The Use of Survivorship Care Plans as a Transition Tool from the Cancer Centre to Follow-Up in Primary Care Settings: Developing Best Practice Recommendations for Implementation

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Preface

The present thesis is manuscript-based and comprises a general introduction, four manuscripts, and a general discussion/conclusion. This work was funded by a Transition in Care project grant from the Canadian Institutes of Health Research (CIHR Operating Grant FRN 16370). The research team included Brittany Mutsaers, Tori Langmuir, Carrie McDonald-Liska, Gail Larocque, Justin Presseau, Cheryl Harris, Marie-Helene Chomienne, Kednapa Thavorn, and Sophie Lebel. In this project, I was responsible for the study conceptualization, grant application, conducting a thorough literature review, preparing all study documents (ethics review board applications, consent forms, interview guides, codebook development, etc.), liaising with team members, data collection, analysis, and manuscript writing. The role of each co-author is summarized below.

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Ms. Carrie Liska, is a registered nurse and former Wellness Beyond Cancer Program care facilitator provided her expert knowledge on cancer survivorship issues, survivorship care plans, and assisted with data collection, analysis, and interpretation.

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Ms. Tori Langmuir, Research Assistant assisted with data collection, data entry, transcription of interviews, data analysis and interpretation. She also contributed to manuscript preparation and dissemination of findings.

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Dr. Marie-Helene Chomienne is a primary care provider and researcher at C.T. Lamont Primary Health Care Research Centre at the University of Ottawa. She assisted with recruiting primary care providers, guided interpretation of the data, and with manuscript preparation.

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General Abstract

After cancer patients have completed active cancer treatment, they have specific follow-up care needs. These needs include ongoing surveillance for new and recurring cancers, managing the side effects of cancer treatment, and psychosocial concerns (Rushton et al., 2015). In the past, cancer centres and oncology specialists provided follow-up care; however, new models of care are needed because cancer centres can no longer provide treatment and follow-up care to all cancer survivors (Jefford et al., 2022). To allocate health care resources, low risk cancer survivors (i.e., breast and colorectal cancer survivors) are being discharged from cancer centres after primary treatment back to their primary care provider (PCP) for follow-up care. Survivorship care plans (SCPs) have been identified as a tool to help survivors and their PCPs with this transition (Rushton et al., 2015). SCPs generally consist of a treatment summary, a schedule for follow-up and surveillance tests, and general health recommendations (i.e., diet and exercise; Howell et al., 2011; Ruston et al., 2015). While SCPs are widely accepted, research on their effectiveness as transition tools has been inconclusive (Hill et al., 2019; Jacobsen et al., 2018). Some studies show positive, neutral, and negative impacts of SCP use, and there are three potential reasons for these mixed findings: 1) there is wide variety in the content, format, delivery, and timing of SCPs which adds considerable variance when studying the impact of SCPs; 2) the use of outcomes to measure the usefulness of SCPs as transition tools that are beyond the scope that information about treatment history and follow-up guidelines could impact and; 3) that SCPs are not effective as transition tools (Hill et al., 2019; Jacobsen et al., 2018). An important first step in clarifying whether SCPs are effective transition tools is to understand how SCPs are being used in real world practice (Hill et al., 2019; Jacobsen et al., 2018).

The overall purpose of this study was to develop best practice recommendations for implementing SCPs. This was achieved through three study objectives: 1) to comprehensively identify barriers and facilitators perceived to influence SCP use among cancer survivors and primary care providers (PCPs); 2) to identify evidence-based approaches to address barriers and enhance facilitators of SCP use; and 3) to develop best practice recommendations that can be used by implementors of SCPs that are adaptable across different contexts.

Article 1 presents the results of semi-structured interviews with breast and colorectal cancer survivors who had received a SCP at least 12 months prior to the interview. The interviews were based on the Theoretical Domains Framework, version two (TDF-2; Cane et al., 2012) and comprehensively identified barriers and facilitators of SCP use amongst breast and colorectal cancer survivors. Thirty cancer survivors (17 female, 13 male) participated in the 30–45-minute interviews, which were then analyzed using content and thematic analysis. Survivors who had received education about the purpose of SCPs and how to use them reported finding their SCP helpful and that they used it to schedule appointments and communicate with their healthcare providers. Barriers to SCP use that were reported by cancer survivors included having lost or not remembering receiving a SCP, not understanding the importance of their SCP, and wanting information about additional supports to be able to follow the SCP (e.g., regular contact from the cancer centre, avenues for peer support). Overall, study 1 found that in order to SCPs to be used as intended transition tools, survivors benefit from receiving education about how to use them and be informed of the expectation that they be actively involved in their follow-up care.

Article 2 presents the TDF-based semi-structured interviews with primary care providers (PCPs). Thirteen PCPs completed 15-20 minute interviews, and content and thematic analysis was conducted. PCPs reported finding SCPs helpful and that they contained relevant information

to provide follow-up care. A key facilitator of using the SCP was the table of follow-up tasks (e.g., mammography, colonoscopy) and their frequencies included in the SCP. Two significant barriers for PCPs using SCPs were: a) logistical issues with ordering follow-up tests and receiving results; and b) a lack of clear avenues to consult with oncology specialists (e.g., managing side effects of medications, actions that need to be taken when follow-up tests are abnormal). Overall, article 2 showed that PCPs appreciate and readily use SCPs, and contextual changes to facilitate clear avenues of communication between primary and tertiary care may be beneficial when implementing SCPs.

Article 3 is a methodology article that presents a detailed explanation and rationale for the implementation science frameworks used and the data analysis chosen. The TDF-2 and Behaviour Change Techniques Taxonomy (BCTTv1; Michie, et al., 2008; Michie et al., 2013). The Human Behaviour Change Project researchers have empirically linked the 14 TDF domains to behaviour change techniques (BCTs), which allowed for multiple options to be developed to address barriers (and promote facilitators) of SCP use among breast and colorectal cancer survivors and PCPs (https://theoryandtechniquetool.humanbehaviourchange.org/tool; Michie et al., 2021). Using the TDF and BCTTv1 showed a dynamic between oncology specialists (e.g., oncologists, oncology nurses), cancer survivors, and PCPs that is involved in ensuring SCPs are implemented in an optimal way. A logic model was used to organize the barriers and enablers into different phases of SCP development, content, delivery, and use by PCPs and cancer survivors in their follow-up care (Mills et al., 2019). A flowchart organizing the recommendations of implementing SCPs was developed, and comprised 10 steps representing interrelationships between cancer centers, PCPs, and cancer survivors. The detailed methodology

article also includes lessons learned and suggestions for implementation science researchers using the TDF and BCTTv1.

Finally, article 4 is written for anyone looking for guidance implementing SCPs or improving upon how SCPs have been implemented already. It differs from article 3 in that it provides practical solutions for implementers. Because this work generated many recommendations, article 4 provides a worked example of how to use the results of this study. It is written in a way that outlines who would benefit from using the recommendations, and how to use the flow chart to narrow down the recommendation to those most relevant to implementors. The recommendations are organized into one of the 10 relationships in the flow chart, along with the purpose of the recommendations, how to implement it, to whom the recommendation targets, and those responsible for enacting the recommendations. The core factors associated with facilitating SCP use by PCPs and cancer survivors were: a) a treatment summary and follow-up guidelines included in the SCP; b) SCP provided to both cancer survivors and their PCP; and c) educating cancer survivors about their role as self-managers of their own care and the expectation that they participate in their follow-up cancer care. Future research on the usefulness of SCPs in follow-up care should include detailed information about the content, format, and receivers of SCPs and the outcomes most realistically influenced by the information included in SCPs. Before throwing the proverbial baby out with the bathwater, the implementation of SCPs requires additional standardization before meaningful investigation of their effectiveness as transition tools can be conducted.

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General Introduction

Cancer in the Global Context

Based on 2020 statistics, over 18 million people were diagnosed with cancer, of which, just under 10 million passed away from the disease (Sung et al., 2021). The most commonly diagnosed cancers internationally were breast, lung, liver, prostate, stomach, and colorectal cancer (Sung et al., 2021). It is expected that annual new cancer diagnoses will reach over 28 million in the next two decades (Sung et al., 2021), and that cancer will become the most common cause of death within the next hundred years (Bray et al., 2021). With more people being diagnosed with cancer, there has been a significant influx in cancer survivors who live many years after initial diagnosis and primary treatment (Canadian Cancer Society's Advisory on Cancer Statistics, 2018; Kantilal et al., 2022; Rushton et al., 2015). Templates for national cancer control plans suggest that survivorship concerns be a key consideration for policymakers adapting to the health care needs of individuals diagnosed with cancer (Oar et al., 2019).

Internationally, breast and colorectal cancers are the first and third most diagnosed, respectively (World Health Organization, 2022, World Cancer Research Fund International, n.d.). Breast cancer is the most frequency diagnosed cancer in women with over 2 million new diagnoses in 2020 (World Cancer Research Fund International, n.d.) and over 800,000 women, and over 1 million men received a diagnosis of colorectal cancer during the year 2020 (World Cancer Research Fund International, n.d.). Further, the overall number of cancer survivors is quickly increasing due to: a) an aging population; and b) better screening for, and treatment of, cancer (Canadian Cancer Society's Advisory on Cancer Statistics, 2017, 2018, 2021).

Colorectal Cancer

Colorectal cancer is characterized by the presence of cancer in the large intestine, consisting of the colon and rectum (Canadian Cancer Society's Advisory on Cancer Statistics, 2018). The colon and rectum consist of a variety of tissues, including: an inner mucous layer, connective tissue, muscle tissue, nerves, blood vessels and the parts of the lymphatic system (Anderson & Robertson, 2013). In general, colorectal cancer often starts as a polyp, which then becomes cancerous (i.e., the polyp turns into a tumour; Anderson & Robertson, 2013). Among males receiving a cancer diagnosis, 14.5% are expected to be diagnosed with colorectal cancer (Canadian Cancer Society's Advisory on Cancer Statistics, 2017). Among, females, colorectal cancer accounts for 11.5% of newly diagnosed cancers (Canadian Cancer Society's Advisory on Cancer Statistics, 2017). Across sexes, colorectal cancer is the second most frequent cancer diagnosis, and it is the second and third most common diagnosis of cancer among males and females, respectively (Canadian Cancer Society's Advisory on Cancer Statistics, 2017). Among individuals diagnosed with colorectal cancer, 67% of Canadian (Canadian Cancer Statistics Advisory Committee, 2021), approximately 70% of Australian (Cancer Australia, 2022), and 60% of English (Cancer Research UK, n.d.), colorectal cancer survivors are expected to live for at least 5 years post-diagnosis.

The Tumour Nodes and Metastasis (TNM) staging system is a way of classifying the progression of cancer (Canadian Cancer Society's Advisory on Cancer Statistics, 2018). For colorectal cancer Stage I refers to cancer that is only found in the inner mucous layer, and where stages II and III indicate that the cancer has spread to deeper layers of tissue in the colon but that it has not moved beyond the colon/bowels (Anderson & Robertson, 2013). Stage IV colorectal cancer indicates that the cancer that started in the colon and/or rectum areas has moved beyond the bowel areas, and into other parts of the body (Anderson & Robertson, 2013). Among

Canadians, colorectal cancer is most commonly diagnosed at stage III (29%) followed by stages I and II (both 23%), and stage IV (20%; Canadian Cancer Society's Advisory on Cancer Statistics, 2018, p.18). Colorectal cancer has an overall 5-year net survival of 67% in Ontario, which is higher if the cancer is diagnosed at stage I (92% for colon cancer, 87% for rectal cancer) than in stage IV (11% for colon cancer, and 12 % for rectal cancer; Canadian Cancer Society's Advisory on Cancer Statistics, 2018). In sum, when colorectal cancer is found and treated at earlier stages, these survivors can expect to live for several years.

Breast Cancer

Breast cancer generally includes the presence of a tumour in the ducts (that transfer breast milk to the nipples) and/or the lobules (where breast milk is produced; Canadian Cancer Society, 2019). Among all Canadian females who receive a cancer diagnosis, one in four will be diagnosed with breast cancer. Based on this, breast cancer is the most frequently diagnosed cancer type among females (Canadian Cancer Society's Advisory on Cancer Statistics, 2018). That said, breast cancer survivors tend to have a high chance of being alive five years after being diagnosed with cancer. For example, 89% of Canadian (Canadian Cancer Statistics Advisory Committee, 2021), 92% of Australian (Cancer Australia, 2023), 85% of English (Cancer Research UK, 2023), and 91% of American (American Cancer Society, 2023) individuals diagnosed with breast cancer can expect to be alive after five years.

In terms of staging, when the cancer is only found in the ducts or the lobules, it is referred to as cancer "in situ" (Huston & Osborne, 2005). Using the TNM staging system, tumours are classified based on their size. For example, a T1 stage would refer to a tumour in the breast that is between 0 and two centimeters in size, and a T4 stage would refer to breast cancer that has spread to nearby tissues (i.e., the chest muscles, or chest wall; Huston & Osborne, 2005). Nodes

are classified based on how much the cancer has moved from the breast into the lymph nodes, and metastases staging indicates the spread of the breast cancer throughout the body (e.g., to the lungs, liver, etc.; Huston & Osborne, 2005). In Canada, breast cancer is most often diagnosed in stage I, which accounts for 46% of all breast cancer diagnoses (Canadian Cancer Society's Advisory on Cancer Statistics, 2018). Breast cancer is diagnosed at stages II and III, 35% and 12% of the time, respectively (Canadian Cancer Society's Advisory on Cancer Statistics, 2018). Only about 5% of breast cancer is diagnosed at stage IV (Canadian Cancer Society's Advisory on Cancer Statistics, 2018). As reported in 2018, the 5-year net survival rate for females diagnosed with breast cancer was 87%, where nearly all females diagnosed with stage I cancer can expect to live 5 years after diagnosis, for those diagnosed stage IV breast cancer the 5-year net survival rate is 22% (Canadian Cancer Society's Advisory on Cancer Statistics, 2018). Given that cancer screening programs have led to breast cancers being diagnosed at earlier stages, many individuals who receive a breast cancer diagnosis will move on to the survivorship stage, which brings with it a number of new challenges (Canadian Cancer Society's Advisory on Cancer Statistics, 2018; Rushton et al., 2015).

Survivorship Health Care Needs

Cancer survivors have been defined as individuals who have been diagnosed with cancer but have completed active treatment and with either no evidence of disease or are continuing to receive adjuvant hormone therapy (Sussman et al., 2019). For low-risk cancer survivors (i.e., breast and colorectal cancer survivors), follow-up needs after primary treatment can be defined as a combination of coordination of care from oncology-based hospitals to primary care in community settings, where ongoing cancer surveillance is completed, along with management of psychosocial concerns and side effects of treatment (Sussman et al., 2019). Follow-up in primary

care would occur until death or a new or recurring cancer led to return for treatment in hospital-based settings (Sussman et al., 2017; 2018; 2019). Cancer treatment, including surgery, chemotherapy, radiation, and adjuvant medications result in late and long-term side effects of treatment that cancer survivors must cope with post treatment (Rushton et al., 2015). Additionally, survivors need to be regularly screened for new or recurring cancers and manage the emotional and psychological impact of experiencing cancer (Howell et al., 2011; McCorkle et al., 2011; Powel & Seibert, 2017; Sussman et al., 2017; Sussman et al., 2018). Late-term side effects of cancer treatment are symptoms that are related to cancer treatment, but that become problematic after treatment ends (Sussman et al., 2018). For example, lymphedema, cancer-related fatigue, peripheral neuropathy, cognitive changes, and cardiovascular issues are considered late-term side effects of treatment (Rushton et al., 2015; Sussman et al., 2018). Long-term effects of treatment include the implications of cancer treatment that occur during treatment and continue to impact the cancer survivor when active cancer treatment ends (Sussman et al., 2018). Long-term effects of cancer treatment can include scarring from surgery, pain, and menopause (Sussman et al., 2018). Common psychosocial concerns among cancer survivors include fear of cancer recurrence, anxiety, depression, and low quality of life (Rushton et al., 2015; Sussman et al., 2018). The management of illnesses that are co-morbid with a cancer diagnosis is also an important aspect of follow-up care (Howell et al., 2011; Rushton et al., 2015). Overall, cancer survivors have complex follow-up health care needs that can include many different health care providers (Sussman et al., 2018). Therefore, developing ways to coordinate health care services to ensure optimum follow-up cancer care is needed (Rushton et al., 2015; Sussman et al., 2018).

Based on focus groups with American colorectal, breast, and prostate cancer survivors, participants highlighted how it is important that survivors know that cancer survivorship is chronic, and that their follow-up needs requires a multi-disciplinary approach (Mead et al., 2020). Survivors also noted that it was important to specifically inform survivors about what to expect in their follow-up care, avenues for connection to other cancer survivors, credible sources of information about follow-up care, and greater access to psychological support (Mead et al., 2020). Logistical themes from the focus groups included having ways to effectively coordinate care across providers, and manage the transition from tertiary to primary care (Mead et al., 2020). Amongst Australian breast cancer survivors, the most reported unmet needs were fear of cancer recurrence, stress management, care coordination, information, side effects of treatment, and supports in navigating follow-up care (Vuksanovic et al., 2021). Survivors' preferences for follow-up appointments included: a) being regularly asked about their symptoms; b) annual testing or new or recurring cancers; c) contact information to consult with professionals to ask questions; d) healthy lifestyle behaviours and; e) education on the signs and symptoms indicating a cancer recurrence (Vuksanovic et al., 2021).

During the global pandemic, unmet needs of cancer survivors became more complicated (Legge et al., 2023). Lockdowns inhibited survivors' ability to move and exercise as usual, made accessing preferred groceries difficult, and limited access to a person's whole social support system (Legge et al., 2023). Worry due to the uncertainty of the pandemic, and fears around contracting COVID-19 exacerbated longstanding worries which contributed to sleep difficulties, making fatigue worse (Legge et al., 2023). Follow-up care appointments moved from in-person to telephone calls or videoconference which had benefits (i.e., minimizing commute to appointments) and drawbacks (i.e., less likely to ask additional questions, challenges adjusting to

different appointment formats). Going to medical appointments alone without the social and emotional support from friends and family was also noted as a challenge associated with the pandemic (Legge et al., 2023). With the changes in the volume of cancer survivors, their specific follow-up care needs, and the context of navigating health care system changes during and post-pandemic, new models of care are needed (Jefford et al., 2022; Legge et al. 2023).

Models of Survivorship Care

Historically, the oncologist's role included follow-up care for cancer survivors (Powel & Seibert, 2017; Sussman et al., 2018), but the number of cancer survivors has become greater than the capacity of cancer centres to provide follow-up care (Fitch, 2018; Jeppesen et al., 2018; Powel & Seibert, 2017; Sussman et al., 2018). New models of care to provide follow-up care for cancer survivors include discharge to primary care, receiving care from both primary care and oncology, and follow-up care led by oncology nursing specialists (Jefford et al., 2022). Discharging low-risk cancer survivors at the end of their active treatment to their community-based primary care provider (PCP; i.e., family physicians) has been proposed as a way of ensuring that cancer survivors have access to high quality follow-up care (Fitch, 2018; Grant et al., 2015; Jeppesen et al., 2018; Rushton et al., 2015; Sussman et al., 2017). As reviewed by Cancer Care Ontario (CCO) in their guideline recommendations for models for cancer survivorship, there is no difference between follow-up care provided by oncology or primary care (Sussman et al., 2017). More specifically, among breast and colorectal cancer survivors, the time it takes to diagnose a recurrence is essentially equivalent for primary and oncology-based care (Sussman et al., 2017). Additionally, there were no differences between follow-up care provided by oncology specialists and PCPs in the management of physical and psychosocial concerns related to survivorship (Sussman et al., 2017). Transitioning care to primary care can

capitalize on the often longstanding relationship between PCP and cancer survivor, and conceptualizing cancer as a chronic illness corresponds to PCPs' usual roles in managing chronic illness (Jefford et al., 2022).

Models where follow-up cancer care is a shared endeavor between oncologists and PCPs can be a helpful way to allocate healthcare resources where oncology specialists continue to be involved in follow-up care. This model can make it easier for PCPs to consult with oncologists when their expertise is required, and permits survivors to maintain contact with both healthcare providers (Jefford et al., 2022). Within this mode of follow-up care the roles of PCPs and oncologists must be clear, and communication ongoing (Jefford et al., 2022). This model also reduces the costs associated with follow-up care provided by oncology alone, and research has shown that cancer survivors are most amenable to this model for follow-up care (Jefford et al., 2022). Oncology nurses also provide follow-up cancer care, where they provide information about signs and symptoms of recurrence, assist with self-management activities, and help with the coordination of care (Jefford et al., 2022).

Transition in Care After Active Cancer Treatment

Although there is evidence to support discharging cancer survivors to primary care settings for follow-up care, there are many challenges that cancer survivors face when they are making this transition (Fitch, 2018; Powel & Seibert, 2017; Rosenzweig et al., 2017; Rushton et al., 2015; Williamson & Stanton, 2018). From the perspective of cancer survivors, being discharged from their oncology specialist care can be anxiety provoking and survivors report numerous unmet health care needs (i.e., fatigue, ongoing side effects of treatment; fear of recurrence, etc.; Fitch, 2018; Howell et al., 2011; Kotronoulas et al., 2017; Rushton et al., 2015). The loss of the support provided by oncology during active cancer treatment when a survivor is

discharged back to primary care can be distressing (Fitch, 2018; Williamson & Stanton, 2018). Cancer survivors may feel isolated as they cope with the uncertainty around their cancer prognosis and the unexpected and ongoing impact of cancer treatment including both physical (e.g., fatigue, neuropathic pain, etc.) and psychosocial (e.g., depression, anxiety, fear of recurrence, impact of symptoms on quality of life etc.) concerns (Fitch, 2018; Liska, et al., 2018; Rushton et al., 2015). Cancer survivors often feel "lost" when discharged to primary care, highlighting the confusion around coordination of care (i.e., which health care provider a survivor should consult for their health care needs; Fitch, 2018; Jabson, 2015). Underlying these other models of cancer survivorship care is the expectation that survivors participate in the management of their own follow-up care (Jefford et al., 2022).

Self-Management

Generally, self-management involves coping with the multifaceted impact of a chronic illness. Individuals are expected to monitor, report, and seek help with medical, psychological, and healthy lifestyle behaviours in a way that promotes a good quality of life (Barlow et al., 2002; Kantilal et al., 2022; Vandrass et al., 2022). Although an in-depth discussion about self-management and self-management interventions is beyond the scope of this work, self-management plays a key role in follow-up cancer care. While highly educated and motivated cancer survivors tend to seek out and engage with self-management resources (Vandrass et al., 2022) healthcare providers can promote self-management with their patients (Kantilal et al., 2022). More specifically, self-management support provided by healthcare professionals may be more accessible to more people in the context of follow-up care (Kantilal et al., 2022). Given

that new models of care place a significant responsibility on survivors themselves, considerations on how to support them in doing so is required (Kantilal et al., 2022). One barrier to self-management interventions provided by healthcare providers is the lack of knowledge and confidence in providing such guidance, which could be ameliorated through training, education, and survivorship care plans (SCPs; Kantilal et al., 2022). Overall, both healthcare providers and cancer survivors would benefit from the development of tools to more smoothly facilitate the transition back to primary care for follow-up (Runowicz et al., 2016; Rushton et al., 2015).

Survivorship Care Plans

Originally recommended by the Institute of Medicine, survivorship care plans (SCPs) are meant to be used as transition tools to assist with cancer survivors' transition from active cancer treatment to discharge to primary care (Runowicz et al., 2016; Sussman et al., 2018). SCPs are recommended by the Pan-Canadian Guideline for Survivorship Services for Adult Cancer Populations (Howell et al., 2011), the American Cancer Society (Runowicz et al., 2016), and are required for some cancer centres in the United States to be accredited (Sussman et al., 2018). According to the Canadian recommendations (Howell et al., 2011), SCPs should include: a) a treatment summary (i.e., type of cancer and the treatments provided); b) expected late and long term side effects of cancer treatment to monitor and report; c) the recommended frequency of follow-up care visits, tests, surveillance and screening with the roles of each health care provider clearly outlined; d) information specific to the psychosocial needs of the survivor (e.g., information about seeking psychological services, peer support groups, rehabilitation); and e) recommended approaches to engage in healthy lifestyle behaviours (e.g., diet and exercise; Howell et al., 2011). It is recommended that SCPs be completed by a member of the oncology team, and that it be used by both cancer survivors and PCPs (Howell et al., 2011; Runowicz et

al., 2016). While SCPs are strongly recommended, there have been challenges to using SCPs in everyday practice, and there is mixed evidence to support the use of SCPs (Jacobsen et al., 2018).

Mixed Evidence on SCP Outcomes: An Implementation Issue?

A systematic literature review by Jacobsen and colleagues (2018) found that the existing evidence to date indicates that SCPs do not have a strong impact on health outcomes for cancer survivors. The authors noted extensive variability across the 24 studies included in their review, in terms of the nature of SCPs (i.e., the information included, who provided SCPs, the recipients of SCPs, and how such recipients received the SCPs), along with a wide array of outcomes assessed (Jacobsen et al., 2018). For example, SCPs were provided anywhere from immediately after cancer treatment was completed, to nearly 30 years after diagnosis for childhood cancer survivors (Jacobsen et al., 2018). While a treatment summary and guideline recommendations for cancer follow-up care were commonly included in SCPs, specific information related to unmet needs, health behaviours, and community resources were not always included (Jacobsen et al., 2018). In some studies, the SCPs were only given to an individual's PCP, and in other studies, cancer survivors received their SCP via regular mail, through online platforms, in-person appointments, or over the telephone (Jacobsen et al., 2018). Overall, there appears to be inconsistency in how SCPs are created and delivered in practice (Jacobsen et al., 2018).

The outcomes of studies in this review on SCPs indicated null, positive, and negative effects of SCPs (Jacobsen et al., 2018). Several studies indicated that whether or not a SCP was created for a cancer survivor, there were no differences in survivors' satisfaction with their follow-up care, distress, and quality of life (Jacobsen et al., 2018). Other studies suggested that those who received a SCP were less likely to experience symptoms related to depression and

worry, were more likely to report health care satisfaction, and felt that they were provided with the information they needed in comparison with those who did not receive a SCP. However, another study found that participants who had SCPs reported experiencing more symptoms, emotional distress, and concerns about their illness (Jacobsen et al., 2018). Similarly to the CCO guidelines (Sussman et al., 2017), this review also found that oncology specialists and PCPs provided the same level of quality of follow-up care (Jacobsen et al., 2018). Finally, the cost effectiveness of SCPs ranged from findings that SCPs were more cost effective, to other results showing that SCPs were more expensive than usual care with little overall benefit (Jacobsen et al., 2018).

So far, the research on SCPs has not provided clear evidence that supports (or discourages) the use of SCPs as tools to facilitate the transition from active cancer treatment to primary care settings (Birken, et al., 2014; Jacobsen et al., 2018; Selove et al., 2016). Several recommendations have been suggested in the literature on how best to move forward with research on SCPs. These include: a) a greater level of consistency in both the content and delivery of SCPs and; b) the outcomes that are measured in future studies need to be outcomes that SCPs would realistically impact (Jacobsen et al., 2018). For example, SCPs would more likely influence: a) the acquisition of knowledge about follow-up care; b) the coordination of follow-up care and clarifying the roles of each health care provider; c) the engagement in health behaviours; and d) ensuring follow-up tests and appointments are scheduled in a timely manner (Jacobsen et al., 2018). Long-term outcomes such as specific health-related outcomes (e.g., cancer recurrence, distress, and quality of life etc.) may not realistically be directly impacted by SCPs (Jacobsen et al., 2018). Therefore, consideration of the purpose of SCPs as transition tools,

and the measurement of appropriate outcomes is important for future research on SCPs (Jacobsen et al., 2018).

Based on the mixed findings on the effectiveness of SCPs, researchers have suggested that issues with implementing SCPs into practice may be contributing to these results (Birken et al., 2014; Jacobsen et al., 2018, Selove et al., 2016). While SCPs can be provided to survivors and their PCPs, the document alone will not be an effective transition tool unless it is actually used (Jacobsen et al., 2018; Selove et al., 2016). Therefore, before SCPs can be meaningfully examined in terms of their effectiveness, guidance on how to successfully implement their use in real-world contexts is needed (Selove et al., 2016). As such, methods associated with implementation science have been recommended to assess the barriers and enablers to optimal SCP use across many different contexts (Birken et al., 2014; Selove et al., 2016).

Implementation Science

Implementation science is an approach to knowledge translation that focuses on the impact of context on the uptake and use of new interventions in everyday practice (Selove et al., 2016). More specifically, barriers and facilitators that influence if and how specific interventions are actually used in practice are examined, which then are used to develop implementation approaches to optimize the use of new practices (Selove et al., 2016). Barriers and facilitators to SCP use have been found in the literature from the perspectives of cancer survivors and multiple health care professionals involved in follow-up care (Birken et al., 2014; Klemanski et al., 2016; LaGrandeur et al., 2018; Lucktar Flude et al., 2018; Mayer et al., 2015; Selove et al., 2016).

PCP Perspectives on Using SCPs

A systematic literature review looking at PCPs' preferences regarding SCPs found that there was general acceptance that SCPs are important transition tools (Klemanski et al., 2016).

PCPs have reported that the information provided in SCPs increases their comfort in providing follow-up care for cancer survivors because they feel that they have adequate information to do so (LaGrandeur et al., 2018). An interview-based study looking at the perspectives of PCPs (family physicians and nurse practitioners) in Ontario found that SCPs are considered important for providing guidance on how to provide the necessary follow-up cancer care for their patients (Lucktar-Flude et al., 2018).

Potential barriers to SCP implementation from the perspectives of PCPs have also been reported in the literature. For example, qualitative interviews conducted with American PCPs identified that high workloads, lack of time, funding, and other system factors (e.g., varying structure of electronic medical records (EMRs), making appointments specifically for SCPs, etc.) were perceived barriers to SCP use among health care providers (Birken et al., 2014). A lack of buy-in from health care providers on SCP use, and a lack of leadership encouraging SCP use were also barriers. For example, participants reported anxiety related to using a SCP when other health care providers with whom they work do not also use SCPs (Birken et al., 2014). PCPs have also noted barriers to providing follow-up cancer care in general. Previous work has shown that PCPs have concerns around their lack of knowledge and confidence in providing follow-up cancer care (Dawes et al., 2015; Lucktar-Flude, 2018). A study based on interviews with Canadian family physicians found that there are several barriers to using SCPs. For example, SCPs that are too long, differences in the content included across SCPs and discharge notes, and difficulties finding SCPs in a patient's EMR were identified barriers that impact the optimal use of SCPs by PCPs (O'Brien et al., 2015). They also noted their preferences for using SCPs, including: a limit of a single page for SCPs, incorporating reminders into EMRs, and having concise versions of guideline recommendations (O'Brien et al., 2015).

Cancer Survivors' Perspectives on Using SCPs

There are two main reasons that SCPs are recommended for cancer survivors: 1) to help survivors better understand their follow-up care; and 2) to provide them with the information they need to become empowered, and actively participate in the self-management of their follow-up care (Dawes et al., 2015; Grant et al., 2015; Jabson, 2015; Lucktar-Flude et al., 2018). In terms of follow-up care in general, the literature suggests that some cancer survivors would prefer to receive follow-up care from their oncology specialists, rather than their PCPs, noting concerns about their PCP's ability to provide follow-up cancer care (i.e., oncologists are more knowledgeable; Fitch, 2018; Hudson et al., 2012). Further, cancer survivors report that the reassurance that their cancer has not come back has greater meaning when provided by an oncologist, as opposed to a PCP (Rosenzweig et al., 2017). A study looking at focus groups with Canadian breast cancer survivors, found that survivors experienced little coordination and communication among the cancer specialists and PCPs at the end of their cancer treatment (Smith et al., 2011). Further, these breast cancer survivors identified their preferences for the content and delivery of SCPs. These included: a summary of diagnosis and treatment; the use of understandable language; specific survivorship information (i.e., on achieving a healthy lifestyle, side effects of treatment, signs and symptoms of recurrence, where to seek support); new research; recommendations for when to arrange follow-up appointments; and a preference for receiving their SCP from an oncology nurse when approaching the completion of their treatment (Smith et al., 2011). There are many difficulties inherent to the transition from active cancer treatment to follow-up care (Fitch, 2018) and SCPs are intended to ease this transition by providing cancer survivors and their PCPs the information they need to move forward (Fitch, 2018). While there is some research related to cancer survivors' preferences and ideas related to

hypothetically using SCPs as a transition tool, to our knowledge, little research has been done looking specifically at *how* cancer survivors *actually use* SCPs. In order to maximize the real-world usefulness of SCPs, it is important to include cancer survivors' perspectives on their experiences with using SCPs in their follow-up cancer care.

Local SCP Use: The Wellness Beyond Cancer Program

The Wellness Beyond Cancer Program (WBCP) provides SCPs to breast and colorectal cancer survivors in the Ottawa area (Rushton et al., 2015). The WBCP was developed in Ottawa, Ontario in 2012, with the goal of "ensuring that, at the end of active cancer treatment, colorectal cancer and breast cancer patients have access to resources that best meet their individual needs and that the most appropriate health care provider provides survivorship care" (Rushton et al., 2015, p. e421). The WBCP is located at The Ottawa Hospital Cancer Centre, and is a cancer survivorship program serving 1.3 million people in Eastern Ontario, which includes a range of rural, remote, and urban populations. Additionally, the WBCP liaises with the Baffin Island Program, which serves Indigenous populations. A multi-disciplinary team of oncology nurses, a program manager, clerical support, and an oncology program lead are all involved in the WBCP (Rushton et al., 2015), and over 5800 breast and over 1600 colorectal cancer survivors have been referred to the WBCP since its creation in 2012 (C. MacDonald-Liska, personal communication May 27, 2019).

The WBCP consists of four main components: a) a needs assessment; b) an education class on follow-up care; c) information materials; and d) a discharge visit with a WBCP nurse where individualized SCPs are reviewed (Rushton et al., 2015). In 2015 both cancer survivors' and PCPs' satisfaction with the WBCP were examined. Data was collected via surveys, which were completed by 289 patients and 412 PCPs (Rushton et al., 2015). Both cancer survivors and

PCPs indicated that they were satisfied with the WBCP program, and over 80% of PCPs felt the WBCP had assisted them in coordinating follow up cancer care for their patients (Rushton et al., 2015).

SCPs are a fundamental aspect of the WBCP because they are intended to be used as a transition tool to facilitate the communication and coordination of care for cancer survivors as they transition to follow-up care (Rushton et al., 2015). The WBCP provides cancer survivors with individualized SCPs, which consist of information about the survivor's cancer diagnosis and their health care team at the cancer centre, a treatment summary, the CCO disease-specific guidelines for follow-up care and surveillance, and any outstanding self-identified physical and/or psychosocial needs. Discharge visits, typically lasting 30 minutes, are arranged with cancer survivors and a WBCP nurse, where the SCP is reviewed, and guidance for addressing ongoing symptoms and self-reported needs is provided. Family and caregivers can accompany cancer survivors throughout all the components of the WBCP (Rushton et al., 2015). The SCPs provided by the WBCP are comprehensive, and their delivery includes providing a copy of cancer survivors' SCPs during a discharge visit where the contents of the SCPs are reviewed in depth, and a copy of each survivors' SCP is automatically sent to their PCP. Accordingly, the WBCP is well positioned to allow for the examination of how SCPs are currently used by cancer survivors and PCPs in practice. Cancer survivors from urban, remote, and rural areas transition from active cancer treatment to primary care through the WBCP, and PCPs who receive SCPs are also located across these areas. Previous work and reviews of the literature on SCPs have noted the differences in resources available to, and challenges associated with, implementing SCPs in primary care across urban and rural areas (Klemanski et al., 2016; Luctkar-Flude et al., 2018; Mayer et al., 2015). Therefore, important factors influencing the implementation of SCPs

specific to diverse contexts (i.e., Canadian rural, remote, and urban primary care settings) can inform the development of recommendations for successfully using SCPs.

Stakeholder Involvement

Another key aspect of implementation science is the involvement of stakeholders throughout the process of conducting research and developing implementation recommendations (Banner et al., 2019; Ritchie, 2013). In the context of this proposal, key stakeholders include staff at the WBCP, researchers, cancer survivors, healthcare providers who work with cancer survivors, and national organizations related to cancer and cancer survivorship. Ultimately, the input from pertinent stakeholders from research design to the interpretation of results, and the development of recommendations for implementing SCPs is important for ensuring that the recommendations are realistic, appropriate, and effective in real-world practice (Banner et al., 2019; Ritchie, 2013).

Theoretical Framework: The Knowledge to Action Cycle

The Knowledge to Action Cycle is one framework that has been used to guide knowledge translation, especially in health care contexts (Graham et al., 2006). This framework consists of two main components: the knowledge creation funnel, and the action cycle. The knowledge creation funnel contains three phases: 1) knowledge inquiry (i.e., research studies); 2) knowledge synthesis (i.e., systematic literature reviews and meta-analyses) and; 3) knowledge tools/products (i.e., recommendations, guidance on decision making based on the literature etc.; Graham et al., 2006). The overall action cycle is made up of several recommended steps to implement behaviour change. The “cycle” implies that these steps influence each other, such that there are no specific start or end points for implementation interventions. In this way, the action cycle allows for movement between each step, providing the flexibility to make modifications to

implementation strategies based on the context where behaviour change is being implemented (Graham et al., 2006). These steps include: identifying a problem that needs to be addressed; identifying barriers and enablers to implementing the changes needed; developing an implementation intervention; designing methods to evaluate outcomes related to the implementation intervention and; sustaining the associated changes in practice (Graham et al., 2006).

Applying the Knowledge to Action Cycle to SCPs

The Cancer Care Ontario guidelines (CCO, 2019), the American Cancer Society (Runowicz et al., 2016), and the Pan-Canadian Guidelines for Survivorship Services for Adult Cancer Survivors (Howell et al., 2011) all recommend the use of SCPs as a transition tool after completing cancer treatment. Within the knowledge to action cycle, these guidelines would be considered "knowledge tools/products" at the end of the knowledge funnel (Graham et al., 2006). In the context of this proposal, the knowledge to practice gap (i.e., the problem to be addressed; Graham et al., 2006) refers to the inconsistent uptake and use of SCPs as they are intended as transition tools in real-world practice.

The next step, adapting knowledge to the local context, can be applied to the approaches taken by the WBCP to assist breast and colorectal cancer survivors with the transition to primary care settings after active cancer treatment (Rushton et al., 2015). This includes the development of individualized SCPs followed by a discharge meeting provided by oncology nurses at the WBCP. The purpose of the SCP and how to use the information it contains is reviewed with cancer survivors and their caregivers during these discharge meetings (Rushton et al., 2015). Assessing barriers to knowledge use is the next phase of the knowledge to action cycle (Graham et al., 2006). For this project, this would refer to how SCPs are actually used in practice after the

WBCP has provided them to cancer survivors and PCPs. The TDF provides a systematic approach to identifying such barriers and enablers to using SCPs as they were intended (i.e., as a transition tool for follow-up care in primary care settings; Atkins et al., 2017).

Implementation Science Frameworks: Theoretical Domains Framework and Behaviour Change Technique Taxonomy

The design of this study, the data analysis approach, and the development of recommendations for SCP use will be guided by two frameworks: The Theoretical Domains Framework (TDF; Cane, et al., 2012; Michie et al., 2005); and the Behaviour Change Technique Taxonomy (BCTTv1; Michie et al, 2008; Michie et al., 2013). Additionally, the overall knowledge translation approach is guided by the Knowledge to Action framework (Graham et al., 2006). The TDF and BCTTv1frameworks are used within different components of the overall Knowledge to Action Framework.

The TDF consists of 14 domains that are based on a number of behaviour change theories, including Operant Theory, Self-Determination Theory, and the Health Belief Model, etc. (Michie et al., 2005; Cane et al., 2012). These domains are: 1) knowledge, 2) skills, 3) social professional role and identity, 4) beliefs about capabilities, 5) beliefs about consequences; 6) environmental context and resources, 7) social influences, 8) intentions, 9) goals, 10) reinforcement, 11) optimism, 12) emotion, 13) memory, attention, and decision processes, and 14) behavioural regulation (Cane et al., 2012). The TDF has been used to identify barriers and enablers to using SCPs in American settings, based on interviews with 13 health care professionals (Birken et al., 2014). The authors identified barriers related to the increased workload involved in SCP use that competes with other demands (Goals), and the lack of systems or information technology for using SCPs in practice (Environmental Context and Resources; Birken et al., 2014). Facilitators to using SCPs included the health care provider's

belief that SCPs are helpful for cancer survivors (Beliefs about Consequences), and having sufficient financial resources to use SCPs (Environmental Context and Resources; Birken et al., 2014). The TDF has also been used to identify barriers and enablers to implementing cooler dialysate temperatures for patients undergoing hemodialysis, which has been shown to reduce instances of low blood pressure, and therefore preventing future cardiovascular problems (Presseau et al., 2017). Eighteen interviews with Canadian physicians and nurses found that barriers included concerns among nurses about the increase in their workload (Beliefs about Capabilities), and concerns that patients will be uncomfortably cold during their dialysis treatment (Emotion). Facilitators included the belief that reduced dialysate temperatures would benefit patients (Beliefs about Consequences), and the ease with which nurses can modify dialysate temperatures (Beliefs about Capabilities and Social Professional Role and Identity; Presseau et al., 2017). In sum, the TDF has been used to systematically identify barriers and enablers to changing behaviour across many different settings and contexts (Atkins et al., 2017). Once barriers and facilitators to a behaviour have been identified using the TDF, behaviour change techniques (BCTs) can be applied to address these barriers and facilitators (Cane et al., 2015; Cadogen et al., 2015; Michie et al., 2008).

The BCTTv1 contains descriptions of 93 unique BCTs that are categorized into 16 groups of similar BCTs: goals and planning; feedback and monitoring; social support; shaping knowledge; natural consequences; comparison of behaviour; associations; repetition and substitution; comparison of outcomes; reward and threat; regulation; antecedents; identity; scheduled consequences; self-belief; and covert learning (Michie et al., 2013). The BCTTv1 provides complete descriptions of the content of these behaviour change approaches in a standardized way, allowing for components of implementation interventions to be better

understood, implemented properly, and easier to replicate (Michie et al., 2013, 2018). BCTs have been used to create behaviour change interventions based on the barriers and enablers identified through the TDF. For example, barriers related to the correct prescribing and dispense of multiple medications to older adults identified through the TDF included an increased workload/lack of staff (Environmental Context and Resources) and the impact of side effects from drug interactions (Beliefs about Consequences; Cadogan et al., 2015). Then the authors chose the BCTs "prompts and cues" (to double check older adults' medications), and "salience of consequences" (provide information on consequences of drug interactions) to address these barriers (Cadogan et al., 2015).

