TRANSITIONS BETWEEN CARE SETTINGS: AN EDUCATION PROGRAM FROM THE ACCC

The Association of Community Cancer Centers (ACCC) released a detailed report regarding the issue of care transition between the hospital cancer program and physician group practices. Within the report, ACCC examined three key areas: 1) the adequacy and completeness of the medical record, 2) the continuity of drug therapy (medication reconciliation), and 3) the communication among providers, such as physicians, nurses, pharmacists, and social workers—both internally (within their own programs) and externally (between the two care settings). [http://www.accc-cancer.org/education/Transitions.asp](http://www.accc-cancer.org/education/Transitions.asp)

NATIONAL CANCER INSTITUTE PDQ: TRANSITIONAL CARE PLANNING

Information on different considerations when transitioning a patient through the phases of care and important members of the care team to include in the planning. [http://www.cancer.gov/cancertopics/pdq/supportivecare/transitionalcare/Patient/page2](http://www.cancer.gov/cancertopics/pdq/supportivecare/transitionalcare/Patient/page2)

Checklist

Below a sample check list is provided to help determine if the appropriate steps have been completed in order to transition the patient to survivorship-focused care.

1. Does the patient have an established relationship with a PCP?
2. Has the SCP been transmitted to the PCP or provider in charge of long-term follow-up care?
3. Have additional resources, such as guidelines, been provided to the PCP?
4. Has patient received the SCP?
5. Has the patient been given the opportunity to review the SCP with a member of the care team?
6. Has the transition of care been clearly communicated to the patient so that s/he understands who will be the lead in coordination of care?