Curricular Components That Support the Functions of EPA 6: Provide a Medical Home for Patients with Complex, Chronic, or Special Health Care Needs

1. Demonstrating knowledge of key community services and agencies, to facilitate appropriate referral of patients with identified needs, and skill to diagnose, refer as needed, counsel, and provide health maintenance for medically complex patients
   - Demonstrates knowledge of commonly seen types of diagnoses including but not limited to asthma, autism spectrum disorder, developmentally delayed patients, children with genetic conditions, sickle cell disease, cerebral palsy, brain injury, rheumatologic conditions, congenital anomalies, oncology patients, children with significant mental health diagnoses, and children with neural tube defects
   - Demonstrates knowledge of the types of medical technology that assist this population of medically complex patients. (This includes nutrition support, venous access, transportation, and respiratory support.)
   - Advocates for medically complex patients and families in regard to access to care, resources and facilitation of effective use and benefit from medical technology

2. Facilitating patient and family centered care in a medical home model in order to emphasize collaboration with an interprofessional team that insures optimal care and empowerment of the patient/family
   - Provides patients and families care within a medical home utilizing interactions that involve shared decision making, care coordination, and support in a collaborative partnership
   - Demonstrates strong relationship building through listening, narrative, and nonverbal communication skills
   - Demonstrates effective education and counseling of patients and families
   - Integrates principles of care coordination in interactions with families and outside resources to optimize patient quality of life and positively impact health outcomes
   - Communicates diagnostic and treatment options in an effective manner with patients and families that assists with decision-making amidst uncertainty and lack of evidence-based information, particularly in rare disorders/conditions
   - Communicates effectively with families of CSHCN in a manner that takes into account the special issues that commonly arise in caring for complex medical conditions such as family autonomy, advance care plans, respite care, financial strategies/assistance, and decision making amidst uncertainty

3. Engaging in and orchestrating the care coordination of CSHCN with appropriate specialists and other health care professionals/agencies (physical therapists, occupational therapists, home health care, dieticians, social workers, psychologists, etc.)
   - Provides comprehensive health maintenance and complex medical care through a multidisciplinary approach by partnering with other health care professionals, and services (physical therapy, occupational therapy, speech, dieticians, payors, respite care services)
   - Fosters clear, bidirectional communication with all of the patient’s subspecialists, allied health professionals, and health care related agencies to allow for optimal care coordination
• Manages and coordinates care for technology dependent special needs children

Curricular Components Authors

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References