Rationale for Articles

In order to make sense of the mixed results when researchers investigate the impact of SCPs as transition tools, more standardization in their content, format, delivery, and implementation is needed (Jacobsen et al., 2018; Hill et al., 2020). This dissertation consists of four articles. Overall objectives of this dissertation were: 1) to comprehensively identify barriers and facilitators perceived to influence SCP use among cancer survivors and PCPs in urban, rural, and remote settings using two implementation science frameworks (TDF, BCTTv1); and 2) develop recommendations for strategies that could be used to address identified barriers and facilitators to SCP use, adapted for urban, rural, remote settings, and to PCPs and cancer survivors. The first objective consisted of the following aims: a) to identify how SCPs have been used by PCPs, breast, and colorectal cancer survivors in real world contexts; b) to use the TDF to systematically identify barriers and facilitators to SCP use for primary care providers and breast and colorectal cancer survivors; and c) identify the most important TDF domains related to barriers and facilitators to SCP use, and link them to behaviour change techniques in the

BCTTv1. The second objective will involve developing best practice recommendations for SCP use that are flexible and adaptable to a wide range of contexts.

Article 1

The first article titled "Developing Best Practice Recommendations for Implementing Survivorship Care Plans Part 1: Experiences of Breast and Colorectal Cancer Survivors" systematically identified the barriers and enablers of SCP use among breast and colorectal cancer survivors who received a SCP from the WBCP based on semi-structured interviews. The data were organized into the 14 TDF domains, and the most relevant domains for SCP use amongst breast and colorectal cancer survivors were identified.

Article 2

Article 2 is titled "Developing Best Practice Recommendations for Implementing Survivorship Care Plans Part 2: Experiences of Primary Care Providers." The objective of the second article was to systematically identify the barriers and enablers of SCP use among PCPs who received a SCP from the WBCP, also based on semi-structured interviews, organized into TDF domains where the most relevant TDF domains were identified.

Article 3

The third article is a methodology article titled "Developing Best Practice Recommendations for Implementing Survivorship Care Plans Part 3: Integrating Implementation Science Approaches to Learn from Real World Practice." This article provides a detailed description and rationale for the implementation science approaches used, and how the barriers and enablers within the TDF domains map onto the BCTTv1.

Article 4

Finally, the fourth article presents the best practice recommendations for implementing SCPs written in a way that implementers can easily tailor the recommendations to their needs. It is titled “Developing Best Practice Recommendations for Implementing Survivorship Care Plans Part 4: Addressing Barriers and Enhancing Enablers of Care Plan Use by Primary Care Providers and Cancer Survivors.”

Ethics approval was provided by the research ethics boards at The Ottawa Hospital Research Institute and The University of Ottawa.

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Developing Best Practice Recommendations for Implementing Survivorship Care Plans Part 1: Experiences of Breast and Colorectal Cancer Survivors

Abstract

Background: Survivorship care plans (SCPs) have been recommended as transition tools for low-risk cancer survivors after treatment. They are intended for use among cancer survivors and their primary care providers (PCPs) to guide the follow-up care process. Research on SCPs has been mixed, and it is unclear whether they are helpful transition tools. The focus of this study was to investigate how cancer survivors have been using their SCPs to systematically identify barriers and enablers of their use.

Method: Interview guides were developed based on the Theoretical Domains Framework (version 2; TDF-2), and breast and colorectal cancer survivors participated in 30–45-minute interviews. Data analysis involved both deductive content (developing a codebook for directed content analysis into the 14 TDF domains) and inductive (theme generation) approaches.

Results: Thirty cancer survivors (11 breast, 19 colorectal) participated in an interview. Key enablers of SCP use by cancer survivors included: SCPs contained relevant information to guide follow-up care (Knowledge), discussing SCPs with their primary care providers (Social Professional Role and Identity), viewing the SCP as a comforting resource (Emotion), seeing their follow-up care as one's own responsibility (Social Professional Role and Identity), and meeting with an oncology nurse or a survivorship education class where the nature of follow-up care and the purpose of SCPs was presented (Environmental Context and Resources). Barriers to using SCPs included: being unable to find their SCP (Memory, Attention and Decision Processes), difficulties accepting discharge back to primary care (Emotion) and wanting continual follow-up from oncology (Behavioural Regulation).

Conclusions: SCPs contained useful information to cancer survivors for managing their follow-up care. Implementation interventions for SCPs may consider the role of providing education on

what to expect in follow-up care and the purpose of, and how to use, SCPs to facilitate their use as transition tools.

Keywords: survivorship care plans, oncology, nursing, theoretical domains framework, cancer survivorship

Contributions to the literature

- In theory, SCPs made sense as transition tools, however they have been less helpful than anticipated in practice.
- This article presents a systematic understanding of how survivors have been using their SCPs in follow-up care, including their perceptions and input on how SCPs can be improved to better meet their needs.
- Before abandoning SCPs, this analysis of barriers and enablers to their use will inform the development of best practice recommendations for implementing SCPs more consistently, so future research on their effectiveness when they are used as intended can be conducted.

An increasing number of cancer survivors can be safely discharged from tertiary healthcare settings upon completion of treatment back to their primary care provider (PCP) for follow-up care (Fitch, 2018; Jeppesen et al., 2018; Powel & Seibert, 2017; Sussman et al, 2018). This approach to managing healthcare research was implemented to reduce the burden on oncology settings (Fitch, 2018; Jeppesen et al., 2018; Rushton et al., 2015; Sussman et al., 2017). No longer can all survivors be followed indefinitely by oncology specialists, rather, their expertise is required for acute cancer patients (Rushton et al., 2015; Sussman et al., 2017). It has been determined that PCPs are able to provide the same level of follow-up care for lower risk cancer survivors (i.e., breast and colorectal cancer survivors) as oncology specialists (Sussman et al., 2017). As a result, there has been a move to equip PCPs and breast and colorectal cancer survivors to arrange follow-up care in the community (Grant et al., 2015; Sussman et al., 2017).

Cancer survivors must cope with late (cancer-related fatigue, peripheral neuropathy) and long term (early menopause, pain, surgical scarring) side effects of their treatment (Rushton et al., 2015; Sussman et al., 2017). Psychosocial concerns are highly prevalent, including fear of recurrence, low mood, and decreased quality of life (Rushton et al., 2015, Sussman et al., 2017). Additionally, many survivors have reported their preference to continue being followed by their oncology team post-treatment, and the loss of this support system can be highly distressing (Fitch, 2018; Jabson, 2015). To help facilitate this transition, survivorship care plans (SCPs) were developed and recommended for use by both cancer survivors and their PCPs (Howell et al., 2011; Sussman et al., 2017).

The purpose of SCPs is to help survivors understand what their follow-up care entails, and to provide the information needed to help them actively participate in the management of their follow-up care (Dawes et al., 2015; Grant et al., 2015; Jabson, 2015; Lucktar-Flude et al.,

2018). Generally, SCPs include: a) a treatment summary (i.e., cancer type, treatments provided); b) expected late and long term side effects of cancer treatment that should be monitored; c) the recommended frequency of follow-up care visits, tests, surveillance, and screening; d) the roles of each health care provider; e) information specific to the psychosocial needs of the survivor (e.g., information about support groups, rehabilitation, psychological services); and f) recommendations to engage in healthy lifestyle behaviours (i.e., diet and exercise; Howell et al., 2011). Though highly recommended by Cancer Care Ontario (CCO, 2019), the Pan-Canadian Guidelines for Survivorship Services for Adult Cancer Survivors (Howell et al., 2011), and the American Cancer Society (Runowicz et al., 2016), systematic reviews have suggested that SCPs may not be helpful transition tools in real world practice (Hill et al., 2020; Jacobsen et al., 2018).

Authors have noted three main reasons for the mixed support for SCPs. The first being that there is a wide variation in the content, format, and delivery of SCPs, thereby suggesting an implementation issue. Second, the outcomes chosen to measure the effectiveness of SCPs are inappropriate (i.e., measuring distress, mood, and quality of life, rather than outcomes that would be more realistically impacted by using a SCP such as increased knowledge, completion of follow-up tests). Third, despite being highly recommended, SCPs may not actually function well as transition tools for survivors (Hill et al., 2020; Jacobsen et al., 2018). Because it is too early to warrant abandoning SCPs, and the best outcomes for measuring their impact have yet to be established, an important first step in more accurately investigating the helpfulness of SCPs is to develop more standardization in their content, format, and delivery (Hill et al., 2020; Jacobsen et al., 2018). Implementation science approaches can be used to learn about how SCPs have been used by cancer survivors, and to systematically identify barriers and enablers to their use as

transition tools, which can be addressed in implementation recommendations (Atkins et al., 2017).

The Wellness Beyond Cancer Program (WBCP) is located in Ottawa, Canada and is part of The Ottawa Hospital Cancer Centre. Since 2012, the WBCP has provided breast and colorectal cancer survivors with education and support as they transition back to their PCP for follow-up care. The WBCP consists of a) a needs assessment (to help populate the SCP); 2) education on what to expect during follow-up care; 3) SCPs that are developed by oncology nurses at the WBCP that are tailored to each individual and provided to both the survivor and their PCP; and 4) a discharge meeting with an oncology nurse to review the SCP (Rushton et al., 2015). The SCPs provided by the WBCP include a treatment summary, guidelines for follow-up care, and individualized unmet needs to facilitate communication between cancer survivors and their PCPs. A copy of the SCP is provided to both the survivor and their PCP. Information booklets are available to survivors on specific topics (e.g., diet, exercise, managing peripheral neuropathy, etc.; Rushton et al., 2015)

This article is part of a larger study aimed at developing best practice recommendations for implementing SCPs that are adaptable and can be used across many contexts using implementation science theories and methods. As SCPs have already been used for over a decade, examining the real-world use of SCPs by survivors and their PCPs is an important first step to understanding how they are actually being used, what has been helpful, and what additional factors may be needed to improve their usability. The present study outlines our investigation into how SCPs have been used in the real world by breast and colorectal cancer survivors, using implementation science approaches to understand the barriers and enablers to

using SCPs as intended. This information is key to developing more standardized recommendations for implementing SCPs.

Method

The French Model (French et al., 2012) provided guidance for the overall project. The first (describing behaviours by delineating "who needs to do what differently") and second (identify a framework) steps of the French Model are pertinent to the present article.

Step 1: Who needs to do what differently?

For the first step of the French Model (French et al., 2012), the Action, Actor, Context, Target and Time (AACTT) framework (Presseau et al., 2019) was used to clarify the behaviours associated with SCP use for cancer survivors. As outlined in Table 1, the actions, actor, context, target, and time associated with survivors using SCPs was defined by the research team. Defining these behaviours carefully was important for creating the interview guides and structuring data analysis (Atkins et al., 2017; Presseau et al., 2019).

Materials

An interview guide was developed for breast and colorectal cancer survivors assessing barriers and enablers to SCP use. The interview guide was based on the second version of the Theoretical Domains Framework (TDF-2), which examines 14 factors that influence behaviour change (Cane et al., 2012; Atkins et al., 2017). The 14 domains are: 1) knowledge; 2) skills; 3) beliefs about capabilities; 4) beliefs about consequences; 5) intention; 6) goals; 7) environmental context and resources; 8) social influences; 9) emotion; 10) social professional role and identity; 11) optimism; 12) reinforcement; 13) memory attention and decision-making processes; and 14) behavioural regulation (Cane et al., 2012). An initial interview guide was developed with at least one question per TDF domain; however, this version was too lengthy and repetitive when piloted

among the research team. The interview guide was revised, and the final version (Appendix E) includes open ended questions and optional prompts to allow for all the TDF domains to be assessed, without being repetitive. The interview was semi-structured where the interviewer could ask follow-up questions appropriate to obtaining relevant information about the barriers and enablers of SCP use (Atkins et al., 2017). Questions for breast and colorectal cancer survivors included "what has gotten in the way of using your SCP" "are there parts of the SCP you don't really use?" and "what information in your SCP has been most useful for you?"

Participants

Female breast cancer survivors, female colorectal cancer survivors, and male colorectal cancer survivors who had received a SCP from the Wellness Beyond Cancer Program in Ottawa, ON, Canada were recruited for this study. The inclusion criteria for survivors were: a) had completed active cancer treatment for breast or colorectal cancer; b) were discharged from the cancer centre back to their PCP for follow-up care a minimum for 12 months prior to the time of the interview (to allow for time to use the SCP in their follow-up care); c) had received a SCP through the WBCP; d) could speak and understand English or French; and e) provided consent to participate in a one-time 30-40 minute telephone interview.

Recruitment

The WBCP provided the research team with a list of 554 breast and colorectal cancer survivors who received a SCP between 2017 and 2019. The research assistant TL screened the Electronic Medical Records (EMR) of all individuals on the list to ensure that they met the following criteria: a) provided consent to be contacted for research purposes through the institutional "permission to contact" process b) were not deceased c) no evidence of current cancer or other major health issues (e.g., kidney disease, organ transplant recipients, cirrhosis,

serious respiratory illness). The mailing addresses of individuals who met the inclusion criteria for screening were retrieved from the EMR (n = 185). The research assistant selected the first three to four participants who received a SCP in January 2017, January 2018, January 2019, then February 2017, 2018, 2019, then March of each year, and so on, from available months from the screened list until the target number of participants for each round of recruitment letters was met.

Mailed invitations were sent to survivors who met the enrollment inclusion criteria (Appendix A and B). The first round of recruitment letters was sent to 50 (4 males) of the 184 randomly chosen survivors who met the inclusion criteria on October 29, 2020. Twelve participants (1 male) completed an interview between October and December 2020. Due to a high rate of female breast cancer survivor respondents to the first round of recruitment, a decision was made to focus the second round of recruitment on colorectal cancer survivors only, particularly males. Invitation letters were sent out to 79 colorectal cancer survivors (36 males) in February 2021 from the list of 185 survivors who met inclusion criteria, of whom 18 participants (six females) completed an interview between February and April 2021. A modified letter was sent in the second round of recruitment letters (February 2021) to males highlighting the need for male colorectal cancer survivors to participate in our research. Of note, invitation letters were not mailed to an equal number of males and females due to a larger number of female survivors on the list of eligible survivors than male. Therefore, all male colorectal cancer survivors who met the inclusion criteria were sent invitation letters. To examine potential sex difference in SCP use, this effort was made to ensure sufficient men were recruited for data saturation (Francis et al., 2010).

Procedure

Interested participants contacted the research team via email or telephone to discuss the study and reviewed the consent form over the telephone with TL (Appendix C and D). Verbal consent was obtained, interviews were scheduled, and a copy of the consent form was mailed or emailed to participants. Participants were also emailed or mailed the list of interview questions beforehand to review them if they wished. Interviews were conducted over the telephone due to the COVID-19 pandemic, were audio recorded, and transcribed verbatim. Breast and colorectal cancer survivors were compensated with a $50.00 gift card. The gift cards were mailed to participants after completion of an interview.

Data Analysis

Detailed information regarding data analysis is described elsewhere (see article 3 of this dissertation; Mutsaers et al., 2023a). Briefly, a codebook was created to delineate the text into the most appropriate TDF domains. Belief statements (represent similar utterances grouped together) were developed within each TDF domain (Atkins et al., 2017; Patey et al., 2012), and subthemes and themes were developed using content and thematic analysis (Creswell, 2015). Data saturation was determined based on the "10+3 rule", where an initial 10 interviews are conducted, and then additional groups of three interviews are completed until no new information is obtained (Francis et al., 2010). Six interviews were double coded for inter-rater reliability, and the Krippendorf's Alpha statistic (0.91) indicated high reliability in coding (McHugh, 2012).

Ethical Approval

Ethics approval was provided by the Ottawa Health Science Network Research Ethics Board (file # 20200152-01H).

Results

A total of 30 cancer survivors participated in an interview comprising 11 female breast cancer survivors, five female colorectal cancer survivors, and 14 male colorectal cancer survivors. The average age of participants was 68 years (range 49-87), and the average reported time since discharge was three years. Interviews lasted on average 27 minutes (range 9-52 minutes). Seventeen participants were from large communities, and 13 were from smaller communities. One participant was from a medium population centre, and the decision was made to categorize them as a large community participant. All participants who indicated an interest and consented completed an interview, and by 13 interviews for females and males, no new information arose, indicating that data saturation was reached (Francis et al., 2010). Tables 2 and 3 summarize the enablers and barriers within each TDF-2 domain, respectively.

Through thematic analysis, four overall themes emerged from the data for breast and colorectal cancer survivors. These were: 1) survivor engagement and motivation to participate in follow-up care; 2) collaboration between survivors and their PCPs in follow-up care; 3) descriptions of how SCPs have been used in the "real world;" and 4) factors influencing the use of SCPs (practical, social, emotional). Table 4 shows the TDF domains associated with each theme. This paper outlines the qualitative results of the survivor interviews, and further analysis of the TDF domains and their link to the Behaviour Change Technique Taxonomy version one (BVTTv1) to develop best practice recommendation for implementing SCPs is described in Article 3 of this dissertation (or Mutsaers et al., 2023a).

Theme 1: Survivor Engagement and Motivation to Participate in Follow-up Care

This theme summarizes how cancer survivors have understood and used their SCPs and navigated their follow-up care. This theme has four subthemes: a) survivors being an active member of their healthcare team; b) how survivors were taught how to use their SCP; c) perceived benefits of using their SCP; and d) survivors' recommendations for improving SCPs.

Survivors Being an Active Member of their Healthcare Team

Interviews from twenty-eight cancer survivors reported utterances that were organized into this subtheme. They described how their SCP contained important information that they needed for their follow-up care. As stated by a female breast cancer survivor,

"it was very interesting to have it because it encapsulated almost everything that I would have wanted to know." (Participant 2)

With the information provided in the SCP, survivors reportedly felt better equipped to advocate for themselves and more confident in their ability to navigate the health care system as it pertained to their follow-up care needs. As described by a female breast cancer survivor,

"It's right there, okay, my doctor should have arranged for a mammogram, I haven't heard from said doctor, oh, I better get in touch and find out how I get a mammogram." (Survivor 6)

Four participants talked about how they utilized the patient electronic medical record (EMR) to access and look up their test results. This reportedly gave these survivors "peace of mind," and allowed them to share their test results with their PCP if there was a delay in the results being sent to their PCP (which usually occurred when PCPs did not have a connection to the hospital's EMR). Overall, most survivors indicated that they gained important knowledge from the SCP that helped them to participate in their health care post cancer treatment.

How Survivors Learned How to Use Their SCP

While the SCP contained information about follow-up care, survivors highlighted the importance of educational support to help them understand the purpose of, and how to use their SCPs. Seventeen cancer survivors described how they learned how to use their SCP, which included: meeting with a nurse, being informed about the importance of the SCP, and attending discharge meetings or education classes provided by the WBCP. As described by a male colorectal cancer survivor:

> *"The only thing I can say is that sheet I got from them really was great. Everything was there and all I had to do was read it. And if there was anything I didn't understand, well, I asked the nurse and she would explain to me."* (Participant 24)

Eight survivors described attending an education class and/or the discharge meeting with nurses from the WBCP. They described how these meetings in conjunction with the SCP helped provide a structure for moving forward in their follow-up care:

> *"It was helpful, the whole experience was very humanizing. You know, treatments can sometimes be rough, and, I mean, very compassionate people all through the process for sure but you know how it is, receiving treatments can feel dehumanizing sometimes so, you know, this one little meeting was, it was a nice little pivot from – we came through a rough time and now you're ready, we feel you're ready to go."* (Female breast cancer survivor, Participant 8)

Other survivors described mixed emotions about their experiences in the WBCP education class. The idea of being discharged from the cancer centre was distressing, as described by a female breast cancer survivor:

> *"But when they were discharging you from the cancer centre, 'you don't need to come back here anymore,' returning you to your family doctor. I always thought was a bit odd. There wasn't really the option or opportunity to ask something specific that you may be concerned about. You know, especially for people who were having a hard time sort of accepting the fact that they were being discharged, and going through maybe, you know, 'okay, my god, what do I do now,' you know? Like, I'm on my own. And those sorts of needs and feelings, I thought that maybe it could have been more individual."* (Participant 1)

The messaging around SCPs and the importance of taking on the role of a "self-manager" of their own follow up care was described as an unexpected challenge for follow-up care. However, survivors reported that understanding how SCPs can help guide this process was helpful:

"they said 'okay, these are your tools, go see your family doctor,' I was like, 'woah, woah, woah, okay, so, now it's about- now I'm responsible,' like a felt a bit of responsibility at first and I was a bit worried about that. Then, as soon as I booked my appointment as we, I brought this with my family doctor, everything was fine, I was a bit anxious, it was like a bit of, 'wow, okay, now I'm in charge, now it's- okay, what do I do?' But now just make a call to my family doctor and it was fine." (Female breast cancer survivor, Participant 10)

Emphasizing the importance of SCP itself, among the many different paper-based resources was noted. Four survivors mentioned that messaging around the importance of the SCP document served as an important reminder to refer to their SCP when needed. As described by a female colorectal cancer survivor:

> *"Yes, clearer instructions for sure. I felt that 'oh, this is just more paperwork,' and I didn't get the feeling of, 'oh, this is important for you to follow-up, or this is important, whatever,' I didn't feel it. Now, maybe that's just me, but I didn't feel the importance of this."* (Participant 17)

While SCPs alone provide important information that survivors can use in transitioning back to their PCP for follow-up, additional support and explanation from oncology health care professionals was important for encouraging survivors to *use* their SCPs.

Perceived Benefits of Using SCPs

Eight participants described their health as being an important motivation to use their SCP in their follow-up care, particularly in preventing a cancer recurrence, or catching a recurrence or a new cancer early:

"I'm keen on following the care plan because I would like to survive, I'd like to live, you know, I'd like to go on with my life." (Male colorectal cancer survivor, Participant 26)

Having oncology specialists highlight the reasons why SCPs are important to follow and emphasize the benefits of having follow-up tests completed on time were described by eight participants as an important motivator to use their SCP. As described by a male colorectal cancer survivor:

"Well, since I was accordant to the oncologists generally, he said that's very important, because I had a meeting with him also. And he said it's very important that you do the CT scan for example, and the blood work because it will help us determine if there's another cancer." (Participant 28)

Noting the positive health consequences of using SCPs by a health care professional adds credence to the purpose and importance of SCPs, especially when referring to cancer recurrence.

Survivor's Recommendations for Improving SCPs

Twenty-two participants provided suggestions and recommendations for helping others use their SCP. Fourteen survivors suggested that SCPs be provided in an electronic format that is updateable, and located on the patient version of the EMR:

"If there's any way of getting this put on to [EMR], I think that would be very beneficial, I have to be honest, I just went hunting earlier in the week for my care program, and I thought I put it in with all my cancer information, I don't know where I put it but I know that if it were on [EMR], I could pull it up in a matter of seconds." (Female breast cancer survivor, Participant 3)

Twelve cancer survivors described wanting continued follow-up from the cancer centre after being discharged back to their PCP. One reason for wanting periodic contact with the cancer centre included concerns about losing their PCP (e.g., due to retirement), as described by a female breast cancer survivor:

"I think the only way that they can, because, because for five years you need that mammogram before you're totally dismissed from there, I think that it should be requested by the oncologist, because, things happen, like I lost my doctor, so I couldn't get one. And because they're the ones that are requesting it. And that's the only, only thing that I can think of, because it kind of just leaves you out in left field wondering what to do." (Participant 4)

Survivors wanted periodic contact with the cancer centre to ask questions, request additional support, and as a reminder to use the SCP. As described by a female breast cancer survivor:

"If someone calls to say, "okay, you were transferred over to your primary care provider", you know, sort of like we're doing right now, but like, you know, "how has that been? You know, are you having any difficulties with that, do you feel like your needs are being met", that sort of thing." (Participant 12).

Six cancer survivors noted that they found the supplementary booklets provided by the cancer centre helpful when they wanted to find additional information related to their specific needs. A male colorectal cancer survivor highlighted that an additional booklet specifically on the late and long-term side effects of treatment was helpful in preparing him for follow-up:

> *"Exactly, there's a booklet that's very, very useful, because they call it the guide and it's useful because it's specific to my cancer, colorectal cancer, and it talks about the long-term side effects of the adjuvant treatments, in my case of the chemotherapy. So, it prepared me for the continuing problems I have been facing."* (Participant 26).

Twenty-two survivors added that they wanted additional individual supports, including information on diet, information on side effects of treatment, and additional information about cancer treatment and history. Recommendations by survivors on ways that SCPs would be more helpful for cancer survivors provided important information to inform the best practice recommendations. These recommendations are elaborated in the fourth article of this thesis (Mutsaers et al., 2023b).

Theme 2: Collaboration Between Survivors and Their PCPs in Follow-Up Care

Twenty-nine survivors described how they worked with their PCP during their follow-up cancer care. Four sub-themes were identified: a) survivors use their SCP as a communication tool; b) survivors' experiences with the limitations that PCPs have in meeting their survivorship needs; c) descriptions of how PCPs and oncology specialists collaborate with one another; and d) survivors being satisfied with the follow-up care provided by PCPs.

Survivors use Their SCP as a Communication Tool

Twenty-four participants described how they have used their SCP as a communication tool with healthcare professionals. Eighteen survivors reported using it to help communicate their survivorship needs with their PCP, for example:

"This is what I use to establish that communication with my doctor, basically to not be walking into his office and saying "I want this, I want that", it's "I've been recommended to do this, this, this, and that", I had something to back it up. Okay, hi, Dr. X, this is what I've been recommended, oh, he says, "yup, familiar with that, let's get going, have an appointment every six months" (female breast cancer survivor, Participant 10)

Five survivors described instances where they took the initiative to contact their PCP after consulting their SCP:

"So, it was just a reminder and sometimes, you know, she was a bit lost or didn't have a follow-up set up, so she had to look at my files" (male colorectal cancer survivor, Participant 28)

When provided with a SCP, many survivors felt empowered or capable of using it with their PCPs during follow-up care.

Half of the survivors indicated that they also see themselves as responsible for their own care. Participants highlighted the importance of advocating for their healthcare needs, emphasized how they are making their health a priority, and understanding their role as a "self-manager." As described by a male colorectal cancer survivor:

"I think the individual has more time than the doctors do, and I think we as individuals need to take more responsibility for our own health, I mean the doctors can only do so much, and they're got hundreds of patients, I would think, and so, if we can make this more important for the individual to take full responsibility for this." (Participant 19).

Another breast cancer survivor described how their perspectives on their health shifted after receiving cancer treatment:

"my health was something I just took for granted and so I wasn't used to being an advocate for my own health, like I just kind of would go to the doctor once a year and that was that, I never thought about it so much, and this follow-up or the program, has just reminded me, no, that I'm the person who is responsible for my health (laughs)." (Participant 8)

It appears that survivors who have an awareness of the distribution of health care services, and the rationale for receiving follow-up care from their PCP are more likely to understand and take on the role of collaborating with their PCP in follow-up care. When survivors receive an SCP, it gives them the information they need to be informed as to what needs to be done in follow-up

care, thereby sharing the responsibility of ensuring their regular tests are booked and results received with their PCP.

Survivors' Experiences with the Limitations that PCPs have in Meeting Survivorship Needs

Ten survivors described having hesitance around receiving their follow-up cancer care from their PCP, rather than from oncology specialists. They indicated that they wanted some connection with cancer specialists after discharge:

> *"Well, when the cancer clinic decides that you're better, and you can now go to your family doctor, and you're ready, you're not certain that you'll be taken as well care of by your family doctor because your doctor is not aware of the cancer problem that might arise with, because it's not their specialty."* (Female breast cancer survivor; Participant 13)

Five survivors discussed their role as a 'self-manager' of their own care as something that they must take on, regardless of whether they wanted this role. These survivors expressed that they did not believe they could rely on their PCP to schedule their follow-up tests and appointments. As described by a female colorectal cancer survivor:

> *"things have slipped up, because he always felt that I was pretty healthy, and I was always bubbly and all this sort of thing. But I kept going for blood tests, because he insisted that I get blood tests every 3 months, and but he's very, very busy, I know that, I've been looking after my blood, and I have to go again, and, but he hasn't really taken, I guess, a leadership role in making sure that I've done all this sort of thing, no. And I'm not blaming him because I think it was my responsibility, really, but I didn't really understand the whole thing."* (Participant 17)

While half of the participants indicated that they were motivated and comfortable using their SCP and working with their PCP, other participants described how taking on the role of self-manager was unexpected. There was some hesitance and lingering confusion about receiving follow up cancer care from a PCP, who are not cancer specialists.

Descriptions of How PCPs and Oncology Specialists Collaborate

Four cancer survivors highlighted their understanding that the WBCP and SCPs are a way for their oncology team to collaborate with their PCP. As described by a female breast cancer survivor:

> *"There is also a feeling of 'oh my god, I'm on my own now,' which is why it's so helpful to have this program and have this plan and have the connection between oncologists taking care of you and your family doctor taking care of you."* (Participant 2)

Another female colorectal cancer survivor described how they felt better about receiving follow-up care from their PCP when they perceived that the WBCP (which provides the SCPs to patients and their PCPs) was a key bridge between oncology and primary care:

> *"So, when you're let go from the cancer clinic, I mean, I was worried, but this Wellness Care Program really helped me, in hindsight, and after meeting my doctor and she was communicating with my oncologist, and everything was under control and I was part of the – it was like a triangle, my oncologist, my family doctor, myself. So it was great. It put my mind at ease. It took a few months, but I think that's normal."* (Participant 13)

These results indicate that the creation of SCPs by oncology specialists is an important factor in helping survivors feel more comfortable transitioning back to their PCP for follow-up.

Survivors Satisfied with Follow-up Care Provided by PCPs

Notably, 23 cancer survivors reported viewing their PCP in a positive way as they transitioned back to primary care for their follow-up. These participants described their PCPs as being very involved in their follow-up care, and they also mentioned that they often do not have to use their SCPs because they can rely on their PCP to keep track of appointments, ordering tests, and receiving test results. As described by a female breast cancer survivor:

> *"I haven't used any of that to be honest with you, I have a very good family physician that I've seen for many, many years, and she's very on the ball, I have to say, so I really haven't used any of that."* (Participant 3).

Based on the interviews, it appears that most cancer survivors perceive their PCP as taking the responsibility of their follow-up care, to the extent that they do not necessarily need to act on the

information included in their SCP. That said, these survivors tended to express relief that they could trust their PCP to provide them with good follow-up care.

Theme 3) Descriptions of How Survivors Have Used their SCP in the Real World

Twenty-seven participants provided descriptions of how they actually used their SCP after it was received. Two subthemes emerged: a) my SCP is an important resource about my cancer history; and b) my SCP provides direction.

My SCP is an Important Resource About My Cancer History

Fourteen cancer survivors highlighted the importance of having detailed information about their cancer diagnosis and treatment. They described how the SCP was helpful to consult when questions arose. As described by a female breast cancer survivor:

> *"It's a very important document for me to have, and I keep it close by me, you know, it's there. You know, if all of a sudden, a question pops into my head or something or I wanna look back, it's right there, and usually I can get my answers in that package."* (Participant 9)

Further, they described how they would use the information again as needed:

> *"But, like I said, if at some point I had a question in my mind about something, I had filed it, I didn't throw it out, I knew where it was, I found it immediately, and it would have been there. And I was impressed with what was in it because I haven't seen it for a few years"* (Female breast cancer survivor; Participant 5)

The cancer history and treatment summary in the SCP was highly valued by participants because it documented their cancer diagnosis and treatment in sufficient and individualized detail to be a useful resource.

My SCP Provides Direction

Twenty-three survivors described how they used the follow-up guidelines in their SCP to navigate their follow-up care. These guidelines helped survivors understand what to expect from follow-up care. This included understanding when they would stop their medication, the

frequency of mammograms, when to schedule scans, etc. As described by a female cancer survivor:

"Because we need some guidance, for sure, and this is a very helpful document to help us get through so that we kind of have some direction as to how to go about taking care of ourselves." (Participant 17).

The SCP was also used by survivors to keep track of their progress in follow-up care, such as tracking when tests were completed. As described by a male colorectal cancer survivor:

"Everything was there, documented, everything was laid out in the plan. All I had to do was just follow it. And of course, I had the doctor phone, or her secretary, and tell, 'don't forget about this appointment and don't forget about this.'" (Participant 24).

Five survivors provided descriptions of how they have used their SCP, one found the SCP to be a helpful summary document:

"I can get lost very easily, and the volume of, you know just the quantity of information that you know, I have to sort of manage, so for me the booklet and having it in writing, having it all sort of together in one file was good." (Female breast cancer survivor, Participant 8)

Another female breast cancer survivor described how they used their SCP to keep track of their follow-up tasks:

'Well, making sure that I'm getting my scheduled scans, and mammograms, and that type of thing and just making sure that everything's happening as it should happen." (Participant 9)

Seven survivors discussed the way they have used the information in their SCP as a communication tool to share information with health care providers. They indicated that they shared their SCP when changing PCPs, or with pharmacists, and when seeing a new specialist. As described by a male colorectal cancer survivor:

"I gave this to my family doctor, when I received this, we were in between doctors, we didn't have a family doctor, our family doctor had retired. So, we were sort of in limbo, so when we found a new doctor at a clinic nearby I gave this document to her. And so, I used it in that sense." (Participant 25)

Overall, it appears that survivors find some aspects of the SCP helpful. They can refer to it as needed and use the information to ensure they are receiving their follow-up care in a timely manner.

Theme 4) Factors Influencing the Use of Survivorship Care Plans

Twenty-six participants explicitly discussed factors that impacted whether they used their SCP. These factors were organized into three subthemes: a) practical factors; b) social factors; and c) emotional factors.

Practical Factors Influencing SCP Use

Fourteen cancer survivors described practical or logistical factors that either helped or hindered their ability to follow their SCP. Three participants described financial limitations that impacted their follow up care such as not having access to transportation for the WBCP education class or discharge meetings by community supports because these were not classified as "medical appointments" and being unable to afford their healthcare providers' preferred brand name medication. Another participant highlighted how their privileged position allowed them to very easily follow their SCP. They also reflected that individuals in more vulnerable or marginalized circumstances would likely have more difficulties having the time to consider what they needed to do in terms of their follow-up care. As she noted:

> *So, I'm hoping in the context of your own study, you're also thinking about, you know, from an equity of health outcome perspective, how it is that those plans might help or be used by individuals that are more vulnerable or marginalized. And I do not fall in that category, right, so for me, it was very like it was very easy to use that plan. I wonder about the ease of its use by somebody that wouldn't be like me, again, that be more marginalized or vulnerable."* (Female colorectal cancer survivor; Participant 20).

As these survivors highlighted, the role of "self-manager" or being an active member of their healthcare team can be difficult for survivors, despite having the knowledge and willingness to do so.

Four survivors stated that they had access to important community supports, including from The Ottawa Hospital's Psychosocial Oncology Program, and local healthcare providers that were able to make home visits. Those in small communities reported that having their PCP within their community was an important factor in making it easier to have their follow-up care. That said, the medical resources available in small communities were limited in comparison to what was available in larger cities. Five survivors in small communities mentioned that the distance between their homes, and the hospital where they have CT scans, mammograms and other follow-up tests completed was time consuming, and expensive. Further examinations of differences in receiving follow-up care with SCPs across survivors living in small and larger communities is reported elsewhere (Babiker et al., 2023).

Additionally, four survivors outlined difficulties their PCPs had in getting access to their SCPs, and test results that were completed at the hospital. More specifically, there was a disconnect in the electronic medical records (EMR) systems of PCPs and the hospital. Survivors seemed to perceive this disconnect between the EMR systems in the hospital vs. the system used by PCPs:

> *"He did mention, he said one thing when I was in there one time, he was reviewing, you know, after my colonoscopy, […] and then he said something about the hospital, but I had a feeling that he felt sort of disconnected, and you know, he didn't say that of course, but I got the feeling that there was a disconnect between the hospital and the doctors, and you know, I just had that feeling."* (Participant 17)

This issue is discussed further in Part 2 of this article series (or Mutsaers et al., 2023c) focusing on barriers and enablers to SCP use among PCPs. In sum, a range of logistical and practical factors impact how survivors use their SCPs, and the ease with which they can take on the "self-manager" role.

Social Factors Influencing the Use of SCPs

Sixteen survivors highlighted the common knowledge and experience that cancer survivors in general can provide one another. In terms of psychosocial support, five survivors indicated it would be helpful to have information on peer support resources in the SCP. As described by a female breast cancer survivor, being able to relate to others' experiences is very important:

> *"Yeah. Been there done that, or, we're all in the same boat, how are you dealing with it and what can you suggest? And just to know that you're not alone, that's the other part, too. You know, this is, as I say with my friend, my colleague, she's commented that she really just felt so alone and she's learned so much just from listening and you know, working through other things that different people experience and she's like, 'wow, yeah, I understand that, I've been there,' that sort of thing."* (Participant 7)

Sharing advice and tips on how to cope with the side effects of treatment and relating to others were also important aspects of follow-up care.

> *"and I think for many people first going to go something like this, you know, and I think - was part of the plan, I know we went to like a seminar, at the beginning, which was quite helpful then because you were with other people going through the same thing. So that was kind of a really useful tool as well."* (Female colorectal cancer survivor; Participant 29)

Support from others with similar experiences is an understandable and important aspect of survivorship. Overall, including resources to connect to others may be a helpful addition to SCPs.

Eleven survivors described how they rely on their family to help them navigate follow-up care. Family members attended appointments, helped keep track of follow-up tasks, and helped survivors understand medical terminology and what their follow-up cancer care entailed. With respect to SCPs, it was often used as a way to communicate the next steps in their healthcare with family:

> "*And this would certainly be helpful, too, I mean if you have, you know, families who, say older people, you know, have maybe a son or a daughter who comes home and says, you know, 'what's*

the doctor say?', well, if you've got a document like this or if the person is knowledgeable at all, like if the person maybe took grade 10 biology, you can actually go onto Google and look up some of the words. You know, they can look through this document and get a pretty good idea of what's going forward, you know." (Male colorectal cancer survivor, Participant 14).

Emotional Factors Influencing SCP Use

Twenty participants discussed their emotional experiences that occurred as they transitioned back to their PCP and moved through follow-up care. Specifically, about the SCP, a survivor noted that it was an important tool in providing some reassurance that there have been efforts to make this transition a smooth process:

"what I'd like to say is to basically say that is a great tool. Like I'm actually really grateful that I had that, just to be able to know what words to use, to know exactly what happened to me, you know, and it's providing me knowledge right, of what I went through. Being able to use it with my family doctor was easy and made things clear. For me it was really easy to use it afterwards and easy to establish communication. I was able to go from one hospital to your family doctor, you know, that was the link, the bridge, and I was thankful for that bridge." (Female breast cancer survivor; Participant 10)

Twelve survivors reported that being discharged from the cancer centre was difficult to accept. They described their belief that they receive better care at the cancer centre because they would be treated by oncology specialists:

"It's a scary thing when you're released, I mean everybody was happy that I'm being let go, they're ringing the bells there, and I was not happy, if I have to be honest, I was – like I felt like I was going to be better cared for at the cancer centre than I was going to be with my own physician. Not because she's not good, just because that's all they do, is cancer." (Female breast cancer survivor; Participant 3)

Overall, survivors described the challenges associated with this transition, but acknowledged that they needed to focus on building trust with their PCP, who has been assigned this new role of providing follow-up cancer care.

Discussion

The purpose of this study was to investigate how SCPs have been used in the real world by breast and colorectal cancer survivors. Barriers and enablers to using their SCPs were systematically identified using the TDF-2 and summarized with four themes: 1) survivors' engagement in follow-up care; 2) collaboration between survivors and their PCPs; 3) descriptions of how SCPs have been used; and 4) the practical, social, and emotional factors influencing if and how survivors use their SCPs. Facilitators of SCP use included: attending a survivorship education class (Environmental Context and Resources), viewing oneself as also responsible for follow-up care (Social Professional Role and Identity), using the SCP as a prompt to discuss follow-up care with their PCP (Social Professional Role and Identity), and having support from family and friends (Social Influences). Most survivors (23/30) reported that they viewed their PCP as in charge of their follow-up care (Social Professional Role and Identity) and stated that their SCP provided direction (Knowledge). Barriers of SCP use among breast and colorectal cancer survivors included: difficulties accepting discharge from cancer centre and coping with the emotional toll of cancer treatment making follow-up care engagement challenging (Emotion). Survivors had many suggested improvements for SCP use including having an electronic version of their SCP and wanting additional supports such as ongoing follow-up from the cancer centre and avenues for peer support (Behavioural Regulation).

Taking on the Role of "Self-Manager"

The realities of the health care system not only in Canada, but also the United States, Ireland, and Australia (Alfano et al., 2019) is that there are insufficient oncology specialists available to carry on providing follow-up care after primary treatment (Biddell et al., 2021; Jefford et al., 2022). New models of care have been described and one such model focuses on

allocating health care resources using a risk stratification approach (Biddell et al., 2021; Mayer & Alfano, 2019; Alfano, 2019). Survivors with low risk and relatively straightforward follow-up care needs are discharged back to their PCPs and are expected to self-manage their health post-cancer treatment (Biddell et al., 2021). In the present study, survivors who described readily using their SCPs for follow-up care understood the purpose of the plan and follow-up care. One aspect of self-management support includes providing follow-up information (e.g., late and long-term side effects of treatment that require attention, signs and symptoms of a recurrence of cancer, how to maintain health behaviours; Howell et al., 2021). Attending an education class on SCPs and the process of follow-up care was an important enabler of SCP use. Knowledge was a key TDF domain with facilitators associated with SCPs, where they often used SCPs as a reference provided guidance on follow-up care. Those who did not use their SCP note that they did not understand the importance of SCPs and filed them away with other documents or were misplaced. Providing information about follow-up care was highlighted as an intervention itself and was recommended by stakeholders which included survivors, caregivers, primary care providers, and policy makers (Murnaghan et al., 2021). The SCP can be one source of information, and ways to continue providing information as the survivorship phase progresses could also be beneficial (Murnaghan et al., 2021).

Improving Survivorship Care Plans

Participants had many recommendations for improving SCPs, including having an updateable and electronic version, and having additional resources for peer support, psychosocial support, and avenues for periodic contact with cancer specialists. Incorporating more individualized and adaptive models of follow-up cancer care, including electronic, application-based, and incorporating an individual's preferences into the content and formal of SCPs have

also been suggested as important facilitators for implementing a stratified model of care (Chen et al., 2022). As outlined by Biddell and colleagues (2021), the needs of cancer survivors can be diverse and require a range of health care providers, thereby the risk stratification approach to follow-up care could lead to better allocation of healthcare resources. SCPs have been identified as tools best suited for survivors with a "medium" level of needs, where SCPs facilitate coordination of care (Biddel et al., 2021; Howell et al., 2021; Jefford et al., 2022). That said, developing SCPs requires time and skilled providers whether that be oncologists, oncology nurses, or other specialised oncology health care providers (Rutkowski et al., 2021; Biddell et al., 2021). While standardized SCPs and individualized SCPs have been shown to provide relevant information to survivors (Rutkowski et al., 2021), it appears that information alone is insufficient for promoting self-management of one's own follow-up care. Education is needed on the responsibilities patients are expected to take on, along with signs and symptoms of worsening illness, and how to use resources (Biddell et al., 2021; Howell et al., 2021).

Future Research

It is yet unclear whether SCPs can help survivors and PCPs manage follow-up cancer care (Hill et al., 2020), but greater consistency in their content, format, and method of delivery is needed to prevent convoluted results when examining their effectiveness (Hill et al., 2020). With respect to content, consistency in the guideline recommendations suggested by oncology specialists is also a key ingredient to implementing SCPs (Hill et al., 2020). Future research could consider examining SCPs with greater standardization, and perhaps include educational and self-management supports in addition to the provision of SCPs. Given the variety of cancer survivors' needs and preferences, SCPs may be helpful for some to navigate follow-up care, but perhaps additional avenues to receive information and support would be helpful (Howell et al.,

2021; Jefford et al., 2022). With respect to implementation recommendations for SCPs, please see Article 4 (Mutsaers et al., 2023b).

Strengths and Limitations

This work has several strengths including interviewing end-users of SCPs (i.e., breast and colorectal cancer survivors) who have been provided with a SCP. Inclusion of survivors of both sexes, and two different cancer types adds some level of generalizability to the results. Furthermore, efforts were made to promote data saturation based on the 10+3 rule (Atkins et al., 2017; Francis et al., 2010), and to promote the trustworthiness of the data (i.e., development of a codebook, independent double coding, high inter-rater reliability). The TDF-2 is a commonly used framework for systematic identification of factors that impact behaviours and includes a manual to ensure consistency and high-quality investigation (Atkins et al., 2017).

Limitations of this work include the study of only one setting where the nature of the survivorship program from which SCPs are developed and provided may be unique. Other cancer types may or may not have reported similar experiences using SCPs. Finally, although participants included those who had and had not used their SCP, participants were self-selected which may have influenced the results and limit their generalizability.

Conclusions

Barriers and enablers to using SCPs among breast and colorectal cancer survivors were identified and will be used to develop best practice recommendations for implementing SCPs. In the context of finding ways to encourage self-management post primary cancer treatment, SCPs may be helpful. Future research is needed to clarify who SCPs are best suited for and the nature of additional supports needed to promote the use of SCPs as transition tools.

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Table 1

AACTT Framework for Cancer Survivor Behaviours Associated with SCP Use

AACTT	Behaviour of Breast/colorectal cancer survivor
Action	Read the SCP Discuss the contents with PCP Call PCP to arrange follow-up appointments
Actor	Self (Cancer Survivor)
Context	At home; at the PCP's office
Target	Self, and PCP
Time	Before upcoming appointments with PCP; during PCP appointment

Table 2

Summary of Enablers of SCP Use by Cancer Survivors

TDF Domain	Belief Statement	# Survivors Reporting
Knowledge	I use my SCP as a reference	14
	My SCP has a phone number to call	3
	I refer to my SCP to know the cancer drugs I received	3
	I refer to the SCP to make sure my follow-up appointments are on time	5
	I use the physical activity guidelines in the SCP	5
	I use the SCP to look up specific dates	3
	I use the SCP to refer to information about my cancer treatment	7
	I use the SCP to refer to information about my cancer history	4
	The SCP has everything I wanted to know	11
	Meeting with a nurse helped me understand my SCP	7
	The SCP is a helpful way to provide information to other doctors	7
	My SCP gives me direction for my follow-up care	23
Skills	I look up and can interpret my test results	4
	I made the follow-up appointment with the right person	3
	I use my SCP to manage my follow-up care	5
Social Professional Role and Identity	I contact my oncologist when needed	3
	I discussed my SCP with my PCP	18
	I am responsible for my follow-up too	15
	My PCP is on top of my follow-up care	23
Beliefs about Capabilities	I advocate for myself	5
	I am confident in my ability to navigate follow-up care	10
Beliefs about Consequences	Using my SCP will help prevent cancer recurrence	7
Memory, Attention, and Decision Process	I use my SCP as a reminder of the follow-up care I need	8
	I would forget the treatments I received if I did not have the SCP	6

Environmental Context and Resources	Availability of local supports	4
	I received my SCP at a discharge meeting	5
	I received my SCP in the mail	3
	I went to the discharge meetings	7
	I went to the WBCP education class	11
Social Influences	My family helps me use my SCP	11
	I relate to other cancer survivors	5
Behaviour Regulation	Survivors should attend discharge meeting	4
	Supplemental booklets are helpful	6

Table 3

Summary of Barriers of SCP Use by Cancer Survivors

TDF Domain	Belief Statement	# Survivors Reporting
Social Professional Role and Identity	My PCP is not a cancer specialist	4
Intention	I wish I knew how important the SCP is	2
Memory, Attention, and Decision Process	Not sure/don't remember receiving a SCP	2
	I put my SCP away and forgot about it	5
Environmental Context and Resources	Difficulties with follow-up care due to different EMRs	4
	I have to travel long distances for follow-up care	5
	The medications I need are not available in my town	1
Social Influences	I don't relate to other cancer survivors	2
Emotion	It is difficult to accept being discharged back to PCP for follow-up care	3
	Cancer treatment's emotional toll making follow-up challenging	4
Behavioural Regulation	Electronic version of SCP	4
	Wanting additional supports	22
	- Ongoing follow-up from cancer centre	12
	- Avenues for peer support	5
	- Ways to contact cancer specialists	5

Table 4

TDF Domains within each Theme

Theme	TDF Domains
1) Survivors engaged and motivated to use SCP	Knowledge Skills Social Professional Role and Identity Beliefs about Capabilities Beliefs about Consequences Intention Environmental Context and Resources Behavioural Regulation
2) Collaboration Between Survivors and Their PCPs in Follow-Up Care	Social Professional Role and Identity Intention Social Influences Beliefs about Consequences
3) Descriptions of How Survivors Have Used their SCP in the "Real World"	Knowledge Skills Memory, Attention, and Decision-Making Processes Intention Behavioural Regulation
4) Factors Influencing SCP Use	Environmental Context and Resources Emotion Social Influences Behavioural Regulation

Developing Best Practice Recommendations for Implementing Survivorship Care Plans Part 2: Experiences of Primary Care Providers

Abstract

Background: Primary care providers (PCPs) have been given the responsibility of managing the follow-up care of low-risk cancer survivors, rather than survivors continuing their follow-up with oncology specialists. While this shift in duties can allow for better allocation of health care resources, guidance is needed for PCPs and their patients who are cancer survivors. Survivorship Care Plans (SCPs) were developed to facilitate survivors' transition back to primary care, but research indicates SCPs may not be effective transition tools. This article presents the systematic identification of barriers and enablers to SCP use by PCPs in real world practice.

Method: An interview guide was developed based on the second version of the Theoretical Domains Framework (TDF-2). Physicians working in primary care settings participated in 15–20-minute semi-structured interviews. Qualitative content analysis was used to develop a codebook to code text into each of the 14 TDF-2 domains. Thematic analysis was also used to generate themes and subthemes within and across the TDF domains.

Results: Thirteen primary care providers (all medical doctors) participated in an interview. Key barriers to SCP use for PCPs were: unfamiliarity with the side effects of cancer treatment (Knowledge), lack of clarity on the roles of different healthcare professionals (Social Professional Role and Identity), follow-up tasks being outside of scope of practice (Social Professional Role and Identity), increased workload, lack of options for psychosocial support for survivors, managing different electronic medical records systems, logistical issues with liaising with oncology (Environmental Context and Resources), and patient factors (Social Influences).

Conclusions: PCPs accept and generally feel comfortable taking on the role of managing follow-up cancer care. They value the information provided in SCPs and found the follow-up guidance provided most helpful. SCP use could be improved through streamlining methods of

communication and collaboration between oncology centres and community-based primary care settings.

Keywords: survivorship care plans, oncology, primary care, primary care providers, theoretical domains framework, cancer survivorship

Contributions to the Literature

- As SCPs are intended to be used by both cancer survivors and PCPs, developing a better understanding of how they are used in real world practice is an important first step in developing best practice recommendations for implementing SCPs.
- As end users of SCPs, the perspectives of PCPs on the factors that hinder and facilitate their provision of follow-up care is key to working toward improvements in the content, format, and delivery of SCPs.
- Before abandoning SCPs and deeming them ineffective, a detailed examination of factors that influence their use by PCPs in practice is needed to understand how to either improve SCPs or find alternatives to facilitate cancer survivors' return to follow-up care post primary cancer treatment.

Cancer survivors have specific and changing needs as they complete treatment and move into follow-up care (Fitch, 2018; Howell et al., 2011; Kotronoulas, et al., 2017; Rushton et al., 2015). These include regular surveillance for new or recurring cancers, management of the side effects of treatment (e.g., neuropathy, fatigue), providing emotional support, and managing other health issues. The breadth and individualized nature of follow-up cancer care has led to new models of cancer care being developed in order to meet the needs of cancer survivors (Biddell et al., 2021; Jefford et al., 2022; Mayer & Alfano, 2019). For certain survivors with fewer needs requiring specialists care, primary care providers (PCPs) may be an appropriate health care provider to manage follow-up care (Biddell et al., 2021). The rationale for the inclusion of PCPs includes: the nature of follow-up care is in the purview of PCP tasks, PCPs have long standing relationships with their patients, and a way to allocate healthcare resources so that oncology centres can focus on acute treatment and new diagnoses (Biddell et al., 2021; Fitch, 2018; Grant, et al., 2015; Jeppesen et al., 2018; Rushton et al., 2015; Sussman et al., 2017).

Research shows that PCPs provide the same level of cancer follow up care as would cancer specialists (Sussman et al., 2017). The time needed to diagnose a cancer recurrence were the same among PCPs and oncology specialists, and the management of physical and psychosocial (e.g., mood, anxiety, fear of recurrence) was provided at the same level of care among PCPs and oncologists (Grant et al., 2015; Sussman et al., 2017). As noted by the authors of guidelines for models of cancer survivorship, discharging low-risk cancer survivors (e.g., breast and colorectal) for follow-up care with their PCPs is safe (Grant et al., 2015; Sussman et al., 2017).

The transition back to primary care post cancer treatment can be challenging. Survivors tend to feel a mix of relief that they are being discharged, but also fear of losing the support of

oncology specialists (Fitch, 2018; Williamson & Stanton, 2018). PCPs play a key role in facilitating this transition. They are often the health care professional who found the cancer and have expertise in managing chronic illness (Jefford et al., 2022). That said, cancer survivors have specific follow-up cancer care needs that are now the responsibility of PCPs. Additional supports are needed to equip PCPs with the information, resources, and connection to oncology specialists needed for a successful post-treatment transition (Fitch, 2018). Survivorship programs and survivorship care plans (SCPs) can bridge the gap between tertiary and primary care (Rushton et al., 2015).

The Wellness Beyond Cancer Program (WBCP) is one such survivorship program associated with The Ottawa Hospital Cancer Center in Ottawa, Ontario Canada (Rushton et al., 2015). The program is geared toward breast and colorectal cancer survivors deemed low-risk and discharged by their oncologists back to primary care for follow-up. One of the resources the WBCP provides is individualized SCPs that are provided to both cancer survivors and their PCPs. SCPs outline key information about the individual's cancer history and treatments, identification of specific needs (e.g., chronic fatigue, psychological distress), healthy lifestyle behaviours recommended, and instructions for follow-up care. Instructions generally include the frequency of surveillance tests (mammograms, colonoscopy), recommendations for managing late and long-term cancer treatment side effects, signs and symptoms of recurrence, and contact information of local oncology centres (Rushton et al., 2015). SCPs are provided to both survivors and their PCPs to facilitate collaboration, and encourage survivors to take an active role in managing their follow-up care. The intention is that survivors take on responsibility for booking appointments and reminding their PCPs of their follow-up needs rather than depending solely on PCPs, who already have very high workloads (Birken et al., 2014).

Although SCPs make sense in theory, there lacks consistent evidence supporting their use (Hill et al., 2020; Jacobsen et al., 2018). As outlined in two systematic reviews of research studies on the impact of SCPs, there appears to be large differences in the content, format, and delivery of SCPs, inconsistent or irrelevant outcomes used to measure their effectiveness, and the possibility that SCPs are not useful for PCPs and cancer survivors for facilitating the transition back to follow-up care (Hill et al., 2020, Jacobsen et al., 2018).

PCPs perspectives on using SCPs

In general, PCPs are accepting of SCPs as transition tools (Klemanski et al., 2016) because they contain the information needed to provide follow-up cancer care, which increases their comfort in taking on the role (LaGrandeur et al., 2018). Potential barriers to SCP use among PCPs have been identified in an American setting, which included issues around funding for providing follow-up care, lack of time, issues with using different electronic medical records, and an already high workload (Luckter-Flude et al. 2018). Low levels of buy-in about the necessity of SCPs, and the need to have champions are also needed to facilitate their use (Birken et al., 2014). Furthermore, PCPs have reported concerns about their level of knowledge and confidence in providing follow-up care for cancer survivors (Dawes et al., 2015; Lucktar-Flude, 2018). Specifically in Canada, PCPs identified the following barriers to SCP use: the documents are too long, difficulties finding information in the EMR, and variation in the information provided in SCPs and associated discharge notes (O'Brien, et al., 2015). That said, PCPs have described factors increasing the usability of SCPs, such as a length of one page, clear and easy to find guideline recommendations, and developing systems for setting up follow-up care reminders (O'Brien et al., 2015).

Before abandoning SCPs more consistency in how SCPs are implemented is needed. This article is part of a larger study on developing best practice recommendations for implementing SCPs. An important step is to investigate how SCPs have been used by PCPs, one of the end-users of SCPs, in order to find ways to improve their uptake and usability as transition tools. The purpose of this study is to systematically identify barriers and enablers of SCP use among PCPs (Atkins et al., 2017).

Method

Detailed methodology is described in Part 3 of this series of articles (Mutsaers et al., 2023a). Using the guidance of the French Model (French et al., 2012), the first step delineating the behaviours associated with SCP use by PCPs was identified (French et al., 2012).

Step 1: Who needs to do what differently?

When considering a behaviour, researchers have identified the factors comprising behaviours with the Action, Actor, Context, Target, and Time (AACTT Framework; Presseau et al., 2019). Explicitly defining behaviours is important for structuring data collection and analysis (Atkins et al., 2017; Presseau et al., 2019). The research team used the AACTT framework to clarify the behaviors associated with PCPs using SCPs (See Table 1; Presseau et al., 2019).

Materials

A semi-structured interview guide was developed based on the second version of the Theoretical Domains Framework (TDF-2; Cane et al., 2012). The 14 different domains allow for systematic assessment of the barriers and enablers to specific behaviours, in this case PCPs using SCPs (Atkins et al., 2017). First, a minimum of one question per domain was created, and revised by the research team to include open-ended questions with prompts to avoid a sense of repetitiveness (Atkins et al., 2017). Questions for PCPs included “Did you feel you had the

necessary information to provide follow-up care for your patient?" and "What would make it easier to use SCPs?" If participants had never used an SCP, information was provided on their content and purpose, and their feedback was sought on the usefulness of such a document, and what would be needed to ensure SCPs are used consistently.

Participants

For PCPs, the inclusion criteria were a) a general practitioner/family medicine physician, or a nurse practitioner; b) had received at least one SCP from the WBCP at least 12 months prior to the interview (to ensure they had time to have used the SCP); c) could speak and understand English or French; and d) provided consent to participate in a one-time 15–20-minute telephone interview.

Recruitment and Procedure

PCPs were recruited from a database connected to the WBCP and were mailed invitations to participate in an interview. Because PCPs are highly difficult to recruit (Davin, 2022), PCPs were also recruited by networking among PCPs, including telephone or email invitations by known PCPs (i.e., co-investigator Dr. MH Chomienne). All PCPs who participated in an interview were medical doctors. PCPs who were interested in participating contacted the research team through telephone or email communications, and consent was reviewed (Appendix C) and verbal consent was obtained over the telephone with TL. A copy of the consent form was mailed or emailed to participants based on their preference, and a copy of the interview questions (Appendix F) were provided ahead of the interview if the participant wanted to review them before the interview. BM conducted interviews in English, and SL conducted an interview in French. Interviews were conducted over the telephone as per public health restrictions during the COVID-19 pandemic, were audio-recorded and transcribed. The French interview was translated

from French to English by a member of the research team. PCPs were compensated with a $100.00 gift card, which were mailed to participants after the interview.

Data Analysis

A summary of the data analysis is presented here (see Paper 3 of this series for a detailed description of the data analysis; Mutsaers et al., 2023a). In order to promote consistency of the text coded into each of the 14 TDF domains, BM and TL created a codebook to guide initial content analysis (Appendix H). Within each of the TDF domains text with similar concepts were grouped together and represented with a "Belief Statement" (Atkins et al., 2017; Patey et al., 2012). Using thematic analysis, themes and subthemes were identified across the TDF domains (Creswell, 2015). The 10+3 rule for data saturation (Fancis et al., 2010) guided the recruitment of 13 PCPs, and no new information was found after the initial 10 PCP interviews. To increase the trustworthiness of the data analysis four PCP interviews were independently coded into the 14 TDF domains by BM and TL. The Krippendorf's Alpha statistic was used to measure inter-rater reliability and was 0.89 which indicates there was high agreement and reliability in the coding (McHugh, 2012).

Ethical Approval

Ethics approval was provided by the Ottawa Health Science Network Research Ethics Board (file # 20200152-01H).

Results

Thirteen PCPs completed an interview. The average number of years in practice reported at the interview was 15 years (range 5 to 38 years). The average duration of the interviews was 21 minutes (range 14 to 30 minutes). After 10 interviews, an addition three were conducted and no new information arose, suggesting that data saturation was reached (Francis et al., 2010).

Knowledge, Social Professional Role and Identity, Environmental Context and Resources, Social Influences, and Behavioural Regulation were the most prevalent TDF domains for the use of SCPs by PCPs. Tables 2 and 3 outline the barriers and enablers of SCP use, respectively.

Three themes emerged from the data: 1) coordination of care with other specialists and healthcare professionals (Knowledge, Social professional Role and Identity, Beliefs About Capabilities, Environmental Context and Resources, Behavioural Regulation); 2) collaboration between PCP and survivor (Social Professional Role and Identity, Environmental Context and Resources, Social Influences, Emotion); and 3) acceptance and understanding of PCPs being in charge of follow-up care (Social Professional Role and Identity, Beliefs About Consequences, Intention, Memory Attention and Decision Process, Environmental Context and Resources, Emotion). Table 4 outlines the TDF domains within each theme.

Theme 1) Using SCPs to Coordinate Follow-up Care

In coordinating follow-up cancer care for their patients, ten PCPs stated that the information included in the SCP is highly relevant and useful. More specifically, they found the follow-up care instructions summarized in a table at the end of the SCP particularly useful:

> *"I think having a very detailed and very clear plan from the treatment team is so useful in being able to just go over it with the patient so that they know that, you know, we're all on the same page in terms of what the type of, you know, interval will be for subsequent examinations and investigations and monitoring."* (PCP 8)

PCPs also noted that the other information included in the SCP was helpful to refer to if needed, but that the summary table was highlighted as a factor promoting the use of SCPs, because it was easy to find when needed:

> *"The other information is good if I need to do a deep dive, but 90 percent of the time I'm looking at the note, I don't need to do a deep dive. I need to, in the middle of a meeting, go back and say, "OK, this was related to your cancer. Let's go back and just see what the cancer care guide said about how we're supposed to pull this out. OK, great. This is*

> *our follow-up, boom, and we're going to do this." If I have to wade through 10 pages to figure out what my actions were, that's not a useful note to me."* (PCP 13)

All thirteen PCPs described their processes for providing follow-up cancer care, which involved booking appointments, ordering tests, and responding to patient's concerns. SCPs were used as a starting point to discuss the process of follow-up care with their patients. The plans also provided PCPs with a framework for organizing themselves for providing follow-up care, and receipt of a SCP prompted PCPs to set reminders for appointments based on the recommended follow-up guidelines. PCPs noted that performing the tasks outlined at the end of the SCP was easy. As described by a PCP discussing follow-up care for a colorectal cancer survivor:

> *"…like colonoscopy, I can arrange that, it's not a problem, uh, chest X-ray, CT scan, if needed, you know, CEAs, you know, the follow-up is fairly easy."* (PCP 4)

They described how receiving guidance from oncology specialists streamlined the process as they often do not have time to review and keep up with changing guideline recommendations for each cancer type. They also found the follow-up information reassuring because they knew it was provided by oncology specialists:

> *"…as family doctors, we're not always able to be, you know, right up to date with the most recent guidelines and recommendations for, you know, each type of cancer, the appropriate follow up, so, having that road map that's provided in the document is key, just to make sure that I know that I'm providing the care that, you know, the level of care that I'm hoping to provide to my patients and that they're being followed appropriately."* (PCP 8)

Seven PCPs described several challenges associated with performing the tasks outlined in the SCP. They described logistical challenges with ordering follow-up tests which was a reportedly convoluted process:

> *"…with regards to guidelines being easy, from my perspective, that once it goes on to colonoscopy, it's no longer easy and guidelines and recommendations are very conflicting"* (PCP 10)

They also described how tests they had ordered had not actually been ordered, leaving PCPs to search for alternative options to ensure that their patient's follow-up tests are completed on time. As described by one PCP:

> *"I was the one calling back and forth, the paper says it was ordered, and then cancer centre saying, "well no, we didn't do it", and then in the meantime, my patient has now been 9 months post, you know, she was supposed to have it, and now there is none, and I'm supposed to run around trying to find her a mammogram, like, yesterday, kind of thing."* (PCP 2)

They also described how they dealt with conflicting guidelines, and had concerns about guidelines changes in the future:

> *"I'm also aware that the guidelines will change, right? So, what is, for the Wellness Beyond Cancer Program plan that you sent me now, you know, I'm still ordering things in five or ten years, but then, you know, will that still be up-to-date, right? I don't have access and I wouldn't know where to find the guidelines or how to implement them"* (PCP 6)

Additionally, three PCPs identified aspects of providing follow-up care that requires more clarity. For example, when follow-up care tasks should end:

> *"So, you know, really, what do I need to know, you know, keep it to a minimum what I need to know, but more importantly, what do I need going forward? So, if it's a certain exam, if it's a mammogram, it's knowing how long they need to be on their hormone replacement therapy."* (PCP 11)

Nine participants spoke about how they defer to specialists when needed. A key issue reported by PCPs was how best to seek help from oncology specialists:

> *"...having that be clearer on the wellness paper that we get that, you know, "here's how you would go about, you know, calling us and contacting us if you have any concerns or questions about, you know, the patient's ongoing care needs."* (PCP 8)

They also mentioned how communication with oncology specialists initiated by PCPs and/or by cancer survivors often became circular. As described by one PCP:

> *"Yeah, and I also find the notes, and I think it's in the cancer plan, but the note in the discharge plan says "for any questions, just contact your primary care provider", and sometimes we're not very well-equipped to answer these questions, right, like they'll ask me a question and I'm like, "I don't know, my answer would be to call them back", because they're the cancer specialists and this is all they do, but then they run into the problem of "well, when I call them, they said to call you" and I'm like, yeah okay, I'm not gonna throw you back to them, I guess I can deal with it myself."* (PCP 2)

PCPs noted that while the information in the SCP contains helpful guidance, they were unsure of the process around consulting cancer specialists regarding unusual test results:

> *"...like if something happens, if your test result comes back abnormal, who to contact, right? But most of the time, as I said – it just happened actually, that the patient is in remission and I got the result, abnormal. So, but I had all the information there so I right away sent the letters, informed the patient, booked a follow-up call, so she doesn't think I'm just sending it, I will have a follow-up with that."* (PCP 5)

It appeared that the contact information that PCPs can use to consult with oncology specialists is included in discharge notes, rather than in the SCP specifically:

> *"Yes, exactly, whenever I receive anything, and I think the oncologists write it at the end of their notes, like, "if you have any questions or if anything changes, you are more than welcome to contact us at this number for this information", so I always keep it with me, making sure that in case I need it, I can contact."* (PCP 5).

These PCPs described how they frequently used an e-consult service when they had questions for specialists:

> *"...when the primary care provider has a question specifically for a specialist, and we will – we can write online, the only issue with E-consult is it's great but it's not in our EMR. If I have a question for example, I have this patient, cancer survivor, has had this type of breast reconstruction surgery, what type of mammogram should I be ordering? Like what type of frequency, what kind of sites are able to do the mammogram, and things like that, so I'll send it off to oncology, and sometimes there's like, oncology breast, or oncology lung, so you will submit these types of question to a specialist and they will respond within a week or two weeks, which is really great, we get a rapid response."* (PCP 6)

Furthermore, six participants described how they approach psychosocial concerns brought up by their patients who are cancer survivors. They noted that providing or referring to community resources for psychosocial supports is difficult because such resources are limited:

> *"So, that's a burden that unfortunately all family docs have to overcome with all of their patients in a world where there's very little to offer for free, for mental health, so unfortunately that's all of us that struggle with that. And definitely there's no obvious solution any time soon."* (PCP 10)

Nine PCPs described the benefits and challenges of using the electronic medical record (EMR) in providing follow-up cancer care. They stated that they used their EMR to set reminders for when follow-up tests need to be ordered. However, the process of getting the SCP integrated into the PCPs' specific EMR can be time consuming:

> *"And it's impractical that the care plan is not integrated in the EMR, but it's fine, you know, I would still have to set myself a bunch of reminders, so I take 15-20 minutes, go through the care plan, set all my reminders, then I'm good to go, right?"* (PCP 6)

Another PCP reported that when they receive a SCP it is directly inputted in their EMR, thereby making this process easier:

> *"I think it's quite standard now, because we receive the faxes through the EMR now, so whenever the faxes come it comes directly in the EMR and we enter it into the file. And sometimes it comes directly from the hospital, like my clerks don't have to enter in in my patient's file, it automatically is transferred."* (PCP 5)

PCPs described finding SCPs a helpful source of information and guidance but face logistical barriers that can be improved upon to make providing follow-up care a smoother process.

Theme 2) Collaboration Between PCPs and Survivors

All PCPs described how they collaborated with their patients to whom they are providing follow-up care. Five PCPs described how they took on the responsibility of ensuring the patient adheres to the follow-up schedules:

> *"it puts a lot more of the ownership on us to make sure that we've ordered the tests and received the tests, because a lot of the time patients will assume that no news is good news, so it kind of just forces me to do a lot more sort of background checking, and you know, setting reminders in my EMR to look out for those results in 6 months' time, was it ordered, was it done? So, it does force us to be more proactive in ordering, especially for checking."* (PCP 7)

Ten PCPs empathized with the emotional experiences of cancer survivors, including how some survivors may feel hesitant about leaving the cancer centre, coping with the impact of being diagnosed with a life-threatening disease, fear of recurrence, and feeling relieved about being healthy enough to be discharged from the cancer centre. For example:

> *"I think if the patient is just discharged and saying, you know 'Go see your family doctor if anything comes up' and, you know, it would be - that would be that would be very, I think that would cause a lot of anxiety on the physician's part and the patient's part. I think the care plan is really helpful."* (PCP 9)

They also acknowledged that it makes sense that they provide follow-up cancer care because of their ongoing relationship with their patients:

> *"The fact of coming to the physician is, uh – well, we – usually we have been through the screening, the detection of the cancer, the initial steps, and as patients, know I follow them all through their cancer treatment and follow-up, so it's just a natural thing to follow-up with them, and I think they're happy with that."* (PCP 4)

PCPs also discussed how despite their efforts to ensure their patients have their follow-up tests completed on schedule, some survivors did not participate in these tasks:

> *"I guess if things were to change with the patients, if you know, there was a change to the health status, or if there was a change in their approach, like if they feel it's too onerous, like they don't want to do a test or two every year, they don't want to do it anymore, and I'm making sure that they understand the pros and cons and making an informed decision, I'll go with their decision ultimately."* (PCP 7)

As described by one PCP, treating other health issues can become a higher priority than follow-up care tests:

> *"And there's always other distracters that come in, well, not other distractors, there's other medical issues that come in. So, [a patient] has no problem coming in for her hypertension exam. But when it comes time for her breast exams, it's really not the reason why she's there. So - and it's sometimes they're coming in for their anxiety, sometimes they're coming in for their depression, and that's their primary motivator to come in and they'll minimize that part of the follow up. And then it becomes secondary."* (PCP 11)

Four PCPs highlighted how their patients use their SCPs to initiate appointments:

> *"…usually people are pretty good at remembering that, so, there's a back-up because I have it in my file, and the patient has it in hers, you know, so it's unlikely that we're going to miss, so I don't think scheduling is a big problem, because there's two of us that put in reminders in our agendas."* (PCP 4)

The importance of patients taking some responsibility for their follow-up care was echoed by seven PCPs. For example:

> *"I also try – like, most of my patients are quite good, they're also young, so mostly I also leave it a lot up to them, to say like, "look, I have a message in the chart, but it's also your responsibility to at least check in with me every 6 months, so that when I see your name and I go into the chart, then I have that reminder to be like, oh, okay, it's November, we're due to do like, all of this stuff."* (PCP 2)

> *"I don't have a system in place that regularly calls the patient in for a specific exam, whether it be for abdomen or breast or chest wall exam, and I leave that portion up to the patient."* (PCP 6)

PCPs appear to understand their role in follow-up care, and see the SCP as an important tool for both themselves and cancer survivors. Generally, the attitudes of PCPs reflect the viewpoint that survivors are expected to take on some aspects of their follow-up.

Theme 3) Acceptance and Understanding that PCPs Have the Role of Providing Follow-up Care

All 13 PCPs accepted the role of providing follow-up cancer care and reported that SCPs are helpful in this endeavor. Four PCPs accepted their role in providing follow-up care, but acknowledged that this leads to increased workload:

> *"because the reality of primary care, as I'm sure you're aware, is there's a lot of long-term follow-ups that are being downloaded on family physicians, you know? So, the geriatric network, cancer follow-up, preventative care and things of the sort, and there's only so many things I can track, right?"* (PCP 6)

Another PCP acknowledged the challenges of having to add provision of follow-up cancer care to their already full workload:

> *"I mean, there's probably some resentment in that, you know, it's now, all of a sudden there's more work, for what I was considering at that point a shared patient, but you*

> *know, in a system like ours, I recognize that there is going to be a certain amount of downloading so that we can preserve resources for the most appropriate use, and if the patient doesn't have cancer, there isn't really any reason for them to see cancer doctors."* (PCP 3)

Five PCPs described feeling negative emotions about providing follow-up cancer care, including frustration because of these logistical issues and lack of clarity around how to handle abnormal test results:

> *"I find what's not clear is what they're gonna do if I find something, that I find a little annoying, to be quite honest."* (PCP 2)

On the other hand, five PCPs described feeling positive about providing follow-up care because it represents survivors recovering from a cancer diagnosis, and creating a closer, trusting doctor-patient relationship. For example:

> *"So, it's actually very fulfilling to be able to kind of reconnect with them and to kind of see them, as they kind of go on to restart the kind of next chapter after having successfully gone through the treatment process. I think it's very, it's very rewarding*." (PCP 8)

> *"Yeah, so, being a family doctor that whenever we receive the cancer survivors and all the details and you know, their – how to care for them, like in the future, I feel like it strengthens my relationship with the patients because they feel like they're not just left alone, because once they stopped with their oncologist, like their wellness care, they have this ongoing support from me. And that's not only important for them, but for myself too, right, because I know what exactly is happening and how I would be helping them in the future."* (PCP 5)

With respect to the SCP, two PCP noted that it provided a sense of security around providing follow-up care:

> *"I mean, that's basically been my experience is that, you know, being a primary care physician, you often are not sure, depending on the type of cancer, what sort of frequent, what sort of follow up is expected and what frequency is expected and so on. And that plan is usually helpful in relieving a lot of the uncertainty from the physician point of view, but also the insecurity from the patient point of view."* (PCP 9)

SCPs appeared to be a helpful tool to facilitate PCPs' role in providing follow-up care. Barriers to following SCPs were primarily related to logistical factors, and despite logistical challenges, all the PCPs interviewed viewed this role as appropriate and were willing to provide follow-up cancer care to their patients.

Discussion

The present study focused on systematically identifying barriers and enablers to SCP use by PCPs. Barriers were primarily related to additional workload due to a lack of clarity around the best procedures for ordering and receiving follow-up test results. Contact with oncology specialists was needed throughout the process of providing follow-up care. When confusion arose around the best ways to consult with oncology, PCPs problem-solved to have their questions answered (i.e., reviewing other documentation, using e-consult). Although PCPs did acknowledge the increased workload associated with being assigned the role of providing follow-up care, any negative experiences or emotions reported were related to environmental barriers within the healthcare system. The SCP itself was described as helpful and included relevant information in an easy-to-follow format. PCPs found that it was a helpful tool to discuss follow-up care with their patients, and that patients also having a copy of the plan facilitated the timely scheduling of follow-up appointments. Overall, the SCP was an important source of information about follow-up care, but additional supports are needed depending on their patients' individual needs.

Allocation of Health Care Resources: The Role of PCPs

In risk-stratified models of care, PCPs have been deemed appropriate to support low-risk cancer survivors who can self-manage their care after active treatment (Biddel et al., 2021; Jefford et al., 2022). Survivors with more complex needs are also discharged back to primary

care where their care could be shared between PCPs and oncology specialists (Biddell et al., 2021; Chan et al., 2023; Jefford et al., 2022; Mayer & Alfano, 2019). In order to implement these models of care, care planning, information provision, and ways to coordinate care are needed (Chan et al., 2023). Systematic reviews have found that the following factors are important in facilitating good health outcomes: a) clear avenues of communication; b) planning ways to meet the needs of survivors and; c) ensuring guidelines for each cancer type are followed (Chan et al., 2023). The PCPs interviewed in the present study found SCPs helpful in guiding follow-up cancer care, but additional supports are needed. As reflected in the literature, PCPs need more education and information on cancer-specific issues, despite having experience managing other chronic illnesses (Biddell et al., 2021; Chan et al., 2023). Many PCPs described the need to consult with oncology specialists on an ongoing basis. In line with these results, authors have argued that it is not realistic to expect PCPs to be able to manage follow-up care without the input of specialists. Despite wanting to learn more about cancer survivorship, other demands on PCP's time can interfere with their ability to do so (Chan et al., 2023; Mayer & Alfano, 2019).

When considering ways to promote the use of SCPs, the results indicate that factors within the health care system itself must be examined. As highlighted in a systematic review of new models of care for cancer survivorship, a key facilitator of implementation was offering a range of options for communicating and coordinating care (Chan et al, 2023). More specifically, application-based, virtual/telehealth and other technologies can streamline the process of communication among PCPs, oncologists, and patients (Biddell et al., 2021; Chan et al., 2023). Preliminary work on videoconferencing between PCPs and oncologists, suggests that such methods of communication can facilitate the provision of follow-up care in a timely fashion that specifically meets the individual needs of survivors (Trabjerg et al., 2021). Furthermore,

consistent policies around how best to order follow-up screening for new and recurrent cancers, and consulting oncology specialists when survivorship needs are out of scope for PCPs to manage are needed (Biddell et al., 2021; Becevic et al., 2023).

Future Research

While PCPs' role in different models of follow-up care have continued to be explored (Biddell et al., 2021), SCPs appear to be a useful source of information for PCPs. Additional research is needed on ways to improve their integration into the daily practice of PCPs such that the addition to their workload is minimized. Streamlined approaches to communication between PCPs and oncology specialists is needed to facilitate PCPs' ability to follow through with test ordering, receipt of results, and the steps that need to be taken should test results indicate that further action is required. Paper 4 outlines implementation recommendations for SCPs (Mutsaers et al., 2023b).

Strengths and Limitations

The barriers and enablers of SCP use were identified based on the perspectives of PCPs, who are one of the intended end-users of SCPs (Rushton et al., 2015). Participants were familiar with SCPs and had used them prior to the interview which is an important strength. Data saturation was reached based on the guidance from the 10+3 rule (Francis et al., 2010). The research team developed a detailed codebook outlining the decision rules for organizing texts into each of the 14 TDF domains, which facilitated a high inter-rater reliability suggesting that the analysis was consistent across independent coders (Atkins et al., 2017; McHugh, 2012). Limitations included the small sample size, and the inclusion of PCPs from the Ottawa area only may limit the generalizability of the barriers and enablers identified.

Conclusions

With the barriers and enablers of PCPs using SCPs identified in the present study, best practice recommendations for implementing SCPs will be developed. Within the overall context of finding ways to ensure cancer survivors receive the follow-up care they need, SCPs have a place in coordinating care between PCPs, oncology specialists, and cancer survivors. SCPs also provide succinct information that facilitate the provision of follow-up cancer care.

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Table 1

AACTT Framework for Primary Care Provider Behaviour Associated with SCP Use

AACTT	Behaviour of Primary Care Providers
Action	Read the SCP Book follow-up tests Book follow-up appointments Interpret test results Answering patient's questions Responding to patient's needs (e.g., for psychosocial resources) Make decisions for patient care when patients' needs are out of scope of practice (e.g., consulting specialists, other members of patient's cancer care team) Following up on the status of follow-up tests booked, and associated results Seeking out knowledge and consultation on cancer-specific treatments (e.g., when to stop tamoxifen)
Actor	PCP
Context	The PCP's office
Target	Patients for whom an SCP was provided Guidance for self on managing follow-up cancer care
Time	Every 3-6 months (depending on when tests need to be ordered and followed up on)

Table 2

Summary of Enablers to SCP Use by PCPs

TDF Domain	Belief Statement	#PCPs Reporting
Knowledge	SCP has follow-up care guidelines	7
	Information in SCP is relevant	10
	SCP outlines tasks for PCPs	10
Social Professional Role and Identity	I book tests, appointments, respond to concerns, etc.	13
	I can solve problems using the SCP	2
	Patients should take responsibility too	7
	Oncology specialists create the plan, so I follow it	4
	I'm used to providing follow-up cancer care	9
Beliefs About Capabilities	Providing follow-up cancer care is easy	8
	I can handle the responsibility of providing follow-up cancer care	3
Beliefs about Consequences	Using SCPs will lead to a positive outcome	2
Memory, Attention and Decision Processes	I use the SCPs to create reminders for myself	9
Environmental Context and Resources	Layout of SCP makes things clear	5
Social Influences	I keep the patient on schedule	5
	I provide patients with the support they are asking for	6
	Patients remind me when follow-up tests are needed	4
Emotion	PCP's positive emotions about providing follow-up care	5

Table 3

Summary of Barriers to SCP Use by PCPs

TDF Domain	Belief Statement	#PCPs Reporting
Knowledge	I don't know what treatments my patient is receiving	7
	Not knowing about side effects of cancer-specific medication	5
Social Professional Role and Identity	I need to defer to specialists	9
	I don't know what to do if test results are abnormal	2
	I don't know who is responsible for a task	4
	Some tasks of follow-up cancer care are outside of my scope of practice	3
Beliefs About Capabilities	Challenges providing follow-up care	7
Beliefs about Consequences	Providing follow-up care adds to my workload	4
Environmental Context and Resources	Challenges with finding psychosocial support for patients	6
	I don't have the SCP	2
	Logistical issues	11
	Using e-consult	3
Social Influences	Patient emotions affects SCP use	7
	Patient intentions affect SCP use	8
	Patients miss follow-up appointments	3
Emotion	Impressions of patients' feelings about receiving follow-up cancer care from PCP	10
	PCP's negative emotions around providing follow-up care	5
Behavioural Regulation	Clarity needed on expectations for follow-up cancer care	3
	Suggestions to improve format or delivery of SCPs	7
	More information needed on psychosocial supports available to patients	5
	Descriptions of the type of information that would be helpful to include in SCPs	6

	Patient education on follow-up cancer care is needed	3
	PCPs wanting a streamlined way to contact oncology specialists	2
	Develop ways to update plan or patient information	5

Table 4

TDF Domains Within Each Theme

Theme	TDF Domains
1) Using SCPs to coordinate follow-up care	Knowledge Social Professional Role and Identity Beliefs about Capabilities Environmental Context and Resources Behavioural Regulation
2) Collaboration between PCP and survivor	Social Professional Role and Identity Environmental Context and Resources Social Influences Emotion
3) Acceptance and understanding of PCPs being in charge of follow-up care	Social Professional Role and Identity Beliefs about Consequences Intention Memory, Attention and Decision Process Environmental Context and Resources Emotion

Developing Best Practice Recommendations for Implementing Survivorship Care Plans Part 3: Integrating Implementation Science Approaches to Learn from Real World Practice

Abstract

Background: The effectiveness of Survivorship Care Plans (SCPs) as a tool to help cancer survivors transition back to primary care for long-term follow-up after they complete active treatment is unclear. While initially strongly recommended, the lack of standardization in the content, format, and delivery of SCPs across studies may be important contributors to the mixed evidence. The purpose of this study was to use Implementation Science approaches to explore how SCPs have been used in practice by survivors and their primary care providers (PCPs) and develop best practice recommendations to optimize the implementation of SCPs. This paper aims to: 1) provide rationale for the frameworks used and how they were integrated; 2) present a detailed example of how these frameworks were used from study development through final recommendations; and 3) outline lessons learned and guidance for implementation researchers.

Method and Results: Thirteen PCPs, and 30 breast and colorectal cancer survivors participated in semi-structured interviews based on the Theoretical Domains Framework (TDF). Analysis involved integrating the TDF (i.e., coding utterances into TDF domains), the Behaviour Change Technique Taxonomy (BCTTv1; linking BCTs to TDF domains to develop strategies to address barriers and enhance enablers to SCP use), and a logic model to ultimately develop a user-friendly flow chart to help implementers of SCPs easily find evidence-based suggested approaches that are adaptable to different contexts. This approach generated detailed data that allowed for flexible and adaptable implementation recommendations to be developed. Analyses provided a thorough understanding of the inter-relationships between survivors, PCPs, and oncology specialists that are needed to successfully implement SCPs for use as intended. Using the Human Behaviour Change Project's latest work linking TDF domains to BCTs was an

essential component of the analysis that generated a wide variety of implementation ideas that could be helpful in multiple settings.

Conclusion: This work presents a rationale and worked example of how the TDF and the BCTTv1 taxonomy can be integrated to develop flexible, adaptable, and relevant implementation recommendations.

Keywords: implementation science, theoretical domains framework, behaviour change technique taxonomy, primary care, cancer survivorship

Contributions to the literature

- Implementation science literature includes many theoretical frameworks, taxonomies, and approaches with the aim to generate greater consistency in reporting across studies, however there are few worked examples in the literature demonstrating how these frameworks and taxonomies can be integrated to develop implementation interventions
- Generally, published implementation science articles do not describe their approach to study development and analysis in sufficient detail to allow others to learn from or replicate their approach
- This work also demonstrates how to approach complex contexts involving primary and tertiary health care systems
- It is hoped that this detailed, step-by-step presentation of the methodology will assist other researchers in implementation intervention development and to facilitate replicability across studies.

