Curricular Components That Support the Functions of EPA 6: Facilitate the Transition of Care

1. Recognizing when another provider is better suited to care for one’s patient based on age, other socio-demographic factors, and medical issues
   - Identifies patients who are appropriate for transition of care to a primary care provider or another oncologist with expertise in survivorship for routine health maintenance
   - Facilitates the transition of care for patients requiring a change in pediatric hematology/oncology provider because of change in location for family, change in insurance coverage status, or other socio-demographic reasons
   - Knows and participates in the transition process for patients in the adolescent age range with the ultimate goal of successful participation as an adult in the appropriate health care system by 18–21 years of age

2. Assessing for transition readiness
   - Identifies the components of transition readiness
   - Conducts regular age-appropriate transition readiness assessments of patients and families to identify and discuss needs and goals in self-care and disease management
   - Develops goals and prioritized actions with the patient and family and documents these regularly in a plan of care

3. Educating the patient/family and receiving care team and engaging in a longitudinal process for care transition
   - Identifies appropriate tools available for long term disease management and follow-up for specific diagnoses (e.g., Children’s Oncology Group long-term follow-up guidelines for survivors of childhood cancer, National Heart, Lung, and Blood Institute (NHLBI) health maintenance guidelines for patients with sickle cell disease)
   - Develops and regularly updates the plan of care, medical summary, and readiness assessments. Provides education on identified deficiencies in understanding of the medical issues for patient and family members as needed
   - Plans with family and patient optimal timing of care transfer. Assists patient and family in identifying a new provider and communicates with the provider of pending transition of care

4. Navigating the health care system in order to coordinate care
   - Identifies and understands linkages to insurance resources, care management information, and culturally appropriate community supports
   - Applies an adult approach to care for patients 18 years old and older, including legal changes in decision making, adherence to care recommendations, privacy, and consent, as well as self-advocacy and access to information
5. Communicating before, during, and after the initial transition with one’s interprofessional colleagues to ensure that the transition has been seamless
   - Confirms date of first appointment with new provider
   - Completes transfer package, including final transition assessment, plan of care, medical summary, emergency care plans, and additional provider records
   - Continues to ensure appropriate care for patient until first appointment with new provider and responsibility of care is transferred
   - Builds ongoing and collaborative relationships with primary care and specialty providers to educate and provide referral networks for patients and their families
   - Completes follow-up with patient and new care provider for feedback on transfer of care process for purposes of improvement

References


Curricular Components Authors

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