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Following through: The consistency of survivorship care plan use in United States cancer programs

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Abstract

Background—The Institute of Medicine suggests that consistent survivorship care plan (SCP) use involves developing and delivering SCPs to all cancer survivors and their primary care providers (PCPs). We describe the consistency of SCP use in US cancer programs and assess its relationship with cancer program-level determinants.

Methods—We surveyed employees knowledgeable about survivorship practices in cancer programs reporting current SCP use (n=36; 81% response rate). We operationalized consistent SCP use as whether SCPs were (1) developed for 75% survivors; (2) delivered to 75% survivors; (3) delivered to 75% PCPs; and (4) all of the above. We use descriptive statistics to report SCP use consistency and evaluate associations using Fisher's Exact and Wilcoxon Rank Sum tests.

Results—SCPs were developed for 75% survivors in five programs (15%); eight (25%) delivered 75% SCPs to survivors; seven (23%) delivered 75% SCPs to PCPs; only one program (4%) met all three criteria. We found relationships between SCP use consistency and geographic

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region ($p = .05$); initiating SCP use in response to survivors' requests ($p = .03$); and membership in the National Cancer Institute's National Community Cancer Centers Program ($p = .01$).

Conclusion—SCP use is highly inconsistent. Survivors and cancer care quality improvement organizations may play a key role in improving the consistency of SCP use in US cancer programs. Survivors can initiate SCP use. Cancer care quality improvement organizations can specify how cancer programs' compliance with SCP guidelines will be assessed. Future research should identify mechanisms underlying the relationships that we found.

Keywords

Survivorship care plan; health care quality; barriers; cancer program

Introduction

The transition from cancer treatment to follow-up care is often difficult for the nearly 14 million cancer survivors in the United States [27]. Survivors have unique physical, psychological, social, and spiritual health needs that are optimally addressed through the prevention and detection of new cancers, surveillance for cancer spread or recurrence, intervention for consequences of cancer and its treatment, and coordination between oncologists and primary care providers (PCPs) [16, 7, 29]. Optimal care may be compromised by PCPs' and oncologists' conflicting perspectives on their roles in survivorship care, which may result in the duplication or omission of services [5, 10, 24]. Survivors often report feeling poorly educated regarding psychological, social, and sexual health issues and their risk for recurrence, and they report being dissatisfied with care following cancer treatment [15, 1, 21, 18].

Citing the unmet needs of US cancer survivors, the Institute of Medicine (IOM) report *From Cancer Patient to Cancer Survivor: Lost in Translation* recommended survivorship care plans (SCPs) as tools for improving communication among oncologists, survivors, and PCPs [16]. SCPs are written documents that often, but not always, include a summary of cancer treatment and recommendations for surveillance, preventive care, wellness behaviors, and symptoms to report following treatment. The IOM report suggested that *high-quality SCP use* involves including in SCPs each element of the IOM's framework (e.g., likely course of recovery). The report suggested that *consistent SCP use* involves developing and delivering SCPs to all survivors and their PCPs.

Evidence suggests that few cancer programs meet the IOM's recommendations for high-quality SCP use [28, 26]; the extent to which cancer programs meet the IOM's recommendations for consistent SCP use is less clear. In a previous study, we found a discrepancy between SCPs development and delivery to survivors and PCPs across US cancer programs [4]. The extent to which SCPs are developed but not delivered within cancer programs is unknown. If SCPs are not developed and delivered to all survivors and their PCPs – that is, used consistently – then the intent underlying the IOM's recommendation to use SCPs as a tool to foster communication among survivors, oncologists, and PCPs will not be met, regardless of content.

In this paper, we (1) describe SCP use consistency in US cancer programs and (2) assess relationships between SCP use consistency and hypothesized determinants (e.g., cancer program characteristics). In so doing, we fill a gap in the literature and describe current levels of compliance with SCP use guidelines. Results also encourage cancer care quality improvement organizations to consider how to assess compliance with guidelines. Specifically, is developing high-quality SCPs sufficient to comply with guidelines, or is delivering SCPs to survivors and their PCPs also necessary for compliance? This clarity and knowledge of factors that promote consistent SCP use may aid cancer programs in effectively implementing SCPs.