To better allocate health care resources, low risk cancer survivors (i.e., breast, colorectal) are discharged after active cancer treatment back to primary care for follow-up (Fitch, 2018; Grant, et al., 2015; Jeppesen et al., 2018; Rushton et al., 2015; Sussman et al., 2017). To help facilitate this transition, survivorship care plans (SCPs) were initially recommended by the Institute of Medicine in 2006 (Runowicz et al., 2016; Sussman et al., 2018) and were also highly recommended by several organizations, including the American Cancer Society (Runowicz et al., 2016). In Canada, SCPs have been recommended by the Pan-Canadian Guideline for Survivorship Services for Adult Cancer Populations (Howell et al., 2011). The content includes an individualized summary of a survivor's cancer treatment, information about surveillance tests and follow-up guidelines, and recommendations about healthy living (Howell et al., 2011). While SCPs are believed to be helpful tools facilitating the transition back to primary care, systematic reviews do not provide strong support for the use of SCPs, with some studies finding positive, neutral, and even negative impacts of SCPs on cancer survivors (Hill et al., 2020; Jacobsen et al., 2018). As summarized by Hill and colleagues (2020), these findings may be due to 1) using irrelevant outcomes to measure the impact of SCPs, 2) significant variation in the content, format, and delivery of SCPs, and 3) the possibility that SCPs are not helpful transition tools as survivors return to primary care for follow-up.

1) Outcomes

The first potential reason for the inconsistent findings in systematic reviews of the impact of SCPs is that measuring distress, satisfaction, quality of life, or the presence of mood or anxiety disorders is beyond the scope of impact that a document with information about follow-up could have (Hill et al., 2020; Jacobsen et al., 2018). Because SCPs contain information that survivors and their primary care providers (PCPs) can use to ensure that their health care needs

are met, outcomes related to surveillance appointments being scheduled and attended, medication adherence, catching a new or recurring cancer early, access to psychosocial supports etc. are best suited to measuring the impact of SCPs (Jacobsen et al., 2018). A more meaningful examination of the impact of SCPs should include relevant outcomes that reflect the actual purpose of SCPs as transition tools that provide important information about managing their healthcare post cancer treatment (Jacobsen et al., 2018).

2) Differences in SCPs Across Studies

The second potential reason for the inconsistent findings in systematic reviews on SCPs is the wide variation in the content of SCPs, how they are delivered, to whom they are delivered, and their format (Hill et al., 2020; Jacobsen et al., 2018). This lack of standardization across studies makes research on the usefulness of SCPs more convoluted (Jacobsen et al., 2018). To address this issue, researchers have suggested that implementation science approaches be employed to optimize the use of SCPs and allow for more consistency across studies looking at the impact of SCPs on cancer follow-up care (Hill et al., 2020; Jacobsen et al., 2018).

3) SCPs are Not Effective?

A recently published systematic review and meta-analysis appeared to show that SCPs are ineffective as transition tools for cancer survivors (Hill et al., 2020). The authors highlighted that receiving a SCP can be mistaken for general information about cancer, and so survivors may not understand its value upon receipt. The authors also note that SCPs alone cannot bear the responsibility of survivorship care, and that research would benefit from considering the realistic purpose of SCPs (Hill et al., 2020). Therefore, before making the conclusion that SCPs are not sufficiently effective to justify the labor-intensive process of creating them, more meaningful examination with appropriate outcomes and consistency is warranted (Hill et al., 2020).

The Wellness Beyond Cancer Program

The SCPs examined in the present work were created by The Wellness Beyond Cancer Program (WBCP) which is part of The Ottawa Hospital Cancer Centre in Ottawa, Canada and was established in 2012 (Rushton et al., 2015). The WBCP provides SCPs to breast and colorectal cancer survivors who are referred to the program by their oncologists when they are ready to transition back to their PCP for follow-up care. The program also offers a needs assessment to populate the SCP, and an education class provided by nurses outlining the process of follow-up care, how to manage late and long-term side effects of treatment, and signs and symptoms of recurrence. SCPs are created by nurses at the WBCP, are individualized, paper-based and provided to survivors during a discharge meeting with an oncology nurse. The same SCPs are also sent to survivors' PCPs (Rushton et al., 2015).

Study Objectives

This article is a methodology paper presenting the development of best practice recommendations for implementing SCPs. The purpose of this article is to outline and provide an example of the implementation science methodology that was used to generate these recommendations. The overall research questions across both articles are: 1) how have SCPs been used in real world practice by primary care providers and breast and colorectal cancer survivors? 2) What are the barriers and enablers to SCP use? and 3) How can the barriers and enablers identified inform best practice recommendations for SCP use that are flexible and adaptable to a wide range of contexts? This work presents the process of study development and analysis with detailed supplementary files for interested readers to consult. Overall, it is hoped that this method can be used by other implementation researchers when a nuanced and complex implementation intervention needs to be created.

Method and Results

Choosing Implementation Science Frameworks

The number of approaches to implementation science research has ballooned in recent years (Damschroder, 2020; Nilsen, 2019), with experts in the field creating methods to help sift through the options and identify the most appropriate tools, often organized into theories, models, and frameworks, (Birken et al., 2018; Damschroder, 2020). The Theory, Model, and Framework Comparison and Selection Tool (T-CAST; Birken et al., 2018) was created to compare different implementation science approaches (i.e., theoretical models and frameworks) that could be used in implementation projects. The guidance provided by the Dissemination and Implementation Models in Health (University of Colorado Denver, 2022; https://dissemination-implementation.org/tool/) was also used in conjunction with the T-CAST to help clarify the most appropriate frameworks to use in developing recommendations to optimize the implementation of SCPs. The premise of this work was to examine how the end users of SCPs (i.e., PCPs and cancer survivors) actually use them in the real world. Based on the experiences and opinions of these end users, recommendations to optimize the implementation of SCPs across settings would be created. Based on these two purposes, two implementation science frameworks were chosen: 1) The Theoretical Domains Framework (TDF; Cane et al., 2012) and; 2) The Behaviour Change Technique Taxonomy version one (BCTTv1; Michie et al., 2008; 2013).

1) Using the TDF to Systematically Identify Barriers and Enablers to SCP Use

As defined by Nilsen (2015), one type of implementation science frameworks is a determinant framework. Determinant frameworks were developed to help identify how different factors (characterised as barriers and enablers) impact behaviours and related outcomes. These

frameworks also allow researchers to explore the interrelationships between the barriers and enablers, and to consider how such interactions could be modified to achieve a different or preferred outcome (Nilsen et al., 2015). The Theoretical Domains Framework (TDF) is a determinant framework initially published in 2008 with 12 different domains that help systematically look for barriers and enablers to desired behaviours (Michie et al., 2005). The TDF was validated, and a revised version (TDF-2) was published in 2012 where 10 domains from the initial version of the TDF were unchanged, the domain "Nature of the Behaviours" was removed, and the domains Optimism, Reinforcement, Goals, and Intention were added (Cane et al., 2012). The TDF has been used for behaviour change in implementation projects related to changing healthcare practice, lifestyle change programs, and mental health supports (Atkins et al., 2017). A manual has been developed for the TDF that is applicable to both versions outlining how to define the behaviours being examined, to collect and analyze data, and reporting the results (Atkins et al., 2017). The TDF-2 was chosen for this study because it is a standardized way of systematically identifying barriers and enablers to SCP use among PCPs and breast/colorectal cancer survivors. Given that participants will have used a SCP as part of their follow-up care, the systematic nature of the TDF-2 allowed for the detailed and nuanced factors related to SCP use to be identified (Atkins et al., 2017).

2) Using the BCTTv1 to Create Implementation Recommendations to Optimize SCP Use

In addition to providing a framework for systematically examining influences on behaviour, the TDF-2 is linked to the Behaviour Change Technique Taxonomy (Version 1; BCTTv1) which is made up of 93 specific and precise definitions of strategies to change behaviour (Michie et al., 2008; 2013). Since the use of SCPs involves complex behaviours, the BCTTv1 was chosen because a range of implementation suggestions can be created that are

adaptable to different contexts (Cane et al., 2015; Michie et al., 2008; 2013). Importantly, the BCTTv1 is one of the most researched and expert approved taxonomy for developing implementation interventions, thus bolstering the rigour of this work (Michie et al., 2021). A tool linking the 14 TDF-2 domains to specific BCTs has been developed based on research on these links and expert consensus (Michie et al., 2021). An online tool presents these links in a table that provides researchers with a visual representation of these links between the TDF domains and the BCTs (Human Behaviour Change Project, n.d.; https://theoryandtechniquetool.humanbehaviourchange.org/tool; Michie et al., 2021).

Study Design

With the TDF-2 and the BCTTv1 chosen as the main frameworks to create implementation recommendations to optimize the use of SCPs, the French Model (French et al., 2012) was used to guide the overall study design. As shown in Table 1, The French Model (French et al., 2012) comprises four steps: 1) describe the target behaviours by considering "who needs to do what differently"; 2) find a framework to guide the investigation of barriers and enablers of those behaviors; 3) describe applicable behaviour change techniques and ways to deliver them in practice; and 4) highlight key outcomes to measure the impact of the intervention on changing target behaviours (French et al., 2012; see table 1). For the first step the "Action, Actor, Context, Target, Time" (AACTT) Framework (Presseau et al., 2019) was chosen to define the behaviours applicable to SCP use. Within step 2 the Theoretical Domains Framework (TDF-2; Cane et al., 2012) was chosen to create the interview guides (one for PCPs and one for cancer survivors) and guided the development of a codebook to organize the interview text into the 14 TDF domains (Atkins et al., 2017). Within step 3, the Behaviour Change Technique Taxonomy (BCTTv1; Michie et al., 2008; 2013; 2021) was chosen to generate specific implementation

strategies to change behaviours associated with SCP use. Finally, step 4 included the use of a logic model to determine the most appropriate outcomes to measure the impact of SCP use, and suggestions for evaluating these implementation approaches.

Step 1: Who needs to do what differently?

For the first step of the French Model (French et al., 2012), the AACTT framework (Presseau et al., 2019) was used to clarify the behaviours associated with SCP use for both PCPs and cancer survivors. As outlined in Table 2, using SCPs as intended involves different, but complimentary behaviours between survivors and PCPs. These behavioural definitions were created and revised by the research team. Defining these behaviours carefully was important for creating the interview guides and structuring data analysis (Atkins et al., 2017; Presseau et al., 2019).

Why did we choose the AACTT framework?

Defining the behaviours that need to be changed by an implementation intervention has been notoriously vague in the literature (Presseau et al., 2019). The AACTT framework helps researchers to define behaviours in a precise way, which can allow for: a) more standardization and replicability; and b) to allow implementation researchers to learn from each other, which can help move the literature forward in a helpful way (Presseau et al., 2019). In terms of the present study, taking the time to carefully define the behaviours associated with SCP use clarified the format of the questions in the interview guide and helped the interviewer remain focused on the behaviours being assessed with follow-up questions. The thorough nature of the TDF-2 with 14 potential domains that could influence behaviour was also needed. Having 14 domains to assess allowed for a better understanding of the contextual influences on using SCPs and helped capture nuances in this process. Further, defining behaviours precisely can help in identifying the most

relevant outcomes to measure because carefully defining the behaviours addressed in an implementation intervention provides a better idea of what can reasonably be impacted by implementation interventions (Presseau et al., 2019).

Ethical Approval

Ethics approval was provided by the Ottawa Health Science Network Research Ethics Board (file # 20200152-01H).

Step 2: Examination of Barriers and Enablers of SCP Use

For the second step of the French Model (French et al., 2012), the TDF-2 (Cane et al., 2012) informed the creation of the interview guides for PCPs and breast and colorectal cancer survivors (Atkins et al., 2017). Having two interview guides was important because the implementation and real-world use of SCPs is complex, and involves multiple contexts in primary care, tertiary care, and in survivors' daily lives. By investigating, in detail, the factors influencing the end users (i.e., PCPs, cancer survivors), a range of options can be developed to enhance enablers and address barriers to their effective use of SCPs.

Step 2 a) Using the TDF to Develop the Interview Guides

Separate interview guides were created for PCPs and cancer survivors because the behaviours required for intended SCP use differed (Appendix E and F) The interview guides were initially modelled on those created by Presseau and colleagues (2017) where each of the 14 TDF domains had at least one question related to them, and participants could reflect on hypothetical behaviors if they had not yet had experience with the target behaviour (Presseau et al., 2017). The initial interview guides were initially long and repetitive. Based on team discussion, open-ended questions about SCP use with prompts were developed and refined to

ensure that the TDF domains were examined but repetitiveness was reduced (Atkins et al., 2017; Presseau et al., 2017). Questions for PCPs included: “Did you feel you had the necessary information to provide follow-up care for your patients?” and “[Are there] any time, resource, or logistical issues?” Questions for survivors included: “How has your SCP been useful to you?” and “What has gotten in the way of using your SCP?” Thirteen PCPs and 30 cancer survivors were interviewed over the telephone (due to the COVID-19 pandemic).

Data Saturation

The “10+3 Rule” has been used as a way of considering data saturation in qualitative methods used in implementation research (Francis et al, 2010). This rule has been recommended for use with the TDF (Atkins et al., 2017), and it suggests that after 10 interviews, additional interviews should occur in groups of three until no new information is found in these subsequent interviews (Francis et al., 2010). We wanted to make sure that there was sufficient saturation in three participant groups (PCPs, female breast/colorectal cancer survivors, male colorectal cancer survivors), and so a minimum of 39 participants (i.e., 13 in each group). In addition to including two types of cancer survivors (i.e., breast and colorectal), both biological sexes, and across urban and rural areas, (based on postal code) was the goal of recruitment. Please see related articles for additional information about differences in SCP use based on sex and cancer type (Giguère et al., 2023), and differences based on geographical location (Babiker et al., 2023).

Participant Compensation

PCPs were compensated for their time with a $100 gift card, and breast and colorectal cancer survivors were compensated with a $50 gift card. The gift cards were sent to participants via mail after participation in an interview.

Step 2 b) Created a Codebook and Coded the Interview Data into the TDF-2 Domains

To ensure consistency in coding utterances into the 14 TDF domains, BM and TL created two codebooks (one for survivors and one for PCPs) comprising decision rules for the content appropriate for each TDF domain (Appendix G and H). This step is important because differentiation between certain domains can be difficult once large amounts of data are analyzed and is considered good practice in demonstrating rigorousness in the qualitative analysis (Atkins et al., 2017). After all the data had been collected the survivors' interviews were put in a random order (using a random number generator; https://www.random.org) and the development of the codebook began with two interviews which were reviewed by BM and TL together to initially populate the codebook. Next, three additional randomly chosen interviews were coded independently. After each interview was coded, BM and TL met to discuss agreements and discrepancies in coding and the codebook was revised in an iterative process as decision rules were developed. The codebook for cancer survivors required ten interviews to develop, and final decision rules were reviewed by JP, an expert in implementation science and the TDF.

Creating the codebooks was an extensive and time-consuming process. Having two members of the research team who were familiarized with the transcripts and the TDF was essential to making the final decision rules differentiating between the 14 domains. Having an expert to consult and who provided guidance on strategies and ways to think about each domain was key and having had previous experience with codebook development and TDF coding facilitated the process. When differentiating between domains, consulting the tool linking TDF domains with BCTs (Human Behaviour Change Project, n.d.; https://theoryandtechniquetool.humanbehaviourchange.org/tool) was helpful because the BCTs that would make sense to address the utterances would correspond to a specific TDF domain. For

example, a belief statement related to PCPs reporting that they were not sufficiently aware of the side effects of cancer treatment: “I'm kind of in deep water when it comes to dealing with possible side effects of some of the medications. I might be a bit unsure if someone's joint pain is because of their breast cancer medication that they're on, trying to sort that out.” (PCP 8) could have been coded in Knowledge or Beliefs about Capabilities. The quote could align with the Knowledge domain because it relates to a need for information, but it could also align with Beliefs about Capabilities because it reflects doubt in their own judgement or ability to manage specific aspects of follow-up cancer care. The Knowledge domain is linked to the BCTs “Instruction on how to perform the behaviour” and “Information about health consequences.” While Beliefs about Capabilities also included the “Instruction on how to perform the behaviour” BCT, it was also linked with “Demonstration of the Behaviour” and “Behavioural practice/rehearsal.” When considering these links, the decision rule was made to code utterances about being unsure about side effects of treatment as Knowledge because providing information would be an appropriate way of addressing this barrier. It was more challenging to consider how showing PCPs how to manage the side effects of cancer treatment and having them practice that behaviour would occur given that PCPs are capable of managing side effects. Being equipped with additional information would likely be sufficient to help PCPs feel more confident in identifying side effects of cancer treatment.

Furthermore, the Skills domain was difficult to define for the PCP codebook because the tasks of follow-up care were already in the scope of practice of PCPs, and coding text as a barrier related to the Skills domain for PCPs had been difficult to differentiate from barriers associated with logistical factors (i.e., Environmental Context and Resources). After discussion amongst the research team, it was decided that no text would be coded in the Skills domain because it made

sense in the context of this study to assume that licensed health care providers have the skills to provide follow-up care. Relatedly, the literature on follow-up care has shown that PCPs provide the same level of care as oncology centres (Sussman et al., 2017), further suggesting that the idea of a lack of skill conceptualized as a barrier did not fit with the results. Based on the data, barriers and enablers to using SCPs were much more related to other TDF domains. After all the interviews were coded, the TDF-2 domains Optimism and Reinforcement did not have any text coded in them across both PCPs and survivor interviews. Finally, when conceptualizing Intention vs. Goals in the codebook development, the decision rule was made to not code text into the Goals domain. For example, in the survivor interviews, codes related to referring to information in a SCP as part of a course of action, or looking up specific dates, treatment history, or follow-up schedules as needed to reach a health-related goal were considered as decision rules for the Goals domain. When coding the text for both PCPs and survivors, utterances that could have potentially been coded into Goals, were primarily coded into Knowledge and Beliefs About Consequences domains. As an example, consider the quote "I use my SCP to avoid a return of the cancer diagnosis, or, if it were to return, ensuring that the return is caught early" (Survivor 11). The statement is an enabler to SCP use and could be coded into the Goals domains because the implication is that using the care plan would be in line with the goal of reducing the risk of having a cancer recurrence. However, the same text could also be coded in the Beliefs About Consequences domain because the participant describes the expected consequences of using the SCP. Referring to the Theory and Technique Tool (Human Behaviour Change Project, n.d.; https://theoryandtechniquetool.humanbehaviourchange.org/tool), Beliefs about Consequences was related to the BCTs "Information About Health Consequences," "Anticipated Regret," and "Comparative Outcomes of Future Outcomes." These BCTs appeared more actionable than

different forms of goal setting when considering implementation recommendations. The Goals and Intention domains were also convoluted. When coding, the Intention domain was determined to be a better fit in the context of SCP use for both PCP and survivor interviews. Again, the BCTs related to the Intention domain lend themselves better to addressing barrier and enablers than those BCTs related to the Goals domain. In sum, when creating the codebook and analysing the data it is important to also consider the purpose of the study and the next step of the data analysis when making decision rules. Using this approach in which the Theory and Technique Tool (Human Behaviour Change Project, n.d.) was used to differentiate between TDF domains was a helpful way to clarify the codebook and ensure more consistency among the two coders.

Krippendorf's Alpha for Inter-rater Reliability

Interviews were double coded in groups of two until a minimum of six (20%) of the interviews were double coded with good (minimum of 80% agreement) inter-rater reliability (Joffe, 2011). This method provided us with assurance that the codebooks were precise enough for replicability in coding (i.e., another member of the research team could likely reliably code the interview text into the same TDF domains that BM coded (Atkins et al., 2017; Presseau et al., 2017). Inter-rater reliability was calculated by Krippendorf's alpha separately for PCP and survivor data because the codebooks were different (Joffe, 2011; McHugh, 2012). The Krippendorf's alpha statistic was used to measure inter-rater reliability because it is a more conservative approach than other methods (i.e., kappa) since it controls for agreement based on chance (McHugh, 2012). A Krippendorf's Alpha of 0.8 or higher indicates strong inter-rater reliability (McHugh, 2012; Presseau et al., 2017). The average inter-rater reliability for the coding of six survivors' interviews and four PCP interviews was excellent at 0.91 and 0.89, respectively.

Step 2 b) Created Belief Statements, Subthemes, and Themes Across TDF Domains

After the data was coded into the 14 TDF domains, belief statements were created to organize similar utterances together within the TDF domains (Patey et al., 2012). Themes and subthemes across domains to more broadly understand how SCPs were used in practice were generated and are reported in the Parts 1 and 2 of this article series (Mutsaers et al., 2023a; Mutsaers et al., 2023b). For this article, similar utterances within each TDF domain for PCP and survivor behaviours were grouped together and belief statements were created to represent each group (Atkins et al., 2017; Patey et al., 2012; Table 4 and Table 5; Appendix I and J).

Based on these belief statements, the most relevant TDF domains were determined according to three criteria: 1) belief statements with a high number of utterances; 2) TDF domains where conflicting belief statements are present; and 3) belief statements strongly held by participants (Atkins et al., 2017, Patey et al., 2012). For PCPs, the relevant TDF-2 domains were: Knowledge; Social Professional Role and Identity; Beliefs about Capabilities; Beliefs about Consequences; Memory, Attention and Decision Processes; Environmental Context and Resources; Social Influences; and Behaviour Regulation. For survivors, the relevant TDF-2 domains were: Knowledge, Skills, Social Professional Role and Identity; Beliefs about Capabilities; Intention; Memory, Attention and Decision Processes; Environmental Context and Resources; Social Influences; and Behaviour Regulation. Once the relevant TDF domains were identified, they were then linked to the Behaviour Change Technique Taxonomy (BCTTv1; Michie et al., 2008; 2013).

Step 3 Mapping BCTs to TDF Domains

Step 3 a) Mapping BCTs on to the relevant TDF domains?

As described above the most relevant TDF domains had been identified, and then the Theory and Techniques Tool was used to identify the BCTs related to each domain (https://theoryandtechniquetool.humanbehaviourchange.org/tool). For example, the BCTs related to the Intention domain of the TDF-2 included "Goal setting," and "Information about health consequences." When TDF-2 domains did not have a clear link with any BCTs, such as the Social Professional Role and Identity domain, the "inconclusive" links were used because the other BCTs had no evidence of a link with this domain. Therefore, the BCTs "Credible source," "Identity associated with changed behaviour," "Social support (unspecified)" and "Social comparison" were considered linked with the Social Professional Role and Identity domain (Human Behaviour Change Project, n.d.). For a complete list of linked BCTs and TDF domains, please see Appendix K and L.

Step 3 b) Organizing Belief Statements into Barriers and Enablers

For each belief statement, the linked BCTs were operationalized to relate to the behaviours associated with SCP use (see Appendix K and L). Tables 6 and 7 provide examples of the how the BCTs could address barriers and enhance enablers for cancer survivors and PCPs, respectively.

After this process, a total of 140 BCTs were generated (60 for survivors, 80 for PCPs). At this point a higher level of organization was needed to promote communication and ease of use for the large number of BCTs created.

Step 4 Summarize implementation recommendations for SCP use among cancer survivors and PCPs

With a large number of recommendations for enhancing enablers and addressing barriers of SCP use it was important to a) present them in a user-friendly way; and b) to suggest

appropriate outcomes to measure the impact of implementing SCPs based on these recommendations. A key finding was the ongoing dynamic between PCPs, cancer survivors, and oncology. Rather than a linear pathway of survivors being discharged after active cancer treatment to follow-up in primary care, there were important and ongoing interactions between PCPs and survivors, and PCPs and oncology. As shown in Figure 1, managing follow-up care well appeared to hinge on communication and collaboration as oncology had the role of helping survivors understand their new role in self-managing their own care. Survivors and PCPs had ongoing cyclical interactions to ensure follow-up care needs were met, and PCPs needed to be able to contact the cancer centre to order and receive test results and consult as needed to manage abnormal test results and other cancer-specific questions.

Furthermore, an effort was made to organize the BCTs in a way that was linked to the corresponding barriers and enablers of SCPs and presented a range of options to allow for adaptation to different contexts. As part of exploring appropriate outcomes that would best reflect the realistic impact of SCPs, the use of a logic model was considered. Based on the description of "complicated" (i.e., a "one size fits all" approach to interventions) vs. "complex" logic models (i.e., interventions that are meant to be tailored to different contexts) by Mills and colleagues (2019), a complex logic model appeared to be the most applicable to guide the understanding of the implementation suggestions derived from this work. Using the ideas associated with a Type 4 logic model described by the authors, the following four schematics were created: Figure 2, outlining the tasks of follow-up care; Figure 3, outlining the internal and external resources, inputs, and influences on oncology/survivorship programs along with the associated outputs needed for PCPs (Figure 4), and Survivors (Figure 5).

With a vast amount of data, it was important to take the time to think through what the data indicated was needed to successfully implement SCPs. Doing so facilitated a deeper understanding of the process. As shown in Figure 3, many resources, both financial and in terms of specialist time are needed, along with infrastructure in place to facilitate the communication between the cancer centre and the PCP on an ongoing basis throughout follow-up care. This highlights the importance of having a designated survivorship program like the WBCP because in addition to creating the SCP, education, a needs assessment, a discharge meeting, and additional information resources appeared to be key facilitators of SCP use for cancer survivors (see Ruston et al., 2015).

As shown in Figure 4, PCPs need the outputs from oncology/survivorship programs in addition to their own internal staff and infrastructure to effectively use SCPs. Through this process they can provide follow-up care to their patients (i.e., outputs). Ideally, PCP-based follow-up care would reduce the number of survivors needing to return to the cancer centre for follow-up concerns (Rushton et al., 2015). If cancer were to recur, the regular follow-up appointments survivors have with their PCP could help find it at an earlier stage (Ruston et al, 2015). Figure 5 shows how the outputs provided by both oncology/survivorship programs and PCPs are needed in addition to social support, instrumental support, and logistical support (e.g., transportation to appointments and tests) to more effectively use SCPs. As shown in the logic model, appropriate short-term outcomes would be increased communication with their PCP, fewer visits to the cancer centre, and attendance and completion of follow-up tests in a timely manner. Although this very detailed process was informative, these logic models are complex, and a more user-friendly approach was needed to guide the use of SCPs in different settings.

The logic model template provided by the Dissemination and Implementation Models in Health described above (University of Colorado Denver, 2022; https://dissemination-implementation.org/tool/) was used to provide a high-level summary of the data. An important aspect of this logic model was the differentiation between dissemination and implementation outcomes from longer term outcomes (University of Colorado Denver, 2022; https://dissemination-implementation.org/tool/). This method was important because choosing inappropriate outcomes to measure the impact of SCPs in past research studies may be contributing to the mixed evidence that does not necessarily support their use. The logic model template has the following six components (Table 8):

This process supported the idea that short term outcomes make the most sense to measure when assessing the usefulness of SCPs. In this case, the "dissemination/implementation" outcomes could include tracking the follow-up appointments scheduled and attended, when tests are ordered and when test results are received, the number of survivors returning to the cancer centre, number of consultations between PCPs and oncology specialists, number of referrals for psychosocial supports, and number of SCPs received. Outcomes related to perceived increase in knowledge of, and comfort in the management of follow-up care could also be used for both PCPs and survivors to measure the effectiveness of SCPs. Ultimately, in keeping with the realistic impact that a document can have on survivorship follow-up care, it is most appropriate to measure outcomes directly related to the guidance provided in SCPs.

Format of Best Practice Recommendations for Using SCPs

Article 4 of this thesis (Mutsaers et al., 2023c) outlines ways to optimize the implementation of SCPs in various settings how to address barriers and enablers associated with SCP use. The models shown in this methodology paper are complex and are meant to

demonstrate a deep and nuanced understanding of the factors associated with the ways SCPs are actually used in practice. The end users of these recommendations do not necessarily need such detailed and theoretical information and so a more intuitive presentation of the results needed to be developed. As shown in Figure 6, a streamlined flow chart was created with the relationships between oncology/survivorship program, PCPs and survivors are numbered. A corresponding table (see Table 9) presents barriers and enablers associated with that specific relationship and BCTs that could be used and adapted to ultimately enhance facilitators and address the barriers to SCP use in their specific setting. Please see article 4 and Appendix M for a full list of recommendations.

Discussion

The present paper focused on providing a detailed example of the methodology used to generate adaptable best practice recommendations for implementing SCPs based on the real-world experience of PCPs and cancer survivors. The theoretical approaches included using the TDF-2, and the BCTTv1 to systematically identify and address barriers and enablers linked to PCPs and cancer survivors using SCPs. The systematic data collection and analysis provided insight into the ongoing relationships between the WBCP, PCPs, and cancer survivors that appeared to be a major factor in successful use of SCPs as transition tools. This work also allowed for the identification of appropriate outcomes directly related to the intended uses of SCPs including tracking appointments, ordering tests, receiving test results, number of visits back to the cancer centre etc. Overall, this methodology fit the purposes of this work in that its detailed nature allowed for the complexity of SCP use to be described and a range of implementation recommendations generated to allow for the optimization of SCP use across various settings. It is also hoped that these recommendations for implementing SCPs will provide

greater consistency across studies and provide evidence supporting the importance of using realistic outcomes when measuring the effectiveness of SCPs.

TDF-1 vs. TDF-2

Creating the codebooks and decision rules around differentiating the content applicable to each domain was an iterative and onerous process, ultimately requiring the input from three members of the research team. After eliminating the Goals domain for both PCPs and survivors, and coding little to no text into the Optimism, and Reinforcement domains (which were added to the TDF-2) it appeared that this process would have been made easier using the original TDF. Firstly, there would only have been 12 domains to attempt to differentiate from one another. Although the original Goals domain was split into the Intention Domains and the Goals domain in the TDF-2, in practice it was very difficult to choose between these two domains, suggesting that it may not be helpful or necessary to make this subtle distinction. Although the conceptual differences between these two domains can be appreciated theoretically, coding utterances from interviews did not lend well to capturing the higher-level differences between Intention and Goals. On the other hand, the decision rule to remove the Skills domain for the PCP codebook was specific to this study because it was appropriate to assume that licensed medical professionals had the skills needed to provide follow-up care. Skills was a helpful domain to code utterances from survivors' interviews. Finally, it was difficult to capture descriptions of the process participants used when following a SCP in a single domain. It became clearer once themes and subthemes were developed (see articles 1 and 2; Mutsaers et al., 2023a; 2023b), but it would have been helpful to have used the Nature of the Behaviour domain in the original TDF to capture this information earlier on in the analysis. In a TDF-based study looking at potential barriers and enablers to setting cooler dialysate temperatures in line with most recent evidence,

the authors used the TDF-2 but with the additional Nature of the Behaviour Domain to capture descriptions of the target behaviours in real world contexts (Presseau et al., 2017). Given that both versions of the TDF are widely used in the literature (Atkins et al., 2017), considering including the Nature of the Behaviour domain may be a helpful approach when examining behaviour change.

Linking the TDF to BCTs

Using the TDF and the AACTT frameworks were paramount for defining and exploring the influences on the behaviours associated with SCP use in the end users of SCPs (i.e., breast and colorectal cancer survivors and PCPs in this context). The AACTT framework has been recommended for research looking at patient reported outcomes in health care settings (Stover et al., 2021), and for implementation approaches with a randomized design (Wolfenden et al., 2021) for its specificity. Furthermore, the AACTT framework has been highlighted as a valuable addition for clinical and public health research because of its ability to carefully define a range of behaviours from multiple providers across different levels of health care, thereby allowing for complex behaviours to be analyzed and changed to be more in line with the most recent scientific evidence (Presseau et al., 2019; Rudd et al., 2020). As highlighted by Rudd and colleagues, defining behaviours in detail helps researchers identify the most appropriate outcomes to measure (Rudd et al., 2020). In the context of this study, using the AACTT framework as a basis for understanding how SCPs are intended to be used was essential for investigating the factors presenting as barriers and enablers to their ideal use. Given that systematic reviews on the effectiveness of SCPs as transition tools have shown mixed evidence that could indicate that they are not useful, a closer review of the articles included finds that long term outcomes such as improved quality of life, less distress and fear of recurrence are commonly used and are likely

too far beyond the scope of what a care plan alone can accomplish (Hill et al., 2020; Jacobsen et al., 2018). Defining the behaviours realistically associated with SCP use was helpful in determining more appropriate outcomes specifically related to increased knowledge and implementation outcomes such as the number of appointments attended, follow-tests conducted, contact between PCPs and cancer survivors, and PCPs with cancer centres (University of Colorado Denver, 2022; https://dissemination-implementation.org/tool/). It is recommended that future research on the effectiveness of SCPs include these shorter-term outcomes directly related to the content and purpose of SCPs as a transition tool back to primary care after active cancer treatment.

Accordingly, the TDF allowed for the systematic exploration of barriers and enablers of SCP use based on the defined behaviours which captured important nuance on the interrelationships required for successfully implementing SCPs as transition tools. A key finding was that implementation of SCPs appear to require additional supports. The WBCP provided education, nurse-led discharge meetings, and additional resources that were commonly mentioned by cancer survivors as important facilitators for understanding and using their SCPs. Furthermore, the WBCP provides a phone number for PCPs to consult oncology as needed, thereby suggesting that this information needs to be presented in a different way to bring greater awareness of this option (Rushton et al., 2015; Carrie MacDonald-Liska, Personal Communication September 14, 2021). Overall, the WBCP itself is a crucial part of implementing SCPs in a way that they will be used as intended by PCPs and cancer survivors. This topic is elaborated on further in articles 1 and 2 but represents how provision alone does not necessarily appear sufficient to prompt their use by cancer survivors. Those considering implementing SCP use should consider the additional facilitators that appear to be important for helping survivors

understand the importance of SCPs and their new role in managing their follow-up care (Hill et al., 2020; Jacobsen et al., 2018; Rushton et al., 2015).

Finally, the BCTTv1 was key for developing a range of implementation suggestions that can be adapted to a wide range of settings. In particular the Human Behaviour Change Tool (https://theoryandtechniquetool.humanbehaviourchange.org/tool) based on the work by Michie and colleagues (Michie et al., 2021) with its links to the TDF domains based on expert consensus provided a through line for data analysis that clarified how the data could be operationalized specifically for SCPs. This standardized approach helped to ground the process of analyzing a large amount of data associated with complex behaviours. Although other theoretical approaches such as the commonly used Consolidated Framework for Implementation Research (Damschroeder et al., 2009) would likely have been helpful to use, it was ultimately too broad for the needs of the present study. As shown by Birken and colleagues, adding a determinant framework such as the TDF is justified when a more systematic and specific approach is needed (Birken et al., 2018). Because this work required extremely detailed information on the factors influencing SCP use, the use of the TDF and the carefully defined BCTs provided the appropriate frameworks.

Strengths and Limitations

This work had several strengths, including analysing the behaviours of both end users of SCPs (i.e., cancer survivors and PCPs), recruiting participants who had already received an SCP which helped with gaining a deeper understanding of why some participants remembered receiving it and actually used it, or did not remember or did not use their SCP. Additionally, the perspectives of PCPs on how they have used SCPs in practice also allowed for important logistical issues to be uncovered and recommendations for addressing these key barriers based

on the BCTTv1 to be developed. The theoretical frameworks were carefully chosen to best fit the purpose and objectives of the work. The rigour in developing a codebook and using a conservative inter-rater reliability measure suggests that the data collection and analysis is trustworthy and a good reflection of the use of SCPs in practice (Atkins et al., 2017; Joffe et al., 2011; McHugh, 2012). Having participants from two common cancer types and both sexes also suggests greater generalization potential of these results. Finally, including stakeholders from the WBCP, experts in the field of implementation science and experts in psychosocial oncology, along with a primary care provider in the process from study conception to analysis and conclusions also strengthens the work as all team members provided valuable insight throughout the length of this project.

That said, the study has limitations related to participants self-selecting to be involved in the study, recruiting participants who had received an SCP from one survivorship program, and recruiting relatively few PCPs. Although survivors who participated had experience using their SCP, some also participated who did not recall or did not use their SCP which allowed for some exploration of barriers to SCP use. Although some participants did not remember receiving their SCP, they also provided helpful information that would have otherwise been missed if only those who used their SCPs were included. The WBCP is a unique survivorship program that provides many avenues for supporting cancer survivors and PCPs in the process of transitioning to community settings for follow-up care (Rushton et al., 2015). This high level of resources and personnel is likely not generalizable across studies, but it is hoped that the flexibility of the recommendations for SCP use can provide some guidance for centres wanting to implement SCPs in their settings. Finally, only 13 PCPs participated in an interview. While data saturation

was reached, the small number of participants may limit the generalizability to other PCPs outside of the Ottawa area.

Lessons Learned and Recommendations for implementation Science

This methodology paper presented the implementation science approaches to explore barriers and enablers to SCP use among PCPs and breast and colorectal cancer survivors who had received a care plan from the WBCP. Based on this work, it is recommended that researchers use tools like the T-Cast (Birken et al., 2018) and the Dissemination and Implementation tool (University of Colorado Denver, 2022; https://dissemination-implementation.org/tool/) to carefully consider the most appropriate theoretical approach for their specific research questions. Specifically, the aptly titled "Clarity out of Chaos" article by Nilsen (2020) and the recent work by Damschroder (2020) are particularly helpful starting points for designing a theory-informed implementation intervention. This methodology was labour intensive and developed in the context of a dissertation. While detail and conduction of a large number of interviews was needed for the purpose of this work, it is not recommended for all implementation science projects. That said, when working with contexts that involve multiple health care providers and multiple settings and when the aim is to develop adaptable implementation recommendations, the intensity of the work is required. With a large number of detailed results, it was difficult to create high level ways of presenting them in a way that highlights the important points. While the process of working through logic models was helpful in understanding subtle barriers and enablers of SCP use, approaches such as the Behaviour Change Wheel (Michie et al., 2011) and the CFIR (Damschroder et al., 2009) inherently capture the higher-level factors associated with implementation development. Perhaps the most important take away from this work is to be systematic in data collection and coding yet open to what the data presents. In this way, taking an

additional qualitative stance and developing themes and subthemes was a way of uncovering important insights into the process of implementing SCPs. Ultimately, it is hoped that this approach can be applied to research questions in the future and provide a helpful example of the process for those wishing to undertake implementation intervention development.

Considering the Knowledge to Action Framework (Graham et al., 2006), future research could examine how these implementation recommendations are applied in different locations and contexts wanting to add SCPs to their survivorship processes, followed by looking into the acceptability and feasibility of specific recommendations or combinations of recommendations. It will also be important to pilot test interventions for implementing SCPs to clarify what works and what does not, to then revise implementation strategies. In terms of follow-up care itself, consideration of more specific self-management interventions in addition to the SCP may be helpful (Howell et al., 2017).

Conclusion

This methodology paper outlined an approach to investigating ways to optimize the implementation of SCPs in an attempt to increase the standardization in the content, format, and delivery of SCPs to more meaningfully examine their effectiveness as transition tools. Additionally, this implementation science approach included the use of logic models based on the results to help identify more appropriate outcomes that lend themselves to what SCPs alone can reasonably impact. Overall, the results indicate that additional supports and education for survivors is needed for them to understand their role in participating in their own follow-up care and how the SCP guides this process. For PCPs, the clarity and inclusion of follow-up guidelines appear to meet their needs when providing follow-up cancer care.

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Table 1

Overall Approach to Data Collection and Analysis

French Model	Description
Step 1	Defining behaviours, AACTT Framework
Step 2	Examining barriers and enablers of the target behaviours, TDF a) Created interview guides using the TDF (Appendices E and F) b) Created a codebook and coded the interview data into the TDF-2 Domains (Appendices G and H) c) Created belief statements and organized them across domains into subthemes and themes, identified most relevant TDF domains based on frequency, opposing beliefs and importance (Patey et al 2012; Appendices I and J)
Step 3	Mapped BCTs to TDF domains using https://theoryandtechniquetool.humanbehaviourchange.org/tool a) Translated what these BCTs could look like in the context of SCP use by PCPs, breast, and colorectal cancer survivors (Appendices K and L) b) Organized belief statements into barriers and enablers within each TDF domain, and from this generated implementation ideas based on the BCTs linked to the TDF domains (Appendices K and L)
Step 4	Summarize implementation recommendations for SCP use among cancer survivors and PCPs (See article 4; Mutsaers et al., 2023c). a) Use a logic model to provide guidance on evaluating implementation recommendations b) Identify appropriate outcomes to measure the effectiveness of SCPs on facilitating a smooth transition from active cancer treatment back to primary care for follow-up

Table 2

AACTT Framework for Cancer Survivor Behaviours Associated with SCP Use

AACTT	PCP	Breast/colorectal cancer survivor
Action:	Read the SCP	Read the SCP
	Book follow-up tests	Discuss the contents with PCP
	Book follow-up appointments	Call PCP to arrange follow-up appointments
	Interpret test results	
	Answer patient's questions	
	Respond to patient's needs (e.g., for psychosocial resources)	
	Make decisions for patient care when patient's needs are out of scope of practice (e.g., consulting specialists, other members of patient's cancer care team)	
	Track the status of follow-up tests booked and associated results	
	Seek out knowledge and consultation on cancer-specific treatments (e.g., when to stop tamoxifen)	
Actor:	PCP	Self (Cancer Survivor)
Context:	The PCP's office	At home; at the PCP's office
Target:	Patients for whom an SCP was provided; guidance for self on managing follow up cancer care	Self, and PCP
Time:	Every 3-6 months (depending on when tests need to be ordered and followed up on)	Before upcoming appointments with PCP; during PCP appointment

Table 3

Example Belief Statements for PCPs

Belief Statements	# of PCPs Reporting	# of utterances	TDF Domain	Example Quote (s)
SCP outlines tasks for PCPs	10	27	Knowledge	"I mean it's a nice little summary at the beginning of it, but a lot of the other stuff, I read it once, but that's not the part that I refer to. I'm going to refer to that last page that says, "every 6 months, do this". - PCP_2 "Because it's well done, like just a quick spreadsheet with like, "here's the system and here's the problem and here's what you need to do."" - PCP_10
I book tests, appointments, respond to concerns, etc.	13	47	Social Professional Role and Identity	"I see them, order tests for them, you know, troubleshoot if they're having issues." - PCP_1 "Whenever I receive anything I go through each and every step, and I always book an appointment with my patient, I go through all the details with them and tell them how it will be in the future" - PCP_5

Table 4

Example Belief Statements for Survivors

Belief Statements	# of Survivors Reporting	# of utterances	TDF Domain	Example Quote (s)
Discussing SCP with PCP	18	37	Social Professional Role and Identity	"I made an appointment with my family doctor and that's how it started. Basically, sitting down and having a discussion, how to go about it." - Surv_10
Feel like getting better care at cancer centre	5	7	Emotion	"I felt like I was going to be better cared for at the cancer centre than I was going to be with my own physician. Not because she's not good, just because that's all they do, is cancer." - Surv_3
Family Support	11	19	Social Influences	"My wife is on top of it all the time, she keeps notes and journals and writes it on the calendar, but if I was alone, (laughs) I probably wouldn't keep on to all of this stuff." - Surv_19

Table 5

Barriers and Enablers of SCP use with Corresponding BCTs: Cancer Survivors

Barrier/ Enabler	Belief Statement	TDF Domain	BCTs	Implementation Ideas
Enablers	I was driven to use the SCP to make sure I received good care	Intention	5.1. Information about health consequences	5.1 Provide information on the purpose of SCP (help with managing side effects, checking for recurrence of a new cancer, health and fitness, more information, ways SCP is useful).
	Use SCP when change in PCP	Intention	5.1. Information about health consequences	5.1 Provide information on how SCP can help share information
	Use SCP when changing health care professional	Intention	5.1. Information about health consequences	5.1 Provide information on how SCP can help share information
	I will use my SCP with my PCP	Intention	5.1. Information about health consequences	5.1 Provide information on how SCP can help share information, plan for follow-up tests, communicate with PCP
	I will use my SCP when I have questions	Intention	5.1. Information about health consequences	5.1 Provide information on the purpose of SCPs (e.g., as a reference)
	I will use my SCP again in the future	Intention	5.1. Information about health consequences	5.1 Provide information about the purpose of SCPs
Barriers	I didn't see the SCP as important	Intention	5.1. Information about health consequences	5.1 Provide information about the purpose of SCPs
	I don't need to use the SCP someone will call me	Intention	5.1. Information about health consequences	5.1 Provide information about the purpose of SCPs
	I wish I knew how helpful the SCP is	Intention	5.1. Information about health consequences	5.1 Provide information on the purpose of SCPs

Table 6

Barriers and Enablers of SCP use with Corresponding BCTs: PCPs

Barrier/ Enabler	Belief Statements	TDF Domain	BCTs	Implementation Ideas
Enabler	Follow up guidelines	Knowledge	4.1. Instruction on how to perform behaviour	4.1 Follow up guidelines provided in the SCP have the necessary information
	SCP contains relevant info	Knowledge	4.1. Instruction on how to perform behaviour	4.1 Follow up guidelines provided in the SCP have the necessary information
	SCP outlines tasks for PCPs	Knowledge	4.1. Instruction on how to perform behaviour	4.1 Follow up guidelines provided in the SCP have the necessary information
	Looking up information	Knowledge	4.1. Instruction on how to perform behaviour	4.1 Follow up guidelines provided in the SCP have the necessary information
Barriers	Not knowing about side effects of Cancer treatment	Knowledge	4.1. Instruction on how to perform behaviour	4.1 Providing resources/a number to call for help with cancer-specific medication, abnormal results, side effects, etc.
	I don't know exactly what treatment by patient is receiving	Knowledge	4.1. Instruction on how to perform behaviour	4.1 Providing resources/a number to call for help with cancer-specific medication, abnormal results, side effects, etc.

Table 7

Components of a Logic Model in Relation to SCPs

Logic model component	Application to SCP study
Problem/gap	Research has not necessarily supported the effectiveness of SCPs as tools to help facilitate the transition to follow-up in primary care after their active treatment completed. This may be due to: a) SCPs are not actually effective b) Variation in content, format, and delivery of SCPs c) Researchers not using realistic outcomes relevant to using SCPs (Hill et al., 2020; Jacobsen et al., 2018).
Evidence-based program	Wellness Beyond Cancer Program: provides SCPs to breast and colorectal cancer survivors and their PCPs Program also includes: - Needs assessment - Education class - Discharge meeting - Rapid re-entry System (Rushton et al., 2015)
Dissemination and implementation strategies	Generated based on the data collection and analysis in the present study using the TDF (Cane et al., 2012) and BCTTv1 (Michie et al., 2008)
Mechanisms/mediators	Survivors: Receipt of SCP, attendance at education class, transportation to discharge meetings, support from friends and family, ability to see PCP, completion of needs assessment, discharge meeting with nurse, etc.
	PCPs: Environmental and system supports (to order tests and results) Increased knowledge and self-efficacy Ability to consult with oncologist Confidence in ability to manage follow-up care Available of psychosocial services Receipt of SCP
Dissemination and implementation outcomes	Survivors: Appointments scheduled and attended on time Follow-up tests completed Regular appointments Increased knowledge about how to manage side effects of treatment Contacting PCP as needed
	PCPs:

	Tests ordered and results acted on (if needed) Increased collaboration with oncology Tests completed on time Increased knowledge on how to manage follow-up care Knowledge of available psychosocial supports Receive SCPs
Long-term outcomes	Increased knowledge about survivorship care Knowledge of the late and long-term side effects of treatment and how to manage them Knowledge of signs and symptoms of recurrence Confidence consulting PCP Survivors managed in primary care; needs met Increased QOL for survivors Increased collaboration PCP, survivors, oncology Decreased distress Fewer returns to cancer centre Decreased severity of cancer recurrence

Based on the guidance from outcomes (University of Colorado Denver, 2022; https://dissemination-implementation.org/tool/)

Table 8

Format of Recommendations for Implementing SCPs

Relationship	Recommendation	How?	Target(s)	Actor	Purpose
9	Establish rapport and trust with patient	Validate: - Cancer survivors will be more aware of bodily symptoms	Survivor	PCP	Empowering survivors to self-manage follow-up care
9	Problem-solve barriers to making/attending follow-up appointments	- Encourage patients to share SCP with friends or family members to help them keep track of follow-up care - Encourage survivors to bring family or friends to appointments for support in asking questions, scheduling, and remembering appointments	Survivor Caregivers Family Members	PCPs	Instrumental support to help survivors engage in follow-up care

Figure 1

Venn Diagram Showing the Interaction Between Oncology, PCPs and Survivors

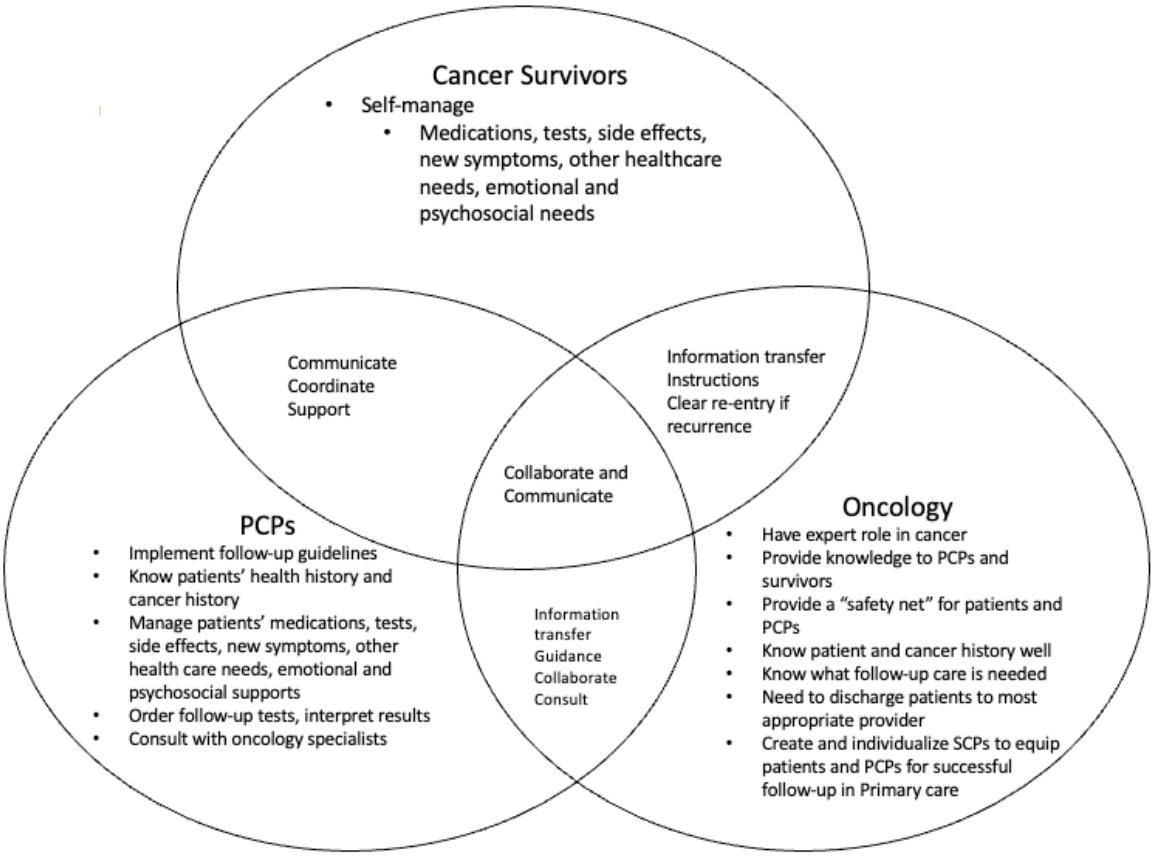


Figure 2

Schematic of the Tasks of Follow-up Care for Oncology/Survivorship Programs, Primary Care Providers, and Cancer Survivors

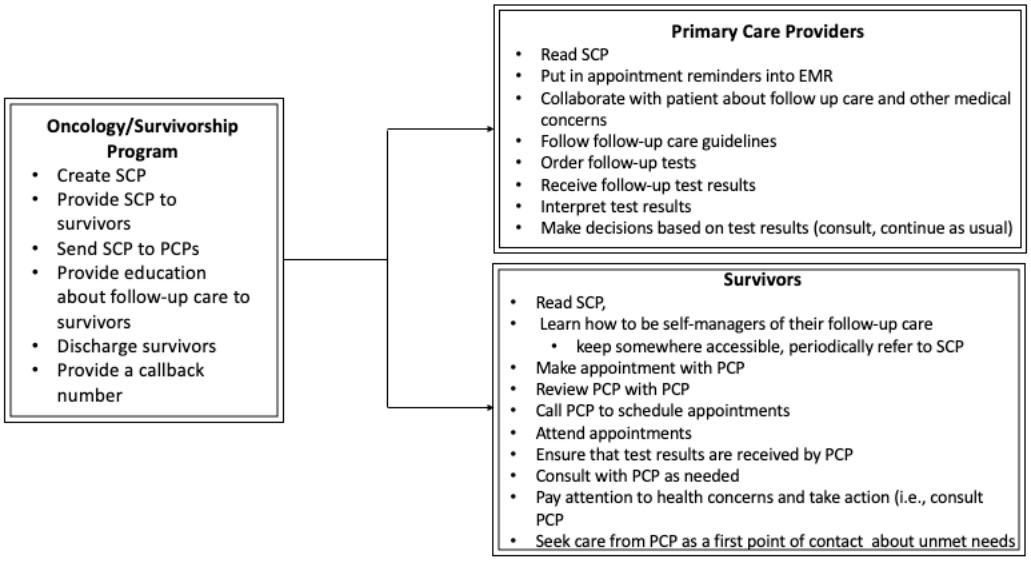


Figure 3

Logic Model for Oncology/Survivorship Programs Providing Survivorship Care Plans

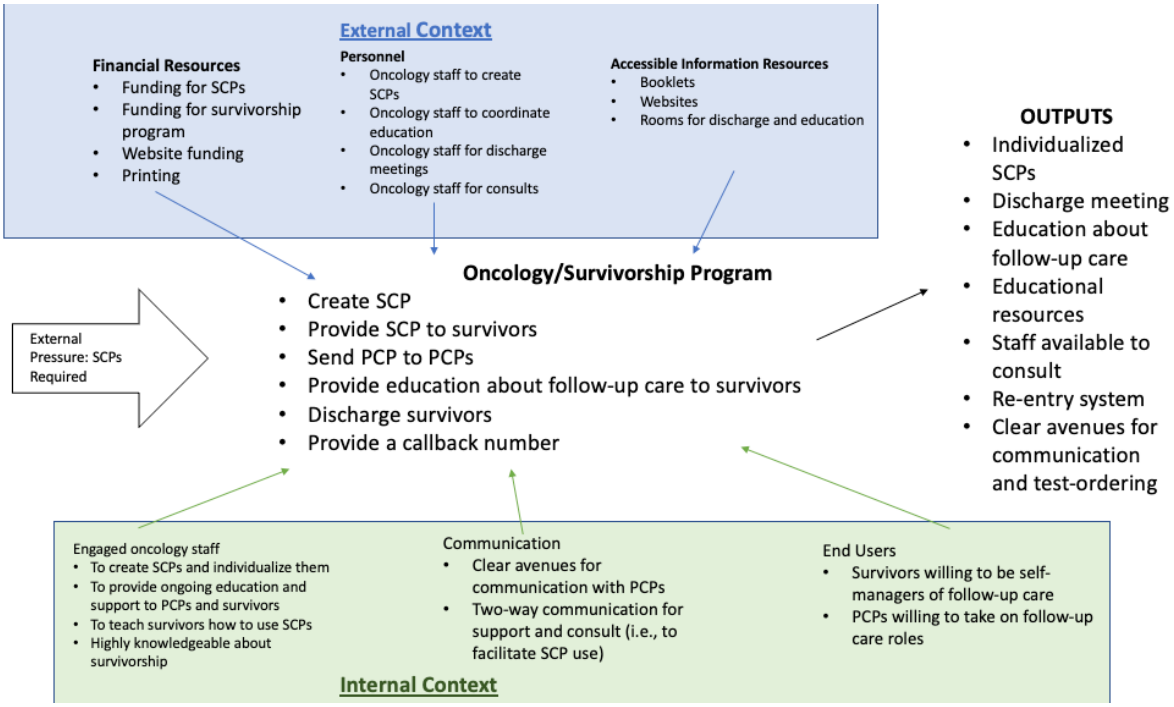


Figure 4

Logic Model Outlining the Factors Needed for Primary Care Providers to Provide Follow-up Cancer Care

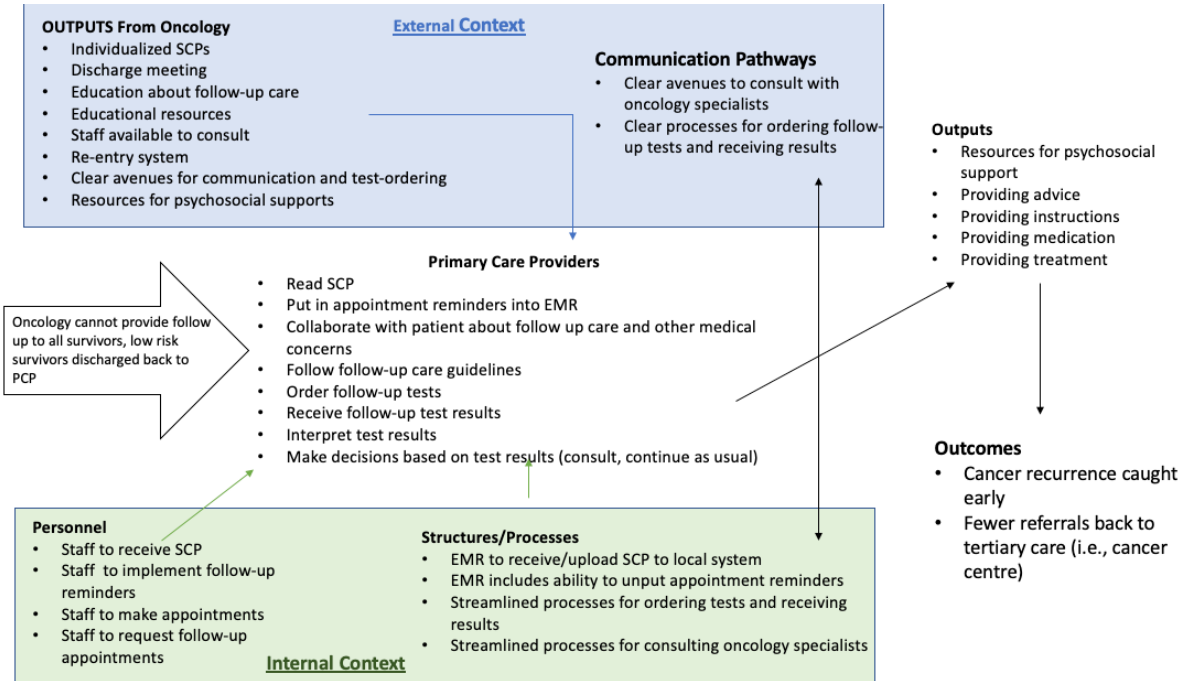


Figure 5

Logic Model Outlining How the Outputs from Oncology/Survivorship Programs and Primary Care Providers Could Lead to Follow-up Care Outcomes

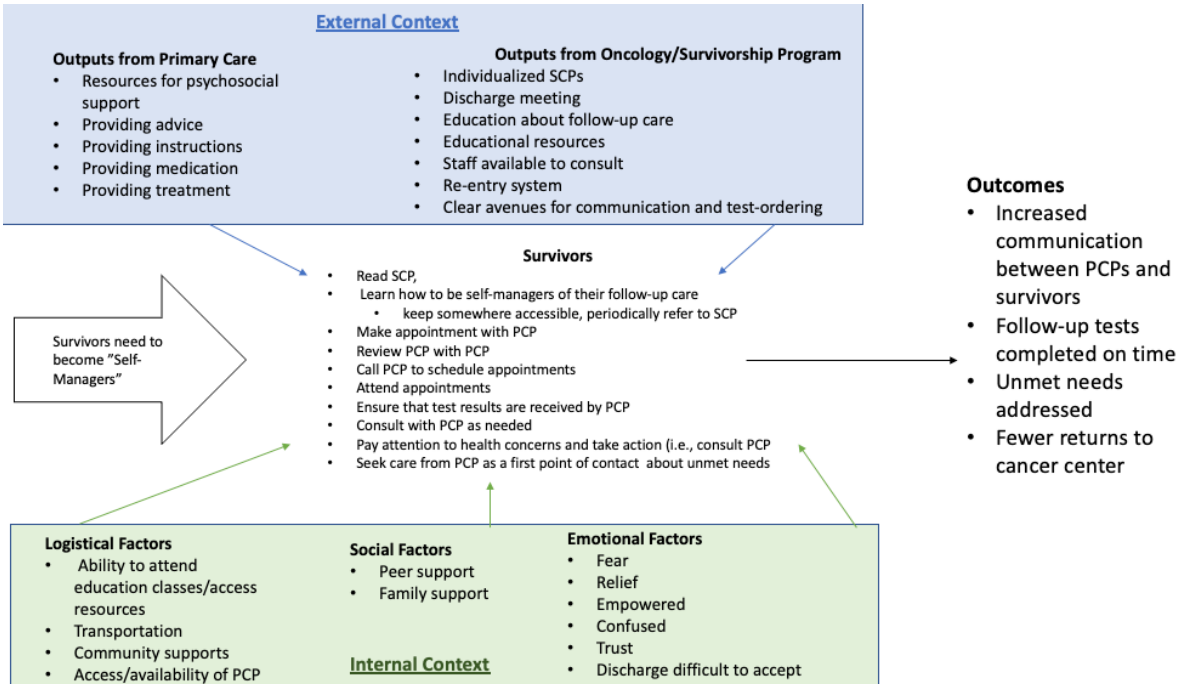
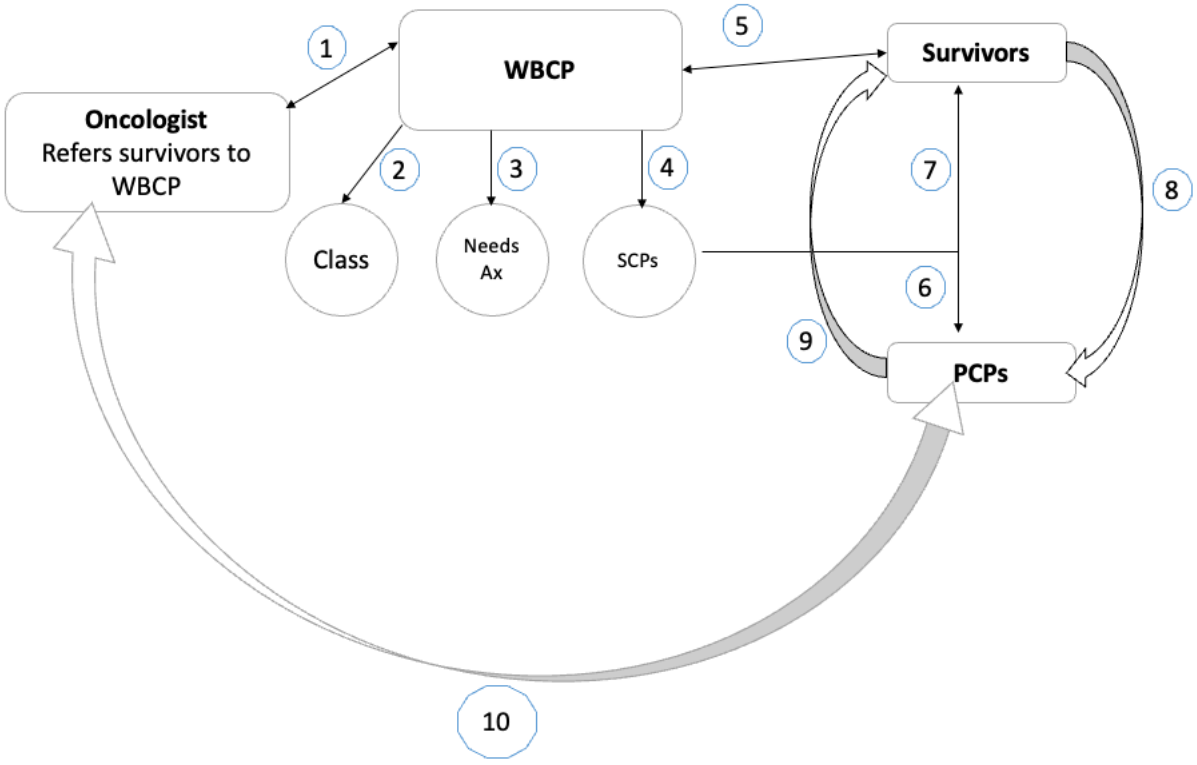


Figure 6

Flow Chart Summarizing the Process of Implementing SCPs



Developing Best Practice Recommendations for Implementing Survivorship Care Plans Part 4: Addressing Barriers and Enhancing Enablers of Care Plan Use by Primary Care Providers and Cancer Survivors

Abstract

Background: Survivorship care plans may be helpful transition tools for cancer survivors and their primary care providers (PCPs) after completion of primary treatment. Research to date has been inconclusive on their effectiveness in real world practice. Standardization in implementing SCPs in terms of their content, format, and delivery could help clarify the impact of SCPs on facilitating the transition back to primary care for follow-up. The purpose of this article is to present the best practice recommendations for implementing SCPs based on a theory-driven examination of the barriers and enablers reported by end users (i.e., breast and colorectal cancer survivors, PCPs) who had received a SCP from the Wellness Beyond Cancer Survivorship Program from The Ottawa Hospital Cancer Center.

Method: Barriers and enablers to SCP use were systematically identified using the Theoretical Domains Framework (TDF). The TDF domains were linked to the Behaviour Change Techniques Taxonomy (BCTTv1), and behaviour change techniques (BCTs) were used to develop recommendations to enhance enablers and address barriers to SCP use in the real world. A logic model was developed to guide the implementation of SCPs and recommendations were organized in a way that they can be adapted to different needs and contexts.

Results: A flow chart representing the process associated with implementing SCPs was developed and highlighted the dynamic relationships between cancer centres, PCPs and cancer survivors that were key factors in successfully implementing SCPs for use as a transition tool. Ten relationships were elucidated, and best practice recommendations were organized into these relationships. The three most important considerations in implementing SCPs are to 1) include follow-up guidelines outlining the tasks PCPs are responsible for in the SCP; 2) a treatment

summary in the SCP, 3) provide the SCP to both cancer survivors and their PCPs, and 4) provide education around how to use SCPs in the context of follow-up care.

Discussion: It is hoped that those looking to implement SCPs in their setting will be able to refer to these recommendations to help guide this endeavor. Not all recommendations will be applicable to all settings, but the high volume of recommendations are intended to provide comprehensive suggestions that can be applicable across settings.

Conclusions: For researchers to discern the helpfulness of SCPs more accurately in facilitating the transition from tertiary to primary for long term follow-up cancer care these best practice recommendations were developed to increase consistency in implementation.

Keywords: survivorship care plans, best practice recommendations, implementation science, breast cancer, colorectal cancer, primary care providers, survivorship programs

Survivorship care plans (SCPs) have been widely recommended in the context of changing models of care for low-risk cancer survivors (Jefford et al., 2022; Jacobsen et al., 2018; Hill et al., 2020). As they complete active treatment at cancer-specific settings, some survivors with relatively straightforward follow-up care needs are discharged back to their primary care provider (PCP) for long term follow-up (Biddell et al., 2021; Fitch, 2018; Grant et al., 2015; Jeppesen et al., 2018; Rushton et al., 2015; Sussman et al., 2017). SCPs, containing a treatment summary, and recommendations for follow-up exams, surveillance tests, and management of late and long-term side effects of treatment, are provided to both PCPs and cancer survivors to facilitate the transition back to primary care (Howell et al., 2011; Rushton et al., 2015). Currently, the research on the helpfulness of SCPs as transition tools is unclear (Hill et al., 2020; Jacobsen et al., 2018). Although the idea of providing pertinent information about follow-up care to those responsible to managing and participating in it (i.e., PCPs and cancer survivors) makes logical sense, it is possible that 1) the outcomes and methods that researchers have used to measure the usefulness of PCPs are beyond the scope of what a SCP can realistically impact (e.g., fear of recurrence, depression, quality of life); 2) greater consistency is needed on how SCPs are developed, their content, and to whom they are delivered or 3) that SCPs are not helpful transition tools (Hill et al., 2020; Jacobsen et al., 2018). This work is part of a larger study focused on understanding how SCPs have been used in real world practice, identifying the factors that help or hinder their use, and developing recommendations for implementing SCPs in an optimal way.

To briefly summarize the study findings: PCPs reported feeling comfortable with providing follow-up care, aspects of coordinating follow-up care tasks were onerous because of logistical problems, and avenues to consult with oncology specialists (i.e., oncologists, oncology

nurses) were identified as an important factor in providing follow-up cancer care. Breast and colorectal cancer survivors reported that the SCP was a helpful tool, and that education on the purpose of SCPs as transition tools and knowing the expectations that survivors be actively involved in their follow-up care were most helpful in supporting their use of SCPs.

This work is based on implementation science frameworks. End users who have been using SCPs for a minimum of one year were recruited for a semi-structured interviews based on the Theoretical Domains Framework (TDF-2; Cane et al., 2012), an implementation science framework associated with changing behaviours (Atkins et al., 2017). Participants were breast and colorectal cancer survivors who had been discharged and received a SCP at least 12 months prior to the interview. Eleven female breast cancer survivors, five female colorectal cancer survivors, and 14 male colorectal cancer survivors participated in the interviews. As PCPs are also end users of SCPs, thirteen participated in 15–20-minute interviews also based on the TDF. The SCPs used by the participants in the study were developed within the context of the Wellness Beyond Cancer Program, a survivorship program in Ottawa, Ontario, Canada (Rushton et al., 2015). The SCP is one component of the overall program which also includes a needs assessment, education classes on what to expect in follow-up care, provision of a SCP, a discharge meeting to review the SCP, and a process to be quickly referred back to the cancer centre should cancer recur (Rushton et al., 2015). This article provides a high-level summary of the results and outlines how to use the recommendations for implementing SCPs.

General Summary of the Overall Study

While the information in the SCP is pertinent and helpful, additional supports are needed to facilitate follow-up care. For cancer survivors, the SCP may be perceived as generic information or paperwork that is filed. Cancer survivors are assigned a new role in follow-up

care as they are expected to keep track of their follow-up care and ensure that they communicate with their PCP to arrange follow-up test, and act on abnormal test results. Survivors also need to take initiative to discuss ongoing and emerging survivorship issues (new mood changes, side effects of treatment) with their PCP. For PCPs, logistical problems associated with the tasks of follow-up care can inhibit follow-up care (e.g., lack of clarity on whether follow-up tests went through, receipt of test results). Overall, the implementation of SCPs involves a dynamic process between PCPs, cancer survivors, and cancer centres.

Method

Detailed methods on the development of these best practice recommendations for SCP use is described in Article 3 of this dissertation (Mutsaers et al., 2023c).

Results

Who are these recommendations for?

These recommendations are for anyone looking for ways to help cancer survivors and their PCPs with the transition to primary care for follow-up cancer care post primary cancer treatment in specialized cancer centres. PCPs can use these recommendations to problem-solve challenges associated with using SCPs and providing follow-up care to cancer survivors. Researchers can use these recommendations to implement SCPs in a more consistent way, but that also allows for adaptability across settings. It is hoped that the greater standardization will reduce the variability when examining the impact of SCPs. This report is applicable to policymakers to understand the factors around SCPs that are needed to ensure they are used as transition tools. Finally, oncology centres can use this work to develop SCPs, inform their content, format, and delivery.

How to use these recommendations?

The best practice recommendations are organized into 10 relationships outlined in Figure 1:

1. Oncologist refers survivors to Wellness Beyond Cancer Program (WBCP) to be discharged back to their PCP.
2. The WBCP provides survivors with an Education Class about what to expect in follow-up care.
3. The WBCP provides a needs assessment to populate the SCP.
4. The WBCP creates SCPs using electronic medical records system.
5. Survivors interact with the WBCP as needed until discharge. There is also a rapid re-entry program for survivors should they have a new or recurrent cancer.
6. PCP receives SCP from the WBCP, a discharge note is included with contact information for support from oncology specialists if needed.
7. Survivors receive a copy of their SCP which is reviewed with an oncology nurse via phone, one-on-one meetings, or group meetings.
8. Survivors interact with their PCPs to discuss SCP, arrange follow-up tests, report ongoing health concerns as needed, and report their unmet needs.
9. PCPs interact with survivors to organize follow-up tests, discuss the SCPs, treat ongoing health concerns, and coordinate help for unmet needs of survivors.
10. PCPs and oncology interact with one another when booking follow up tests and receiving results and interacting when support is needed.

Appendix M consists of detailed recommendations for implementing SCPs organized into these 10 relationships. The recommendations are based on the barriers and facilitators to SCP use, and the high volume of recommendations reflect nuances that are not applicable to all settings. To focus on relevant recommendations, users of these recommendations should identify which of the ten relationships are most applicable to a question or challenge, then review the implementation recommendations associated with that relationship. Only those recommendations

that are applicable to the user's needs should be used rather than trying to implement SCPs based on all the recommendations within each relationship. As shown in Table 1 each recommendation includes information on the purpose of the recommendation, how to implement the recommendations, to whom the recommendation is meant to help (Target) and the personnel needed to implement the recommendation (Actor; Presseau et al., 2019).

High Level Summary of Recommendations Within Each Relationship

Relationship 1: Oncologist refers survivors to Wellness Beyond Cancer Program to be discharged back to their PCP

Those implementing SCPs may benefit from having a structured way of identifying the low-risk cancer survivors who would be eligible to be discharged back to follow-up care (Rushton et al., 2015). A survivorship program (such as the Wellness Beyond Cancer Program; Liska et al., 2018; Rushton et al., 2015; Rutkowski et al., 2020) can provide such structure. This recommendation also includes suggestions from cancer survivors interviewed for this study for additional supports that a survivorship program would be best positioned to provide. These supports include periodic check-ins from oncology specialists, and to create avenues for peer support.

Relationship 2: The WBCP offers cancer survivors an education class about what to expect in follow-up care

Providing information about the purpose and function of SCPs, along with providing messaging that cancer survivors were meant to be actively involved in their own healthcare were important facilitators to using SCPs as transition tools. Instruction of when and how to use SCPs (e.g., using SCP to schedule and keep track of follow-up tasks, to refer to dates, previous treatments, cancer history, to advocate for follow-up needs etc.) were identified as important

facilitators for using SCPs. Education should also include reasoning for receiving follow-up care with one's PCP (i.e., allocation of resources, healthy enough to go back to care with PCP), what to expect in follow-up care (i.e., frequency of appointments, follow-up tests), and how the SCP can be a helpful communication tool for coordinating care with other healthcare professionals (e.g., new or changing PCPs, other specialists, pharmacists, etc.). Education on SCPs and follow-up care can be provided in person in a classroom/auditorium setting, online, videos, handouts, etc.

Relationship 3: The WBCP provides a needs assessment to populate the SCP

A questionnaire with common needs is completed by cancer survivors where they identify their needs, have opportunities to add needs that were not included in the questionnaire, and to rate the intensity of each need. The needs assessment can be completed in person, or online through an individual's medical chart. The comprehensive needs assessment can be inputted into the SCP to be noted by the survivor and their PCP. Commonly reported needs included instrumental supports (e.g., rides to follow-up appoints), additional informational needs, peer support, and other individualized needs. If the needs assessment is incomplete, rather than leaving this section of the SCP blank, it is recommended that a link to general information resources be provided should they be of interest in the future. If the context in which SCPs are to be implemented serves rural and remote areas, the needs assessment should include factors such as travel time, availability of specialized healthcare services (e.g., cancer-specific medications), and availability of community-based supports.

Relationship 4: The WBCP creates individualized SCPs using electronic medical records system

It is recommended that the SCP be provided to both cancer survivors and their PCPs to provide them with the information needed to move forward with follow-up cancer care. Doing so facilitates the involvement of cancer survivors in their follow-up health care and provides PCPs with direction on the tasks of follow-up care. Resources to address psychosocial concerns (e.g., anxiety, fear or recurrence, depression) were suggested by many participants as important additions to the content of SCPs. It is recommended that those implementing SCPs consult with mental health professionals with experience working with cancer survivors to identify resources that can be compiled and accessed through a link in the SCP. In an effort to prevent losing SCPs and to make them easier to find when needed it is recommended that hardcopies of SCPs be printed on cardstock and/or on coloured paper. The treatment summary, follow-up guidelines, and cancer history were identified as helpful information in helping survivors and SCPs navigate follow-up care. For example, when communicating their health history to a pharmacist, a new medical specialist, when to call their family doctor, and when to expect follow-up tests to occur. Additional suggestions from survivors included creating an updateable SCP, an electronic version of the SCP available through patient-facing electronic medical records systems, and additional individualized resources (e.g., healthy eating and exercise, long-term survivorship). To minimize the length of the SCP, it is recommended that additional resources be available online for interested survivors to consult as needed.

Relationship 5: Survivors interact with the WBCP as needed until discharge. There is also a rapid re-entry program available should the survivors have a new or recurrent cancer

This component of the WBCP (Rushton et al., 2015) provides reassurance and support to survivors and PCPs if follow-up tests indicate a return to the cancer centre is needed. No additional recommendations emerged from the data.

Relationship 6: PCP receives SCP from the WBCP, a discharge note is included with contact information for support from oncology specialists

The SCPs include a table with the guidelines for providing follow-up care which was a key facilitator reported by PCPs providing follow-up care. It is recommended that this table be included on the first page of the SCP. A highly reported barrier to providing follow-up care was PCPs reported needing to consult with oncology specialists for a range of issues including: discussing patient's requests to stop cancer medications, advice on how to proceed with abnormal test results, and how to help survivors cope with the side effects of cancer treatments. The contact information for consulting with oncology specialists should ideally be highly visible on the first page of the SCP. Additional resources on cancer specific medications, research on the outcomes of follow-up care provided in oncology vs. primary care settings, and psychosocial supports specific to cancer survivors were also highlighted as important facilitators to providing follow-up cancer care that would be helpful to add to the SCP. Messaging around consultation with fellow PCPs could also be indicated in the notes for follow-up care to help PCPs navigate patient's concerns. Finally, messaging around SCPs should highlight how many of the tasks of follow-up care are already within the usual activities completed by PCPs (e.g., ordering and interpreting test result, physical exams, helping patients with mental health concerns, managing chronic illness).

Relationship 7: Survivors receive a copy of their SCP which is reviewed with an oncology nurse via phone, one-on-one meetings, or group meetings

Messaging around the expectation that survivors are to be actively involved in their follow-up care, and instructions on how to do so were key facilitators of SCP use among breast and colorectal cancer survivors. Rather than providing the SCP alone, additional supports, whether that be education classes, discharge meetings, telephone calls, etc., are needed to ensure SCPs are used as intended. Directly stating that their PCP is now the health care provider most responsible for their healthcare is important to highlight and could facilitate better communication and use of the SCP in primary care settings. The breast and colorectal cancer survivors who participated in this study reported individualized needs that emerged throughout the course of follow-up care. Based on this, it is recommended that the SCP include a link to a webpage with resources on many different topics for survivors to review as needed. Including all these resources within the SCP would make it too long, and the information would not be relevant to all survivors. For example, colorectal cancer survivors reported more informational needs regarding diet than breast cancer survivors reported. The rationale for providing SCPs and noting that oncology specialists developed the SCP and view PCPs as the best healthcare provider to manage follow-up was an important facilitator for SCP use. Examples of how to use the SCP to book follow-up appointments on time, to refer back to treatment, to remember important dates, and information about one's cancer history would be helpful to show survivors how SCPs can be used in follow-up care or after discharge from the cancer center. Instructing survivors on how to use the patient-facing electronic medical records system for test results and ensuring follow-up tests are scheduled were also highlighted as important contributors to survivors being actively involved in follow-up care. Because many follow-up tests (e.g., bone

density tests, colonoscopy, mammograms) were performed within hospital settings, PCPs noted a significant barrier to follow-up care provision was not having access to the results of follow-up tests. Since survivors reported having access to these results, a recommendation for survivors is to share these results with their PCP in situations where the PCP has not received the information. Additional recommendations for SCP use are to suggest that survivors take a photo of their SCP on their phones to ensure they can easily access the document when needed.

Relationship 8: Survivors interact with their PCPs: to discuss the SCP, arrange follow-up tests, report ongoing health concerns as needed, report their unmet needs

The most important facilitator of SCP use was survivors knowing that they can use the SCP to communicate with their PCP about their follow-up care needs. For example, SCPs provide survivors with the knowledge and confidence to advocate for their follow-up care with their PCP. Specific facilitators to SCP use were: 1) survivors knowing how to use the SCP as a communication tool to share information about their cancer history with healthcare providers; 2) knowing what to expect in follow-up care and; 3) having an understanding of how to refer to the follow-up schedule to ensure surveillance tasks and exams are completed on time. Rather than being perceived by busy healthcare providers as asking for tests without a clear rationale, breast and colorectal cancer survivors reported that having the SCP allowed them to advocate for their follow-up care needs to be met more easily.

Relationship 9: PCPs interact with survivors, organize follow-up tests, discuss the SCPs, treat ongoing health concerns, coordinate help for unmet needs of survivors

PCPs encouraging their patients to contact them when needed, and to take initiative in booking appointments and keeping track of follow-up care were important facilitators of SCP use by cancer survivors. PCPs initiating the first appointment post discharge to discuss the SCP

also helped survivors use their SCP. PCPs described how the table of follow-up recommendations was helpful, and noted that they used the SCP to set reminders in their electronic medical records systems to ensure follow-up tasks were completed based on the recommended frequencies. The needs assessment prompted PCPs to check in with their patients about their psychosocial needs, and it is recommended that PCPs regularly ask their patients about mental health needs because needs can change and arise throughout the course of follow-up care. When PCPs receive many SCPs, it is recommended that they designate the inputting of reminders for follow-up tasks into the electronic medical system, and asking administrative staff to call patients to remind them of their follow-up appointments. Additionally, it is recommended that PCPs consider choosing electronic medical record systems that can automatically upload faxes in case the SCPs are sent to PCPs via fax. Praising and reassuring patients when they initiate contact with their PCP for help with psychosocial concerns and to schedule follow-up appointments is also recommended to facilitate survivors' use of their SCP. In situations where patients are unable to attend appointments in-person, it is recommended that PCPs, where possible, offer telehealth to facilitate follow-up care.

Relationship 10: Primary care providers and oncology specialists interact around booking follow-up tests, receiving test results, and consulting when support is needed

PCPs noted that ongoing consultation with oncology specialists (e.g., nurses, oncologists) was needed in the process of follow-up cancer care. Although the tasks of follow-up care are in the scope of practice of PCPs, oncology expertise was needed according to the PCPs who participated in the study. More specifically, PCPs stated that it would be helpful for SCPs to be updated when guidelines changed, and for longer term cancer survivors at year 5, and year 10. It is recommended that a link to trustworthy and evidence-based resources regarding interpreting

abnormal test results, side effects of cancer treatments and medications, and long-term cancer survivorship be included in the SCP. Having a clear way of consulting oncology specialists with contact information directly on the PCP version of the SCP is recommended. A key logistical barrier for PCPs following the SCPs was the confusing process of ordering test results, dealing with ordered tests that were not received, and having access to test results. With PCPs assigned the role of providing follow-up cancer care, it is recommended that cancer centres provide the infrastructure and technology to prevent unnecessary frustrations and increase in workload for PCPs.

Worked Example of How to Use These Recommendations

For those interested in implementing SCPs in their setting, it is recommended that they review the details of the WBCP (Rushton et al., 2015) to better understand the nature and components of the survivorship program. From there, it is recommended that implementers choose the aspects of the WBCP that are relevant and could be realistically included in the setting. At minimum, it is recommended that implementers consider four key factors: 1) the content of SCPs should include the follow-up tasks and their frequencies that PCPs are responsible for; 2) a brief treatment summary including cancer diagnosis, types of treatments, start and end dates of medications, and the healthcare professionals who were involved in the patients' cancer treatment; 3) provide the SCP to both PCPs and cancer survivors; and 4) education for survivors on the purpose of SCPs, how to use them, and what to expect in follow-up care. Factors 1 and 2 correspond to relationship 4, factor 3 corresponds to relationships 6 and 7, and factor 4 could relate to relationships 2 and 7. When developing SCPs, implementers should follow the recommendations in relationship 4 to guide the content and format of SCPs. Delivery of SCPs to PCPs and cancer survivors should be developed based on the context and

available resources within the setting, and then the barriers and recommendations in relationships 6 and 7 should be reviewed and the recommendations applicable to the setting should be considered. As education around the purpose of SCPs and how to use them is strongly recommended for cancer survivors, the recommendations in relationships 2 and 7 can be used to guide the content and format options for the education. Ultimately, implementers can review and choose the recommendations most suited to their needs. For example, implementers in a setting with minimal funding could focus on recommendations related to online resources for educating survivors on SCPs. Implementers in settings where PCPs are scarce should focus on providing education and highlighting how survivors need to keep track of and initiate their own follow-up appointments prior to being discharged back to their PCP.

In situations where SCPs are already created and provided, these recommendations may be helpful to problem-solve issues that could arise. In this situation, it is recommended that problems with the implementation of SCPs be defined, and then related to one of the ten relationships. Once the applicable relationships are identified, the "Purpose" column of the table of recommendations should be reviewed to narrow down the recommendations to the most applicable options. Once potential recommendations have been identified, looking at the "How," "Target(s)" and "Actor(s)" columns should be reviewed as potential ways to address problems. For example, if it is noticed by cancer programs that survivors are not using their SCPs, relationship 7 would be a good starting point to identify applicable recommendations.

Discussion

This report describes how to use the best practice recommendations for implementing SCPs included in the Appendix. For more details on the development of these recommendations, please see articles 1-3 of this series (included above in this dissertation; Mutsaers et al., 2023a;

2023b; 2023c). The recommendations are organized into 10 relationships with a range of recommendations within each relationship. Not all recommendations are meant to be used; instead, the recommendations relevant across different settings, or applicable to specific problems in the process of providing SCPs can be chosen. That said, it is recommended that implementors of SCPs strongly consider the key facilitators of SCP use as transition tools: 1) inclusion of follow-up guidelines in the SCP; 2) inclusion of the treatment summary in the SCP; 3) providing the SCP to cancer survivors and their PCPs and; 4) education for cancer survivors on the purpose of SCPs and how to use the SCP in follow-up cancer care. Designated survivorship programs may be helpful to manage survivorship issues and create the SCPs. Anticipating and addressing potential logistical issues around PCPs ordering follow-up tests, receiving results, and consulting with oncology specialists as needed are also important considerations to limit the increased workload on PCPs. Overall, it is hoped that these best practice recommendations allow implementors to tailor a process to provide SCPs that fit within different settings.

Future research

Researchers examining the impact of SCPs on follow-up care may find these recommendations helpful in designing studies examining the impact of SCPs on follow-up cancer care. When designing studies, it is important to have more consistency in the content, format, and delivery of SCPs (Hill et al., 2020; Jacobsen et al., 2018), and these recommendations would be helpful in achieving more standardization. In considering how SCPs can be improved, (Rushton et al., 2015), we examined the four studies in a systematic review by Hill and colleagues (2020) that reported an increase in knowledge about what to expect in follow-up care amongst those who had received an SCP. Two of these four studies provided

SCPs with a treatment summary and follow-up guidelines, the SCP was provided to both cancer survivors and their PCPs, and some educational support was provided around SCPs and follow-up care (Grunfeld et al., 2011; Palmer et al., 2015). One of the four studies showing an increased knowledge of follow-up care after receipt of a SCP included an educational component and a survivor-created treatment summary (Casillas et al., 2011). The content of SCPs and supports included in their provisions were not described in the fourth study (Faul et al., 2014). Future studies on SCPs should include detailed descriptions around the information included in the SCP, to whom and how they are delivered, and the context supporting survivors navigating follow-up care (i.e., education, identification of needs, available resources) as these were key facilitators in the present study and published work.

Strengths and Limitations

This work has several strengths, mainly related to their development being guided by evidence-based implementation science frameworks (Theoretical Domains Framework; Cane et al., 2012; Behaviour Change Technique Taxonomy; (https://theoryandtechniquetool.humanbehaviourchange.org/tool), and the experiences of PCPs and cancer survivors who have been using their SCPs and navigating their follow-up cancer care in real world settings. The recommendations are detailed and flexible to allow for them to be applied across various settings, including urban, rural, and remote areas, to other Canadian provinces, along with other countries looking to implement SCPs.

Limitations of this work relate to investigating the barriers and enablers of SCP use in one Canadian city, and with only breast and colorectal cancer survivors. It is unclear how generalizable these recommendations could be, despite efforts to ensure they can be flexibly applied and adapted across settings.

Conclusions

Before abandoning SCPs as transition tools in follow-up care, it is recommended that implementors of SCPs, and researchers examining the usefulness of SCPs consider using these recommendations to optimize and promote the use of SCPs as intended.

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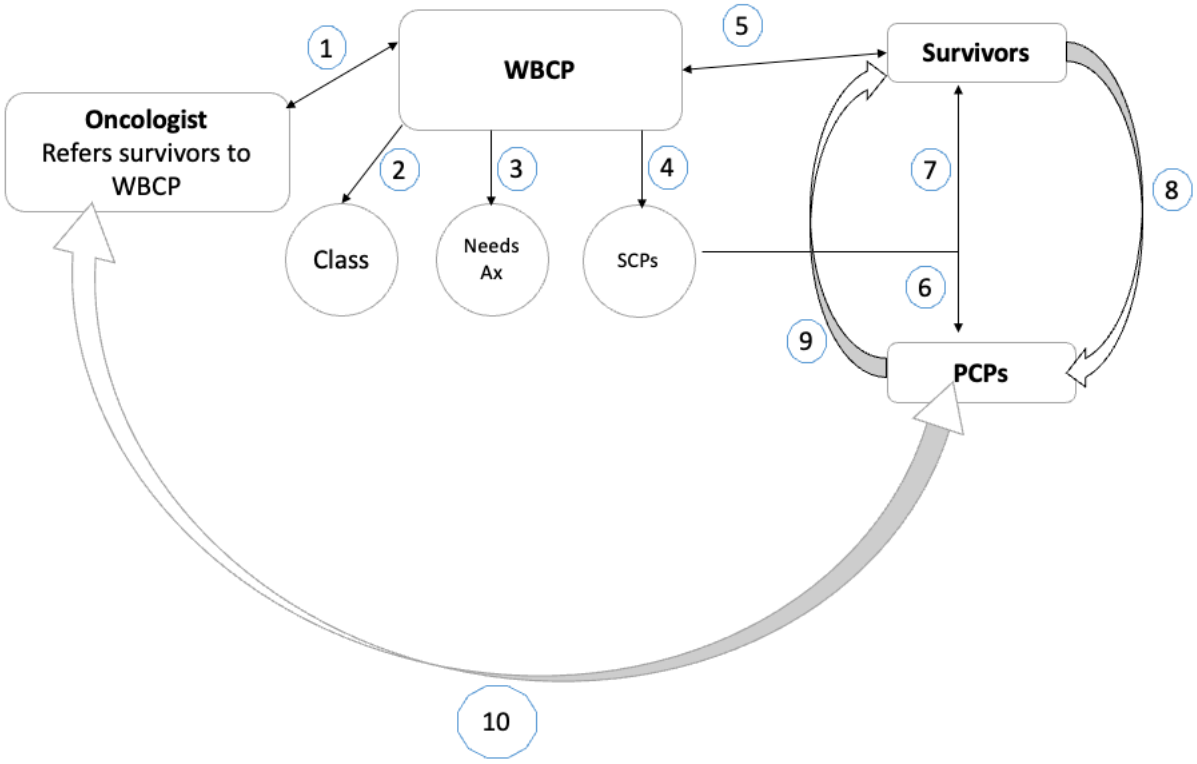
Table 1

Example Recommendations for Implementing SCPs

Relationship	Recommendation	Purpose	How?	Target(s)	Actor(s)
7	Advise patients to call their PCPs if they have concerns/need an appointment	To demonstrate how survivors can use their SCP to engage in their own follow-up care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship

Figure 1

Ten Relationships Associated with Implementing SCPs



1. Oncologist refers survivors to Wellness Beyond Cancer Program (WBCP) to be discharged back to their PCP.

2. The WBCP provides survivors with an Education Class about what to expect in follow-up care.

3. The WBCP provides a needs assessment to populate the SCP.

4. The WBCP creates SCPs using electronic medical records system.

5. Survivors interact with the WBCP as needed until discharge. There is also a rapid re-entry program for survivors should they have a new or recurrent cancer.

6. PCP receives SCP from the WBCP, a discharge note is included with contact information for support from oncology specialists if needed.

7. Survivors receive a copy of their SCP which is reviewed with an oncology nurse via phone, one-on-one meetings, or group meetings.

8. Survivors interact with their PCPs to discuss SCP, arrange follow-up tests, report ongoing health concerns as needed, and report their unmet needs.

9. PCPs interact with survivors to organize follow-up tests, discuss the SCPs, treat ongoing health concerns, and coordinate help for unmet needs of survivors.

10. PCPs and oncology interact with one another when booking follow up tests and receiving results and interacting when support is needed.

General Discussion

Thesis Rationale

The four articles comprising this dissertation aimed to better understand how SCPs have been used by PCPs and cancer survivors in the real world. Barriers and enablers using SCPs as transition tools were systematically identified using the TDF, and then mapped onto the BCTTv1 to create recommendations for implementing SCPs. The recommendations enhance enablers and address barriers of the behaviours required to use SCPs. To make sense of the mixed evidence supporting SCPs, greater standardization was needed to clarify whether SCP are actually useful transitions tools. Implementers of SCPs can use these best practice recommendations to address problems with SCPs already in place, or to guide programs incorporating SCPs for cancer survivors.

The first two articles presented the barriers and enablers of SCPs reported by breast and colorectal cancer survivors, and PCPs, respectively. The third article presented a detailed rationale and approach to the methodology used to generate the best practice recommendations. The final article summarized the best practice recommendations and provided instructions on how to quickly identify potentially helpful recommendations based on the nature of the implementation problem. This dissertation was completed in collaboration with the WBCP, the Psychosocial Oncology Program (PSOP), implementation science experts at The Ottawa Hospital Research Institute, and a PCP in Ottawa, Ontario Canada.

To review, SCPs contain a diagnosis and treatment summary, follow-up guidelines specific to cancer type, and a section on unmet needs (Howell et al., 2011; Rushton et al., 2015). The purpose of SCPs is to provide information and guidance for cancer survivors and PCPs on the expectations for follow-up care, frequency of follow-up tasks, and functions as a tool to

facilitate the transition from tertiary to primary care (Howell et al., 2011; Jacobsen et al., 2018; Hill et al., 2020; Rushton et al., 2015).

On the surface, SCPs appear to be a straightforward tool that would be helpful for the end users (i.e., cancer survivors and PCPs). However, systematic reviews looking at the usefulness of SCPs has been mixed, where findings have shown both positive and negative results of using SCPs, and that SCPs have no impact on cancer survivorship concerns (Hill et al., 2020; Jacobsen et al., 2018). These inconclusive findings are thought to be due to 1) differences in the information included in the SCP and whether SCPs are in paper-based or electronic formats; 2) the outcomes used in research on the impact of SCPs are beyond what an information resource could realistically impact (i.e., fear of recurrence, depression); and 3) the possibility that SCPs are not functional transition tools (Hill et al., 2020; Jacobsen et al., 2018). As outlined by Jefford and colleagues (2022), SCPs are no longer seen as mandatory for survivors and PCPs, though survivorship programs are seen as a path to provide the support and resources to help with the transition back to primary care.

Before SCPs are deemed unhelpful, additional research is needed to clarify the reasons behind the mixed results (Jacobsen et al., 2018). Standardization in the informational content, to whom and when SCPs are delivered, and the way they are delivered (hardcopy, electronic) is a first step in working to clarify the inconsistent results on the impact of SCPs. Two implementation science frameworks the TDF-2 and the BCTTv1 were used to develop best practice recommendations to optimize SCP use as transition tools (Cane et al., 2012; Michie et al., 2008; 2013). The four articles in this dissertation outline the systematic identification of barriers and enablers to the behaviours involved in SCPs for breast and colorectal cancer survivors, and PCPs. The barriers and enablers identified were mapped onto behaviour change

techniques and relationships between primary care, cancer survivors, and cancer centres/survivorship programs were clarified. The best practice recommendations were organized based on these relationships to help implementors identify the most relevant recommendations for their contexts. Because there are many different approaches to implementation science (Nilsen, 2015), the third article described the detailed methodology and rationale for the frameworks used to guide the development of best practice recommendations for SCPs. The general discussion reports the findings from each article, contextualize the results into theoretical models, and note the limitations, strengths, implications for cancer survivors, and areas for future research.

Article 1: Review of Objectives

The first article presents the systematic identification of barriers and enablers of SCP use by breast and colorectal cancer survivors. The behaviours associated with using SCPs as intended were defined using the AACTT framework (Presseau et al., 2019) and a semi-structured interview was developed based on the TDF to identify the barriers and enablers experienced by breast and colorectal cancer survivors. A codebook was developed to guide content analysis of statements into the TDF domains, and thematic analysis was used to generate themes within and across domains.

Article 1: Main Findings

The behaviours associated with SCP use for breast and colorectal cancer survivors (actor) were reading the SCP, discussing the contents with PCP, and call PCP to arrange follow-up appointments (action), at home or in the PCP's office (context), to help PCPs meet the follow-up care needs of survivors (target). Thirty cancer survivors participated in an interview (11 female breast cancer survivors, five colorectal cancer survivors, and 14 male colorectal cancer

survivors). Four main themes emerged from the thematic analysis. The first theme was survivor engagement and motivation to participate in follow-up care which included the knowledge, skills, social professional role and identity, beliefs about capabilities, beliefs about consequences, intention, environmental context and resources, and behavioural regulation TDF domains. The second theme was related to collaboration between survivors and their PCPs in follow-up care which included social professional role and identity, intention, social influences, and beliefs about consequences domains. Theme three focused on descriptions of how survivors have used their SCP in the real world which included the knowledge, skills, memory, attention, and decision processes, intention, and behavioural regulation. The fourth theme was the practical, social, and emotional factors influencing SCP use which encapsulated the TDF domains environmental context and resources, emotion, social influences, and behavioural regulation.

Specific facilitators for breast and colorectal cancer survivors were engaging in a survivorship education class (environmental context and resources), understanding that survivors are expected to also take responsibility of their follow-up care (social professional role and identity), and following the guidance in the SCP to prompt discussions about their follow-up care with their PCP (social professional role and identity).

Specific barriers of SCP use for breast and colorectal cancer survivors were coping with the emotional toll of their cancer experience, and the concern and uncertainty around being discharged from the cancer centre (emotion), not understanding the purpose and importance of SCPs (intention), and having misplaced the SCP (memory, attention, and decision processes). The most common suggestions for improvement from cancer survivors were wanting more information about diet and side effects, connections to peer supports, access to an electronic version of the SCP, and continued connection with cancer specialists. Overall, education on how

to use SCPs and information on what to expect in follow-up care (e.g., signs of recurrence, managing side effects, and health behaviors) should be provided in addition to the SCP.

Article 2: Review of Objectives

The second article presents the barriers and enablers of using SCPs from the perspective of PCPs. For PCPs, the behaviours associated with SCP use were defined using the AACTT framework (Presseau et al., 2019). Barriers and enablers to these behaviours were systematically identified using a semi-structured interview based on the TDF-2. Content and thematic analysis were used to code the text into the TDF domains and generate themes across domains. The TDF domains relevant to barriers and enablers of SCP use amongst PCPs were identified to be mapped onto the BCTTv1 to inform best practice recommendations for implementing SCPs. Thirteen PCPs, all medical doctors participated in an interview.

Article 2: Main Findings

As defined using the AACTT framework (Presseau et al., 2019) the behaviours that are associated with PCPs (actor) using SCPs are: reading the SCP, booking follow-up tests, booking follow-up appointments, interpreting test results, answering patient's questions, responding to patient needs (e.g., psychosocial needs), making decisions on consultation and referrals when patient's needs are outside of scope of practice, and following up on the status of follow-up tests (actions). The context of these behaviours is in the PCP's office, and the information in the SCP provides guidance for cancer survivors and PCPs (target). These behaviours occur every three to six months depending on the needs for cancer survivors (time). Three overall themes were found, where the first was using SCPs to coordinate follow-up care (knowledge, social professional role and identity, beliefs about capabilities, environmental context and resources, behavioural regulation). The second theme describe how PCPs and cancer survivors collaborate with each

other (social professional role and identity, environmental context and resources, social influences, emotion). The third theme was acceptance and understanding that PCPs are responsible for follow-up cancer care (social professional role and identity, beliefs about consequences, intention, memory attention and decision process, environmental context and resources, emotion).

Enablers of SCPs in the knowledge domain were the relevant and helpful information about the follow-up guidelines, clearly laid out follow-up tasks, and PCPs viewing SCPs as a useful resource. In the social professional role and identity domain, facilitators of SCP use were: a) PCPs viewing themselves as responsible for booking tests, appointments, and responding to patient concerns; b) seeing the SCP as helpful for problem-solving in follow-up care; c) believing that patients should also be involved in follow-up care; d) knowing that oncology specialists created the SCPs; and e) being familiar with providing follow-up cancer care. PCPs viewed providing follow-up care as easy, and a responsibility that they can take on (beliefs about capabilities). Believing that using the SCP would lead to positive outcomes (beliefs about consequences), using the scheduling recommendations to create reminders in their electronic medical records (memory, attention, and decision processes), and feeling good about providing follow-up cancer care (emotion) were also important facilitators of SCP use by PCPs.

Barriers to SCP use in the knowledge domain were not knowing about other treatments their patients are receiving, and not knowing about the side effects of cancer-specific medication. In the social professional role and identity domain, barriers included difficulties consulting with cancer specialists, not knowing what to do if test results are abnormal, a lack of clarity over the healthcare professionals responsible for follow-up tasks and finding that some aspects of follow-up care are outside of their scope of practice. Within the environmental context and resources

domain barriers to PCPs using SCPs included challenges finding social support for patients, logistical challenges when trying to consult with oncology, ensuring tests are ordered, and results received because these issues interfered with their ability to smoothly follow-through with the tasks of follow-up care noted in the SCP.

PCPs suggested several ways to improve SCPs that were focused on improving the format and delivery of SCPs, more resources on psychosocial supports, suggesting more patient education, to update SCPs, and having clearer ways to contact oncology specialists (behavioral regulation). Overall, avenues to limit the extra work associated with logistical problems for PCPs following the guidelines in the SCP are needed. Additionally, complexities associated with cancer could leave PCPs feeling unsure about the best way to meet patients' needs. Ways to consult with SCPs more easily could facilitate follow-up care provided mainly by PCPs.

Article 3: Review of Objectives

The overall purpose of this dissertation was to examine the barriers and enablers of SCPs in order to develop best practice recommendations for implementation. Article three provided rationale for the implementation science frameworks chosen, and methodology for how they were integrated. A detailed example of how the TDF-2 and BCTTv1 were used to inform the design of the studies through to the development as best practice recommendations was provided, along with methodological suggestions for implementation researchers.

Article 3: Main Findings

Two resources were used to identify the most applicable implementation science frameworks for the goals of this dissertation. The first was the Theory, Model and Framework Comparison and Selection Tool (T-CAST; Birken et al., 2018), and the tools provided by the Dissemination and Implementation Models in Health (University of Colorado Denver, 2022;

https://dissemination-implementation.org/tool/). A determinant framework was chosen (i.e., the TDF-2) because they help researchers assess factors that influence behaviours and outcomes (Nilsen et al., 2015). The TDF-2 is linked to the BCTTv1 which is a framework that has 93 standardized behaviour change techniques (Michie et al., 2008; 2013). The TDF-2 has 14 domains to systematically identify barriers and enablers of SCP use and allows for a detailed examination of factors impacting the associated behaviors (Atkins et al., 2017; Cane et al., 2012). The 14 TDF domains have been mapped onto the BCTTv1 based on research and expert consensus (Michie et al., 2021).

A detailed codebook was developed to promote consistency in coding the text of the interviews into the 14 TDF domains. Inter-rater reliability of interviews coded independently by two members of the research team showed excellent inter-rater reliability using the Krippendorf's alpha statistic (McHugh, 2012). Belief statements were developed that summarize similar quotes together within the TDF domains (Atkins et al., 2017). Barriers and enablers within each TDF domain were applied to the applicable BCTs using the Theory and Techniques Tool (https://theoryandtechniquetool.humanbehaviourchange.org/tool).

Analysis showed that cancer survivors, PCPs, and cancer centres/survivorship programs need to interact to successfully implement SCPs. Cancer survivors are expected to self-manage their medications, tests, side effects, emotional needs, and psychosocial needs. PCPs need to perform the follow-up tasks outlined in the SCPs, understand the patient's cancer history, manage their specific needs, order follow-up tests, interpret results, and consult with oncology specialists. Oncology centres or survivorship programs provide knowledge to PCPs and cancer survivors, discharge cancer survivors back to primary care, create individualized SCPs. Cancer survivors and PCPs must communicate, coordinate and support. Cancer survivors and oncology

need to interact through providing directions on follow-up care (i.e., SCPs) and provide a clear re-entry system back to the cancer centre if a recurrence or a new cancer develops (Ruston et al., 2015). PCPs and oncologists must share information, oncology specialists need to provide guidance, collaborate and consult with PCPs as needed. In sum, there are more complex dynamics at play than a direct discharge and management of follow-up care in primary care. Type 4 logic models (Mills et al., 2019) were created to detail the specifics of contextual, factors associated with implementing SCPs.

A flow chart was created to outline the process of implementing SCPs at a high level. Ten relationships were outlined in the flow chart: 1) oncologist refers survivors to the WBCP to be discharged back to their PCP; 2) the WBCP provides survivors with an education class about what to expect in follow-up care; 3) the WBCP provides a needs assessment to populate the SCP; 4) the WBCP creates SCPs using electronic medical records system; 5) survivors interact with the WBCP as needed until discharge. There is also a rapid re-entry program for survivors should they have a new or recurrent cancer; 6) PCP receives SCP from the WBCP, a discharge note is included with contact information for support from oncology specialists if needed; 7) survivors receive a copy of their SCP which is reviewed with an oncology nurse via phone, one-on-one meetings, and group meetings; 8) survivors interact with their PCPs to discuss SCPs, arrange follow-up tests, report ongoing health concerns as needed, report their unmet needs; 9) PCPs interact with survivors to organize follow-up tests, discuss the SCPs, treat ongoing health concerns, coordinate help for unmet needs of survivors; and 10) PCPs and oncology interact with one another when booking follow-up tests and receiving results and interact when support is needed (Rushton et al., 2015). More detail about the WBCP can be found in the articles by

Rushton and colleagues (2015), Liska and colleages (2018), and Rutkowski and colleagues (2021).

For implementation researchers it is recommended tools be consulted to think through the options for theoretical frameworks to guide implementation projects. The level of detail was labour intensive to complete this dissertation, and it is not realistic for most implementation science research. More complex methods may be helpful in situations where implementation interventions are being created that involve multiple contexts and recommendation that can be adaptable to different contexts (Mills et al., 2019. Taking a qualitative approach (i.e., thematic analysis) was helpful in maintaining openness to seeing patterns in the data beyond the content analysis into the TDF domains.

Article 4: Review of Objectives

The final article is a report outlining how to choose applicable recommendations for implementing SCPs based on the unique barriers) and enablers in different settings.

Article 4: Main Findings

Many implementation recommendations were developed, which were organized into a flow chart with 10 interrelationships. Not all recommendations should be used for every implementation intervention for SCPs, but the following four recommendations are important facilitators for SCPs as transition tools: 1) outlining the follow-up guidelines in the SCP; 2) a treatment summary in the SCP; 3) SCPs available to both PCPs and cancer survivors; and 4) survivors should have access to education about follow-up care and the purpose and function of SCPs. When a process for providing SCPs has already been implemented these recommendations can be used to problem-solve implementation issues, and programs looking into implementing SCPs can start with the recommendations that would best fit within their

context. Ultimately, the last article in this dissertation (Mutsaers et al., 2023d) provides a range of best practice implementation recommendations for SCPs that can be tailored across settings.

Integration of Findings within Theoretical Models

The main implementation science theoretical model was the Knowledge to Action Framework (Graham et al., 2006). Facilitating the transition back to primary care is associated with the concept of self-management (Jefford et al., 2022; Howell et al., 2021) and the Social Cognitive Theory (Bandura, 2004).

Knowledge to ActionCycle

The Knowledge to Action Cycle is an implementation approach that is directly related to health care settings (Graham et al., 2006). The framework is made up of the knowledge creation funnel which links to the objectives of the study. SCPs have been examined in research since they were originally recommended (Runowicz et al., 2016) which correspond to the knowledge inquiry component of the knowledge creation funnel (Graham et al, 2006). The two main systematic reviews on SCPs cited throughout all four studies by Jacobsen and colleagues (2018) and Hill and colleagues (2020) corresponds to the knowledge synthesis part of the knowledge creation funnel (Graham et al, 2006). Then the survivorship guideline recommendations such as the Cancer Care Ontario guidelines (Cancer Care Ontario, 2019), the Pan-Canadian Guidelines for Survivorship Services for Adult Cancer Survivors (Howell et al., 2011), and the survivorship guidelines outlined by the American Cancer Society (Runowicz et al., 2016) related to the end of the knowledge funnel related to tools from the knowledge from the research and systematic reviews. The systematic reviews (Hill et al., 2020; Jacobsen et al., 2018) delineated the knowledge to practice gap (Graham et al., 2006), highlighting that a lack of standardization of

how SCPs are created and delivered (i.e., why there is mixed evidence on the effectiveness of SCPs as transition tools; Hill et al., 2020; Jacobsen et al., 2018).

The Action Cycle, which is the other main part of the Knowledge to Action Cycle (Graham et al., 2006) would start at the Adapting Knowledge to the Local Context step for this dissertation. The SCPs provided to the PCPs and cancer survivors who participated in the interviews were created by the WBCP, and the additional supports provided (i.e., the education class, discharge meetings, needs assessment, rapid re-entry pathway; Rushton et al., 2015) relate to the Adaptation of Knowledge (i.e., the follow-up guidelines and discharge to follow-up care) to the Local Context (i.e., the WBCP). The results of this dissertation around identifying the barriers and enablers of SCP use relates to the next step of the action cycle (Graham et al., 2006) and were presented in articles one and two. The next part of the Action Cycle is to Select, Tailor, Implement Interventions (Graham et al., 2006) corresponds to articles three and four that were focused on mapping of the TDF-Domains onto the BCTTv1 to create best practice recommendations for implementing SCPs that are adaptable across contexts relates (Graham et al., 2006). As described below under future directions, the monitoring knowledge use, Evaluation of Outcomes, and Sustaining Knowledge use (Graham et al., 2006) are the next applicable steps in the Action Cycle, which relate to implementors using the best practice recommendations developed in this thesis to tailor their own approach to developing and delivering SCPs.

Self-Management

With the shift toward follow-up care in primary care settings, there is the expectation that survivors take an active role in their own health care (Rushton et al., 2015). Models of self-management are applicable to the rationale behind SCPs (Jefford et al., 2022). As described by

Barlow and colleagues (2004), self-management approaches should include information about the illness and what to expect over time, information about medication use, how to manage symptoms and side effects, psychosocial supports, healthy lifestyle behaviours, and suggestions on how to communicate with healthcare professionals (Barlow et al., 2004). A systematic literature review on self-management interventions highlighted the following three factors: managing medications and side effects, understanding the roles of survivors and healthcare professionals, and coping with psychosocial concerns (Cuthbert et al., 2019). This literature noted that the interventions that were based on theoretical models that focused on behaviour change (Cuthbert et al., 2019). Education was an important facilitator of SCP use for cancer survivors, where information about what to expect in follow-up care and the purpose of function of SCPs (as described in Rushton et al., 2015 provided by the WBCP). Education is an important part of self-management and was included in most of the self-management interventions included in the review on cancer, healthy lifestyle behaviors, and how to manage concerns and stressors (Cuthbert et al., 2019). One theory that has been used to understand self-management is the Social Cognitive Theory (Bandura et al., 2004; Cuthbert et al., 2019).

Social Cognitive Theory

As this work found that there is a dynamic interplay between cancer centres/survivorship programs, PCPs, and cancer survivors, the inherent social influences in the delivery of SCPs and managing follow-up care became apparent. Social cognitive theory, developed by Bandura (2004), can be related to managing one's own health care as is expected of cancer survivors upon discharge after primary care (Hill et al., 2020; Jacobsen et al., 2018). There are six main components of this theory (Bandura, 2004) that are related to implementing SCPs. The first is knowledge (Bandura, 2004) where the SCP provides guidelines for managing follow-up cancer

care to PCPs, and informs breast and colorectal cancer survivors of what to expect in follow-up care. This dissertation also found that providing education about how to use the SCP, late and long term side effects of treatment, and directly communicating the expectation that survivors need to be actively involved in their follow-up care which is also applicable the knowledge component of the Social Cognitive Theory. The second component of the theory is perceived self-efficacy (Bandura, 2004), which relates to consideration of what can be reasonably transferred to PCPs in follow-up care. The guideline recommendations clearly laid out in the care plan was an important facilitator of SCP use amongst PCPs, and several PCPs commented on how many of the tasks of follow-up care were already within their scope of practice. Furthermore, PCPs' reported frustration with the logistical challenges with receiving follow-up test results and being unsure about how to manage cancer-specific medications, what the next steps are for addressing abnormal test results could be viewed as related to low self-efficacy. The best practice recommendations for implementing SCPs related to providing access to cancer-specific information, and creating avenues to more easily consult with oncology specialists as needed may increase self-efficacy in PCPs. For cancer survivors, the SCP provides a clear outline of what to expect in follow-up care, and an explanation of the expectations for survivors in follow-up could be phrased in ways that highlights how these tasks are already part of how survivors have been navigating their cancer diagnosis and treatment.

Component three of the social cognitive theory is outcome expectations (Bandura, 2004) which fits in with the rationale behind follow-up cancer care, especially related to surveillance tests, maintaining health, and managing symptoms over the long term. Both PCPs and cancer survivors described facilitators of care plan use related to the TDF domain beliefs about consequences. Namely beliefs that following the SCP will catch a potential cancer recurrence

early. Goals, which is the fourth component of the social cognitive theory (Bandura, 2004) relates to the implementation of SCPs where the frequency of follow-up care tasks could be viewed as goals with steps to take to meet said goals (i.e., read the SCP, call PCP to schedule appointments). The fifth and sixth parts of the social cognitive theory are related to barriers and facilitators of behaviour change (Bandura, 2004), which relates to both the environmental consequences and resources domain where logistical factors impact whether the SCP can be used as intended (i.e., ordering tests and receiving results efficiently, incompatible EMRs). Additionally, the self-management research may also be applicable to supporting cancer survivors post primary treatment (Howell et al., 2021; Jefford et al., 2022).

Dark Logic Models: Unintended Consequences of Implementing SCPs

Although not directly assessed, the idea of a dark logic model that considers the potential negative impact of implementation interventions is important to consider (Bonell et al., 2015; Duncan et al., 2022). When considering the barriers and enablers of SCP use for breast and colorectal cancer survivors the expectations that survivors take an active role in follow up care even education classes and discharge meetings can be difficult to attend if travel is required to attend. Furthermore, if survivors received a SCP, but do not know how to use it and their PCP is unaware of their follow-up care needs, it is possible that important surveillance tasks won't be completed which could have negative health consequences. The burden of managing one's own follow-up care may be an unrealistic expectation for some cancer survivors, and implementors of SCPs may benefit from needs assessments inquiring about survivors' willingness and ability to participate in follow-up care. Additionally, if a survivor's PCP retires, moves, or otherwise becomes unavailable, shouldering the burden of follow-up care without one's PCP becomes more difficult. For both cancer survivors and PCPs, finding resources for help with psychosocial

concerns was difficult, and the financial means needed to access services present inequalities in access to care (Moroz et al., 2020).

For PCPs, the shift in the provision of follow-up care from oncology centers to primary care adds to their workload, as was reported in article two and in other work on SCPs (Birken et al., 2014). However, the increase in workload regarding the tasks outlined in the SCP were not reported as a significant barrier to using SCPs as intended in article two. Rather, it was the difficulties with communication and correspondence between PCPs and oncology centres where follow-up tests were often conducted. PCPs spoke about having to spend extra time trying to track down whether ordered follow-up tests were received and trying to get access to the test results. Concerns related to missing a recurrence or other health issue because of delays in follow-up tests or delaying diagnosis and treatment are potential negative outcomes if logistical barriers are not addressed. Overall, when follow-up care is delegated to PCPs, additional infrastructure is needed to ensure that there are streamlined ways to follow through with the associated tasks to prevent undue frustration and stress.

Thesis Limitations

This dissertation focused on SCPs that were created and delivered in the context of the WBCP that provides survivorship care to Ottawa, ON Canada and surrounding areas (Rushton et al., 2015). The WBCP may be a unique setting where education and nursing support around the SCP are integrated into the program itself (Rushton et al., 2015). Amongst the breast and colorectal cancer survivors who participated in this study there were participants who did not remember receiving a SCP; however, those who participated in the study may have different characteristics than those who did not thereby limiting the generalizability of the results. Additionally, there were only 13 PCPs who participated in an interview who all worked in the

Ottawa and surrounding areas and the barriers and enablers identified may not be applicable to all settings.

Thesis Strengths

Strengths of this dissertation include how the barriers and enablers to SCP use were assessed using a theory-based approach, and that interviews were conducted with PCPs and cancer survivors who had received a SCP and had experience using them in the context of follow-up cancer care. The perspectives of both breast and colorectal survivors and both sexes added more generalizability than if only one cancer type or sex been included.

Methodologically, data saturation was considered and the 10+3 rule was used to guide and assure that data saturation was reached (Francis et al., 2010; Atkins et al., 2017). To promote trustworthiness and consistency in the data analysis, a detailed codebook was created for both PCP and cancer survivor interviews defining the content that should be organized into the TDF domains (Atkins et al., 2017). The TDF-2 (Cane et al., 2012) encapsulates many theories and constructs related to behaviour change (Cane et al., 2012; Michie et al., 2005). Carefully defining the behaviours associated with SCP use for both PCPs and cancer survivors and examining the barriers and enablers to these behaviors allowed for a systematic and nuanced understanding of how SCPs have been used. The TDF-2 and BCTTv1 were chosen after considering other implementation frameworks because they fit the research questions and objectives of the thesis. Importantly, stakeholders from the WBCP, experts in cancer survivors and implementation science, and a primary care provider provided input into the development of the project through to analysis which strengthened the work. The best practice recommendations developed are flexible and it is hoped that they can be used across multiple settings.

Clinical Implications

SCPs may be helpful transition tools for cancer survivors and their PCPs. From the perspective of PCPs, the SCP provides clear and understandable follow-up care guidelines that were reported as being easily integrated into their practice. Given that PCPs are expected to provide follow-up care in the changing models of care that are needed to meet the needs of cancer survivors (Jefford et al., 2022) the SCP was reportedly helpful in moving into this role. The lack of confidence PCPs can have in taking on the role of managing follow-up cancer care (Birken et al., 2014) can be addressed through an SCP via a credible source (oncology specialists). Overall PCPs feeling comfortable providing follow-up care can positively impact survivors because their follow-up needs will likely be met. The PCPs who participated in these studies were highly engaged with their patients and took follow-up care seriously which allowed for the communication and collaboration inherent in the SCP.

Different approaches to follow-up cancer care are needed to ensure that cancer survivors continue to receive the follow-up care they need (Hill et al., 2020; Jacobsen et al., 2018; Jefford et al., 2022). Whether SCPs are continued to be implemented or researched, educational supports and guidance on longer term cancer survivorship is needed (Biddell et al., 2021; Howell et al., 2021; Jefford et al., 2022). The SCP provides a concise way of communicating to survivors what to expect in follow-up care and serves as a communication tool for survivors to advocate for their own needs and ongoing surveillance testing. Providing survivors with information about follow-up care can help survivors self-manage in the context of their follow-up care which is an important role for cancer survivors (Cuthbert et al., 2019). SCPs can be on potential option among many to provide information about cancer survivorship (Murnaghan et al., 2021). That said, self-management support requires more than receipt of a SCP, and additional information is helpful (Biddell et al., 2021; Howell et al., 2021). Implementors of SCPs may or may not be able

to provide all the same resources as the WBCP, but this work found that the SCP plus an explanation of their purpose and function are the minimum factors required to facilitate their use as transition tools.

Future Directions

As mentioned above, the next steps in the Action Cycle are monitoring knowledge use and evaluate outcomes (Graham et al., 2006). Accordingly, consistent content, format, and to whom SCPs are provided could clarify the results of research on SCPs. Implementers of SCPs may benefit from using these recommendations to promote the consistency across studies that is needed to investigate the usefulness of SCPs more meaningfully (Hill et al., 2020; Jacobsen et al., 2018). As mentioned in the fourth article, implementers are not meant to use all the recommendations, but can choose applicable recommendations to their contexts knowing that the recommendations were informed from interviews with end users, and generated using evidence-based approaches (i.e., the TDF-2 and BCTTv1). The steps of the action cycle can be followed in both clockwise and counter-clockwise to continue refining implementation interventions (Graham et al., 2006). Ultimately, finding ways to sustain the implementation of SCPs is an area for future research. In the shorter-term, future research examining these recommendations is important for understanding which BCTs have the most impact in the implementation of SCPs.

As outlined by Jefford and colleagues (2022), there has been a move away from using SCPs that is generally due to the lack of clarity of their usefulness. The recommendations developed and presented in article four can also be applicable to survivorship support without using SCPs specifically. Additionally, self-management theories and approaches would also be applicable to follow-up care (Cuthbert et al., 2019). The self-management of chronic illness literature has a range of implementation options and theoretical approaches that can provide

inspiration or guidance for supporting cancer survivors (Howell et al., 2021; Kantilal et al., 2022). For PCPs, future work is recommended to create smoother communication links between oncology specialists and PCPs, along with straightforward ways to order and receive test results.

Relatedly, the process of developing and delivering SCPs should be described in greater detail to facilitate replicability across studies, as it is difficult to compare SCPs provided alone, and SCPs provided in the context of a defined survivorship program with integrated education and nursing support (Hill et al., 2020; Jacobsen et al, 2018), for example as provided by the WBCP (Rushton et al., 2015). SCP use among other types cancer survivors who are discharged back to follow-up care is also an avenue for future research. Finally, an important issue discussed by Hill and colleagues (2020) is that the outcomes chosen can be realistically impacted by SCPs (e.g., increased knowledge, follow-up tests completed on time, recurrences noticed and treated earlier). Future research should carefully consider the outcomes chosen to measure the impact of SCPs, and focus on knowledge about survivorship, consultations with PCPs, and completion of follow-up tests in a timely manner based on recommendations in the SCP.

Conclusion

This work presented best practice recommendations for implementing SCPs that are adaptable across different settings. It is hoped that the recommendations can foster more consistency in SCPs and allow for more meaningful research on SCPs that can clarify the mixed results on the impact of SCPs as transitions tools. SCPs were helpful to PCPs as they provided concise direction for their responsibilities in providing follow-up care. The time after discharge from the cancer centre is a difficult time for cancer survivors (Rushton et al., 2015), and it is hoped that SCPs or other avenues of support can be provided to cancer survivors to facilitate a smoother transition back to primary care.

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Appendix A
Recruitment Letter for Primary Care Providers

Inspired by research.
Driven by compassion.

The Ottawa Hospital
Research Institute
Affiliated with uOttawa

Date
PCP's Name and Address

Dear Dr./Mr./Ms. _____,

A research study is being conducted to examine if and how cancer survivors and primary care providers (family physicians and nurse practitioners) use the survivorship care plans provided by The Wellness Beyond Cancer Program. This work is part of a University of Ottawa doctoral student's thesis and is being conducted in conjunction with The Wellness Beyond Cancer Program and The Ottawa Hospital Research Institute.

- As more cancer survivors complete treatment and receive follow-up care in primary care settings, Survivorship Care Plans are recommended as a tool to help facilitate this transition.
- We are reaching out to you because you received a survivorship care plan from the Wellness Beyond Cancer Program for at least one of your patients in 2017 or 2018.

WHY THIS RESEARCH IS IMPORTANT?

- The transition to primary care after completing active cancer treatment at The Cancer Center can be challenging.
- The goal of this research study is to develop ways to make this transition easier for cancer survivors and their primary care providers through the use of survivorship care plans.

INTERESTED IN PARTICIPATING?

- Participating in this study will involve a one-time 15-20 minute in-person or telephone interview
- **You will be compensated with a $100.00 gift card for your time**
- Participation is voluntary and you may withdraw from the study anytime you would like to

To participate in this study or for more information, please contact our research assistant at:

613-798-5555 ext. XXXXX or **XXXXX@ohri.ca**

Sincerely,

Brittany Mutsaers, B.Sc.
Doctoral Student

Dr. Cheryl Harris, Ph.D., C.Psych
Principal Investigator

Dr. Amirrtha Srikanthan
Physician Lead, Wellness Beyond Cancer Program Clinics

Kate Duke
Clinical Manager, Ottawa Hospital Cancer

Version date of this form: 2020-10-19 File # 20200152-01H

Appendix B
Recruitment Letter for Cancer Survivors

Date
Patient's Name and Address

Dear Mr./Ms. _____,

A research study is being done to determine when and how cancer survivors and primary care providers (family physicians and nurse practitioners) use the survivorship care plans provided by The Wellness Beyond Cancer Program. This work is part of a University of Ottawa doctoral student's thesis and is being conducted in conjunction with The Wellness Beyond Cancer Program and The Ottawa Hospital Research Institute.

- As more cancer survivors complete treatment and receive follow-up care in primary care settings, Survivorship Care Plans are recommended as a tool to help facilitate this transition.
- We are reaching out to you because you received a survivorship care plan from the Wellness Beyond Cancer Program in 2017 or 2018.

WHY THIS RESEARCH IS IMPORTANT?

- Returning to your primary care provider after completing active cancer treatment at The Cancer Center can be challenging.
- The goal of this research study is to develop ways to make this transition easier for cancer survivors and their primary care providers through the use of survivorship care plans.

INTERESTED IN PARTICIPATING?

- Participating in this study will involve a one-time 30-45 minute in-person or telephone interview
- **You will be compensated with a $50.00 gift card for your time**

- Participation is voluntary and you may withdraw from the study any time you would like to

To participate in this study or for more information, please contact our research assistant at:
613-798-5555 ext. XXX XX or XXXX**@ohri.ca**
To participate in this study or for more information, please contact our research assistant at:
613-798-5555 ext. XXXX or **XXX@ohri.ca**

Sincerely,

Brittany Mutsaers, B.Sc.
Doctoral Student

Dr. Cheryl Harris, Ph.D., C.Psych
Principal Investigator

Dr. Amirrtha Srikanthan
Physician Lead, Wellness Beyond Cancer Program Clinics

Kate Duke
Clinical Manager, Ottawa Hospital Cancer

Version date of this form: 2020-10-19 File # 20200152-01H

Appendix C
Informed Consent Form PCPs

Telephone Minimal Risk Informed Consent Form for Participation in a Research Study

Verbal Consent Script: Returning Interested Participant's Voicemail

Hello, may I please speak with [insert the name of the potential participant here].

If the potential participant is not home, ask if there is a better time to call. Do not leave a message as it may be a confidential matter you are calling about that may not be apparent to you

If they are home, continue with the conversation

Hi, [insert the name of the potential participant here] this is [insert your name here] calling from the [The Ottawa Hospital]. I received your voicemail message indicating that you are interested in participating in our survivorship care plan study.

I am calling today to confirm your interest in participating, and provide you with more information. I will go over the informed consent form that outlines what is involved with participating.

Are you still interested in hearing more about this study?

