EPA 6: Provide a Medical Home for Patients with Complex, Chronic, or Special Health Care Needs

Supervision Scale for This EPA

1. Trusted to observe the EPA
2. Trusted to practice EPA only under proactive, full supervision as a coactivity with the supervisor
3. Trusted to practice EPA only under proactive, full supervision with the supervisor in the room and ready to step in as needed
4. Trusted to practice EPA only under reactive, on-demand supervision with supervisor immediately available and ALL findings double checked
5. Trusted to practice EPA only under reactive, on-demand supervision with supervisor immediately available and KEY findings double checked
6. Trusted to practice EPA only under reactive, on-demand supervision with supervisor distantly available (e.g., by phone), findings reviewed
7. Trusted to practice EPA unsupervised
8. Trusted to supervise others in practice of EPA (where supervision means ability to assess patient and learner needs ensuring safe, effective care and further trainee development by tailoring supervision level)

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. This activity requires the health care professional to be a key facilitator and champion of patient and family centered care, working in collaboration with an interprofessional team. Working knowledge of vulnerable populations is critical to this EPA. The activity often requires engagement with and coordination of multiple specialists and health care professionals. The activity also requires knowledge of and ability to access community resources. Entrustment to provide comprehensive care for medically complex children in a medical home may require different knowledge, skills, and attitudes for different age groups. As a result, entrustment decisions may require stratification by age group.

The specific functions which define this EPA include:

- 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
- 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
- Engaging in and orchestrating the care coordination of Children with Special Health Care needs (CSHCN) with appropriate specialists, subspecialists, and other healthcare professionals/agencies (physical therapists, occupational therapists, home health care, dieticians, social workers, psychologists, etc.)
Judicious Mapping to Domains of Competence

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

Competencies Within Each Domain Critical to Entrustment Decisions

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<tr>
<th>Domain</th>
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<td>PC 9:</td>
<td>Counseling patients and families</td>
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<tr>
<td>PC 10:</td>
<td>Providing health maintenance</td>
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Context for the EPA

Rationale: Pediatricians must be able to care for children with special health care needs (CSHCN) defined as children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who require health and health related services of a type or amount beyond that required by children generally.\(^1\) The most medically fragile of this group has also been designated as children with medical complexity (CMC).\(^2\) Providing a medical home is a key approach to care that promotes access to all of the services and community supports needed for each patient. Developing a partnership with families to provide the needed care and services is a critical component.

Scope of Practice: Providing comprehensive care in a medical home is an expansive endeavor. Caring for patients with complex, chronic and special health care needs involves pediatric patients in all age ranges from birth to adulthood. It also involves transitions to adult care for many CSHCN who need assistance with care coordination to adult specialists. The specific diagnoses that fall under this EPA are numerous and varied, but regardless of complexity or diagnosis, the expected abilities of a pediatrician will allow him/her to provide coordinated and effective care within a medical home. The generalist must communicate, collaborate, and facilitate access to resources that meet these needs, and do so in a manner that is culturally sensitive and professional in nature.

Curricular Components That Support the Functions of the EPA

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 evidenced 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