



Entrustable Professional Activities

EPA 3 for Pediatric Hematology-Oncology

EPA 3: Provide a Medical Home for Patients with Hematologic, Oncologic, or Stem Cell Transplant Needs

Supervision Scale for This EPA

1. Trusted to observe only
2. Trusted to execute with direct supervision and coaching
3. Trusted to perform with supervisor serving as a consultant for all tasks
4. Trusted to perform with supervisor serving as a consultant but for a few complex tasks
5. Trusted to perform without supervision

Description of the Activity

The medical home is a partnership between patient, family, and primary care practice, nested in the patient's community, that optimizes access to and coordination of care and resources. Patients with disorders requiring care by subspecialists in hematology/oncology often have unique, complex needs, requiring the medical home to be located in the subspecialty practice.

The specific functions which define this EPA include

1. Being a key facilitator and champion of patient and family centered care
2. Working in collaboration with an interprofessional team
3. Developing and maintaining a knowledge of health literacy and vulnerable populations
4. Engaging and coordinating with multiple specialists and health care professionals [e.g., primary care provider, physical therapy/occupational therapy (PT/OT), social work (SW), nutrition]
5. Developing and maintaining a knowledge of and ability to access community resources

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

Competencies Within Each Domain Critical to Entrustment Decisions

PC 10:	Providing health maintenance
PBLI 9:	Educating others
ICS 3:	Communicating with health professionals
P 3:	Demonstrating humanism
P 4:	Demonstrating cultural competence



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SBP 2:	Coordinating care
SBP 3:	Incorporating cost awareness into care
PPD 6:	Providing leadership to improve care

Context for the EPA

Rationale: Providing a medical home with coordinated care for patients with special health care needs is the foundation for efficient and effective health care delivery. Pediatric hematology/oncology trainees must understand the components of a medical home and be able to successfully coordinate care that is multidisciplinary, comprehensive, coordinated, accessible, and patient-centered, meeting the medical, social, developmental, behavioral, educational, and financial needs of the patient and family.

Scope of Practice: Scope of practice involves any child from birth to young adulthood who has been diagnosed with a cancer or blood disorder who has complex needs requiring the medical home to be located in the subspecialty practice. Effective care for the pediatric hematology/oncology patient is necessarily complex, requiring in-depth knowledge of the specific needs of each individual patient and their family, as well as the resources available to meet those needs. The resources available vary widely across institutions, communities, and patient populations. Thus, this document focuses on the knowledge, skills, and attitudes required to identify individual patient/family needs, identify available resources (including other medical professionals), coordinate complex care, and lead an interprofessional team.

Curricular Components That Support the Functions of the EPA

1. Being a key facilitator and champion of patient and family-centered care
 - Accurately assesses and identify the patient/family's needs, including medical, dental, social, educational, developmental, mental health, and financial needs
 - Involves the family and patient in decisions regarding health care, tailored to fit their needs
 - Establish clear goals for the patient, family, and team members, with input from the patient/family being sensitive to their language, values, and culture
 - Communicates effectively with the patient and family, conveying new information or changes in plan of care in an appropriate time frame, using appropriate language and literacy level and modifying to meet their current needs
 - Creates and implements a comprehensive written care plan that is clearly documented and states therapeutic interventions and goals
 - Assesses test results and recommendations from team members, modifying the care plan in response to changing needs
 - Considers insurance/reimbursement issues and institutional guidelines, modifying the care plan where appropriate to practice cost-effective health care and resource allocation that does not compromise quality of care
2. Working in collaboration with an interprofessional team
 - Coordinates and effectively leads multidisciplinary rounds and care conferences
 - Establishes clear goals and responsibilities among team members and with the patient and family to comprehensively address patient needs



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- Communicates with involved health care team members, adapting as needed to ensure effective collaboration
 - Analyzes and assesses recommendations from team members, modifying the care plan as needed
3. Developing and maintaining knowledge of health literacy and vulnerable populations
- Accesses the literature relevant to health literacy and vulnerable populations
 - Identifies situations where health literacy and/or vulnerability impacts the patient's clinical and research needs
 - Actively assesses patient/family for level of health literacy and/or vulnerability and adjusts communication to fit that level
 - Modifies communication and care plan to fit the patient/family's level of health literacy or vulnerabilities
4. Engaging and coordinating with multiple specialists and health care professionals (e.g., primary care provider, PT/OT, SW, nutrition)
- Identifies and consults appropriate team members to address the patient/family's needs
 - Communicates with involved health care team members, adapting as needed to ensure effective collaboration
 - Analyzes and assesses recommendations from team members, modifying the care plan as needed
 - Maintains a cohesive care plan that is clearly communicated to the patient/family, avoiding duplication of service in order to practice cost effective health care while optimizing care for the patient
5. Developing and maintaining a knowledge of and ability to access community resources
- Accesses the appropriate entities (health information technology, consultants) to identify any relevant community resources
 - Identifies frequently used community resources available to the patient population that are cost effective, taking into consideration insurance/reimbursement issues
 - Includes appropriate resources in written care plans

Note: This EPA is not limited to any specific problem or diagnosis. The medical home may need to be located in the subspecialty practice when the patient is seen more often by the subspecialist than the primary pediatrician or when the needs of the patient are complex or unique.

References

1. American Academy of Pediatrics Policy Statement: Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems. May 2014.
2. <https://medicalhomeinfo.aap.org/Pages/default.aspx>
3. https://medicalhomeinfo.aap.org/tools-resources/Documents/Complete-FE-Learning%20Guide_4-29-09.pdf
4. [AAP Health Literacy](#)



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