Pediatrics: Core EPA #11

Coordinating transitions of care for patients with medical or psychosocial complexity

Key Features:

- This EPA builds on the skills of Foundations, adding patient care scenarios that are more complex (from a medical, social, psychosocial perspective) as well as transitions that may require coordination of multiple teams or professionals.
- This includes assessing the needs of the patient and family, orchestrating the team that will be involved in the patient's care, making optimal use of community resources, providing handover to receiving physicians, and ensuring that patient's family understands the current status of the patient health care needs and the management and follow-up plan.
- This EPA includes: inter-facility or intra-hospital transfer of a patient; movement of patients between health care professionals and/or settings, including admission from community setting, emergency department, different level of care within a hospital, and transfer of care from one practitioner to another; discharging a patient from an inpatient facility; and, transition of care to the adult setting.

Assessment Plan

Direct observation and/or case review by supervisor, senior resident, nurse practitioner or other with expertise in transitions

Use form 1. Form collects information on:

- Case complexity (select all that apply): medical; multisystem; social; other complexity
- Transition type (select all that apply): transfer of care; discharge
- Settings: inpatient; outpatient; emergency department; community; PICU; NICU
- Age: neonate; infant; preschool; school age; adolescent

Collect 4 observations of achievement.

- At least 1 of each transition type
- At least 2 different observers

CanMEDS milestones

1 **ME 2.2 Integrate clinical information to determine the patient's clinical status and health care needs**

2 **L 2.1 Apply knowledge of the resources and/or services available in other care settings**

3 **ME 2.4** Anticipate changes in health status at the time of transition

4 **ME 4.1 Establish plans for ongoing care, follow-up on investigations, response to treatment and/or monitoring for disease progression**

5 **COL 1.2 Consult as needed with other health care professionals, including other physicians**

6 **HA 1.1 Work with other health care professionals to address barriers to access to resources and services**

7 **COM 3.1 Convey information and provide anticipatory guidance to the patient and family regarding the patient's care needs and treatment plan**

8 **COM 4.3** Answer questions from the patient and/or family

9 **HA 1.2 Select and/or provide access to family education resources**

10 **COL 3.2 Communicate effectively with the accepting physician, providing a summary of patient issues and ongoing guidance for care**