Methods

Study sample

We conducted a cross-sectional survey of cancer programs throughout the US with a wide range of annual incident cancers, program types, and cancer care quality improvement organization (e.g., Commission on Cancer [CoC]) memberships. A sampling frame was created for programs with membership in at least one of the following cancer care quality improvement organizations: CoC [8], the Association of Community Cancer Centers [3], the National Comprehensive Cancer Network [20], and/or the American Society of Clinical Oncology's Quality Oncology Practice Initiative [2]. We took this approach because CoC programs serve 80 percent of all newly diagnosed US cancer patients [8]; therefore, our sampling frame included programs that serve the majority of US cancer survivors. We improved upon these figures by including programs that were members of cancer care quality improvement organizations other than CoC.

After eliminating programs with the same name in the same state, 1,991 programs were included in the sampling frame. We eliminated another 141 programs that were duplicate listings of programs with different names but the same location and/or staff. The final sampling frame included a total of 1,850 programs. Given the time-consuming process of identifying potential survey respondents (employees with knowledge regarding survivorship practices; see below) from these 1,850 programs, we drew a simple random sample of 100 programs (5%).

Survey development

The survey was based on a review of the Institute of Medicine's report: *From Cancer Patient to Cancer Survivor: Lost in Transition* [16] and scientific literature. A team of experts developed the survey. Survivorship experts, including a practicing provider of breast cancer survivorship care, ensured that the survey reflected relevant clinical and policy issues, such as the importance of developing and delivering SCPs to survivors and their PCPs, and activities of key cancer care quality improvement organizations. Experts in dissemination and implementation of innovations in cancer care ensured that the survey reflected key indicators of SCP use consistency. Survey methodologists promoted the likelihood that potential respondents would complete the survey. We also refined the survey based on cognitive interviews with 8 employees who had knowledge of survivorship practices in programs not included in the final study sample. Survey items were phrased to elicit

responses regarding SCP use any time in their program's history. The final survey consisted of 15 items (see Table 1).

Survey respondent identification

We acknowledge that SCP use consistency may vary within cancer programs. However, given our objective of identifying organization-level determinants of SCP use consistency, we sought a single respondent per program who could answer questions about their program's characteristics (e.g., annual incident cancers). The following method was used to identify potential respondents. A research assistant used publicly available information to call sampled programs to identify employees with knowledge regarding survivorship practices who could respond to the survey. The research assistant asked for someone in the program who knew about how the program's survivors were transitioned to follow-up care after treatment was complete. This process continued until the research assistant identified an employee in the program who would be able to answer questions regarding (1) whether or not SCPs were used in the program and (2) reasons why SCPs were or were not used in the program. The research assistant collected a specific address, direct phone number, and email address for the employee.

Survey administration

The survey was conducted between January and May 2013 using the standards of Dillman's Total Design Method [9]. Initially, depending on the availability of an email address, we sent an email or a letter to respondents letting them know that they would soon receive an invitation to complete the survey. Three days later, we sent an introductory email with a link to an online version of the survey or an envelope containing a cover letter, survey, and return envelope. Emails or postcards were sent to thank respondents who completed the survey and to remind non-respondents to complete the survey. Two weeks after the initial survey mailing, replacement surveys were sent to non-respondents by first class mail or email. Two weeks later, non-respondents were called to request a response. This pattern repeated, allowing two-week intervals between contacts for as many as ten total attempts. Upon completing the survey, respondents had the option of being entered into a raffle to win an iPad. An employee with knowledge of survivorship practices from 81 of the 100 programs contacted completed the survey (81% response rate). The sample for the study reported here includes cancer programs in which respondents reported that SCPs were used at the time of the survey ("regularly" or "sometimes"; $n = 36$). The other 45 respondents reported that SCPs were not used in their cancer programs at the time of the survey, so they were excluded from the present study. The institutional review board at the University of North Carolina at Chapel Hill exempted the study from human subjects review.

