



Entrustable Professional Activities

EPA 4 for Adolescent Medicine

EPA 4: Transition Care of the Adolescent and Young Adult Patient to Adult Health Care Settings

Supervision Scale for This EPA

1. Trusted to observe only
2. Trusted to provide care with direct supervision and coaching for all steps in the transition process
3. Trusted to provide care with indirect supervision and discussion of steps in the transition process for most simple and some complex cases
4. Trusted to provide care with indirect supervision but may require discussion of steps in the transition process for a few complex cases
5. Trusted to provide care without supervision

Description of the Activity

Healthy adolescents and young adults as well as those with special health care needs and chronic health conditions need to acquire developmentally appropriate self-management skills to enable a successful transition to adult-oriented care. Adolescent specialists play a role in working with patients, and their families as appropriate, to facilitate the learning of self-management and shared decision-making skills and the identification of adult-oriented resources.

The specific functions which define this EPA include:

1. Assessing the health literacy of the patient and family (caregivers) as well as the developmental level of the patient
2. Transitioning healthy, typically developing adolescents from pediatric to adult systems of care
3. Preparing the adolescent and young adult as well as their family, especially those with special health care needs, to begin the transition process
4. Deciding which components of care are important to transition (i.e., primary care or subspecialty care for chronically ill or special needs youth), recognizing that transition may not be simultaneous for all components of care
5. Educating the patient, family, and care team, as appropriate, in the longitudinal process for transition
6. Counseling the adolescent/young adult patient and the family, as appropriate, to empower the patient to utilize self-management skills, including but not limited to the maintenance of medication records, medical history and medical provider information (electronically and/or by paper copies) and to engage in shared decision-making regarding his/her health with the health care team to the extent possible
7. Counseling the patient and the family, as appropriate, regarding navigation of the health care system
8. Communicating during the transition process with adult-oriented providers and teams

Judicious Mapping to Domains of Competence

- Patient Care
 Medical Knowledge
 Practice-Based Learning and Improvement



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- Interpersonal and Communication Skills
- Professionalism
- Systems-Based Practice
- Personal and Professional Development

Competencies Within Each Domain Critical to Entrustment Decisions

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| PC 3: | Transferring care |
| PC 9: | Counseling patients and families |
| PC 11: | Using information technology |
| ICS 1: | Communicating with patients/families |
| ICS 3: | Communicating with health professionals |
| ICS 5: | Consultative role |
| P 2: | Demonstrating professional conduct |
| SBP 2: | Coordinating care |

Context for the EPA

Rationale: Adolescent medicine specialists must be able to coordinate and facilitate the transition of medical care of adolescents with complex health care needs as well as those with typical developmental needs to adult health care providers, if they are not adult providers themselves.

Scope of Practice: An adolescent medicine specialist typically cares for young people aged 10–25 years of age. The need for transition of the patient to receive services by adult health care providers needs to be flexible with consideration of both the age of the patient and their chronic medical conditions and special health care needs. Transition includes the facilitation of inpatient and outpatient service provision, especially for those young people with chronic health conditions who require frequent hospitalizations. Transition of care planning is a process that may start as early as the early teenage years, and may be completed in stages, with the transition of primary care adolescent services often occurring last, after the coordination of subspecialty services is complete.

Curricular Components That Support the Functions of the EPA

1. Assessing the health literacy of the patient and family (caregivers) as well as the developmental level of the patient
 - Evaluates the health literacy level of the patient and his/her family to aid in the decision when to start transition and provides transition process needs
 - Evaluates the cognitive and developmental capacity of the patient for self-care, which may include reviewing past educational testing or the use of a brief cognitive capacity tool
2. Transitioning healthy, typically developing adolescents from pediatric to adult systems of care
 - Describes a plan to identify healthy adolescents at the age of 16–18 for transition planning, including self-management skills
 - Determines changes in health insurance coverage based upon age



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- Describes preparation needed for education of the youth and parent/caregiver for adult approach to care at age 18, including legal changes in decision-making and privacy and consent, self-advocacy, and access to information
 - Describes planning needed with youth/parent/caregiver for identification of an adult oriented provider, and optimal timing of transfer, if needed
3. Preparing the adolescent and young adult with special health care needs, as well as their family, to begin the transition process
- Describes a plan to identify all young people at the age of approximately 13–14 years of age for transition planning
 - Describes elements of a transition policy/statement, with input from youth and families that states the practice's approach to transition, including elements of the process and privacy and consent information
 - Identifies all those relevant to the transition process and describes an education and communication plan for transition
4. Deciding which components of care for chronically ill or special needs youth are important to transition (i.e., primary care or subspecialty care), recognizing that transition may not be simultaneous for all components of care
- Describes state and federal laws relevant to transition, including educational policy, medical decision-making, and guardianship
 - Describes the institution of regular transition readiness assessments, beginning at approximately age 13–14, to identify and discuss with youth and parents/caregivers their needs and goals in self-care
 - Determines adult specialists and hospitalists needed for facilitation of outpatient and inpatient transition
5. Educating the patient, family, and care team, as appropriate, in the longitudinal process for transition
- Identifies specific tasks and their timing during the transition process. For example, patients seen by self as part of visits, patients involved in health decisions, patients knowing their own medications and reproductive health counseling would be earlier in the transition process, and patients scheduling their own appointments, creating an updated portable medical summary, knowing who and how to call for insurance issues, and guardianship/power of attorney would be later tasks
 - Describes a system for utilizing an individual flow sheet or registry to update the plan of care and to track youth's transition progress using EHR
 - Describes preparation needed for education of the youth and parent/caregiver for adult approach to care at age 18, including legal changes in decision-making and privacy and consent, self-advocacy, access to information, and expectations from college/university health services, if attending higher education, including coordination of care with the college health center
 - Determines the level of need for decision-making supports for youth with intellectual challenges and describes process to make referrals to legal resources including formal guardianship for medical decision-making and care because of significant cognitive and or mental health problems
6. Counseling the adolescent/young adult patient and the family, as appropriate, to empower the patient to utilize self-management skills, including but not limited to the maintenance of medication records, medical history and medical provider information (electronically and/or by paper copies) and to engage in shared decision making regarding his/her health with the health care team to the extent possible



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- Describes a process of counseling to jointly develop goals, medical summary and emergency care plan, and prioritized actions with youth and parent/caregiver, and document regularly in a plan of care
 - Describes options for providing a portable medical summary and/or care plan to the youth/parents/caregiver in an electronic form or paper summary such as an EHR summary or portable paper summary
7. Counseling the patient and the family, as appropriate, regarding navigation of the health care system
- Describes techniques to provide counseling and linkages to insurance resources, self-care management information, college health services, and culturally appropriate community supports
 - Describes planning needed with youth/parent/caregiver for optimal timing of transfer. If both primary and subspecialty care are involved, discusses optimal timing for each
8. Communicating during the transition process with adult-oriented providers and teams
- Describes a communication plan with youth/young adult's subspecialty pediatric provider(s) and arranges for consultation assistance, if needed
 - Describes a plan for initial transfer including consent from youth/guardian for release of medical information, and ensures adult provider receives transfer items such as a final transition readiness assessment, plan of care with transition goals and pending actions, medical summary and emergency care plan, legal documents (if needed), and confirms date of first adult provider appointment
 - Describes a communication plan with adult providers confirming completion of transfer and offers of consultation assistance, as needed

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The Adolescent EPAs were developed by consensus with adolescent provider representatives from the AAP, SAHM, CoPS, and the ABP.

Curricular Components Authors

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