

American Society of Clinical Oncology Clinical Expert Statement on Cancer Survivorship Care Planning

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Abstract

The seminal report from the Institute of Medicine, "From Cancer Patient to Cancer Survivor: Lost in Transition," identified four essential components of survivorship care and recommended that a survivorship care plan (SCP), consisting of a treatment summary and follow-up care plan, be developed and used as a tool to deliver patient-centered care by enhancing communication between the oncology team and the patient as well as communication and coordination of care between the oncology team and the primary care provider (PCP). Nearly a decade ago, the American Society of Clinical Oncology (ASCO) initiated a series of activities to promote chemotherapy treatment plans and sum-

maries and SCPs. Unfortunately, there has been limited success in implementing SCPs in oncology practice because of barriers including, but not limited to, the time-consuming process of completing an SCP, lack of role clarity, and lack of reimbursement for preparation time. ASCO developed this statement and revised template to provide a framework for completing and sharing SCPs and to set clear expectations for survivorship care planning in the oncology setting. This statement is intended to help clinicians recognize the importance of developing patient-centered SCPs and delivering the information to both the patient and PCP and to identify barriers that may exist in completing and delivering these documents effectively.

Introduction

The seminal report from the Institute of Medicine (IOM), "From Cancer Patient to Cancer Survivor: Lost in Transition,"¹ identified four essential components of survivorship care:

1. Prevention of recurrent and new cancers and of other late effects.
2. Surveillance for cancer spread, recurrence, second cancers, and medical and psychosocial late effects.
3. Intervention for consequences of cancer and its treatment (eg, medical problems, symptoms, psychological distress experienced by cancer survivors and their caregivers, and concerns related to employment, insurance, and disability).
4. Coordination between specialist and primary care providers to ensure that all of the survivor's health needs are met.

The report also recommended that a survivorship care plan (SCP), consisting of a treatment summary and follow-up care plan, be developed and used as a tool to communicate and coordinate survivorship care. In particular, the SCP was promoted as a means to deliver patient-centered care by enhancing communication between the oncology team and the patient as well as communication and coordination of care between the oncology team and the primary care provider (PCP). The IOM report provided a comprehensive list of components to include in the SCP, covering both the treatment summary and follow-up care plan.²

Nearly a decade ago, the American Society of Clinical Oncology (ASCO) initiated a series of activities to promote chemotherapy treatment plans and summaries and SCPs. This work included definitional statements and modifiable templates. This work was done to help improve documentation and coordination of cancer treatment and survivorship care. The templates were intended to facilitate provider-to-provider and provider-to-patient communication.

Templates for SCPs were also developed by other organizations, including LIVESTRONG as well as individual cancer centers. Unfortunately, over the past decade, there has been limited success in implementing SCPs in oncology practice, as measured by the ASCO Quality Oncology Practice Initiative (QOPI) in community-based settings, in LIVESTRONG centers, and in National Cancer Institute–designated cancer centers.³⁻⁷

Barriers to implementing SCPs into practice include: the time-consuming process of preparing an SCP, lack of role clarity regarding who will be completing and maintaining the information (oncologists, oncology nurse practitioners, or nurses), lack of reimbursement for preparation and development time, lack of partnership between oncology and PCPs to facilitate communication and coordination of care, paucity of data about the association between SCPs and improved patient outcomes,⁸⁻¹² and lack of compatibility of existing templates with electronic health records (EHRs) and the difficulty in capturing critical information in the SCP.

ASCO has worked to develop Health Level Seven (HL7) standards for SCPs, and cancer programs and EHR vendors are

developing EHR functionality to address survivorship care. However, consistent implementation may be years away for many settings, and oncology providers are struggling to implement SCPs in practice now. The difficulty of implementing SCPs in practice has become more of a concern for clinicians, given the American College of Surgeons Commission on Cancer proposed standard 3.3 (scheduled to begin implementation in 2015), requiring that “the cancer care committee develops and implements a process to disseminate a comprehensive care summary & follow-up plan to patients with cancer completing cancer treatment.”^{13(p78)}