Variable descriptions

Survey items and response options are listed in Table 1. To measure *SCP use consistency*, we asked respondents, to the best of their ability, to estimate the percentage of survivors for whom SCPs were developed and the percentages of survivors and PCPs to whom SCPs were delivered. We operationalized *consistent SCP use* in four ways: SCPs were (1) *developed* for at least 75 percent of the cancer program's *survivors*; (2) *delivered* to at least 75 percent

of *survivors* for whom an SCP was developed; (3) *delivered* to at least 75 percent of survivors' *PCPs*; and (4) all three of the above (see Table 2).

Determinants of SCP use consistency—Cancer programs may be more likely to use SCPs consistently when the motivation, means, and opportunity exist [30]. To assess *motivation* to use SCPs consistently, we asked respondents why SCPs were used in their programs (e.g., survivors requested SCPs). To assess whether or not cancer programs had the *means* to use SCPs consistently, we asked respondents about barriers to SCP use in their program. We operationalized the *opportunity* to use SCPs consistently as cancer program characteristics that might increase their chances of consistently using SCPs. For example, studies have shown relationships between health services utilization and geographic location [23, 12, 31, 13]. To assess geographic variation in SCP use consistency, we captured programs' *location* using ZIP codes. When available, ZIP codes were converted to rural/urban indicators using Rural-Urban Commuting Areas data [25]. ZIP codes were identified as a rural or urban subtype; subtypes were aggregated into dichotomous rural and urban categories. To assess variation in SCP use consistency across program size, we operationalized *annual incident cancers* as a program's unduplicated number of cancer patients. American College of Surgeons assigns the *program types* listed in Table 1 based on organization type (e.g., academic), services provided, and number of cancer patients served [2]. To assess variation in SCP use consistency associated with *cancer care quality improvement organizations'* SCP use guidelines and recommendations, we asked respondents whether their program was a member of one of the organizations listed in Table 1. Since program members' professional background may influence their perspective on SCP use, respondents were also asked which *position* they held at their program at the time of the survey.

Analysis

The unit of analysis was the program. To describe SCP use consistency and program and respondent characteristics, we report response frequencies and percentages with 95% exact binomial confidence limits around select percentages. To compare (1) respondents to programs in the sampling frame not randomly selected for inclusion in the study sample and (2) programs that consistently used SCPs to those that did not consistently use SCPs, we used Wilcoxon Rank Sum tests for continuous independent variables (e.g., annual incident cancers) and Fisher's exact tests for categorical independent variables (e.g., program type). Unadjusted two-tailed p-values are reported. Relationships between variables were considered significant at the $p < .05$ level. Analyses were conducted using SAS statistical software v9.3 (Cary, NC).

Results

There were no differences in location, annual incident cancers, or program type between programs that returned surveys and programs that were not included in the sample (all $p > .13$).

Descriptive statistics

SCP use consistency—The majority of respondents (25/36; 69%; CI: 52–84%) indicated that SCPs were used for fewer than half of survivors in their programs. In most programs, SCPs rarely reached their intended audience: Most respondents reported that SCPs were delivered to 50% or fewer survivors (22/35; 63%; CI: 45–97%) or their PCPs (22/36; 61%; CI: 43–77%).

Table 2 contains descriptive statistics for variables representing SCP use consistency. Respondents did not always know the answers to the survey questions, so not all programs could be classified. Few cancer programs consistently used SCPs: Fifteen percent of respondents (5/33; CI: 5–32%) reported that SCPs were *developed* for at least 75 percent of the cancer program's survivors; a quarter (8/32; CI: 11–43%) *delivered* at least 75 percent of *SCPs* to survivors for whom an SCP was developed; a quarter (7/30; CI: 10–42%) *delivered* at least 75 percent of SCPs to survivors' *PCPs*; and only one program of 26 (4%; CI: 1–20%) *developed and delivered* SCPs to at least 75 percent of survivors and their *PCPs*.

Hypothesized determinants of SCP use consistency—Barriers to SCP use. The most commonly reported barrier to SCP use was lack of resources (80%). Other commonly cited barriers included the perception that SCPs are difficult to use (29%), that influential people (e.g., physician champions, managers) had not advocated for SCPs to be used (26%), and the perception that SCPs are not useful (20%). Few respondents cited other barriers, such as the perception that influential people's advocacy does not motivate providers to use SCPs (9%), that providers do not feel confident in using SCPs (6%), or lack of opportunities to use SCPs (3%).

Reasons for SCP use. The most commonly cited reason for using SCPs was the CoC's 2012 program standards (75%). Other commonly cited reasons were the belief that SCP use may improve quality of care (69%), National Comprehensive Cancer Network guidelines (47%), American Society for Clinical Oncology guidelines (39%), and the National Cancer Institute's National Community Cancer Centers Program (NCCCP) guidelines (39%).

Cancer program characteristics. Two respondents were physicians (6%), 8 were nurse practitioners (23%), 14 were registered nurses (40%), 6 were other clinical staff (17%), and 5 were non-clinical administrative staff (14%). Respondents reported an average of 1,280 annual incident cancers (range 1–14,000) in their programs. A third of respondents were employed in community comprehensive cancer programs (29%), a quarter (24%) came from academic cancer programs, a fifth were employed in community hospital cancer programs (20%), and less than 10 percent of sampled programs fell into other program type categories, including National Cancer Institute comprehensive cancer programs and pediatric cancer programs. Most respondents' programs were members of CoC (83%). Forty-three percent of respondents were members of the Association of Community Cancer Centers. A third of respondents were members of the American Society of Clinical Oncology's Quality Oncology Practice Initiative (34%) and National Comprehensive Cancer Network (33%). A quarter of respondents' programs were members of the National Comprehensive Cancer Control Program (23%). Most cancer programs were located in the Midwestern US (38%); nearly a third (29%) were in the South; eighteen percent were in the West; and fifteen

percent were in the Northeast. Ninety-one percent were in urban locations; nine percent were rural.

Relationships between SCP use consistency and hypothesized determinants

SCPs developed for at least 75 percent of the cancer program's survivors—

Differences among regions were detected with respect to whether or not SCPs were developed for at least 75 percent of cancer programs' survivors ($p = .05$). In particular, cancer programs in the Northeast delivered SCPs for at least 75 percent of their survivors 40 percent (2/5) of the time, whereas cancer programs in the West, Midwest and South reported doing so infrequently (0 percent [0/5], 0 percent [0/12], and 20 percent [2/10], respectively). Other hypothesized relationships were not statistically significant.

SCPs delivered to at least 75 percent of survivors—We found no statistically significant relationships between hypothesized determinants and whether or not SCPs were delivered to at least 75 percent of survivors for whom an SCP was developed.

SCPs delivered to at least 75 percent of survivors' PCPs—Regional differences were detected with respect to whether or not SCPs were delivered to at least 75 percent of survivors' PCPs ($p = .02$). In particular, cancer programs in the Northeast delivered SCPs to at least 75 percent of survivors' PCPs 80 percent of the time (4/5), whereas cancer programs in the West, Midwest and South did so infrequently (17 percent [1/6], 10 percent [1/10], and 11 percent [1/9], respectively). Using SCPs per survivors' request was positively associated with delivering SCPs to at least 75 percent of survivors' PCPs ($p = .03$): Seventy-five percent (3/4) of programs that began using SCPs per survivors requests delivered them to survivors' PCPs 75 percent of the time, compared to only 15 percent (4/26) of those that began for other reasons. Other hypothesized relationships were not statistically significant.

SCPs developed for at least 75 percent of the cancer program's survivors and delivered to at least 75 percent of survivors and their PCPs—Only one program indicated that SCPs were developed and delivered to both survivors and their PCPs at least 75 percent of the time. As such, associations were not assessed for this indicator of SCP use consistency.

SCPs delivered to at least 75 percent of survivors and their PCPs—In post-hoc analysis, we assessed another measure of SCP use consistency: whether SCPs were delivered to at least 75 percent of survivors and their PCPs (this measure eliminated the requirement that SCPs be developed for at least 75 percent of the cancer program's survivors). Five respondents' cancer programs (14 percent [5/28]) met this definition of SCP use consistency. We found that members of NCCCP were more likely to deliver SCPs to both survivors and their PCPs compared to those that were not members (50 percent [4/8] versus 5 percent [1/20]; $p = .01$).

Discussion

The IOM suggested that consistent SCP use involves developing and delivering SCP to all survivors and their PCPs [16]. Evidence of the extent to which SCPs are used consistently is

scant. In this paper, our objectives were to (1) describe SCP use consistency in US cancer programs and (2) assess relationships between SCP use consistency and hypothesized determinants. Our results suggest that SCP use is highly inconsistent in US cancer programs. Few cancer programs develop SCPs for all survivors, let alone deliver SCPs to all survivors and their PCPs. In fact, we found that only one cancer program used SCPs according to IOM recommendations, developing and delivering SCPs to all survivors and their PCPs. We describe several possible explanations for the gap that we found between SCP development and delivery elsewhere [4]. Briefly, cancer programs may not have fully implemented SCPs at the time of the survey – nearly two years before SCP use requirements take effect; programs may lack the resources to deliver SCPs; or they may develop SCPs to meet minimum standards for compliance with cancer care quality improvement organizations' SCP use requirements.

Interestingly, our results suggest that SCPs reach PCPs almost as often as they reach survivors. This is surprising, given that delivering SCPs to PCPs requires an additional step for cancer programs or survivors. Our finding that SCPs were more frequently delivered to PCPs in cancer programs that began using SCPs per survivors' request may offer clarity: Survivors who request SCPs may be motivated to ensure that their PCPs receive a copy. Our cross-sectional study design limits our ability to infer causality, so reverse causality is possible: Survivors who were more likely to request SCPs may have chosen cancer programs that offer SCPs; however, survey item wording minimizes this possibility (see Table 1). Consistent SCP use was also positively associated with NCCCP membership; NCCCP's SCP use goals and support may facilitate SCP use.

We also found regional variation in SCP use consistency. The patterns that we detected are aligned with studies that have found geographic variation in the use of other health services [23, 12, 31, 13]. In particular, SCPs are more consistently used in the Northeastern US. Scholars have suggested that variation may be attributed to regional variation in sociodemographics and payment structures. The extent to which these factors apply to SCP use consistency is unclear. Evidence of disparities in the receipt of SCPs across sociodemographic factors including survivor age and gender exists [17], but it is unclear whether disparities exist across regions. Anecdotal evidence suggests that some cancer programs have identified mechanisms for reimbursement for activities related to SCP use, but whether geographic variation in reimbursement opportunities exists is unclear.

Limitations

Our study has several limitations. Survey items were not validated. Consequently, respondents may have varied in how they interpreted the items about SCP development and delivery despite our effort to word survey items to emphasize the distinction between SCP development and delivery (see Table 1). Measurement bias may have contributed to our nonsensical finding that there were more respondents who reported delivering an SCP to at least 75 percent of survivors and their PCPs than respondents who reported developing and delivering an SCP to at least 75 percent of survivors and their PCPs; ostensibly, an SCP must be developed prior to delivery. Further, we did not ask respondents to distinguish between reasons and barriers to SCP development and SCP delivery. This limits our ability

to assess relationships between SCP use consistency and hypothesized determinants. Measurement bias emphasizes the need for the development of measures in dissemination and implementation research [11]. Validated measures will promote stronger research in a rapidly developing field. In addition, social desirability bias may have caused respondents to over-report SCP use.

Our sampling frame may not have been accurate. Using cancer care quality improvement organizations' websites to develop the sampling frame may have resulted in duplicates, despite our efforts to eliminate them. Also, our sampling frame excluded programs that are not members of at least one cancer care quality improvement organization; however, our sampling frame included all CoC programs, which serve 80% of all newly diagnosed US cancer patients [8].

Our sample size limited our ability to detect small but potentially meaningful relationships between SCP use consistency and hypothesized determinants. We were unable to conduct some analyses because, for example, only one cancer program reported that SCPs were developed and delivered to at least 75 percent of survivors and their PCPs. Future studies may be able to assess these relationships because SCP use will likely increase when CoC SCP use program standards go into effect in 2015.

