



Entrustable Professional Activities

EPA 6 for Pediatric Hematology-Oncology

EPA 6: Facilitate the Transition of 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 without verification of information after the handover for most simple and some complex cases
4. Trusted to execute with indirect supervision without verification of information after the handover for all but a few complex cases
5. Trusted to execute without supervision

Description of the Activity

During their practice, pediatric hematologists/oncologists transfer the care of patients to other providers (e.g., physician experts, primary care providers, or adult medicine counterparts). This has necessitated an accountability to these patients on the part of a pediatric hematologist/oncologist to insure a seamless transition process.

The specific functions which define this EPA include:

1. Recognizing when another provider is better suited to care for one's patient based on age, other socio-demographic factors, or medical issues
2. Assessing for transition readiness
3. Educating the patient/family and receiving care team and engaging in a longitudinal process for care transition
4. Navigating the health care system in order to coordinate care
5. 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

Competencies Within Each Domain Critical to Entrustment Decisions

PC 3:	Transferring care
PC 10:	Providing health maintenance



Entrustable Professional Activities

EPA 6 for Pediatric Hematology-Oncology

PBLI 1:	Identifying gaps
ICS 1:	Communicating with patients/families
ICS 3:	Communicating with health professionals
ICS 6:	Maintaining medical records
SBP 2:	Coordinating care
SBP 4:	Advocating for quality care

Context for the EPA

Rationale: Pediatric hematologists/oncologists must be able to effectively transition the care of patients to other providers as required by the patient's age, therapeutic requirements (i.e., patient completed with therapy and now in long-term follow-up care), or other socio-demographic factors (i.e., patient relocation, change in insurance coverage status). The needs of the individual patient and family will vary, but include education, planning, and communication at multiple levels to ensure a seamless transition of care.

Scope of Practice: To achieve optimal health, all patients require appropriate care that is medically and developmentally appropriate. Effective health care transition ensures that appropriate health care services are available in an uninterrupted manner as patients move from one health care setting to another, and as patients move from the child to adult model of health services. Coordination of patient, family, and provider responsibilities for pediatric patients at all ages is critical. For a successful transition of care, pediatric hematologists/oncologists must engage the patient, family, and receiving health care provider in education and assess the readiness to transition that is specific to their setting and population. Special consideration is required for patients with special health care needs as they transition from adolescence to an adult care model, particularly those between the ages of 18–21 years.

Curricular Components That Support the Functions of the EPA

1. Recognizing when another provider is better suited to care for one's patient based on age, other socio-demographic factors, and medical issues
 - Identifies patients who are appropriate for transition of care to a primary care provider or another oncologist with expertise in survivorship for routine health maintenance
 - Facilitates the transition of care for patients requiring a change in pediatric hematology/oncology provider because of change in location for family, change in insurance coverage status, or other socio-demographic reasons
 - Knows and participates in the transition process for patients in the adolescent age range with the ultimate goal of successful participation as an adult in the appropriate health care system by 18–21 years of age
2. Assessing for transition readiness
 - Identifies the components of transition readiness
 - Conducts regular age-appropriate transition readiness assessments of patients and families to identify and discuss needs and goals in self-care and disease management
 - Develops goals and prioritized actions with the patient and family and documents these regularly in a plan of care



Entrustable Professional Activities

EPA 6 for Pediatric Hematology-Oncology

3. Educating the patient/family and receiving care team and engaging in a longitudinal process for care transition
 - Identifies appropriate tools available for long term disease management and follow-up for specific diagnoses (e.g., Children's Oncology Group long-term follow-up guidelines for survivors of childhood cancer, National Heart, Lung, and Blood Institute (NHLBI) health maintenance guidelines for patients with sickle cell disease)
 - Develops and regularly updates the plan of care, medical summary, and readiness assessments. Provides education on identified deficiencies in understanding of the medical issues for patient and family members as needed
 - Plans with family and patient optimal timing of care transfer. Assists patient and family in identifying a new provider and communicates with the provider of pending transition of care
4. Navigating the health care system in order to coordinate care
 - Identifies and understands linkages to insurance resources, care management information, and culturally appropriate community supports
 - Applies an adult approach to care for patients 18 years old and older, including legal changes in decision making, adherence to care recommendations, privacy, and consent, as well as self-advocacy and access to information
5. Communicating before, during, and after the initial transition with one's interprofessional colleagues to ensure that the transition has been seamless
 - Confirms date of first appointment with new provider
 - Completes transfer package, including final transition assessment, plan of care, medical summary, emergency care plans, and additional provider records
 - Continues to ensure appropriate care for patient until first appointment with new provider and responsibility of care is transferred
 - Builds ongoing and collaborative relationships with primary care and specialty providers to educate and provide referral networks for patients and their families
 - Completes follow-up with patient and new care provider for feedback on transfer of care process for purposes of improvement

References

1. American Academy of Pediatrics, American Academy of Family Physicians and American College of Physicians, Transitions Clinical Report Authoring Group. Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics* 2011;128;182; originally published online June 27, 2011; DOI: 10.1542/peds.2011-0969. www.pediatrics.org/cgi/doi/10.1542/peds.2011-0969
2. Six Core Elements of Health Care Transition 2.0. Center for Health Care Transition Improvement, [www.GotTransition.org](http://www.gottransition.org). 01/2016. <http://www.gottransition.org/resourceGet.cfm?id=206>.



Entrustable Professional Activities

EPA 6 for Pediatric Hematology-Oncology

EPA Authors

Mark P Atlas, MD (lead), Alexander Chou, MD, Tim Garrington, MD, Michelle Hermiston, MD, PhD, Rima Jubran, MD, MPH, MACM, Jennifer C. Kesselheim, MD, EdM, Richard L Tower, MD, MS

Curricular Components Author

Gary Crouch, MD, Mark P Atlas, MD, Leslie Kersun, MD, MSCE, MEd, Anne Warwick, MD, Rima Jubran, MD, MPH
MACM