To address this need, ASCO developed this clinical expert statement to define the minimum essential elements needed in an SCP and to identify current barriers to using an SCP and provide feasible solutions for overcoming these barriers. To develop this statement, a consensus conference was held in September 2013, and the deliberations from this meeting were used by the Survivorship Care Planning Workgroup to generate the recommendations contained herein. This statement defines the minimum elements needed to complete an SCP that serves the needs of patients and their families and PCPs caring for those survivors after cancer treatment. We acknowledge the importance of other data elements of interest to treating oncologists and researchers that can be captured and communicated more readily through the EHR, but that is beyond the scope of our charge and of these recommendations. However, we do support other EHR capabilities that could be designed for additional purposes to improve survivorship care, quality improvement, and clinical research efforts.

Methods

In 2012, ASCO established a joint workgroup of the Cancer Survivorship Committee and the Quality of Care Committee to develop a strategy for improving the practice of survivorship care planning in oncology practice. First, the Survivorship Care Planning Workgroup reviewed existing literature regarding the implementation of SCPs in practice. The results of this review and the discussions of the committees suggested the need for a shorter, simpler SCP template. Thus, the workgroup undertook an initiative to identify the essential components for an SCP that addresses the needs of key stakeholders. A survey was developed and fielded to practicing oncology and primary care clinicians and patients. Finally, a multistakeholder consensus conference was convened in September 2013, with the goal of revisiting the IOM-recommended SCP components and the original ASCO templates, to determine the minimum key components needed in an SCP. The assumption for this was that including only minimal key components would facilitate completion of these documents. Participants at the conference represented a variety of stakeholder groups, including medical, surgical, and radiation oncologists, oncology nurses, PCPs, patient navigators, social workers, cancer survivors, oncology practice administrators, and insurers.

Before the conference, each participant was asked to complete a questionnaire to rate the importance of specific items for inclusion in the treatment summary and follow-up care plan

documents. To develop the questionnaire, the workgroup drew from the IOM standards for SCPs as well as the ASCO generic treatment plan and summary template. To identify barriers that may exist for completing and delivering these documents effectively, additional questions were added for the oncology respondents to rate the feasibility of completing each of these items in practice. The goal of the questionnaire exercise was to inform discussion at the in-person conference by assembling a prioritized list regarding which elements respondents felt were essential in an SCP and the feasibility of collecting these data in practice. The questionnaire was circulated to stakeholder groups beyond the conference participants to ensure broad and varied input to support the discussions. In total, 301 complete responses were received; the demographics of respondents are listed in the Data Supplement. Participants were provided with the summary results of the questionnaire at the conference (Data Supplement).

To promote productive discussion, meeting participants were assigned to three breakout groups; each breakout group included members representing a variety of stakeholder groups (eg, medical oncology, radiation oncology, primary care, and survivors). Each group was asked to determine which data elements it felt were essential to an SCP (with separate discussions for treatment summary and follow-up care plans). Additionally, barriers were documented. These group discussions accepted the assumptions outlined in Table 1 when making decisions about inclusion of key components in an SCP. The results from each breakout group were reported to the general session, and areas of disagreement were discussed until consensus was obtained.

Table 1. Key Assumptions Regarding Intent of SCP Agreed on by Participants

Key Assumption
The SCP is a two-part tool, a treatment summary and care plan, intended to facilitate communication and coordination of care between the patient, oncology providers, primary care providers, and other providers.
The SCP does not replace discussions but rather is an adjunct to those discussions. The SCP should be given to the patient, but delivery of an SCP without discussion is not desirable. This discussion should occur between the oncology provider and patient at the conclusion of acute treatment. The SCP should also be delivered to the patient's PCP and any other key health care providers.
The SCP should be as simple, clear, and understandable as possible to meet the needs of the intended users; if actions are identified, the SCP should include who is primarily responsible.
The SCP is not intended to be or replace the medical record; detailed original source documentation may be needed by providers for clinical care.
The SCP developed in this process is intended for patients treated with curative intent for adult cancers regardless of tumor type. Future development of SCPs intended for other patients (eg, survivors with advanced cancer) is needed.
The SCP developed in this process is intended to be presented to patients who have completed active therapy and have no evidence of disease; survivors may be on maintenance or ongoing therapy (eg, hormonal therapy) beyond the acute treatment period.
The SCP can be an evolving document in that it may be updated and reissued as needed. It may not always be developed and/or presented in an electronic format, but its documentation should be included in the survivor's medical record along with a copy sent to the primary care provider.

Abbreviation: SCP, survivorship care plan.

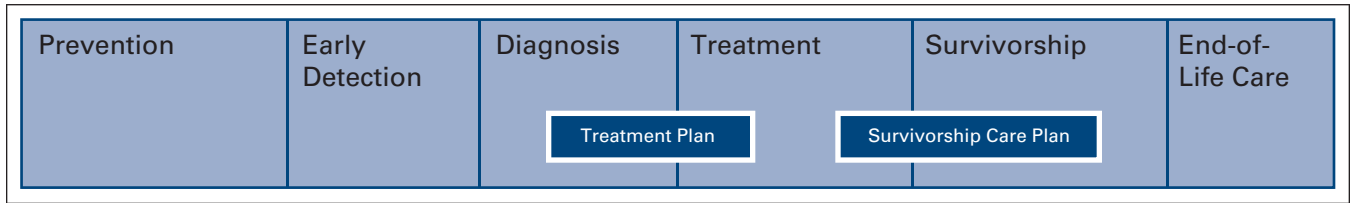


Figure 1. Timing of survivorship care plan delivery.

Results

Treatment Summary

The treatment summary is the middle of three potentially separate but related documents, temporally occurring between the treatment plan, which should be given at the time of diagnosis, and the follow-up care plan, to be delivered at the end of therapy (Figure 1). Although the treatment plan was not addressed by this workgroup, it sets the stage for the development of the treatment summary and follow-up care plan included in an SCP. Specifically, when a patient initiates treatment, a treatment plan should be created by the oncology provider and include data such as patient demographics, diagnosis and stage of disease, treatment intent (curative *v* palliative), and planned treatment components (chemotherapy, surgery, radiotherapy, and so on) and duration. The treatment plan would provide a document to support discussion between the patient and family and the oncology provider about the planned treatment and would inform other providers such as the PCP. The data from the treatment plan would then inform the treatment summary, although the critical difference is that the treatment summary would describe what was actually administered to the patient. Likewise, the treatment summary should inform the follow-up care plan, because this should be determined by the patient’s diagnosis, specifics of therapy received, and his or her specific potential short- and long-term complications and effects.

During the consensus meeting, based on the agreed-on assumptions outlined in Table 1, recommendations were made about the key components of a treatment summary (Table 2). Specifically, the group recommended the inclusion of the following components:

1. Contact information for providers and centers who administered the treatment.
2. Basic diagnostic and staging information.
3. Information on surgery, radiation therapy, systemic therapy (both chemotherapy and biologic therapies), and ongoing significant toxicities, including dates (year and maybe month but not specific days).

Details regarding the specific dose and fraction for a course of radiotherapy were not considered to be critical components, in general. For instance, if the patient were to require irradiation of the same or adjoining area, the radiation oncologist considering this would need to review the detailed primary records of the previous radiation therapy. Similarly, chemotherapy agents should be listed, but details of dosing, dose modification, and schedule would not be relevant for much of care delivered in the future. If chemotherapy were considered again in the future, the

medical oncology team would possibly need to review the primary documentation of previous treatment.

Although universal inclusion of tumor grade and nonanatomic staging data was not recommended, inclusion of these data elements where relevant was advised. Thus, tumor grade is important to include for specific cancers where it has an impact on long-term care. Furthermore, nonanatomic staging should also be included but limited to data that influence treatment decisions (eg, estrogen receptor status for breast cancer or *KRAS* status for colorectal cancer). Because this varies from cancer to cancer, rather than mandating this for all cancers, extra space was included on the template. These factors will invariably change with time as new knowledge becomes available and if disease-specific templates are developed.