- No, *If no, thank them for their time and say good-bye*
- *Yes, *If yes, Is this a convenient time for you?*
  - Yes, *If yes, continue*
  - No, *If no, i*s there a time more suitable for you to discuss the study? *[Provide some contact times that is more convenient for the participant].*

Verbal Consent Script: Directly Answering Call from Interested Participant

Answer the phone: *"Hello, [Name] speaking "*

- Listen to potential participant; confirm he or she is interested in participating in the survivorship care plan study.
- Thank caller for his/her interest in participating. *"We can start with me telling you more about the study and then I will go over the informed consent form that outlines what is involved with participating."*
- *Is this a convenient time for you?*
  - Yes, *If yes, continue*
  - No, *If no, i*s there a time more suitable for you to discuss the study? *[Provide some contact times that is more convenient for the participant]*

- The study is being conducted by Brittany Mutsaers, a Ph.D. student in clinical psychology under the supervision of Dr. Cheryl Harris at The Ottawa Hospital Cancer Centre.
- As you saw in the letter we sent out, we are interested in hearing your thoughts about the survivorship care plan that was provided to you by The Wellness Beyond Cancer Program.
- This study would involve a one-time 30-45 minute telephone interview.
- Based on these interviews, we hope to get a better understanding of the experiences of cancer survivors and their primary care providers during the transition from active cancer treatment at the Cancer Centre to follow-up care in the community.
- More specifically, we are interested in learning about using your survivorship care plan during this transition.
- Ultimately, we hope to develop recommendations for improving survivorship care plans to better meet the needs of survivors and primary care providers in follow-up care.

As a note, taking part in this study is voluntary. Deciding not to take part or deciding to leave the study later will not result in any penalty or affect current or future health care.

Any questions/concerns so far before I go into more detail?

Any questions/concerns so far before I go into more detail?

I am now going to read some important information about our study. Please feel free to stop me to ask questions at any time.

OHSN-REB Number*:* 20200152-01H

Principal Investigator: Dr. Cheryl Harris, Ph.D., C.Psych. Psychology, 613-737-8899 x79533

Funder: CIHR Operating Grant: Transitions in Care – Best and Wise Practice Grants

INTRODUCTION

You are being invited to participate in a research study. You are invited to participate in this study because you received a survivorship care plan from The Wellness Beyond Cancer Program for at least one of your patients. This consent form provides you with information to help you make an informed choice. Please listen carefully and ask any questions you may have. All your questions should be answered to your satisfaction before you decide whether to participate in this research study.

Please take your time in making your decision. You may find it helpful to discuss it with your friends and family.

Taking part in this study is voluntary. You have the option to not participate at all or you may choose to leave the study at any time. Whatever you choose, the decision will not affect your

employment or your relationship with The Ottawa Hospital Cancer Centre or The Wellness Beyond Cancer Program.

IS THERE A CONFLICT OF INTEREST?
There are no conflicts of interest to declare related to this study.

WHY IS THIS STUDY BEING DONE?

The purpose of this study is to look at how cancer survivors and their primary care providers (i.e., family physicians and nurse practitioners) use survivorship care plans for follow-up care after completing active cancer treatment. Barriers and enablers to using survivorship care plans will be identified across urban, rural and remote settings. Recommendations will then be developed to promote the use of survivorship care plans.

HOW MANY PEOPLE WILL TAKE PART IN THIS STUDY?

It is anticipated that about 39 people will take part in this study (26 breast and colorectal cancer survivors; 13 primary care providers), from research sites associated with The Ottawa Hospital.

This study should take 1 year to complete and the results should be known in about 1.5 years.

WHAT WILL HAPPEN DURING THIS STUDY?

You will be asked to attend 1 interview. During this interview, you will meet with 1-2 member(s) of the research team. Each interview will be about 15-20 minutes in length and will take place over the telephone.

You will be asked to speak about if and/or how you have used survivorship care plans from the Wellness Beyond Cancer Program in providing follow-up care to your patients who are breast or colorectal cancer survivors

You will be audio recorded during the interview.

WHAT ARE THE RESPONSIBILITIES OF STUDY PARTICIPANTS?

If you choose to participate in this study, you will be expected to:

- Share your honest your opinion about:
  - Your experiences providing follow-up cancer care to your patients
  - If and/or how you have used survivorship care plans
  - Your recommendations around how to make survivorship care plans easier to use as a tool to facilitate a smooth transition from The Cancer Centre to receiving follow-up care in primary care settings

HOW LONG WILL PARTICIPANTS BE IN THE STUDY?

Your participation on this study will last for about 15-20 min during the one-time interview.

CAN PARTICIPANTS CHOOSE TO LEAVE THE STUDY?

You can choose to end your participation in this research (called withdrawal) at any time without having to provide a reason. If you choose to withdraw from the study, you are encouraged to contact the research team.

You may withdraw your permission to use information that was collected about you for this study at any time by letting the research team know. However, this would also mean that you withdraw from the study.

If you decide to leave the study, you can ask that the information that was collected about you not be used for the study. Let the research team know if you choose this.

WHAT ARE THE RISKS OR HARMS OF PARTICIPATING IN THIS STUDY?

There are no serious risks to participating in the study, but taking part in this study may make you feel uncomfortable. You may choose not to answer questions or to leave the interview at any time if you experience any discomfort.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?

You may not receive direct benefit from participating in this study. We hope the information learned from this study will help cancer survivors and primary care providers navigate the transition to primary care for follow-up after completion of active cancer treatment in the future.

HOW WILL PARTICIPANT INFORMATION BE KEPT CONFIDENTIAL?

If you decide to participate in this study, the research team will only collect the information they need for this study.

Records identifying you at this center will be kept confidential and, to the extent permitted by the applicable laws, will not be disclosed or made publicly available, except as described in this consent document.

Authorized representatives of the following organizations may look at your original (identifiable) records at the site where these records are held, to check that the information collected for the study is correct and follows proper laws and guidelines.

- The Ottawa Health Science Network Research Ethics Board who oversees the ethical conduct of this study.
- Ottawa Hospital Research Institute to oversee the conduct of research at this location.
- The University of Ottawa Research Ethics Board, to oversee the conduct of research at this location

Information that is collected about you for the study (called study data) may also be sent to the organizations listed above. Your name, address, email, or other information that may directly identify you will not be used. The records received by these organizations may contain your participant code, sex, and age.

During the interview, participants will be encouraged to refrain from using names. If names or other identifying information is shared during the discussion, it will not be included in the written records.

The audio recordings will be stored in a secure location and listened to only by members of the research team. The recordings will be kept until they have been transcribed (turned into written records), and then they will be destroyed.

If the results of this study are published, your identity will remain confidential. It is expected that the information collected during this study will be used in analyses and will be published/ presented to the scientific community at meetings and in journals.

Your de-identified data from this study may be used for other research purposes. If your study data is shared with other researchers, information that links your study data directly to you will not be shared.

Even though the likelihood that someone may identify you from the study data is very small, it can never be completely eliminated.

WHAT IS THE COST TO PARTICIPANTS?

Taking part in this study may result in added costs to you. For example:

- You may miss work as a result of participation in this study.

ARE STUDY PARTICIPANTS PAID TO BE IN THIS STUDY?

If you decide to participate in this study, you will receive a $100.00 gift card (Tim Horton's, Petro-Canada or President's Choice, based on your preference) after completing the interview in person or via mail after completion of the interview over the telephone. Should you decide to end the interview before it has been completed, you will still receive a $100.00 gift card at the end of the interview if conducted in person or via mail if the interview was conducted over the telephone.

WHAT ARE THE RIGHTS OF PARTICIPANTS IN A RESEARCH STUDY?

You will be told, in a timely manner, about new information that may be relevant to your willingness to stay in this study.

You have the right to be informed of the results of this study once the entire study is complete. If you would like to be informed of the results of this study, please inform the interviewer or contact the research team.

Your rights to privacy are legally protected by federal and provincial laws that require safeguards to ensure that your privacy is respected.

You will be given a copy of this consent form via email or regular mail prior to participating in this study.

WHOM DO PARTICIPANTS CONTACT FOR QUESTIONS?

If you have questions about taking part in this study, you can talk to the Principal Investigator. That person is:

Dr. Cheryl Harris, Ph.D., C. Psych 613-737-8899 ext. 79533
Principal Investigator Name Telephone

If you have questions about your rights as a participant or about ethical issues related to this study, you can talk to someone who is not involved in the study at all. Please contact The Ottawa Health Science Network Research Ethics Board, Chairperson at 613-798-5555 extension 16719.

Do you have any questions?
[Answer any questions they may have]

Comments: _____

I can send you the informed consent form by mail or email. What is your preference?

- Mail, if yes, confirm address: _____
- Email, if yes, confirm email address: _____

Do you mind if I call you back [specify time] to obtain your decision and answer any further questions you may have?

- Yes
- No

Comments: _____

Verbal Informed Consent Form

Study Title: The Use of Survivorship Care Plans as a Transition Tool from the Cancer Centre to Follow-Up in Primary Care Settings

OHSN-REB Number*:* 20200152-01H

Name of Participant: _____

Date of Discussion: _____

Duration of Discussion: _____

SIGNATURES

- ☐ The participant's questions have been answered,

- ☐ The participant understands the information within this informed consent form,
- ☐ Each page of the Verbal Informed Consent Form has been read to the participant.
- ☐ The participant agrees to take part in this study.

Investigator or Delegate Statement

I have carefully explained the study to the study participant. To the best of my knowledge, the participant understands the nature, demands, risks and benefits involved in taking part in this study.

_____	_____	_____
Signature of Person Signature of Person Conducting the Consent Discussion	Printed Name and Role	Date

Appendix D
Informed Consent Form Survivors

Telephone Minimal Risk Informed Consent Form for Participation in a Research Study

Verbal Consent Script: Returning Interested Participant's Voicemail

Hello, may I please speak with [insert the name of the potential participant here].
*If the potential participant is not home, ask if there is a better time to call. Do not leave a message as it may be a confidential matter you are calling about that may not be apparent to you**

If they are home, continue with the conversation

Hi, [insert the name of the potential participant here] this is [insert your name here] calling from the [The Ottawa Hospital]. I received your voicemail message indicating that you are interested in participating in our survivorship care plan study.

I am calling today to confirm your interest in participating, and provide you with more information. I will go over the informed consent form that outlines what is involved with participating.

Are you still interested in hearing more about this study?

- No, **If no, thank them for their time and say good-bye*
- *Yes, *If yes, Is this a convenient time for you?*
  - Yes, **If yes, continue*
  - No, **If no, i*s there a time more suitable for you to discuss the study? *[Provide some contact times that is more convenient for the participant].*

Verbal Consent Script: Directly Answering Call from Interested Participant

Answer the phone: *"Hello, [Name] speaking "*

- Listen to potential participant; confirm he or she is interested in participating in the survivorship care plan study.
- Thank caller for his/her interest in participating*. "I can start with going over the informed consent form that outlines what is involved with participating."*
- *Is this a convenient time for you?*

- Yes, **If yes, continue*
- No, **If no, i*s there a time more suitable for you to discuss the study? *[Provide some contact times that is more convenient for the participant]*

- The study is being conducted by Brittany Mutsaers, a Ph.D. student in clinical psychology under the supervision of Dr. Cheryl Harris at The Ottawa Hospital Cancer Centre.
- As you saw in the letter we sent out, we are interested in hearing your thoughts about the survivorship care plan that was provided to you by The Wellness Beyond Cancer Program.
- This study would involve a one-time 30-45 minute telephone interview.
- Based on these interviews, we hope to get a better understanding of the experiences of cancer survivors and their primary care providers during the transition from active cancer treatment at the Cancer Centre to follow-up care in the community.
- More specifically, we are interested in learning about using your survivorship care plan during this transition.
- Ultimately, we hope to develop recommendations for improving survivorship care plans to better meet the needs of survivors and primary care providers in follow-up care.

As a note, taking part in this study is voluntary. Deciding not to take part or deciding to leave the study later will not result in any penalty or affect current or future health care.

Any questions/concerns so far before I go into more detail?

I am now going to read some important information about our study. Please feel free to stop me to ask questions at any time.

Study Title: The Use of Survivorship Care Plans as a Transition Tool from the Cancer Centre to Follow-Up in Primary Care Settings

OHSN-REB Number*:* 20200152-01H

Principal Investigator: Dr. Cheryl Harris, C.Psych, Psychology, 613-737-8899 ext. 79533

Funder: CIHR Operating Grant: Transitions in Care – Best and Wise Practice Grants

INTRODUCTION

You are being invited to participate in a research study. You are invited to participate in this study because you received a Survivorship Care Plan from the Wellness Beyond Cancer Program at The Ottawa Hospital Cancer Centre within the last 2 years. This consent form provides you with information to help you make an informed choice. Please listen carefully and

ask any questions you may have. All your questions should be answered to your satisfaction before you decide whether to participate in this research study.

Please take your time in making your decision. You may find it helpful to discuss it with your friends and family.

Taking part in this study is voluntary. You have the option to not participate at all or you may choose to leave the study at any time. Whatever you choose, it will not affect the usual medical care that you receive outside the study.

IS THERE A CONFLICT OF INTEREST?

There are no conflicts of interest to declare related to this study.

WHY IS THIS STUDY BEING DONE?

The purpose of this study is to look at how cancer survivors and their primary care providers (i.e., family physicians and nurse practitioners) use survivorship care plans for follow-up care after completing active cancer treatment. Factors that make it easier and/or more challenging to use survivorship care plans will be identified across urban, rural and remote settings. Recommendations will then be developed to promote the use of survivorship care plans.

HOW MANY PEOPLE WILL TAKE PART IN THIS STUDY?

It is anticipated that about 39 people will take part in this study (26 breast and colorectal cancer survivors; 13 primary care providers), associated with The Ottawa Hospital.

This study should take 1 year to complete and the results should be known in about 1.5 years.

WHAT WILL HAPPEN DURING THIS STUDY?

You will be asked to attend 1 interview. During this interview, you will meet with 1-2 member(s) of the research team. Each interview will be about 30-45 minutes in length and will take place over the telephone. You will be asked to speak about if and/or how you have used your survivorship care plan provided to you by The Wellness Beyond Cancer program.

You may experience emotional distress when talking about your experiences as a cancer survivor. If this occurs during the interview, please inform the research team and a one-time session with Dr. Sophie Lebel, a clinical psychologist at the University of Ottawa will be offered to you.

You will be audio recorded during the interview.

WHAT ARE THE RESPONSIBILITIES OF STUDY PARTICIPANTS?

If you choose to participate in this study, you will be expected to:

- Share your honest opinion about:
  - Your experiences navigating your follow-up cancer care with your primary care provider
  - If and/or how you have used your survivorship care plan

- Your recommendations around how to make survivorship care plans easier to use as a tool to facilitate a smooth transition from The Cancer Centre to receiving follow-up care from your primary care provider

HOW LONG WILL PARTICIPANTS BE IN THE STUDY?

Your participation on this study will last for about 30-45 minutes during the one-time interview.

CAN PARTICIPANTS CHOOSE TO LEAVE THE STUDY?

You can choose to end your participation in this research (called withdrawal) at any time without having to provide a reason. If you choose to withdraw from the study, you are encouraged to contact the research team.

You may withdraw your permission to use information that was collected about you for this study at any time by letting the research team know. However, this would also mean that you withdraw from the study.

If you decide to leave the study, you can ask that the information that was collected about you not be used for the study. Let the research team know if you choose this.

WHAT ARE THE RISKS OR HARMS OF PARTICIPATING IN THIS STUDY?

There are no medical risks to you from participating in this study, but you may become uncomfortable while discussing your experiences. You may choose not to answer questions or to leave the interview at any time if you experience any discomfort.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?

You may not receive direct benefit from participating in this study. We hope the information learned from this study will help other cancer survivors with the transition to follow-up with their primary care provider after completing active cancer treatment in the future.

HOW WILL PARTICIPANT INFORMATION BE KEPT CONFIDENTIAL?

If you decide to participate in this study, the research team will only collect the information they need for this study.

Records identifying you at this center will be kept confidential and, to the extent permitted by the applicable laws, will not be disclosed or made publicly available, except as described in this consent document.

Authorized representatives of the following organizations may look at your original (identifiable) records at the site where these records are held, to check that the information collected for the study is correct and follows proper laws and guidelines.

- The Ottawa Health Science Network Research Ethics Board who oversees the ethical conduct of this study.
- Ottawa Hospital Research Institute, to oversee the conduct of research at this location.
- The University of Ottawa Research Ethics Board, to oversee the conduct of research at this location

Information that is collected about you for the study (called study data) may also be sent to the organizations listed above. Your name, address, email, or other information that may directly identify you will not be used. The records received by these organizations may contain your participant code, sex, and age.

During the interview, participants will be encouraged to refrain from using names. If names or other identifying information is shared during the discussion, it will not be included in the written records.

The audio recordings will be stored in a secure location and listened to only by members of the research team. The recordings will be kept until they have been transcribed (turned into written records), and then they will be destroyed.

If the results of this study are published, your identity will remain confidential. It is expected that the information collected during this study will be used in analyses and will be published/ presented to the scientific community at meetings and in journals.

Your de-identified data from this study may be used for other research purposes. If your study data is shared with other researchers, information that links your study data directly to you will not be shared.

Even though the likelihood that someone may identify you from the study data is very small, it can never be completely eliminated.

ARE STUDY PARTICIPANTS PAID TO BE IN THIS STUDY?

If you decide to participate in this study, you will receive a $50.00 gift card (Tim Horton's, Petro-Canada or President's Choice, based on your preference) via regular mail after completing the interview over the telephone. Should you decide to end the interview before it has been completed, you will still receive a $50.00 gift card at the end of the interview if conducted in person or via regular mail if the interview was conducted over the telephone.

WHAT ARE THE RIGHTS OF PARTICIPANTS IN A RESEARCH STUDY?

You will be told, in a timely manner, about new information that may be relevant to your willingness to stay in this study.

You have the right to be informed of the results of this study once the entire study is complete. If you would like to be informed of the results of this study, please mention this to the interviewer or a member of the research team.

Your rights to privacy are legally protected by federal and provincial laws that require safeguards to ensure that your privacy is respected.

You will be given a copy of this consent form over email or regular mail prior to participating in this study.

WHOM DO PARTICIPANTS CONTACT FOR QUESTIONS?

If you have questions about taking part in this study, you can talk to the researcher. That person is:

Dr. Cheryl Harris, Ph.D., C. Psych 613-737-8899 ext. 79533
Principal Investigator Name Telephone

If you have questions about your rights as a participant or about ethical issues related to this study, you can talk to someone who is not involved in the study at all. Please contact The Ottawa Health Science Network Research Ethics Board, Chairperson at 613-798-5555 extension 16719.

Do you have any questions?
[Answer any questions they may have]

Comments: _____

I can send you the informed consent form by mail or email. What is your preference?

- Mail, if yes, confirm address: _____
- Email, if yes, confirm email address: _____

Do you mind if I call you back [specify time] to obtain your decision and answer any further questions you may have?

- Yes
- No

Comments: _____

Verbal Informed Consent Form

Study Title: The Use of Survivorship Care Plans as a Transition Tool from the Cancer Centre to Follow-Up in Primary Care Settings

OHSN-REB Number*:* 20200152-01H

Name of Participant: _____

Date of Discussion: _____

Duration of Discussion: _____

SIGNATURES

- The participant's questions have been answered,
- The participant understands the information within this informed consent form,
- Each page of the Verbal Informed Consent Form has been read to the participant.
- The participant will allow access to medical records and/or specimens as explained in this consent form,
- I understand that the family doctor/health care provider will/may be informed of participation in this study,
- The participant agrees to take part in this study.

Investigator or Delegate Statement

I have carefully explained the study to the study participant. To the best of my knowledge, the participant understands the nature, demands, risks and benefits involved in taking part in this study.

Signature of Person Conducting the Consent Discussion	Printed Name and Role	Date

Appendix E
Interview Guide Survivors

Interview Guide for Cancer Survivors

Explanation:

- Thank you for taking the time to speak with me. The purpose of this (call/meeting/interview) is to talk about your perspectives on using your survivorship care plan (SCP) in your follow-up cancer care
- Approximately 30-45 minutes – will be audio recorded
- Your input as a cancer survivor is very useful as we are trying to understand how to help cancer survivors have a smooth transition from active cancer treatment at the Cancer Centre to follow-up care in primary care settings
    - We hope to make recommendations on how best to use survivorship care plans as a tool to ensure that cancer survivors receive the follow-up care needed
- Feel free not to answer any of the questions and you can withdraw at any time
- Transcripts will be anonymized (i.e., any details that could identify you will be removed)
- There may be overlap, some repeated answers ok
- There are no right or wrong answers, and I'll probably ask you for clarification throughout our discussion.
- Any questions before we start?

ID:
Gender:
Cancer type:
Age:
Time since discharge from cancer center:

Location (City/town)	☐ Urban
	☐ Rural
	☐ Remote

When you were discharged from the cancer centre, usually you are given a document called a SCP (show blank copy) do you remember receiving a care plan?

Circle one: YES NO

******If NO treat the following questions as hypothetical**

1. Can you tell me about how you have used your SCP??
    i. Prompt: Did you read it
    ii. Prompt: Some people use it for: (i.e., Did you use it to book an appointment, discuss with PCP, know when to call to book a mammogram, bringing up psychosocial concerns with primary care provider).

b. Can you give me an example of a time when you used your SCP? Tell me how you typically use it?
    i. Prompt: have you used it with your primary care provider? How? or Why not?
c. How has it been useful to you?
    i. Prompt: What information in your SCP has been most useful to you? Why?
    ii. Prompt: Are there parts of your SCP that you don't really use? Why?
d. What has gotten in the way of using your SCP?
    i. Prompt: What additional information do you think would be helpful to include in your SCP? Why?
    ii. Prompt: What has been challenging about using your SCP?
    iii. Prompt: What else do you need to be able to use your SCP? (e.g., time, support from family/health care providers etc.)

2. Based on your experience, do you have any suggestions or strategies that you would recommend for how we could go about helping cancer survivors use their SCP in their follow-up care?
    a. What are the most important factors that would influence you to use your SCP?
        i. Prompt: What do you think is needed to help ensure that cancer survivors use their SCP for navigating their follow-up care with their PCP?

Is there anything else you'd like to expand on?

Thanks very much for your time.

Appendix F
Interview Guide Primary Care Providers

Interview Guide for Primary Care Providers

Explanation:

- Thank you for taking the time to speak with me about your perspectives on providing follow-up care for cancer survivors
- Approximately 15-20 minutes – will be audio recorded
- Your input as a primary care provider is very useful as we are trying to understand how to ensure that cancer survivors have a smooth transition from active cancer treatment at the Cancer Centre to follow-up in primary care settings, and more specifically, how survivorship care plans can be used during this transition
- Feel free not to answer any of the questions and you can withdraw at any time
- Transcripts will be anonymized (i.e., any details that could identify you will be removed)
- There may be overlap, some repeated answers ok
- There are no right or wrong answers, and I'll probably ask you for clarification throughout our discussion.
- Any questions before we start?

ID:

Provider Type	□ General Practitioner (MD) ☐ Nurse Practitioner (NP)
# Years in practice:	
Location (City/town)	☐ Urban ☐ Rural ☐ Remote
Received a SCP from WBCP?	☐Yes ☐No

1. Tell me about your experience providing follow-up cancer care for your patients?
   - How do you feel about providing follow-up care to cancer survivors?
   - What are the challenges associated with taking on this responsibility?
     - *Prompt if necessary*…do you feel comfortable? Is this an added task you had not previously encountered? Do you feel this was somewhat imposed?
   - Did you feel you had the necessary information to provide follow-up care for your patient?
   - Did your patient feel comfortable with receiving follow-up care from you? Did he/ she have any concerns?

2. As a primary care provider, how do you manage the follow-up care for your patients who have been discharged from the cancer centre?
   - Prompt: Meeting with cancer survivor patients, conducting history and physicals, ordering surveillance tests; referring to other health care professionals etc.
   - Prompt: Any time, resource, or logistical issues?

- Prompt: Do you know of any guidelines /do you use any guidelines recommendations for follow-up cancer care? Any tools? What is your source? (Where did you find them)
  - If you do not use any guidelines – would guidelines be useful to you?
  - Do you feel the Cancer Centre should be providing you with those guidelines?
- Are you comfortable or sufficiently aware of the side effects of their medication
- How do you approach cancer survivors' psychosocial concerns related to follow-up care (i.e., anxiety, depression, fear of recurrence, sexual concerns, etc.)

3. Have you used patients' survivorship care plan in providing follow-up care?
   - Yes
     - How do you typically use the SCP?
     - How have SCPs been useful? Less useful?
     - Which parts of the SCP did you find most useful?
     - What gets in the way of using a patient's SCP?
       - Prompt: What led to the decision to not use a SCP?
     - What would make it easier to use SCPs
       - Prompts: different format; change in content; more time, etc.
     - Are there situations where you would probably not use a patient's SCP? Why?

If never received a SCP

[Note: Show/refer to blank copy of SCP; explain content and purpose of SCP if needed: Survivorship care plans are provided by the Wellness Beyond Cancer Program to breast and colorectal cancer survivors who have been discharged from the cancer centre for follow-up in primary care settings. The survivorship care plans are individualized and include a treatment summary, surveillance guidelines, and information about the patient's unique survivorship needs. They are recommended as a transition tool by Cancer Care Ontario.]

- Would receiving a SCP be useful for you when providing follow-up care?
  - Prompt: Why/why not, how, in what situations.
- Would there be situations where you would probably not use a patient's SCP? Why?

4. Based on your experience, do you have any suggestions or strategies that you would recommend for how we could go about implementing the use of SCPs in primary care?
   - What are the most important factors that would influence you to use SCPs when providing follow-up cancer care to your patients?
     - Prompt: What do you think is needed to ensure that SCPs are consistently used for follow-up cancer care?

Is there anything else you'd like to expand on?

Thanks very much for your time.

Appendix G
Codebook Survivors

CODEBOOK Cancer Survivors

TACT-A Specified Behaviours (Presseau et al., 2019)

Target:	Cancer survivor, and PCP
Action:	Read the SCP, discus0s the contents with PCP, book appointments, call primary care provider's office
Context:	At home; at the PCP's office
Time:	Before upcoming appointments with PCP; during PCP appointment
Actor:	Cancer survivor

Coding Instructions:

1. The framework used for data analysis is the 14 domain TDF-2 (Cane et al., 2012).

2. Code text into domains, and wherever possible use its corresponding constructs to justify coding the text into a domain. Definitions of the constructs and domains are included. Please use the definitions provided in this codebook to justify coding.

3. Please use the "Coding Instructions" column to supplement the description of domains and constructs for this context. Also see this "Coding Instructions" column for when text can be justifiably coded into multiple domains.

TDF Domain	Constructs	Coding Instructions	Example
Knowledge An awareness of the existence of something	Knowledge: An awareness of the existence of something	Consider coding to this domain: □ Knowing who to contact for concerns/support □ Updating information on SCP □ Descriptions of the information in a care plan without describing how it would be used □ Content in SCP no longer relevant (I.e., medication completion, other aspects of care plan are resolved) □ Descriptions of information that is missing in the care plan that would be relevant □ Using SCP as a reference □ Description of Cancer-specific information needed (e.g., referring to colon cancer booklet re: washroom and shower). □ Comments on having all information in one place (i.e., the SCP) rather than having to sift through many, many documents	"I refer to it once in a while if I'm looking up a specific date, you know, when something happened" [Survivor 1] "I think it was that nurse that was running it if I remember correctly. You know, having input there and knowing what to expect and what to do, you know, in different circumstances" [Survivor 29] "I had dates, so what I could expect, when to, uh- how long to be on [Medication], and when I was likely to need a bone density test, and when I would have needed mammograms." [Survivor 2]
	Procedural knowledge: Knowing how to do something		
	Knowledge of task environment: Knowledge of the social and material context in which a task is undertaken		

		□ Discussions about survivorship booklets □ Descriptions about how having a health care professional help them understand how to use SCP, also consider coding to Environmental Context and Resources Inappropriate coding to this domain: □ Knowledge about the health care system See: Skills □ Specific discussion of attending the nurse discharge meeting or WBCP education class See: Environmental Context and Resources	
Skills An ability or proficiency acquired through practice	Skills: An ability or proficiency acquired thought training and/or practice Skills development: The gradual acquisition or advancement through progressive stages of an ability or proficiency acquired through training and practice Competence: One's repertoire of skills, and ability especially as it is applied to a task or a set of tasks	Consider coding to this domain: □ Knowing how to use the SCP after receiving it □ Navigating the healthcare system (e.g., calling doctors appointments, arranging follow up care), particularly in	"...this is something that I know again from my own experience is that maybe somebody else wouldn't know. It's not like, you know, if you need that that MRI, you know, April, you probably don't, you know, engage your family doctor

	Ability: Competence or capacity to perform a physical or mental act. Ability may be either unlearned or acquired by education and practice	reference to instructions on the SCP □ Descriptions of using the SCP to make sure they complete their follow-up tasks on time and with the right person. Inappropriate coding to this domain: □ Descriptions of information included in the SCP, See: Knowledge □ Using SCP as a reference about past occurrences (I.e., specific dates, cancer history, treatment history) See: Knowledge	on April 24th to say I need it done this month, right?" [Survivor 20] "...so it's just like a second way to check that everything is on track. I've never had problems, my care provider has always been on-track, as I explained, but certainly, it's on way of making sure that nothing falls through the cracks, I guess, so it's always on my phone, in my calendar." [Survivor 13]
	Interpersonal skills: An aptitude enabling a person to carry on effective relationships with others, such as ability to cooperate, to assume appropriate social responsibilities, or to exhibit adequate flexibility		
	Practice: Repetition of an act, behaviour, or series of activities, often to improve performance or acquiring a skill		
	Skill assessment: A judgement of the quality, worth, importance, level, or value of an ability or proficiency acquired through training and practice		
Social Professional Role and Identity A coherent set of behaviours and displayed personal qualities of an individual in a social or work setting	Professional identity: The characteristics by which an individual is recognized relating to, connected with or befitting a particular profession	Consider coding to this domain: □ Discussion about who brings up the SCP, who arranges follow-up appointments (I.e., patient initiated for PCP initiated) □ Discussion of how patient does not need to use their care plan because	"I used it on my own and actually my family doctor at that time called me in to go through it in detail with me, so it was very helpful to him and I, that's for sure." [Survivor 9]
	Professional Role: The behaviour considered appropriate for a particular kind of work or social position		
	Social Identity: The set of behavioural or personal characteristics by which an individual is recognizable (and portrays) as a member of the social group		

	Identity: An individual's sense of self defined by a) a set of physical and psychological characteristics that is not wholly shared with any other person and b) a range of social and interpersonal affiliations (e.g., ethnicity) and social roles	their PCP takes on the role of follow-up care completely □ Descriptions of bringing up care plan to doctor □ Discussion of PCPs working with other healthcare professionals (e.g., oncology specialists) □ Discussions about using the information in the care plan toward a health-related goal (I.e., bringing it up with PCP) □ Descriptions of patient taking responsibility for follow-up care □ GP person who found the cancer □ Staying in contact with PCP throughout primary cancer treatment Inappropriate coding to this domain: □ Discussions about support from friends and family See: Social Influences □ Discussions around community supports: See Social Influences or	"I feel I'm in charge of my health, you know, I take responsibility for it." [Survivor 7] "Well, as I said, making sure that I'm getting my scheduled scans, and mammograms, and that type of thing and just making sure that everything's happening as it should happen." [Survivor 9]
	Professional boundaries: The bounds or limits relating to, or connected with a particular profession or calling		
	Professional Confidence: An individual's belief in his or her repertoire of skills, and ability especially as it is applied to a task or set of tasks		
	Group identity: The set of behavioural or personal characteristics by which an individual is recognizable [and portrays] as a member of a group		
	Leadership: the processes involved in leading others, including organising, directing, coordinating and motivating their efforts toward achievement of certain group or organization goals		
	Organizational commitment: An employee's dedication to an organization and which to remain part of it. Organizational commitment is often described as behaving both an emotional or moral element and a more prudent element		

		Environmental Context and Resources	
Beliefs about Capabilities Acceptance of the truth, reality, or validity about an ability, talent, or facility that a person can put to constructive use	Self-confidence: Self-assurance or trust in one's own abilities, capabilities, and judgment	Consider coding to this domain: □ Confidence in one's ability to perform an action (I.e., read the care plan and make the phone call) □ Descriptions of empowerment, advocating for oneself □ Description of beliefs of self-efficacy or locus of control □ Knowing you can use the SCP Inappropriate coding to this domain: □ Descriptions of reasons why they would use SCP in the future □ Descriptions about not initially seeing the importance of SCPs See: Intention	"Yeah, just as a – you know, I can ask him about it, I mean I would never, you know, come down on him or anything like that, just say, you know, "I noticed in my care program that I should be seeing you every three to six months and can I start, can we start to do that." [Survivor 12]
	Perceived competence: An individual's belief in her or her ability to learn and execute skills		
	Self-efficacy: An individual's capacity to act effectively to bring about desired results as percieved by the individual		
	Perceived behavioural control: An individual's perception of the ease or difficulty of performing the behaviour of interest		
	Beliefs: the thing believed; the proposition or set of propositions held true		
	Self-esteem: An individual's capacity to act effectively to bring about desired results, as perceived by the individual		
	Empowerment: The promotion of the skills, knowledge and confidence necessary to take great control of one's life as in certain educational or social schemes; the delegation of increased decision-making powers to individuals or groups in a society or organization		
	Professional confidence: an individual's belief in his or her repertoire of skills, and ability especially as it is applied to a task or set of tasks		

Optimism The confidence that things will happen for the best or that desired goals will be attained	Optimism: The attitude that outcomes will be positive and that people's wishes or aims will ultimately be fulfilled	Consider coding to this domain: Inappropriate coding to this domain:	
	Pessimism: The attitude that things will go wrong and that people's wishes or aims are unlikely to be fulfilled		
	Unrealistic optimism: The inert tendency for humans to over-rate their own abilities and changes of positive outcomes compared to those of other people		
	Identity: An individual's sense of self defined by a) a set of physical and psychological characteristics that is not wholly shared with any other person and b) a range of social and interpersonal affiliations (e.g., ethnicity) and social roles		
Beliefs about Consequences Acceptance of the truth, reality, or validity about outcomes of a behaviour in a given situation	Beliefs: The thing believed; the proposition or set of propositions held true	Consider coding to this domain: □ Reasons prompting use of a care plan □ That by using the care plan, following the direction (I.e., call a doctor's office) will result in positive/expected/helpful outcome	And from the point of view of the ultimate outcome of that plan, I'm presuming it's all about making sure that if there is anything develops, that you want to be able to
	Outcome expectancies: Cognitive, emotional, behavioural, and affective outcomes that are assumed to be associated with future or intended behaviours. These are assumed outcomes can either promote or inhibit future behaviours		
	Characteristics of outcome expectancies: Characteristics of the cognitive, emotional		

	and behavioural outcomes that individuals believe are associated with future or intended behaviours and that are believed to either promote or inhibit these behaviours. Thes include whether they are sanctions/rewards, proximal/distal, valued/not valued, probable/improbable, salient/not salient, perceived risks or threats	□ Believing that using SCP will lead to catching if there is another cancer early □ Belief that their SCP will lead to good health	act on it very quickly." [Survivor 20] And he said it's very important that, you know, you, you do the CT scan for example, and you know, the blood work because it will help us determine if there's another cancer and so on [Survivor 28]
	Anticipated regret: A sense of the potential negative consequences of a decision that influences the choice made: for example an individual may decide not to make an investment because of the feelings associated with an imagined loss	Inappropriate coding to this domain: □ Descriptions of situations that would prompt a survivor to use their SCP, See: Intention	
	Consequents: an outcome of a behaviour in a given situation		
Reinforcement Increasing the probability of a response by arranging a dependent relationship, or contingency, between the response and a given stimulus	Rewards (Proximal/distal, valued/not valued, probable/improbable): Return or recompense made to, or received by a person contingent on some performance	Consider coding to this domain: Descriptions of experiences where using the care plan, following through with directions lead to a positive outcome making it more likely they will do it again Inappropriate coding to this domain:	"She gave me information that made me feel more comfortable"
	Incentives: An external stimulus, such as condition or object, that enhances or serves as a motive or behaviour		
	Punishment: The process in which the relationship between a response and some stimulus or circumstance results in the response becoming less probable; a painful, unwanted or undesired event or circumstance imposed as a penalty on a wrongdoer		
	Consequents: An outcome of behaviour in a given situation		

	Reinforcement: A process in which the frequency of a response is increased by a dependent relationship or contingency with a stimulus		
	Contingencies: A conditional probabilistic relation between two events. Contingencies may be arranged via dependencies or they emerge by accident		
	Sanctions: A punishment or other coercive measure, usually administered by a recognized authority, that is used to penalize and deter inappropriate or unauthorised actions		
Intentions A conscious decision to perform a behaviour or a resolve to act in a certain way	Stability of intentions: Ability of one's resolve to remain in spite of disturbing influences	Consider coding to this domain: □ Being driven to use SCPs □ Being motivated to use care plan □ Descriptions of when/why they would use SCP □ Descriptions of not using SCP or not understanding how important SCPs are Inappropriate coding to this domain: □ Expectations about health outcomes if they use their SCP See: Beliefs About Consequences	"it's right there, okay, my doctor should have arranged for a mammogram, I haven't heard from said doctor, oh, I better get in touch and find out how I get a mammogram," [Survivor 6] "I think if I had any questions about cancer and cancer follow-up, I would use that plan for sure. Especially since I had such a good- recently – had such a good result from using it and contacting the nurse." [Survivor 2]
	Stages of change model: A model that proposes that behaviour changes is accomplished through 5 specific stages: Pre contemplation, contemplation, preparation, action, and maintenance		
	Transtheoretical model and stages of change: A 5 stage theory to explain changes in people's health behaviour. It suggests that change takes time, that different interventions are effective at different stages, and that there are multiple outcomes occurring across the stages		

			"Yes, clearer instructions for sure. More definite kind of purpose, you know, I felt that "oh, this is just more paperwork", and I didn't get the feeling of, "oh, this is important for you to follow-up, or this is important, whatever", I didn't feel it. Now, maybe that's just me, but I didn't feel the importance of this." [Survivor 17]
~~**Goals**~~ ~~Mental representation of outcomes or end states that an individual wants to achieve~~	~~Goals (distal/proximal): Desired state of affairs of a person or system, these may be closer (proximal) or further away (distal)~~ ~~Goal priority: Order of importance or urgency of end states toward which one is striving~~ ~~Goal/target setting: A process that establishes specific time based behaviour targets that are measurable, achievable and realistic~~ ~~Goals (autonomous/controlled): Then end state toward which one is striving: the purpose of an activity or endeavour. It can be identified by observing that a person ceases or changes its behaviour upon attaining this state; proficiency in a task to be achieved within a set period of time~~	~~Consider coding to this domain:~~ ~~Referring to information in a care plan as part of a course of action~~ ~~Looking up specific dates, treatment history, follow-up schedules as needed to reach a health-related goal~~ ~~Consider also coding social/professional role and ID) when explaining that they brought up info in care plan with PCP~~ ~~How much of a priority is using a care plan~~	~~Looking up specific information in the care plan to share with health care provider, or for one's own reference~~ ~~-~~ ~~Descriptions reasons for not needing care plan~~ ~~-~~ ~~Commenting on reasons why care plan is not useful to them – If talking about~~

	~~Action planning: The action or process of forming a plan regarding a thing to be done or a deed~~	~~I AM USING THIS INFO FOR THAT PURPOSE~~	~~PCP taking charge of care plan (SEE Social Professional role and ID)~~
	~~Implementation intention: The plan that one creates in advance of when, where, and how one will enact a behaviour~~	~~Inappropriate coding to this domain:~~ ~~Description of information included in a survivorship care plan, not linked to a goal (SEE: Knowledge)~~	~~SCP use not a priority due to other health issues~~
Memory, Attention and Decision Processes The ability to retain information, focus selectively on aspects of the environment and choose between two or more alternatives	Memory: The ability to retain information or a representation of a past experience, based on the mental processing of learning or encoding retention across some interval of time, and retrieval or reactivation of the memory; specific information of a specific past	Consider coding to this domain: Stating that information provided was helpful for remembering important info (e.g., dates, treatment, etc.) Forgetting to use the survivorship care plan Not remembering if they received a care plan Patient reminded by PCP's/health professional's office for follow-up appointment Descriptions of REMEMBERING to use care plan	"In my case, I did fill out some of it when I first got it, but then it kind of got shoved in the file and I totally forget about it, and so it wasn't something that I used with my doctor back and forth at all." [Survivor 19] "I think, with chemo, some of my brain cells have died (laughs) and it's hard for me
	Attention: A state of awareness in which the senses are focussed selectively on aspects of the environment and the central nervous system is in a stage or readiness to respond to stimuli		
	Attention control: The extent to which a person can concentrate on relevant cues and ignore all irrelevant cues in a given situation		
	Decision making: The cognitive process of choosing between two or more alternatives, ranging from the relatively clear cut to the complex		

	Cognitive overload/tiredness: The situation in which the demands place on a person by mental work are greater than a person's mental abilities	□ The care plan CUES the survivor to perform follow up care behaviour Inappropriate coding to this domain: □ Descriptions of using SCPs to make follow-up appointments on time with the right person See Skills	to – I need things in writing. I can't go back in my memory bank and come up with dates and years and that kind of thing. I need stuff in writing." [Survivor 9]
Environmental Context and Resources Any circumstance of a person's situation or environment that discourages or encourages the development of skills and abilities, independence, social competence, and adaptive behaviour	Environmental stressors: External factors in the environment that cause stress Resources/material resources: Commodities and human resources used in enacting a behaviour Organizational culture/climate: A distinctive pattern of thought and behaviour shared by members of the same organization and reflected in their language, values, attitudes, beliefs, and customs Salient events/critical incidents: Occurrences that one judges to be distinctive, prominent, or otherwise significant Person X environment interaction: Interplay between the individual and their surroundings Barriers and facilitators: In psychological contexts barriers/facilitators are mental,	Consider coding to this domain: □ Did they go to discharge meeting? □ Descriptions of context or how care plans were received □ Did they go to education class? □ Descriptions of systemic issues around access to health care Inappropriate coding to this domain: □ Descriptions of how attending nurse-led discharge meeting or WBCP education	"There was sort of like an exit information meeting with other people that were also being discharged. And then I got it in the mail." [Survivor 1] "I read it when I got it, and it was given to me and explained me to by a nurse. And then there was a follow-up at the [Hospital], like a meeting for everybody, a bunch of cancer survivors to say what the next kind of steps were and stuff." [Survivor 5]

	emotional or behavioural limitations/strengths in individuals or groups	class consider ALSO coding to Knowledge	"I may have transitioned better had I of been able to meet with the person face-to-face, but I couldn't get there, so I don't know if maybe the Cancer Society could for volunteer drives, could somehow alter that policy that that final visit could happen or something? I couldn't get to those things without paying an arm and a leg for a taxi, I missed out on all of that stuff." [Survivor 9]
Social Influences Those interpersonal processes that can cause individuals to change their thoughts, feelings, or behaviours	Social pressure: The exertion of influence on a person or group by another person or group Social norms: Socially determined consensual standards that indicate a) what behaviours are considered typical in a given context and b) what behaviours are considered proper in the context Group conformity: The act of consciously maintaining a certain degree of similarity to those in your general social circles Social comparisons: The process by which people evaluate their attitudes, abilities, or performance relative to others	Consider coding to this domain: □ Discussing experiences with other survivors □ Friends and family helping with follow-up care (I.e., scheduling appointments, looking for test results, etc.) Inappropriate coding to this domain: □ Descriptions of interactions with healthcare providers and	"And my wife is here, she's on top of things all the time, so I'm not, thankfully, losing my mind." [Survivor 19] "And as you start to get stronger, you start to feel more confident about talking to your doctor about it, because we're being a male, you know, speaking with my doctor, it's not

	Group norms: Any behaviour, belief, attitude, or emotional reaction held to be correct or acceptable by a given group in society	PCPs See: Social Professional Role and Identity	something we normally do, you know? I grew up in an environment where being a man, you kind of take it. You got to be tough." [Survivor 21]
	Social support: The apperception or provision of assistance or comfort to others typically in order to help them cope with a variety of biological, psychological and social stressors. Support may arise from any interpersonal relationship in an individual's social network, involving friends, neighbours, religious institutions, colleagues, caregivers or support groups		"If you have experienced it yourself, you're the best subject-matter expert for someone else to learn from. It's like if you've never experienced, you know, the death of a parent for example, how can anyone really talk to anyone about it who hasn't experienced it themselves?" [Survivor 1]
	Power: The capacity to influence others, even when they try to resist this influence		
	Intergroup conflict: Disagreement or confrontation between two or more groups and their members. This may involve physical violence, interpersonal discord, or psychological tension		
	Alienation: Estrangement from one's social group; a deep seated sense of dissatisfaction with one's personal experiences that can be a source of lack of trust in one's social or physical environment or in oneself; the experience of separation between thoughts and feelings		
	Group identity: The set of behavioural or personal characteristics by which an individual is recognizable (and portrays) as a member of a group		
	Modelling: In developmental psychology the process in which one or more individuals or		

	other entities serve as examples (models) that a child will copy		
Emotion A complex reaction pattern involving experiential, behavioural, and physiological elements, by which the individual attempts to deal with a personally significant matter or event	Fear: An intense emotion aroused by the detection of imminent threat, involving an immediate alarm reaction that mobilizes the organism by triggering a set of physiological changes	Consider coding to this domain: □ Mixed emotion when being discharged from cancer centre with SCP □ SCP provided reduced emotional distress / anxiety and/or reassurance related to follow-up care □ Feeling comforted by SCP □ Health-related worries □ Fear of recurrence □ Emotions associated with coping (e.g., humour, moving on with life) □ Descriptions about emotional toll of cancer experience □ Descriptions of emotional triggers in response to using SCP □ Trusting of healthcare professionals or health care system □ Uncertainty at discharge Inappropriate coding to this domain:	"I really like to know all those details, and so to have all those details written down for me makes me feel more comfortable." [Survivor 2] "What was it like? Actually, just receive- Um, well I guess it was kind of a weird experience I guess, just getting this, and it's kind of two-fold I guess, one is a sense of "okay, I'm free" (laughs) "I can go on my merry way", um, but then the second there's always this, "Okay, so now, who's watching over me?" (laughs) You know that – sort of, double-edged sword, but for the most part, um, positive, very positive." [Survivor 1] "Is it scary at the beginning? Totally scary, like you totally lose your safety net." [Survivor 10]
	Anxiety: A mood state characterised by apprehension and somatic symptoms of tension in which an individual anticipates impending danger, catastrophe, or misfortune		
	Affect: An experience or feeling of emotion, ranging from suffering to elation, from the simplest to the most complex sensations of feelings, and form the most normal to the most pathological emotional reactions		
	Stress: A state of physiological or psychological response to internal or external stressors		
	Depression: A mental state that presents with depressed mood, los of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration		
	Positive/negative affect: The internal feeling/state that occurs when a goal has/has not been attained, a source of threat has/has not been avoided, or the attained, or the individual is/is not satisfied with the present state of affairs		
	Burnout: Physical, emotional or mental exhaustion, especially in one's job or career,		

	accompanied by decreased motivation, lowered performance and negative attitudes towards oneself and others	□ Feeling motivated, driven to use SCPs See: Intention	
Behavioural Regulation Anything aimed at managing or changing objectively observed or measured actions	Self-monitoring: A method used in behavioural management in which individuals keep a record of their behaviour, especially in connection with efforts to change or regulate the self; a personality trait reflecting an ability to modify one's behaviour in response to situation	Consider coding to this domain: □ Suggestions for improving SCPs □ ONLY CODE ABOUT EMR WHEN DISCUSSING THE SCP Inappropriate coding to this domain: □ EMR problems in general (I.e., difficulties communicating between hospitals – this is for other studies) -GENERAL without talking about access to SCP	"I'm wondering for better use if it can be electronic, or in some kind of an app that I can access, or that I can update myself, let's say something happened along the way, I could add notes, because it's just a piece of paper. It's very easy to disappear somewhere." [Survivor 1] "If there was some type of follow-up might be helpful, maybe once a year, like an email saying you know, we'd like to follow up with you, are you available to talk at a certain time, and just go over everything, maybe do a review of the care plan, make sure that you know that the patient is happy with what's going on." -

			[Survivor 3] "Phone-call follow-up by Wellness Beyond Cancer Care Plan administrators to ensure that patients are meeting expectations. I think I did receive one or two phone call follow-ups, and I think it's probably important to do it throughout the length of the, oh I guess, three-year follow-up period." [Survivor 11] "Making it quite clear, either on a standalone sheet or in one of the booklets, "if you need help with the plan, either with you doctor or with your family, here's how you can get the help"." [Survivor 6]

Appendix H
Codebook PCPs

Code Book PCPs

TACT-A (Presseau et al., 2019)	PCP	Breast/colorectal cancer survivor
Target	Patients for whom an SCP was provided; guidance for self on managing follow up cancer care	Self, and PCP
Action	Read the SCP Book follow-up tests Book follow-up appointments Interpret test results Answering patient's questions Responding to patient's needs (e.g., for psychosocial resources) Make decisions for patient care when patient's needs are out of scope of practice (e.g., consulting specialists, other members of patient's cancer care team)	Read the SCP, discuss the contents with PCP

	Following up on the status of follow-up tests booked, and associated results Seeking out knowledge and consultation on cancer-specific treatments (e.g., when to stop tamoxifen)	
Context	The PCP's office	At home; at the PCP's office
Time	Every 3-6 months (depending on when tests need to be ordered and followed up on)	
Actor	PCP	Self

Coding Instructions:

1. The framework used for data analysis is the 14 domain TDF-2 (Cane et al., 2012).

2. Code text into domains, and wherever possible use its corresponding constructs to justify coding the text into a domain. Definitions of the constructs and domains are included. Please use the definitions provided in this codebook to justify coding.