Implications

Despite the limitations described above, our findings have implications for cancer care quality improvement organizations, cancer programs, providers, and survivors. Amidst pervasive evidence of poor communication between oncologists and PCPs [6, 24], recent scholarship emphasizes the need to ensure SCPs' practical and clinical benefits [22]. However, the focus on studying SCPs' effectiveness may be premature until SCPs are more routinely used. In light of the inconsistent SCP use we found in this study, SCP effectiveness trials may yield null findings: Effectiveness can only be assessed if SCPs are used in practice. This suggests that cancer care quality improvement organizations' efforts should be targeted at supporting programs in implementing quality improvement tools such as SCPs.

In particular, our results suggest that cancer programs may lack direction regarding how to comply with SCP use guidelines. The discrepancy between SCP use development and delivery may reflect confusion regarding how to address SCP use guidelines. Cancer care quality improvement organizations may promote consistent SCP use by specifying how adherence to guidelines will be assessed. Specifically, is developing SCPs sufficient, or must they also be delivered to comply with guidelines? Clearer guidelines may aid cancer programs in effectively implementing SCPs. In turn, effective SCP implementation will promote effectiveness trials' validity. Results will inform optimal practices; ideally, optimal practices minimize the amount of time providers spend on ineffective practices and maximize survivors' benefit.

Future research

In this study, we explored a broad range of barriers to SCP use consistency; previous studies have focused on lack of resources [14, 19]. Although results were not statistically significant, approximately one quarter of respondents reported that barriers to SCP use in

their cancer program included the perception that SCPs are difficult to use and that influential people (e.g., physician champions, managers) have not advocated for SCPs to be used. Future research should more closely explore these barriers to SCP use. Future research should also identify mechanisms underlying relationships between SCP use consistency and survivors' requests for SCPs, membership in NCCCCP, and geographic region. For example, does a survivor's request for SCPs initiate conversations that encourage providers to prioritize SCP use? Are NCCCCP SCP use goals particularly helpful in promoting consistent SCP use? Are there characteristics of regions in which SCPs are inconsistently used that suggest alternate approaches to promoting SCP use? For example, are electronic health records that can be transmitted from oncologists to PCPs particularly important in low-density areas including parts of the Midwest?

Reliable and valid measures of SCP use consistency and its determinants must be developed. For example, it remains unclear whether developing SCPs and including them in health records is sufficient, or if SCPs must be delivered to survivors and their PCPs to qualify as effective SCP use. Reliable and valid measures will bring us closer to understanding determinants of SCP use consistency; understanding determinants of SCP use consistency will help to target efforts to promote SCP use consistency and, in turn, the potential for survivors to benefit from SCPs.

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Table 1

Survey item response options and frequencies (n = 36)

#	Item	Response options	Frequency (%)
1	For approximately what percentage of all survivors in your cancer center are SCPs developed? <i>Please check one percentage or check "Don't Know."</i>	0–25%	17 (47.22)
		26–50%	8 (22.22)
		51–75%	3 (8.33)
		76–100%	5 (13.89)
		Don't know	3 (8.33)
2	Approximately what percentage of SCPs is delivered to survivors? <i>Please check one percentage or check "Don't Know."</i>	0–25%	16 (45.71)
		26–50%	6 (17.14)
		51–75%	2 (5.71)
		76–100%	8 (22.86)
		Don't know	3 (8.57)
3	Approximately what percentage of SCPs is delivered to survivors' primary care providers? <i>Please circle one percentage or check "Don't Know."</i>	0–25%	19 (52.78)
		26–50%	3 (8.33)
		51–75%	1 (2.78)
		76–100%	7 (19.44)
		Don't know	6 (16.67)
4	Why did/will your cancer program begin using SCPs? <i>Please check all that apply.</i>	Desire to comply with American College of Surgeons (ACoS) Commission on Cancer (CoC) cancer program 2012 standards	28 (77.63)
		Desire to comply with Association of Community Cancer program (ACCC) 2009 guidelines	7 (18.42)
		Desire to comply with National Coalition for Cancer Survivorship (NCCS)/Lance Armstrong Foundation recommendations	3 (9.21)
		Desire to comply with American Society for Clinical Oncology (ASCO) practice guidelines	16 (43.42)
		Desire to comply with National Comprehensive Cancer Network (NCCN) guidelines	19 (53.95)
		Desire to comply with National Cancer Institute (NCI) Community Cancer Centers Program (NCCCP) guidelines	10 (28.95)
		Institute of Medicine's (IOM) <i>From Cancer Patient to Cancer Survivor</i> raised awareness	8 (21.05)
		Grant-funded SCP use project raised awareness	2 (5.26)
		Colleague(s) raised awareness	8 (21.05)
		Competing cancer program that uses SCPs raised awareness	3 (9.21)
		It's a commonly accepted practice	6 (15.79)
		Belief that it may improve quality of care	27 (75.00)
		Survivors requested SCPs	5 (14.47)
Other _____	4 (10.53)		
5	In your opinion, what are barriers to SCP use in your cancer program? <i>Please check all that apply.</i>	Perception that SCPs are not useful.	4 (11.84)
		Perception that SCPs are difficult to use.	10 (28.95)

