



Entrustable Professional Activities

EPA 4 for Adolescent Medicine

EPA 4: Transition Care of the Adolescent and Young Adult Patient to Adult Health Care Settings

Supervision Scale for This EPA

1. Trusted to observe only
2. Trusted to provide care with direct supervision and coaching for all steps in the transition process
3. Trusted to provide care with indirect supervision and discussion of steps in the transition process for most simple and some complex cases
4. Trusted to provide care with indirect supervision but may require discussion of steps in the transition process for a few complex cases
5. Trusted to provide care without supervision

Description of the Activity

Healthy adolescents and young adults as well as those with special health care needs and chronic health conditions need to acquire developmentally appropriate self-management skills to enable a successful transition to adult-oriented care. Adolescent specialists play a role in working with patients, and their families as appropriate, to facilitate the learning of self-management and shared decision-making skills and the identification of adult-oriented resources.

The specific functions which define this EPA include:

1. Assessing the health literacy of the patient and family (caregivers) as well as the developmental level of the patient
2. Transitioning healthy, typically developing adolescents from pediatric to adult systems of care
3. Preparing the adolescent and young adult as well as their family, especially those with special health care needs, to begin the transition process
4. Deciding which components of care are important to transition (i.e., primary care or subspecialty care for chronically ill or special needs youth), recognizing that transition may not be simultaneous for all components of care
5. Educating the patient, family, and care team, as appropriate, in the longitudinal process for transition
6. Counseling the adolescent/young adult patient and the family, as appropriate, to empower the patient to utilize self-management skills, including but not limited to the maintenance of medication records, medical history and medical provider information (electronically and/or by paper copies) and to engage in shared decision-making regarding his/her health with the health care team to the extent possible
7. Counseling the patient and the family, as appropriate, regarding navigation of the health care system
8. Communicating during the transition process with adult-oriented providers and teams



Entrustable Professional Activities

EPA 4 for Adolescent Medicine

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 3:	Transferring care
PC 9:	Counseling patients and families
PC 11:	Using information technology
ICS 1:	Communicating with patients/families
ICS 3:	Communicating with health professionals
ICS 5:	Consultative role
P 2:	Demonstrating professional conduct
SBP 2:	Coordinating care

**Based on original Pediatrics Subspecialty Milestones ©2015 ACGME/ABP. All rights reserved.*

Context for the EPA

Rationale: Adolescent medicine specialists must be able to coordinate and facilitate the transition of medical care of adolescents with complex health care needs as well as those with typical developmental needs to adult health care providers, if they are not adult providers themselves.

Scope of Practice: An adolescent medicine specialist typically cares for young people aged 10–25 years of age. The need for transition of the patient to receive services by adult health care providers needs to be flexible with consideration of both the age of the patient and their chronic medical conditions and special health care needs. Transition includes the facilitation of inpatient and outpatient service provision, especially for those young people with chronic health conditions who require frequent hospitalizations. Transition of care planning is a process that may start as early as the early teenage years, and may be completed in stages, with the transition of primary care adolescent services often occurring last, after the coordination of subspecialty services is complete.