Curricular Components That Support the Functions of EPA 8: Facilitate the Transition from Pediatric to Adult Health Care

1. Developing a therapeutic relationship with patient and family which foundationally supports recognition and timing of transition to adult care
   - Demonstrates strong relationship building through listening, narrative, and nonverbal communication skills
   - Demonstrates effective education and counseling of patient and family
   - Cultivates a partnership with the patient and family while respecting patient privacy and autonomy and maintaining appropriate professional boundaries
   - Demonstrates integrity, honesty, compassion, and empathy in one’s role of accepting responsibility for patient care, including transition to adult care
   - Demonstrates sensitivity and responsiveness to patient’s gender, age, culture, disabilities, ethnicity, and sexual orientation

2. Assessing for transition readiness
   - Recognizes when patient needs, regardless of patient age, are moving beyond the scope of pediatric care, and one’s own knowledge and skills require assistance from adult provider(s)
   - Ascertainment patient and family’s level of understanding of medical needs including medications, care plan, and goals
   - Identifies and addresses concerns of patient and family regarding transition to adult provider(s)
   - Develops shared goals with patient and family and updates them regularly starting in early adolescent years
   - Counsels and empowers the patient and family around self-care
   - Discusses the approach to transition to adult care and initiates the process

3. Transition planning that includes establishing a care team with an adult primary care provider and medical home, adult subspecialists, as needed and community-based resources
   - Develops and regularly updates transition plan, including readiness assessment findings, goals and prioritized actions, medical summary, and emergency care plan
   - Identifies and connects patient to adult primary care provider and medical home that is fitting for the patient’s medical needs
   - Prepares patient and family for any legal changes in decision-making, privacy and consent, and access to information
   - Identifies need for decision-making supports for youth with intellectual challenges and refers family to appropriate legal and social resources
   - Provides information for insurance, community-based resources, and self-care management
• Plans optimal timing of transfer of care, weighing comfort of patient and family and ongoing health needs
• Obtains consent for release of medical information

4. Transferring care to adult health care providers, and coordinating assistance and ongoing support as needed
   • Communicates effectively with adult primary care provider including transfer letter and updated care plan
   • Coordinates comprehensive medical care by effectively communicating and engaging with adult subspecialists and community-based resources as needed
   • Communicates details around transition of care to patient (and family), including updated medical summary and emergency care plan/contacts
   • Plans follow up contact with adult provider(s) to confirm successful transfer of care

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References