

Service Assessment Questionnaire: Providing Survivorship Care

The questions below are designed to assist with the identification of strengths and weaknesses that exist within the practice or care center, and the surrounding community which can then be used to develop the strategy to plan and implement a survivorship care program.

1. Oversight of the program should be housed within an integrated but separate entity within the practice to which it will have accountability. Given this, who will have oversight of the program?
2. What services or post-treatment programs are feasible for your facility to provide?
 - a. Medical follow-up care
 - b. Psychosocial services
 - c. Educational opportunities for patients and providers
 - d. Survivorship research
 - e. Palliative care/symptom management
3. Does your practice have access to electronic medical records and/or patient portals through which coordination and education can be conducted? If not, how will coordination of care and communication with the patient and other members of the care team be done?
4. What resources (including physical, personnel and financial) are available to you?
5. What programs or services are already available within your practice or facility? Within your community?
6. Is there clinical staff with the appropriate expertise within your facility? Within your community? If not, is training available?
7. Are there non-clinical skills among staff that can be optimized to support the survivorship care program (i.e. an assistant with strong internet research skills who could help identify resources within the extended community)?
8. What existing programs could be expanded to include post-treatment patients?
 - a. Support groups (disease or age specific, or family/caregivers)
 - b. Patient education opportunities (online, in-person lectures, individual education during encounters)
 - c. Counseling (including both psychological and financial)
 - d. Complementary medicine (e.g., yoga, acupuncture)
 - e. Palliative care/symptom management
 - f. Physical rehabilitation
 - g. Sexual/reproductive health
 - h. Genetic counseling

- i. Nutrition services
 - j. Smoking cessation
9. What patient populations can you serve (pediatric, AYA, adult)?
 10. How diverse is the survivor population available for long-term follow-up care (types of cancer and treatments received)?
 11. How many patients will be cared for in your facility's program?
 12. How large is the geographic area served by your facility? Is it convenient for patients to continue to return to the treatment facility?
 13. Will the majority of patients treated at your facility have received minimal treatment exposures, or will you have more complex patients (e.g. bone marrow transplant recipients) requiring more intense therapies placing them at greater risk for late and long-term effects?
 14. How might you provide support to the survivor's extended network of family and caregivers? Who will be responsible for addressing family and care giver needs?
 - a. Oncologist
 - b. Nurse practitioner
 - c. Physician assistant
 - d. Primary care physician
 - e. Multidisciplinary team
 15. Though care will be on-going throughout the life of the survivor, will the continued provision of survivorship services be delivered:
 - a. within your practice,
 - b. mostly referred out but primary coordination of patient care remains internal,
 - c. or done as needed on a consultant basis?

Depending on the answers to the questions above, your facility may consider one of or a hybrid of the suggested model types detailed below:

Method of Care Delivery (<i>Services are Provided at the Facility, Referred Out, or Combination</i>)	Consider This Model Type
Care is coordinated/provided by any combination of specialists, primary care physicians, nurses, and/or patient-directed	Shared-Care of Survivor

Care is provided by a specialized long-term effects team in a separate clinic outside of the oncology practice setting	Multi-Disciplinary Survivorship Clinic
Care occurs as a continuation in the oncology setting	Oncology Specialist Care
The Primary Care Physician (PCP), advanced practice nurse, or internist within the community provides care	Community Generalist Model
Initial follow-up is provided in the cancer center with an eventual transition to a PCP; patient may be directed back to the cancer center for needed services at the direction of the PCP	Consultative Survivorship Clinic
Type and intensity of follow-up care is determined by type of cancer treatment received	Disease/Treatment Specific Survivor Clinic
Care will be provided by MD, NP, or PA (not multi-specialty) and implemented at a cancer center, community hospital, or private practice.	General Survivorship Clinic
Care is provided within the oncology setting, which may be located with a cancer center, community hospital or private practice, and may be provided by an MD, NP or PA. Care is coordinated with the PCP and other specialists as needed.	Integrated Survivorship Clinic