The participants engaged in lengthy discussion regarding the level of specificity needed regarding dates of diagnosis and treatment. Arguments centered on the degree to which specific dates would affect the long-term care of the survivor. Ultimately, it was decided that recording the year of diagnosis was essential, with month of diagnosis desirable but not required. Survivors preferred to also include the exact day; however, it was agreed that knowledge of this would have no impact on treatment or follow-up care and would add to the burden of com-

Table 2. Key Components of Treatment Summary

Key Component
Contact information of the treating institutions and providers
Specific diagnosis (eg, breast cancer), including histologic subtype (eg, non–small-cell lung cancer) when relevant
Stage of disease at diagnosis (eg, I to III)
Surgery (yes <i>v</i> no); if yes: <ul style="list-style-type: none"> Surgical procedure with location on the body Date of surgery (year required, month optional, day not required)
Chemotherapy (yes <i>v</i> no); if yes: <ul style="list-style-type: none"> Names of systemic therapy agents administered (listing individual names rather than regimens) End date of chemotherapy treatment (year required, month optional, day not required)
Radiotherapy (yes <i>v</i> no); if yes: <ul style="list-style-type: none"> Anatomic area treated with radiation End date of radiation treatment (year required, month optional, day not required)
Ongoing toxicity or adverse effects of all treatments received (including those resulting from surgery, systemic therapy, and/or radiotherapy) at the completion of treatment; any information concerning the likely course of recovery from these toxicities should also be covered
For selected cancers, genetic or hereditary risk factors or predisposing conditions and genetic testing results if performed

pleting the treatment summary. Similar discussions ensued regarding whether to include specific dates of surgery as well as the start and end dates of chemotherapy and radiotherapy. Participants agreed that knowing the year in which these interventions took place was essential and including the month was desired. However, it was noted that having a diagnosis in December of one year and not having a procedure until January of the next year could be misleading if month was not included. It was felt that including the end date of each treatment was essential to include but the start date would have no impact on follow-up care.

Participants agreed it was important to include an active yes or no regarding whether surgery, chemotherapy, and/or radiotherapy were received by the patient to avoid the appearance that the information was missed or left out. Participants also agreed to combine surgical procedure and location into one element based on the assumption that surgical procedure would also define the location. Osteoporosis prevention, fertility, and sexual function were considered to be relevant if they were specifically associated with late and/or long-term effects of chemotherapy, radiation therapy, or surgery. Therefore, they should be addressed in the ongoing issues section when relevant. There was agreement that there should be a genetics section for predisposing conditions, to include any counseling or genetic testing received and results of testing and any relevant recommendations.

Follow-Up Care Plan

The follow-up care plan is meant to aid in the ongoing care of a cancer survivor by delineating the key components of survivorship care and providing:

1. Surveillance plan to detect recurrence and late adverse effects.
2. Interventions to manage ongoing problems resulting from the cancer and its treatment.
3. Age- and sex-appropriate health care, including cancer screening.
4. General health promotion.

During the consensus meeting, the group reviewed the IOM-recommended elements and reached consensus on items to include in the follow-up care plan (Table 3). Although many patients who have completed treatment may no longer be cared for in a facility, inclusion of the contact information for the oncology team members and location of the treatment facility is important should questions arise about the specifics of the treatment (eg, schedule and dosing of chemotherapy actually administered, doses, and fields of radiation, among others). This information may then be obtained from the original medical record available at the treating institution if needed.

Because many patients continue to undergo treatment (eg, adjuvant hormonal therapy for breast or prostate cancer) after completion of acute treatment (ie, surgery, chemotherapy, or radiation therapy), the group recommended that the follow-up plan include whether such ongoing therapy is advised, how long the therapy should continue, and what adverse effects may be

