

CANCER SURVIVORSHIP CHECKLIST: A GUIDE FOR CLINICIANS

Overview:

- Individuals living with cancer should be provided with information and resources to guide them through the transition from active treatment to surveillance.
- For individuals living with metastatic disease, ongoing maintenance treatment and surveillance should be tailored to the individual's unique needs.
- Clinician is defined as a physician or advanced practice provider.

Survivorship Care Plan and Treatment Summary (SCP):

- Begin discussion at diagnosis with individual patient regarding purpose of survivorship care.
- Work with IT department and/or tumor registry to implement within EHR using available templates (i.e. ASCO).

Coordination of Health Care:

Towards end of active treatment and reinforced at last treatment visit

- Clinician addresses surveillance guidelines for medical tests post-treatment.
- Clinician addresses psychosocial concerns as well as long-term and late effects with patient.
- Clinician reviews signs and symptoms to report and ensures that patient has a point-of-contact to answer their questions or concerns (oncology nurse/oncology nurse navigator).
- Provides referrals as necessary for psychosocial support and/or rehabilitation.
- Discuss the importance of wellness as part of cancer risk reduction. This includes tobacco cessation, maintaining a healthy weight, nutrition, and exercise guidelines.
- Clinician provides SCP to all individuals involved in the patient's care, including the patient, and loads in EHR.

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Coordination of Health Care:

At follow-up visits post-treatment

- Patient receives complete physical exam and history.
- Biomarker, lab testing, and imaging exams are ordered as recommended per evidence-based guidelines (i.e. NCCN, ASCO), and then results are reviewed.
- Assess and address physical and psychosocial long-term effects of treatment, including financial concerns, changes in insurance, and barriers to care (transportation, housing instability, food insecurity, unemployment/job concerns, and safety) that can affect adherence to maintenance therapy and surveillance.
- Assess how patient is coping with roles/relationships with partner, family, co-workers, and others.
- Refer patient to appropriate resources within health system/community to assist with effects of treatment (i.e. social work, psychology, support groups, rehabilitation, and dietitian).
- Patient is included in decision-making regarding follow-up care and receives information on risk reduction, wellness, and next steps in surveillance plan of care.
- Patient and clinician mutually agree when to begin alternating care between oncology team and primary care and when to transition care from oncology team to primary care.

For more information on Survivorship Champions, please visit:

www.canceradvocacy.org/resources/survivorship-champions-program/.

References:

National Coalition for Cancer Survivorship (NCCS). Survivorship Checklist. www.canceradvocacy.org/resources.

National Comprehensive Cancer Network Clinical Practice Guidelines in Oncology (NCCN). Survivorship. Version 3.2021-August 23, 2021. www.nccn.org/survivorship. 10.5.21.

