiting) chronic disease care delivery. 11. Identify local and national public policies and practices that affect chronic disease incidence, management, and access to care.

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