



Entrustable Professional Activities

EPA 3 for Pediatric Rheumatology

EPA 3: Provide or Coordinate a Medical Home for Patients with Complex and Chronic Rheumatic Disease

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 and discussion of information conveyed for most simple and some complex cases
4. Trusted to execute with indirect supervision but may require discussion of information conveyed for a few complex cases
5. Trusted to execute without supervision

Description of the Activity

The medical home is a partnership between patient, family, and practitioners involved in the care of the patient.

The specific functions which define this EPA include:

1. Optimizing access to and coordination of care with the care team members and consultants
2. Being a champion for patient and family-centered care
3. Applying knowledge of cultural competence, health literacy and vulnerable populations in developing a therapeutic relationship with the patient and family
4. Coordinating transitions of care between past, current and future providers

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 10:	Providing health maintenance
PBLI 9:	Educating others
ICS 1:	Communicating with patients/families
ICS 3:	Communicating with health professionals
P 4:	Demonstrating cultural competence



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SBP 2:	Coordinating care
SBP 4:	Advocating for quality
SBP 5:	Working in interprofessional teams

Context for the EPA

Rationale: Rheumatologists must be able to anticipate and manage the health and medical needs of pediatric rheumatology patients within outpatient and inpatient settings, working closely in conjunction with other health care providers.

Scope of Practice: Care is provided in the ambulatory and inpatient setting. The pediatric rheumatologist also serves as a resource for telephone, electronic, and remote consultation, and care is occasionally supervised in-home or at remote sites. The patient population includes all patients with rheumatic, inflammatory, autoimmune diseases, and associated musculoskeletal conditions followed regularly in the pediatric rheumatology clinic and patients evaluated as requested consultations. Patients will range in age from newborns to young adults. This document is intended to address the scope of knowledge and skills of the pediatric rheumatologist, with the understanding that the pediatric rheumatologist will often need to create and lead multidisciplinary teams and require evaluation and management input from other health care professionals.

Curricular Components That Support the Functions of the EPA

A medical home is a model for the delivery of care to infants, children, and adolescents that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. The role of the physician care coordinator has four essential components: 1) integration of care with the care team and consultants, 2) shared decision-making, 3) provision of a therapeutic relationship with consideration of the social, educational and cultural contexts of care, and 4) coordination of transition of care. As such, the entrustable pediatric rheumatologist will master the following curricular components:

1. Optimizing access to and integration of care with the team members and consultants
 - Works with the interprofessional team to clearly define medical home roles and responsibilities of the primary care provider and other care team members
 - Partners with and educates the primary care provider to enhance care quality
 - Communicates effectively with the care team
 - Demonstrates professional conduct with colleagues
 - Actively assists families in navigating the complexities of the health care system
 - Applies knowledge of community resources to accessing them for patients/families
 - Shares information when not readily available such as vaccine records and test results to avoid unnecessary repetition
 - Leads the interprofessional team in cases of complex multisystem rheumatic disease
2. Being a champion for patient and family-centered care
 - Educates and counsels the patient and family to provide patient- and family-centered care
 - Engages the family in shared decision making at all levels of care
 - Develops an open and trusting relationship and communicates effectively with the patient and family



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- Recognizes the social, developmental, behavioral, mental health, educational and financial needs of the patient and family and works with team members to provide community resources to address these problems
 - Identifies the patient's and family's strengths and needs
 - Partners with the family to develop realistic plans for change
 - Empowers the patient to engage to the extent possible in self care
 - Empowers the patient and family members to feasibly and appropriately participate in their own care coordination
3. Applying knowledge of cultural competence, health literacy and vulnerable populations in developing a therapeutic relationship with the patient and family
- Gathers biological and psychosocial information for effective care of the patient and family and reassess at appropriate intervals
 - Applies knowledge of culture in interactions and planning with patient/family and seeks additional information about cultural background from them that may help to inform future encounters and care plans
 - Develops trust and an emotional connection with the patient and family, acknowledging and responding to emotional cues
 - Communicates with the patient and family about the diagnosis and prognosis at a level that corresponds with their health literacy
 - Provides anticipatory guidance about the underlying disease and treatments based on current guidelines and resources available for health maintenance taking patient/ family understanding of the health problems and perception of their impact on daily life into account
 - Educates patients and families about available research opportunities that could offer help beyond standard of care treatment
4. Coordinating transitions of care between past, current and future providers
- Co-creates a transition plan with the family that allows ample time to prepare mentally and emotionally as well as physically to the transition
 - Develops knowledge of available services, referral systems, insurance issues, and transition considerations

EPA Authors

Marilynn Punaro, MD (lead), Lisa Imundo, MD, Eyal Muscal, MD

Curricular Components Authors

Lisa Imundo, MD, Eyal Muscal, MD, Megan Curran, MD, Jay Mehta, MD, Jennifer Huggins, MD, Michael Cidon, MD, Kabita, Nanda, MD, Jay Nocton, MD