Table 3. Key Components of Follow-Up Care Plan

Key Component
Oncology team member contacts with location of the treatment facility (repeat if separate document)
Need for ongoing adjuvant therapy for cancer
Adjuvant therapy name
Planned duration
Expected adverse effects
Schedule of follow-up–related clinical visits (to be presented in table format to include who will provide follow-up visits and how often and where these will take place)
Cancer surveillance tests for recurrence (to be presented in table format to include who is responsible for ordering or carrying out the tests, the frequency of testing, and where these will take place)
Cancer screening for early detection of new primaries; to be included only if different from the general population (presented in table format to include who is responsible for carrying out tests, the frequency of testing, and where these will take place)
Other periodic testing and examinations (rather than outlining specific testing, the group suggested an inclusion of a general statement to “continue all standard non–cancer-related health care with your primary care provider, with the following exceptions: [if there are any]”)
Possible symptoms of cancer recurrence (rather than including a list of possible symptoms, the group suggested inclusion of a general statement: “Any new, unusual, and/or persistent symptoms should be brought to the attention of your provider”)
A list of likely or rare but clinically significant late and/or long-term effects that a survivor may experience based on his or her individual diagnosis and treatment if known (including symptoms that may indicate the presence of such conditions)
A list of items (eg, emotional or mental health, parenting, work/employment, financial issues, and insurance) should be covered with standard language stating that survivors have experienced issues in these areas and that the patient should speak with his or her oncologist and/or PCP if having related concerns; include a list of local and national resources to assist the patient in obtaining proper services
A general statement emphasizing the importance of healthy diet, exercise, smoking cessation, and alcohol use reduction may be included; statements may be tailored if particularly pertinent to the individual

Abbreviation: PCP, primary care provider.

expected. This information is important for both survivor and PCP education about follow-up care.

The group also recommended that the follow-up care plan include a schedule of clinical visits and suggested that this may be achieved in a table format (including who will provide the visit, where this visit will take place, and what will need to occur at this visit) to prevent too frequent or infrequent visits. The logistics for the follow-up visits must be developed in discussions with survivors and tailored to their needs, geographic locations, and other specifics. Likewise, the group recommended that evidence-based cancer surveillance testing for recurrence should also be included in a table format, outlining who is responsible for ordering or carrying out the test, how often and when the testing should occur, and where this will take place to avoid over- or undertesting. Finally, a similar recommendation was made to include cancer screening for new primary cancers, particularly if there was deviation from the general population guidelines (eg, early breast cancer screening for women who underwent chest irradiation for Hodgkin lymphoma). Inclusion of routine screening recommendations that are not different from the general population was not advised.

The group did not recommend the inclusion of itemized periodic testing and examinations that are standard of care for all patients. Rather, the group suggested including a general statement to “continue all standard non–cancer-related health care with your primary care provider.” The group did not recommend the inclusion of specific lifestyle or health promotion elements in the SCP. However, a general statement regarding exercise, nutrition, smoking, and alcohol use may be included (and tailored specifically to the patient if particularly relevant to his or her care).

Survivors and their providers are often concerned about recurrence. The group advised against including a comprehensive list of possible symptoms of cancer recurrence. Rather, the group suggested that the follow-up plan include a general statement, such as “any new, unusual, and/or persistent symptoms should be brought to the attention of your provider.” Similarly, the group advised against including an exhaustive list of late and/or long-term effects of treatment. Although SCPs are only as good as the information included, much remains unknown regarding the late or long-term effects of cancer therapy and how to address them. More research on these topics is warranted and could be included in the SCP as evidence develops. To educate survivors and their PCPs, the group suggested that a focused list of likely and rare but clinically significant effects be included and personalized to the individual’s treatment based on available evidence. Any information concerning the likely course of recovery from toxicities should be covered in the ongoing toxicity or adverse effects section of the treatment summary (rather than in the follow-up care plan).

Psychosocial effects of cancer treatment can be prominent, but they also are individual to the survivor. The group suggested that the follow-up care plan include a statement acknowledging that survivors often face emotional or mental health, parenting, work/employment, financial, and/or insurance issues. The statement should further advise that patients experiencing any of these issues address them with their oncology and/or PCP. However, the group noted that although PCPs may be able to manage many of the psychosocial issues survivors face, they may not have the resources to address other concerns that may be best managed by the oncology team. A list of local and national resources that is developed at individual sites should be provided, as needed.

Barriers to SCP Implementation

During the consensus meeting, the group discussed various barriers to implementation and how they might be overcome. The barriers included:

1. The substantial time required to complete an SCP.
2. Inadequate reimbursement for the time and resources required to complete the SCP.
3. Challenges in coordinating care among providers and between providers and survivors.
4. Incomplete penetration of EHR systems in the marketplace that can facilitate SCP completion.

Here, we briefly describe these issues and outline an agenda for evaluating the effectiveness of the revised SCP templates in addressing these barriers.

Time, resources, and reimbursement. Three of the major obstacles to adoption of SCPs have been the substantial time needed to complete the documents, the level of detail required, which substantially affects the time needed for completion, and the lack of reimbursement for completing the SCP, needed to support this effort.

Even if there are incremental reimbursements for a survivorship visit, if the SCP takes too long to complete, it will be impractical in the context of most busy oncology practices. Thus, the ASCO consensus meeting focused specifically on identifying the elements of SCPs that are both essential and feasible to collect. The resulting recommendations include substantially less detail than in the original ASCO templates. Importantly, the group agreed that the SCP document alone would not be sufficient to address the many and varied concerns or unmet needs that survivors have. ASCO and other organizations could develop resource toolkits for survivors as supplements to the information provided in the SCP.

Coordination among providers. A number of other barriers to survivorship care planning relate to coordination of care between and among providers, both cancer specialists and PCPs, as well as with survivors.¹⁴ Survivors are often left to navigate the SCP process on their own, and many do not have the ability to comprehend or advocate for the directives included. Furthermore, survivors may not have maintained or even had an established relationship with a PCP before or after their cancer diagnosis. Identifying or establishing a PCP at the time of diagnosis would facilitate this activity at the end of treatment. It will also be critical for organizations, cancer providers, and PCPs to establish effective SCP processes.

First, systems and processes are needed to coordinate collection of the relevant data from the multiple providers who may have been involved in delivering the cancer care (eg, medical oncology, radiation oncology, and surgery). Second, completed SCPs are only effective if they are distributed to and followed by the appropriate providers. A lack of integration, whether electronic or otherwise, between the PCP and oncology team could make communication of the SCP more difficult. There is a need to more clearly define not only who is responsible for completing and delivering the SCP but also which provider is responsible for following up on identified needs; this is especially important if care is received at different facilities. Thus, buy-in by the PCPs and other providers, at an individual and organizational level, is required if they are to take responsibility for aspects of follow-up. This buy-in may be encouraged through education of PCPs and other nononcology providers on the value and use of the SCP document. Cancer programs should also have relationships with PCPs to make referrals for those survivors who do not have a PCP. Survivors should be aware of the details for follow-up care using the SCP.

Role of technology. Throughout the discussions, technology in general, and EHRs in particular, were seen as having great but unrealized potential to facilitate the SCP process. For example, automated alerts and reminders can help ensure that SCPs are completed for and delivered to eligible survivors when treatment ends. Given that the information required in the SCP may come from multiple providers, centralized information technology systems through which multiple users can input or access information can be helpful, greatly facilitating gathering the necessary information needed to complete the SCP.

Although the group recognized the potential of technology to facilitate the SCP process, they equally noted that this potential will not be fulfilled until a number of barriers are addressed. These barriers include:

1. Lack of EHR adoption by some providers.
2. Challenges in interoperability across EHR software systems.
3. Limited ability of EHRs to autopopulate treatment summary and SCPs.
4. Difficulty providing plain-language summaries and direction for patients and their PCPs.

The long-term goal for treatment summaries and care plans is to be largely populated directly from data in the EHR; this is an important goal that ASCO and other stakeholders will continue to pursue.¹⁵ As EHR vendors continue to develop ways to facilitate the SCP process and to take full advantage of the functionality of EHRs, we suggest that additional functionality be built to make the extractable data more comprehensive and usable to more users. Examples of how an EHR could expand this functionality include:

1. Surveillance tests, such as laboratory and imaging tests, could be ordered in advance and on a regular schedule (CEA every 3 months, computed tomography in 1 year), with electronic reminder messages sent to the patient (this feature already is in routine usage in other diseases).
2. Alerts could be sent to providers when a test is overdue.
3. Patients could also enter online their toxicity experiences and other patient-reported outcomes.

Evaluating Feasibility of Using Revised ASCO SCP Template in Clinical Practice

The revised SCP template (Data Supplement) was evaluated to determine whether the modifications decrease the time and resources required to complete the forms and increase the feasibility of successful implementation. After obtaining institutional review board approval, a pilot study among QOPI practices was undertaken to test the revised SCP between May and June 2014. QOPI sites with both high and low rates of SCP completion were invited to participate. They were given the new SCP templates and asked to complete them for three to five patients. A follow-up telephone interview assessed time to completion, along with other information. These assessments included who completed the plans (eg, oncologist, nurse practitioner, or nurse), how long it took to complete the templates, and any other comments on the clarity of the form. A

Table 4. Pilot Study of Revised SCP Template (N = 45 SCPs completed from 11 practice sites)

Item	Scale of 1 (strongly disagree) to 5 (strongly agree)	
	Mean	Range
SCP was easy to complete	3.5	1 to 5
Time to complete SCP was reasonable	3.5	1 to 5
Clear what information was needed	3.9	3 to 5
Easy to obtain information for SCP	4.1	2 to 5
Template includes important elements for SCP	4.5	3 to 5
Information is sufficient for SCP	4.1	3 to 5
Template will be useful in discussing follow-up care plans	4.7	3 to 5
Average time to complete (range depended on complexity of patient's treatment and familiarity with the template), minutes	30	10 to 75
Who completed SCP		
Nurse practitioner	4	
Nurse	3	
Nurse with administrator or clerical personnel	2	
Physician	1	
Social worker	1	

Abbreviation: SCP, survivorship care plan.

total of 45 SCPs were developed and delivered by 11 QOPI practices. Most practices found this template easier to use than the previous version. Time to completion varied based on patient complexity and familiarity with the form; times averaged 30 minutes, with a range of 10 to 75 minutes. Practices were asked to rate the SCP on a scale of 1 (strongly disagree) to 5 (strongly agree). Results (listed in Table 4) showed the following:

1. The SCP was easy to complete (mean score, 3.5).
2. Time to complete the templates was reasonable (mean score, 3.5).
3. It was clear what information was needed (mean score, 3.9).
4. It was easy to obtain the information (mean score, 4.1).
5. Overall, the template includes important elements for survivorship care planning (mean score, 4.5).
6. The information is sufficient for an SCP (mean score, 4.1).
7. The template will be useful in discussing follow-up care plans (mean score, 4.7).

Although one site found the SCP redundant to a survivor binder that was given to patients at that practice, a majority of comments were favorable, and suggestions for improvement were incorporated into the template.

Discussion

It is important to demonstrate the value of SCPs to survivors, oncology providers, PCPs, and other providers. Important end points include improved knowledge of and adherence to appropriate follow-up, better identification and management of long-

term and late effects, and improved coordination among cancer and noncancer providers. As EHR technology continues to develop, it will also be useful to complete the template. Once SCPs are adopted on a wider scale, their value for improving the process of survivorship care planning should be evaluated, and other questions regarding improved outcomes can and must be addressed by well-designed and executed research and implementation studies.^{12,16,17}

The cancer survivorship document is designed to serve the needs of patients and their families and PCPs. We acknowledge the importance of other data elements of interest to treating oncologists and researchers that can be captured and communicated more readily digitally than on paper and that the ASCO HL7 draft standard clinical oncology treatment plan and summary is designed to capture more robust amounts of data and flexibly present that data specific to users' needs, be they patients or physicians or researchers.¹⁵

Future studies will be required to determine if there is an increased uptake of the SCP to ensure that patients and PCPs are receiving adequate information about the course of care and to understand what barriers may or may not have been addressed. Furthermore, disease-specific templates and support tools may be considered for future development. Once these

actions are taken, we may have a better understanding of what benefit the SCP has in the quality of care for cancer survivors.

Authors' Disclosures of Potential Conflicts of Interest

Disclosures provided by the authors are available with this article at jop.ascopubs.org.

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