#	Item	Response options	Frequency (%)
		Influential people (e.g., physician champions, managers) have not advocated for SCPs to be used.	9 (23.68)
		Influential people (e.g., physician champions, managers) advocating for SCPs to be used does not motivate providers to use SCPs.	3 (9.21)
		There are not enough resources (e.g., time, staff, training, money) to use SCPs.	27 (76.32)
		There are not enough opportunities to use SCPs.	1 (1.32)
		Providers do not feel confident in using SCPs.	3 (3.95)
		Other _____	8 (22.37)
6	Approximately how many new cancer patients are seen in your cancer program per year? <i>Your best guess is fine.</i>		1279.63 ^a
7	Please enter the ZIP code where your cancer program is located. ^b	Urban	33 (91.20)
		Rural	3 (8.80)
		Northeast	5 (14.70)
		Midwest	14 (38.20)
		South	11 (29.40)
		West	6 (17.60)
8	Please indicate your cancer program type. <i>Please check all that apply.</i>	National Cancer Institute-designated comprehensive cancer program	3 (8.80)
		Teaching hospital cancer program	8 (23.50)
		Pediatric cancer program	3 (8.80)
		Community hospital comprehensive cancer program	11 (29.40)
		Community hospital cancer program	7 (20.60)
		Other ^c	3 (8.80)
9	Of which professional society/societies is your cancer program a member? <i>Please check all that apply.</i>	Association of Community Cancer Centers (ACCC)	15 (42.90)
		American College of Surgeons (ACoS) Commission on Cancer (CoC)	30 (83.30)
		American Society for Clinical Oncology (ASCO) Quality Oncology Practice Initiative (QOPI)	12 (34.30)
		National Comprehensive Cancer Network (NCCN)	12 (33.30)
		NCI Community Cancer Centers Program (NCCCP)	8 (22.90)
		Don't know	1 (2.78)
10	What is your current position in the cancer program? <i>Please check all that apply.</i>	Physician	2 (5.70)
		Nurse practitioner	8 (22.90)
		Registered nurse	14 (40.00)
		Other clinical	6 (17.10)
		Non-clinical administrative	5 (14.30)

^aAverage number of new cancer patients per year

^bZIP codes identified as urban or rural using Rural-Urban Commuting Areas data

^cNetwork cancer program, Veterans Affairs cancer program, pediatric cancer program component, hospital associate cancer program, affiliate hospital cancer program, integrated cancer program, freestanding cancer center program, or National Cancer Institute-designated network

Table 2

Consistency of survivorship care plan (SCP) use (n = 36)

Variable	Frequency (%)
SCPs developed for at least 75 percent of the cancer program's survivors	5 (15.2)
SCPs delivered to at least 75 percent of survivors for whom an SCP was developed	8 (25)
SCPs delivered to at least 75 percent of survivors' primary care providers	7 (23.3)
SCPs developed for at least 75 percent of the cancer program's survivors AND delivered to at least 75 percent of survivors for whom an SCP was developed AND delivered to at least 75 percent of survivors' primary care providers	1 (3.8)