# Curricular Components for General Pediatrics EPA 8

<table>
<thead>
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<th>1. EPA Title</th>
<th>Facilitate the transition from pediatric to adult health care</th>
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| 2. Description of the activity | All children must have an organized transition to adult healthcare. This is particularly true of children with complex or chronic medical conditions. This necessitates an accountability to these patients on the part of a pediatrician to insure a seamless transition process to adult medicine counterparts. The specific functions which define this EA include:  
  - Developing a therapeutic relationship with patient and family which foundationally supports recognition and timing of transition to adult care  
  - Assessing for transition readiness  
  - 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  
  - Transferring care to adult health care providers, and coordinating assistance and ongoing support as needed |
| 3. Judicious mapping to domains of competence | _X_ Patient Care  
    ___ Medical Knowledge  
    _X_ Practice-based Learning and Improvement  
    _X_ Interpersonal & Communication Skills  
    _X_ Professionalism  
    _X_ Systems-based Practice  
    _X_ Personal & Professional Development |
| 4. Competencies within each domain critical to entrustment decisions | PC 3: Transferring care  
    PC 9: Counseling patients and families  
    PBLI 9: Educating others  
    ICS 3: Communicating with health professionals  
    P 2: Professional Conduct  
    SBP 2: Coordinating care  
    PPD 1: Engaging in help-seeking behaviors |
| 5. Curricular Components that support the functions of the EPA (knowledge, skills and attitudes needed to execute this EPA safely): |

**Rationale:** Transitioning patients to adult health care is becoming a more prevalent and intentional activity of pediatricians especially with advances in chronic disease management. With this activity comes requisite knowledge and skills around identifying when the needs of the patient exceed expertise of a pediatric primary care provider, and measuring the readiness of patient and family to transition to adult health care.

**Scope of Practice:** As patients age beyond adolescence, knowledge of illnesses and complications more typical of adults begin to gain importance and at a critical point, the

The pediatrician must make the decision to transition the patient to adult care. At this point, the pediatrician must exercise knowledge and skills that will facilitate a seamless transition. The transition will in some cases necessitate not only transfer of medical care to an adult primary care provider, but also include establishing connections with adult subspecialists and extension to community-based services that are designed to help a patient transition to more independence and self-care, as appropriate. The pediatrician must facilitate this transfer of care in a manner that is sensitive, timely, and comprehensive.

Curricular components that support the functions of the EPA:

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.

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).
- Ascertains 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.

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.

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: