



# Entrustable Professional Activities

## EPA 2 for Pediatric Endocrinology

### EPA 2: Facilitate the Transition of Patients with Endocrine Disorders from Pediatric to Adult Health Care

#### Supervision Scale for This EPA

1. Trusted to observe only
2. Trusted to execute with direct supervision and coaching
3. Trusted to execute with indirect supervision and discussion of information gathered and conveyed for most simple and some complex cases
4. Trusted to execute with indirect supervision but may require discussion of information gathered and conveyed for a few complex cases
5. Trusted to execute without supervision

#### Description of the Activity

Children and adolescents with chronic endocrine disorders require lifelong care. This requires a seamless transition process to adult endocrine/medicine counterparts.

The specific functions which define this EPA include:

1. Recognizing when another provider is better suited to care for one's patients based on age and other socio-demographic factors
2. Recognizing when a patient is ready to assume full responsibility (transition) for their care in a nonpediatric setting
3. Assessing the patient for transition readiness
4. Educating the patient/family as well as the receiving care team and engaging in a longitudinal process for care transition
5. Counseling the patient and family to empower the patient in areas of self-care
6. Navigating the health care system in order to more effectively coordinate care
7. Communicating before, during, and after the initial transition with one's interprofessional colleagues to ensure that the transition has been seamless

#### Judicious Mapping to Domains of Competence

- Patient Care
- Medical Knowledge
- Practice-Based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems-Based Practice
- Personal and Professional Development



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### Competencies Within Each Domain Critical to Entrustment Decisions

PC 3:	Transferring care
PC 9:	Counseling patients and families
PBLI 9:	Educating others
ICS 3:	Communicating with health professionals
SBP 2:	Coordinating care

### Context for the EPA

**Rationale:** Pediatric endocrinologists utilize a variety of biochemical tests and procedures in the evaluation of patients with potential endocrine disorders. Practitioners must be able to 1) determine appropriate testing, 2) discuss the rationale for testing, risks, and benefits with patients and families and 3) interpret results to inform both diagnosis and treatment.

**Scope of Practice:** Patients with chronic endocrinologic disease are most frequently seen in the outpatient setting. The patient populations will range from late adolescence to early adulthood. This document is intended to address the scope of knowledge and skills of the pediatric endocrinologist in both hospital-based and private practice. As such, it focuses on the skills needed by endocrinologists caring for adolescents/young adults with the most common chronic endocrinologic disease requiring lifelong medical treatment, with the understanding that the general pediatric endocrinologist will recognize his/her own limitations and seek additional assistance from subspecialist within and outside the field as needed.

### Curricular Components That Support the Functions of the EPA

Disorders covered under this EPA include but are not limited to

- Type 1 diabetes mellitus
  - Type 2 diabetes mellitus
  - Turner syndrome
  - Adult growth hormone deficiency
  - Panhypopituitarism
  - Adrenal insufficiency
  - Thyroid disorders
1. Recognizing when another provider is better suited to care for one's patients based on age and other socio-demographic factors
    - Knows the limitations of pediatric expertise with respect to medical issues and sequelae more commonly seen in adults
    - Assesses the level of social comfort of patients with continued pediatric care
    - Determines when local care by an adult endocrinologist may be in the best interest of the patient/family
    - Determines the appropriate timing of transition with respect to patient's educational or professional plans



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2. Recognizing when a patient is ready to assume full responsibility (transition) for their care in a nonpediatric setting
  - Identifies the skills necessary for independent self-care with respect to individual disorder in a disease specific manner
  - Determines the psychosocial readiness of a patient to accept increasing responsibility leading to independence
3. Assessing the patient for transition readiness
  - Determines the patient's understanding of the pathophysiology of disease
  - Assesses the patient's understanding of his/her plan of care and the necessity of medication/compliance
  - Utilizes checklists and other transition resources previously developed and available (e.g., Endocrine Society guidelines for Type 1 diabetes, Endocrine Practice resources for Turner syndrome)
4. Educating the patient/family as well as the receiving care team and engaging in a longitudinal process for care transition
  - Discusses the need for transition to adult care with patient/family to determine concerns and addresses these as needed
  - Discusses transition with patients and families as a planned process to develop an appropriate timeline
  - Aids in determining the availability of adult providers with appropriate expertise and in a location appropriate for the patient/family
5. Counseling the patient and family to empower the patient in areas of self-care
  - Discusses the need for the patient to progressively take over health management (e.g., prescription refills, making appointments, insurance needs)
  - Knows how to counsel parents in delegating responsibility to the patient incrementally to encourage self-sufficiency while maintaining appropriate oversight
6. Navigating the health care system in order to more effectively coordinate care
  - Knows the resources available locally to assist with transition (e.g., insurance assistance, social work, support groups)
7. Communicating before, during, and after the initial transition with one's interprofessional colleagues to ensure that the transition has been seamless
  - Notifies the accepting physician/practitioner of planned transition, including anticipated date and brief review of patient's history
  - Documents and provides an appropriate summary of patient's history for accepting provider
  - Encourages accepting provider and patient to be in contact should questions or difficulties arise during/following the process of transition



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