3. Please use the "Coding Instructions" column to supplement the description of domains and constructs for this context. Also see this "Coding Instructions" column for when text can be justifiably coded into multiple domains.

Domain (Cane et al., 2012)	Construct	Decision Rule	Example
1. Knowledge	Knowledge (including knowledge of condition/scientific rationale): An awareness of the existence of something	Appropriate coding to this domain:	"I think it's pretty well laid out" - PCP_8

An awareness of the existence of something	Procedural knowledge: Knowing how to do something Knowledge of task environment: Knowledges of the social and material context in which a task is undertaken	Descriptions of helpful/unhelpful information included in the SCP	"What do I do with [medication] 5, 10 years down the road? Do I just stop it?"- PCP_2
		Descriptions of how clear or well-laid-out the plan is	"I think it's very clear on how often they need to come to the office, what I need to do" - PCP_2
		Descriptions of using the care plan to know what they're responsible for in cancer follow up (e.g., scheduling mammograms/follow up tests on a specific time interval)	"Having a very detailed and very clear plan from the treatment team is useful so that we're all on the same page" - PCP_8
		PCP knows that there are specific tasks they need to perform (awareness of what the plan is telling them to do)	"Having that road map that's provided in the in the document is key" - PCP_8
		Didn't know patient gets SCP too Not feeling comfortable/sufficiently aware of side effects of cancer treatment	"I'm kind of in deep water is when it comes to dealing with possible side effects of some of the medications. I might be a bit unsure if someone's joint pain is because of their breast cancer medication that they're on, trying to sort that out." - PCP_8

2. Skills An ability or proficiency acquired through practice	Skills: an ability or proficiency acquired through training and/or practice	We assume that licensed health care providers have the skills to provided follow up care.	
	Skills development: the gradual acquisition or advancement through progressive stages of an ability or proficiency acquired through training and practice		
	Competence: One's repertoire of skills and ability especially as it is applied to a task or set of tasks		
	Ability: Competence or capacity to perform a physical or mental act. Ability may be either unlearned or acquired by education and practice		
	Interpersonal skills: An aptitude enabling a person to carry on effective relationships with others, such as an ability to cooperate, to assume appropriate social responsibilities or to exhibit adequate flexibility		
	Practice: Repetition of an act, behaviour, or series of activities, often to improve performance or acquire a skill		
	Skills assessment: a judgement of the quality, worth, importance. Level or value of an ability or proficiency acquired through training and practice		

3. Social Professional Role and Identity A coherent set of behaviours and displayed personal qualities of an individual in a social or work setting	Professional Identity: the characteristics by which an individual is recognized relating to, connected with, or befitting a particular profession	Appropriate Coding to this Domain: • Descriptions of the role of other healthcare professionals, e.g., role of specialists in follow-up care; consulting oncology specialists who were partner of the patient's care • Descriptions of activities that are outside of their scope of practice (e.g., managing cancer specific drugs) • Experience and understanding that follow-up care for longer term illness is part of their role as PCPs • Descriptions of what PCPs do to manage follow-up cancer care (i.e., book the appointments and follow-up tests) INCLUDING coordination of care with other HCPS or specialists	"Especially for patients who are like, followed by specialty clinics, that becomes a different problem because they're ordering medications that I'm not aware of." - PCP_1 "Usually we have been through the screening, the detection of the cancer, the initial steps, I follow them all through their cancer treatment and follow-up, so it's just a natural thing to follow-up with them" - PCP_4 "I love engaging the patient in their care. Because I'm not their mother" - PCP_2 "I'm a firm believer that the patient does have a responsibility as well to ensure appropriate follow-ups and things" - PCP_6 "I don't have a system in place that regularly calls the patient in for a specific exam, whether it be
	Professional role: the behaviour considered appropriate for a particular kind of work or social position		
	Social identity: The set of behavioural or personal characteristics by which an individual is recognizable [and portrays] as a member of a social group		
	Identity: an individual's sense of self, defined by A) a set of physical and psychological characteristics that is not wholly shared with any other person; and B) a range of social and interpersonal affiliations (e.g., ethnicity) and social roles		
	Professional boundaries: the bounds or limits relating to, or connected with, a particular profession or calling		
	Professional Confidence: an individual's belief in his or her repertoire of skills and ability, especially as it is applied to a task or set of tasks		
	Group Identity: the set of behavioural or personal		

	characteristics by which an individual is recognizable [and portrays] as a member of a group	• Descriptions of their views on their role in providing cancer follow up care (e.g., I'm used to it")	or abdomen or breast or chest wall exam, and I leave that portion up to the patient." - PCP_6
	Leadership: The professes involved in leading others, including organizing, directing, coordinating and motivating their efforts toward achievement of certain group or organization goals	• Boundaries of role (I.e., wanting to avoid coercing patients)	"Being a family doctor, I think it's really important to keep track, and when they are back to you, you are like, at ease to provide the ongoing care. So, I never had an issue with that" - PCP_5
	Leadership: The processes involved in leading others, including organizing, directing, coordinating and motivation their efforts toward achievement of certain group or organization goals	• Talking about how patients should be involved in their own healthcare and follow-up	
	Organizational Commitment: an employee's dedication to an organization and which to remain part of it. Organizational commitment is often described as having both an emotional or moral element and a more prudent element		"I think it's very appropriate, actually. For the most part, I already have a relationship what that patient, in most cases I actually made the initial diagnosis of cancer, and when the patient no longer has cancer it doesn't make sense for them to keep seeing the cancer centre." - PCP_3 "I also leave it a lot up to them, to say like, "Look, I have a message in the chart, but it's also your responsibility to at least check in with me every 6 months." - PCP_2

			"The biggest problem is when it's the unclear who is doing the follow-up for the cancer, because a lot of the patients, they're followed in specialty clinics initially following their cancer treatment, and then at some point the family physician takes over, but these things are never made clear." - PCP_1 "I'm fine with it. I'd say it's kind of a loaded question. You know, I'm fine with it because I've learned to be fine with it." - PCP_6 "I think that for me, knowing which chemotherapy agent causes which long-term side-effect is really outside of my scope." - PCP_6
4. Beliefs about Capabilities Acceptance of the truth, reality, or validity about an	Self-confidence: Self-assurance or trust in one's own abilities, capabilities and judgment Perceived competence: an individual's belief in his or her ability to learn and execute skills		"I think it's actually fairly straightforward." - PCP_4

ability, talent, or facility that a person can put to constructive use	Self-efficacy: An individual's capacity to act effectively to bring about desired results, as perceived by the individual	Descriptions of challenges PCPs face when providing follow-up care (e.g., confusion around whether tests have been ordered, results received)	"It's been very to the point, very straightforward, very easy to follow. I find it very practical and well summarized." - PCP_10
	Perceived behavioural control: an individual's perception of the ease or difficulty of performing the behaviour of interest	Descriptions of easy/straightforward aspects of providing follow-up care (e.g., I think follow-up care is straightforward (BoCap) VS I think the plan is very clear (code to KNOWLEDGE))	"But this thing doesn't tell me, if I find a lump, then what do I do?" - PCP_2
		Descriptions of not knowing how to proceed with abnormal follow-up tests	"It's always possible that things can falls through the cracks or the patients goes for a test and I don't get the result back." - PCP_7
		Descriptions of problem-solving barriers (e.g., contacting other HCPs	
	Beliefs: the thing believed, the proposition or set of propositions held true		
	Self-esteem: the degree to which the qualities and characteristics contained in one's self-concept are perceived to be positive	Descriptions of confidence in ability to provide follow-up care	"Very easy to look at, very easy to follow and very easy to allow me to do my job as well, because it's easier to send myself a postdated message for all the little things that I need to do." - PCP_10
	Empowerment: the promotion of the skills, knowledge and confidence necessary to take great control of one's life as in certain educational or social schemes, the delegation of increased decision-making powers to individuals or groups in a society or organization.		"Once it goes on to colonoscopy, it's no longer easy and guidelines

	Personal confidence: an individual's beliefs in his or her repertoire of skills, and ability, especially as it is applied to a task or set of tasks		are very and recommendations are very conflicting." - PCP_10 "There's only so many things I can track."- PCP_6
5. Optimism The confidence that things will happen for the best or that desired goals will be attained	Optimism: the attitude that outcomes will be positive and that people's wishes or aims will be ultimately fulfilled Pessimism: the attitude that things will go wrong and that people's wishes or aims are unlikely to be fulfilled Unrealistic optimism: the inert tendency for humans to over-rate their own abilities and chances of positive outcomes compared to those of other people	N/A	
6. Beliefs about Consequences Acceptance of the truth, reality or validity about outcomes of a	Beliefs: the thing believed; the proposition or set of propositions held true Outcome expectancies: cognitive, emotional, behavioural, and affective outcomes that are assumed to be associated with future or intended behaviour. These assumed outcomes can either promote or inhibit future behaviours	Appropriate coding to this domain: □ Increased workload □ Using the care plan because of beliefs that doing so will find new	"All of a sudden there's more work, for what I was considering at that point a shared patient." - PCP_3

behaviour in a given situation	Characteristics of outcome expectancies: characteristics of the cognitive, emotional and behavioural outcomes that individuals believe are associated with future or intended behaviours and that are believed to either promote or inhibit these behaviours. These include whether they are sanctions/rewards, proximal/distal, valued/not valued, probable/improbable, salient/not salient, perceived risks or threats	cancer early, lead to better outcomes for patients etc. Inappropriate coding: □ Generally saying that they will use the SCP without providing specific beliefs about the outcomes of doing so e.g., it is important to me to use the SCP. See: Intention	"There's a lot of long-term follow-ups that are being downloaded on family physicians." - PCP_6 "If the cancer does recur, and you are pursued for this, the courts have historically put it on our shoulders." - PCP_11
	Anticipated regret: a sense of the potential negative consequences of a decision that influences the choice made: for example an individual may decide not to make an investment because of the feelings associated with an imagined loss		"Like I don't see it as a big giant risk you know if somebody's a couple months late for surveillance, or a scan, or a blood test or something like that." - PCP_3
	Consequents: an outcome behaviour in a given situation		"Yes, this breast cancer treatment is over, but in the medical world, we know that it's never really over with breast cancer. That's why they need to follow up." - PCP_11 "It puts a lot more of the ownership on us to make sure that we've ordered the tests and

			received the tests... it does force us to be more proactive in ordering, especially for checking." - PCP_7
7. Reinforcement Increasing the probability of a response by arranging a dependent relationship, or contingency between the response and a given stimulus	Rewards (proximal/distal, valued/not valued, probable/improbable): Return or recompense made to or received by a person contingent on some performance	Appropriate coding to this domain: □ Descriptions of rewarding experiences when providing follow-up cancer care □ Statements about how SCPs are helpful	"It's actually very fulfilling to be able to kind of reconnect with these patients and to kind of see them, as they kind of go on to restart the kind of next chapter after having successfully gone through the treatment process. I think it's very, it's very rewarding." - PCP_8 "It's not only important for us but for the patients too, because they know that after the treatment, it's not like something was just left alone, but we provide the ongoing care for them, so that's really important for us and for them." - PCP_5
	Incentives: an external stimulus, such as a condition or object that enhance or serves as a motive for behaviour		
	Incentives: an external stimulus, such as a condition or object, that enhances or serves as a motive for behaviour		
	Punishment: the process in which the relationships and some stimulus or circumstance results in the response becoming less probable; a painful, unwanted or undesired event or circumstance imposed as a penalty on a wrongdoer		
	Consequents: an outcome of behaviour in a given situation		
	Reinforcement: a process in which the frequency of a response is increased by a dependent relationship or contingency with a stimulus		

	Contingencies: a conditional probalistic relation between two events. Contingencies may be arranged be arranged via dependencies or they may emerge by accident		
	Sanctions: a punishment or other coercive measure, usually administered by a recognized authority, that is used to penalise and deter inappropriate or unauthorized actions		
8. Intention A conscious decision to perform a behaviour or a resolve to act in a certain way	Stability of intentions: ability on one's resolve to remain in spite of disturbing influences	Appropriate coding to this domain: • Statements that using the care plan is important/a priority • Generally saying that they will use the SCP without providing specific beliefs about the outcomes of doing so) e.g., it is important to me to use the SCP Inappropriate coding to this domain: • Once they provide their beliefs about why following the care plan is important/a priority, code under Beliefs about consequences	"I would say that these patients are always a little bit special, because it doesn't happen very often, it might happen, you might have one patient a year or two patients a year that come back from the cancer clinic, so, these patients to me, are quote-on-quote, "special."" - PCP_4 "I will make sure that I follow all the given instructions for that patient." - PCP_5
	Stages of change model: a model that proposes that behaviour change is accomplished through five specific stages		
	Transtheoretical model and stages of change: a five-stage theory to explain changes in people's health behaviour. It suggests that change takes time, that different interventions are effective at different stages, and that there are multiple outcomes occurring across the stages		

9. Goals Mental representations of outcomes or end states that an individual wants to achieve	Goals (distal/proximal): Desired state of affairs of a person or system, these may be closer (proximal) or further away (distal)	N/A	
	Goal priority: order of importance or urgency of end state toward which one is striving		
	Goal priority: order of importance or urgency of end state toward which one is striving		
	Goal/target setting: a process that establishes specific time based behavioural targets that are measurable, achievable and realistic		
	Goals (autonomous/controlled): the end state toward one is striving: the purpose of an activity or endeavour. It can be identified by observing that a person ceases or changes their behaviour upon attaining this state; proficiency in a task to be achieved within a set period of time		
	Action planning: the action or process of forming a plan regarding a thing to be done or a deed		
	Implementation intention: the plan that one creates in advance of when, where, and how one will enact a behaviour		
	Memory: the ability to retain information or a representation of a past experience, based on the mental processes of learning or	Appropriate coding to this domain”	“I write myself a post-dated message, “every six months, do this, every December, do this,

10. Memory, Attention and Decision Processes The ability to retain information, focus selectively on aspects of the environment and choose between two or more alternatives	encoding retention across some interval of time, and retrieval or reactivation of the memory; specific information of a specific task	 PCP creating reminders for themselves for follow up tests Inappropriate coding**:** Descriptions of how patients remind PCPs, or factors influencing the PCP's decision making that directly comes from the patient is best coded under Social Influences	every whatever it says to do"" - PCP_2
	Attention: a state of awareness in which the senses are focussed selectively on aspects of the environment and the central nervous system is in a state of readiness to respond to stimuli		"I don't think scheduling is a big problem, because there's two of us that put in reminders in our agendas." - PCP_4
	Attention control: the extent to which a person can concentrate on relevant cues and ignore all irrelevant cues in a given situation		"You write in reminders depending on the EMR you're using, messages to self. With the MR now it's way easier to flag and remind." - PCP_4
	Decision making: the cognitive process of choosing between two or more alternatives, ranging from the relatively clear-cut to the complex		
	Cognitive overload/tiredness: the situation in which the demands placed on a person by mental work are greater than the person's mental abilities		"I would have to set myself a bunch of reminders, so I take 15-20 minutes, go through the care plan, set all my reminders, then I'm good to go". - PCP_6 "I'm setting up little reminders through the chart for the EMR in order to ensure that we're doing the screening and monitoring investigations that are

			recommended after the interval." - PCP_8 "The patient has notes too, but I send myself reminders. So, the patient knows it and I send myself a reminder." - PCP_12
11. Environmental Context and Resources	Environmental stressors: external factors in the environment that cause stress	Appropriate coding to this domain: □ Includes comments on limited access to therapy for psychosocial concerns □ Impact of pandemic on follow-up care □ Using EConsult □ Not receiving a SCP	"Challenging, in terms of follow-ups, because of housing, or they're incarcerated, they sort of drop off of the map, like I can't get a hold of them anymore, so certainly challenging in terms of follow-ups". - PCP_1 "That's a burden that unfortunately all family docs have to overcome with all of their patients in a world where there's very little to offer for free." - PCP_10 "I feel for a lot of the solo practitioners or the people in groups that don't have an allied health team, because they would not be able to provide the referral
	Resources/material resources: commodities and human resources used in enacting a behaviour		
	Organizational culture/climate: a distinctive pattern of thought and behaviour shared by members of the same organization and reflected in their language, values, attitudes, beliefs and customs		
	Salient events/critical incidents: occurrences that one judges to be distinctive, prominent or otherwise significant		
	Person x environment interaction: interplay between the individual and their surroundings		
	Barriers and facilitators: in psychological contexts, barriers/facilitators are mental, emotional or behavioural		

	limitations/strengths in individuals or groups	□ Format of receipt of PCPs (electronic/fax etc)	to counselling that is covered." - PCP_6
		□ Descriptions of how many SCPs they have seen/worked with	"It's fine for our patients that have good coverage or money to pay for therapy... the reality is that that's often few and far between." - PCP_6
		□ Descriptions of other cancer types they treat	
		□ Descriptions of patient population the PCP serves	"I just find that ever since we've gone to electronic records and, you know, even worse since we've gone to the [EMR] system and everything, it's just pages and pages long and its way longer than it needs to be." - PCP_9
		□ Descriptions of doctor's own EMR, and issues or benefits of their EMR (e.g., sticky note reminders) (receiving too much information, issues with information exchange between EMR.	"I get a note from a from a specialist, but there's no way to contact them." - PCP_13
		□ Statements about how many SCPs they have received	"I think the E-consult is a good thing, however, I find it annoying that it's not someone who knows your patient, so you have to re-copy all of the information down in another portal, and it becomes a

		• Descriptions of how e consult is time consuming	little complicated and time-consuming to be quite honest. Very time-consuming." - PCP_2
		• Time consuming nature of ensuring tests have been booked, and that the results are provided, reaching a specialist to talk to	"I think I've only had the one patient who I've done the survivorship plan for, for colon cancer." - PCP_1
		• Explicit descriptions of logistical issues (e.g., communication with cancer centre, WBCP etc.) that influence the PCP's ability to provide follow up care in a timely manner e.g., no French language education classes, miscommunications about whether tests have been ordered	"I do find that some of my patients don't want to go to the survivorship program, because none of the people are Francophone. I've had about two that didn't feel comfortable going back because no one spoke French." - PCP_2
			"I think all of us have various levels of, you know, of being comfortable with picking up the phone and calling our colleagues there. Some of us may be a bit more unsure about doing that, some of us are, quite frankly, fine with it. So, I think it also probably has to do with experience and contacts." - PCP_8

			“Retrieving it, trying to get on the EMR, making sure that it is readily available to any provider that goes through that patient's chart, it’s more logistics about finding it and making sure you’re ordering at the appropriate time.” - PCP_7
12. Social Influences Those interpersonal processes that can cause individuals to change their thoughts, feelings, or behaviours	Social pressure: the exertion of influence on a person or group by another person or group	Appropriate coding to this domain: Descriptions of interaction with patients Comments on patient’s comfort with receiving follow-up care from PCP Patient’s influence on the behavior of the doctor *e.g., patients not coming in for mammogram appointment even if it was scheduled Descriptions of patient needs and how these needs are dealt with	“When it falls in the hands of people who are involved in their health, I mean there’s some people who say, “okay, five years, that’s it”, and they tend to forget it. I won’t forget, but they may not be as, you know, diligent as others, whether it’s denial, or just to say, “well, I think I’m okay now.”” - PCP_4 “So, if a patient calling me like, “oh I’m having this”, for example having trouble swallowing or something, I know that they have new medication, and I can at least reassure them that it’s that, and what can be done in that case.” - PCP_1
	Social norms: socially determined consensual standards that indicate a) what behaviours are considered typical in a given context and b) what behaviours are considered proper in the context		
	Group conformity: the act of consciously maintaining a certain degree of similarity to those in your general social circles		
	Social comparisons: the process by which people evaluate their attitudes, abilities or performance relative to others		
	Group norms: any behaviour, belief, attitude or emotional reaction held to be correct or acceptable by a given group in society		
	Social support: the apperception or provision of assistance or comfort		

	to others, typically in order to help them cope with a variety of biological, psychological and social stressors. Support may arise from any interpersonal relationship in an individual's social network, involving friends, neighbours, religious institutions, colleagues, caregivers of support groups	Anything that comes from the patient that influences the PCP's behaviour	"Giving her the care that she wanted in the space that she wanted it." - PCP_13
	Power: the capacity to influence others, even when they try to resist this influence	Patient reminds PCP about follow-up care	"Whatever is mentioned I usually follow exactly, unless the patient doesn't want it." - PCP_5
	Intergroup conflict: disagreement or confrontation between two or more groups and their members. This may involve physical violence, interpersonal discord, or psychological tension	Patient emotions influence PCP behaviour	"Whereas, for this sort of thing, yeah okay, the mammogram, we could organize that, and I think they're pretty well OK for that, but in terms of coming in, I don't know if it's a mindset that they have because they left the cancer clinic that their cancer is behind them." - PCP_11
	Alienation: estrangement from one's social group; a deep seated sense of dissatisfaction with one's personal experiences that can be a source of lack of trust in one's social or physical environment or in oneself; the experience of separation between thoughts and feelings	Making the decisions to focus on what patients' healthcare needs are even if the appointment was intended to be focused on cancer care follow up	"If I'm one day late, the patient will call me and say, "oh, you still didn't send it, it's time for my test to be done". - PCP_5
	Group identity: the set of behavioural or personal characteristics by which an individual is recognizable [and portrays] as a member of a group		
	Modelling: in developmental psychology the process in which one or more individuals or other		

	entities serve as examples (models) that a child will copy		
13. Emotion A complex reaction pattern, involving experiential, behavioural and physiological elements, by which the individual attempts to deal with a personally significant matter or event	Fear: an intense emotion aroused by the detection of imminent threat, involving an immediate alarm reaction that mobilizes the organism by triggering a set of physiological changes	Appropriate coding to this domain: □ Negative emotions around providing follow-up care □ Positive emotions around providing follow-up care □ PCP experiences/impressions of patient emotions	"I don't think after 5 years there's much in the way of depression or grief, it has already been lived through..." - PCP_4
	Anxiety: a mood state characterised by apprehension and somatic symptoms of tension in which an individual anticipates impending danger, catastrophe or misfortune		"I think they've all been pretty comfortable, I provide them what they're asking for. Unless the ones who wouldn't be comfortable or have lost trust for other reasons, I'm not sure. But um, yeah, the person was pretty happy with that." - PCP_1
	Affect: an experience or feeling of emotion, ranging from suffering to elation, from the simplest to the most complex sensations of feelings, and from the most normal to the most pathological emotional reactions		
	Stress: a state of physiological or psychological response to internal or external stressors		"I think there's definitely been some who have underlying anxiety and are definitely more anxious about losing that access and that kind of, you know, direct care from their oncologist." PCP_8
	Depression: a mental state that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration		
	Positive/negative affect: the internal feeling/state that occurs when a goal has/has not been attained. A source of threat has/had not been avoided, or the individual		"The plan is usually helpful in relieving a lot of the uncertainty from the physician point of view,

	is/is not satisfied with the present state of affairs		but also the insecurity from the patient point of view.” - PCP_9
	Burn-out: Physical, emotional or mental exhaustion, especially in one’s job or career, accompanied by decreased motivation, lowered performance and negative attitudes towards oneself and others		“Initially, there was probably some resentment in that, you know, it’s now, suddenly there’s more work, for what I was considering at that point a shared patient, but in a system like ours, I recognize that there is going to be a certain amount of downloading so that we can preserve resources for the most appropriate use.” - PCP_3 “I think there's definitely been some who have underlying anxiety and are definitely more anxious about losing that access, that direct care from their oncologist. But for most patients, I think they've been OK with the transition and I haven't run into any major issues there.” - PCP_8 “I feel like for most patients they usually feel like, they feel like they're kind of graduated and they're kind of able to almost normalize some of their medical care again by being able to return

			to their primary care provider. And so, in some ways, it feels like a bit of a return to before, a return to normal." - PCP_8
14. Behavioural Regulation Anything aimed at managing or changing objectively measured actions	Self-monitoring: a method used in behavioural management in which individuals keep a record of their behaviour, especially in connection with efforts to changes or regulate the self; a personality trait reflecting an ability to modify one's behaviour in response to a situation	Appropriate coding to this domain: Recommendations for SCPs Desire for more clarity Desire for more information (e.g., social support, medication side-effects) Format or mode of delivery suggestions Desire for someone to call/refer to with questions about providing follow-up care	"The ability to update survivorship care plan with new medicines incorporated, guidelines, research studies going on, that it would be helpful." - PCP_1 "If you make it into a one-page summary, it would be much better received than getting the five or six pages that we get." - PCP_11 "Insist that people not only take this paper and use it, but bring it to the appointment, and to give me the notes as well, because when we transfer, for example if there are fees to pay on the administrative side to transfer the file, they don't do it necessarily." - PCP_12 "Maybe a a little bit of information provided that, "these are the possible long-term effects of this medication", or "these are the most
	Breaking habit: to discontinue a behaviour or sequence of behaviours that is automatically activated by relevant situational cues		
	Action planning: the action or process of forming a plan regarding a thing to be done or a deed		

		Desire for ability to update plan or patient info	common and, please watch out for A, B and C"" - PCP_9
		Descriptions of changing guidelines and information over time as science evolves	"It's just the emphasis that no, you're not done with cancer surveillance, it's the follow-up now that is going to be at the hands of your primary provider. " - PCP_3
			"Like social resources, or like extra support group resources, that they can access if need be." - PCP_1

Appendix I
Belief Statements – Cancer Survivors

Overall Theme	Subthemes	Belief Statements	# participants report	Frequency of utterance	TDF Domain	Example Quote
	Active member of healthcare team	The SCP has everything I wanted to know	11	16	Knowledge	"I think it contains all the information that is required. I can't think of anything else that should be added to it." - Surv_9 "The sheet that I got from them was great. Everything was there." - Surv_24
		I can call a nurse navigator to have my questions answered	2	2	Skills	"I have the ability to phone, there's a nurse navigator that you can phone and leave a message, and she would get back." - Surv_16
		I do self-exams	1	1	Skills	"My follow-up care is self-examination" - Surv_5
		I can look up and interpret my test results	4	7	Skills	"The results are up pretty quick and I can check them, and it gives you peace of mind, there's less waiting." - Surv_8
		Contacting oncologist when needed	3	3	Social Professional Role and Identity	"My oncologist said, "if you want to reconsult us, your family physician can reconsult us", so that was good to know because they're saying we're not just leaving forever, you can check in with us again if you need to." - Surv_8

Survivors engaged and motivated to use SCP		Needing support from other health care professionals	5	9	Social Professional Role and Identity	“Someone like an experienced or close to retiring nurse that you could sit down and ask all these questions to.” - Surv_21 "I haven’t been able to, uh, find anybody at all at a professional level that has been able to help me.” - Surv_14
		Being an advocate for oneself	5	12	Beliefs about Capabilities	“You really have to be your own advocate.” - Surv_3
		I used my SCP to advocate for my follow-up care	4	7	Beliefs about Capabilities	“It becomes your tool to be your own advocate.” - Surv_10 “The care plan was a good tool to communicate what needed to be done to my physician, and made it clear also for me, but then it also gave me the tools to become my own advocate, asking for specific things also to be done.” - Surv_10
		Confidence in ability to navigate follow-up care	10	22	Beliefs about Capabilities	“Sometimes you think you’re not ready or you’re not sure if you’re ready or are you strong enough, and I remember thinking, “okay, now I’m ready and I’m strong enough”, and then the nurses – it’s kind of, you know, that’s the message they’re giving you, you know, it’s, well done, carry on, all the best, and this little

						booklet here is going to help you." - Surv_8
		I was driven to use the SCP to make sure I received good care	5	8	Intention	"It's right there, okay, my doctor should have arranged for a mammogram, I haven't heard from said doctor, oh, I better get in touch and find out how I get a mammogram." – Surv_6
	How I was taught how to use SCP	Meeting with a nurse about the SCP helped me understand it	7	11	Knowledge	"I remember everything was covered, I had no questions left when I was finished. I did not use it after that, but I knew I had it." - Surv_5
		Seeing importance of discharge meetings	4	9	Behaviour Regulation	"Just the opportunity to have someone go through it with me, you know, person-to-person, and probably get that reassurance that I wasn't being dumped, and I wasn't being cast aside, and perhaps the opportunity then to ask those questions, like, and have a clear picture of what was going on." Survivor 9
		Went to discharge meetings	7	10	Environmental Context and Resources	"I read it when I got it, and it was given to me and explained me to by a nurse." - Surv_5
		Went to WBCP Education Class	11	19	Environmental Context and Resources	"A nurse coordinated the meeting and she explained that we would transition to our family physicians, and then she kind of went through the specifics, the different kinds of follow-up and who would provide what, so that was a good meeting." - Surv_8
	Perceived Benefits of Using SCP	Using my SCP will be good for my health	1	1	Beliefs About Consequences	"My own health and welfare are number one." - Surv_9

		Using SCP will help prevent cancer recurrence	7	11	Beliefs About Consequences	“I use my SCP to avoid a return of the cancer diagnosis, or, if it were to return, ensuring that the return is caught early.” - Surv_11
		Wanting an electronic version of SCP	4	10	Behavioural Regulation	“The plan itself, like, it’s a piece of paper, and I’m wonder for better use if it can be electronic, or in some kind of an app, like that I can access if need be.” - Surv_1
		Wanting both paper and electronic	4	4	Behavioural Regulation	“I don’t think you can do just electronic, I mean not everybody has access to a computer, iPad, or whatever, and given the age of some of the patients, they’re not technically savvy, so, people like to have paper in a lot of cases so I think you need both. “ - Surv_3
		Wanting SCP on patient version of EMR	7	11	Behavioural Regulation	“Somebody like me, I go into MyChart quite a bit, so if I am going through, I would see it and it would prompt me to open it up and look at it, maybe more.” - Surv_12 “If the plan could be hooked up to the EMR it might be easier, you find everything the same place, I don't know whether that's possible at all, but in the future, it might be a benefit.” - Surv_25
		Wanting updateable SCP	3	3	Behavioural Regulation	“I was wondering if they ever do updates on these, or, you know, uh – because at that moment in time,

						whenever I was asked, you know, or if anyone is asked, you may not have any of those concerns, but down the road, you might." - Surv_12
	Recommendations	Wanting information on the frequency of cancer hospital visits	2	2	Behavioural Regulation	"Perhaps a listing of all the scans and tests that ensued, and the dates." - Surv_9
		Wanting follow-up contact with cancer centre	12	26	Behavioural Regulation	"Maybe somebody should follow-up, phone you every six months, ask how you are doing. Maybe some people need more support." - Surv_5 "I think I did receive one or two phone call follow-ups, butI think it's probably important to do it throughout the entire length of the follow-up period." - Surv_11
		Extending SCP for long term cancer survivors	3	5	Behavioural Regulation	"I found the booklet talked about the first six months, let's say, where I personally would have liked information to lead me into the first year, if not past that." - Surv_21
		More information on health and fitness	1	1	Behavioural Regulation	"There's nothing in here for health and fitness, or even things like physio, or chiro, acupuncture, things that might help you with some of your symptoms that sort of linger around after." - Surv_1
		Wanting more info on psychological support	1	2	Behavioural Regulation	"Maybe looking back maybe I should have been seeing a doctor, psychiatrist, maybe they should have scheduled like an appointment maybe

						every month or something like that." - Surv_10
		Supplemental booklets helpful	6	13	Behavioural Regulation	"I picked up a lot of booklets on cancer at the hospital and they were very helpful in understanding my cancer, and cancers that others I know have gone through." - Surv_26
		Videos	1	3	Behavioural Regulation	"If you guys ever got into making videos, oh, my God. It would be the most popular thing in the world. And this way, people can go to the hospital website and we could watch videos from the doctors telling us directly what we need to know." - Surv_21
		Wanting a way to ask questions to cancer specialists	5	12	Behavioural Regulation	"It would be nice if there was some kind of access portal or somebody you can ask the questions you have. Because some of the questions I have, my doctor, it's totally out of her experience." - Surv_14
		Wanting a general phone number of email to contact the cancer centre	1	1	Behavioural Regulation	"There's nowhere on this form that gives any sort of, general phone number or email of where I would start. " - Surv_1
		Wanting extra individualized supports	8	28	Behavioural Regulation	"Like, "If your doctor isn't being supportive enough, if your family is not being supportive enough, if you feel you need more, here's where you can go for some further help."" - Surv_6
		I needed more information about diet	2	4	Behavioural Regulation	"I think that the information package could probably even be more extensive, especially when it came to the nutrition side of things. That was something that I really have to kind of

						research on my own to what foods would be OK for my stomach." - Surv_21
		I needed more information on side effects	3	5	Behavioural Regulation	"Maybe there should have been a whole section about those side effects and what to do to manage those side effects." - Surv_10
		I needed more information about alternative medicines	1	2	Behavioural Regulation	"I would also suggest that they should research more about the good of cannabis, because it saved me from having to spend thousands of dollars on opioids. I just grew my own cannabis and I did well." - Surv_21
		The SCP is missing information about cancer stage	1	2	Behavioural Regulation	"But it doesn't have, like, you know how people say like, "stage two, stage three, stage four", like that sort of information isn't there." - Surv_1
		The SCP is missing information about the doses of chemo medications	1	1	Behavioural Regulation	"There are medications listed, but I would have preferred to also have the doses of those chemo medications." - Surv_2
		Discussing SCP with PCP	18	37	Social Professional Role and Identity	"I made an appointment with my family doctor and that's how it started. Basically, sitting down and having a discussion, how to go about it." - Surv_10
		I am responsible for my follow up care too	15	42	Social Professional Role and Identity	"I think we as individuals need to take more responsibility for our own health, I mean the doctors can only do so much, and they're got hundreds of patients." - Surv_17

	Using SCP as a communication tool					"I believe that people need to take responsibility for their own health. Because we get to know our own bodies better than anybody, and the doctors don't live in our bodies, so we need to be more responsible for ourselves." -Surv_17
		PCP asks me to remind them	1	1	Social Professional Role and Identity	"He says "every month of October you'll receive a call from the hospital for your mammogram, if you don't, please call me, we'll follow up on that"." - Surv_10
		Using SCP to keep PCP on track	5	8	Social Professional Role and Identity	"So, it was just a reminder and sometimes, you know, she was a bit lost or didn't have a follow-up set up, so she had to look at my files." - Surv_28
		Change in PCP	2	4	Intention	"I refer to it quite often actually, simply because my regular family doctor retired and I want to keep the new one on track with what's supposed to be happening." - Surv_9
Working with PCP in follow-up care		Changing health care professional	2	2	Intention	"He would have had this document, so it certainly would have been helpful to them. It spared me from having to explain what was going on." - Surv_14
		I will use my SCP with my PCP	1	3	Intention	"When I go for my next appointment with my doctor, I'll probably bring it with me and I'll just go through it with him." - Surv_12

		Dr. Tells me to do something so I do it	1	2	Social Influences	“It's not something I look forward to, but when the doctor tells you to do something, you sort of do it.” - Surv_27
	PCPs limitations for providing cancer follow-up care	My doctor is NOT on top of my follow up care so I am	5	9	Social Professional Role and Identity	“They will request the first one, but then you’re sort of on your own after that.” - Surv_4
		My PCP is not a cancer specialist	4	4	Social Professional Role and Identity	“When the cancer clinic decides that you’re better, and you can now go to your family doctor, and you’re ready, it’s very um... you’re not certain that you’ll be taken as well care of by your family doctor because your doctor is not aware of the cancer problem that might arise with, because it’s not their specialty.” - Surv_13 “That there are some topics that are very difficult to talk to your own doctor about because my doctor doesn't specialize in cancer. “ - Surv_21
		PCP’s don’t really do Psychosocial Care	1	1	Social Professional Role and Identity	“I was wondering if they ever do updates on these, because at that moment in time, whenever I was asked, you may not have any of those concerns, but down the road, you would just deal with your family doctor, who isn’t really good at those sorts of things, they’re more definitely medical.” - Surv_12

	Collaboration between PCPs and Cancer specialists	Using the SCP will connect the oncologist to my PCP in a helpful way	1	1	Beliefs About Consequences	"But, there is also a feeling of "oh my god, I'm on my own now", which is why it's so helpful to have this program and have this plan and have the connection between oncologists taking care of you and your family doctor taking care of you." - Surv_2
		My PCP and oncologist work together	3	3	Social Professional Role and Identity	"It was like a triangle, my oncologist, my family doctor, myself. It was great." - Surv_13 "They really were in contact with each other all the time." - Surv_18
	I am happy with the FU care from my PCP	PCP helps problem-solve when needed	2	2	Social Professional Role and Identity	"My doctor says "if there's something that doesn't work for you, you feel sick, you come and see me. If you feel something abnormal, something you're not used to, you come, and we'll do it."" - Surv_10
		PCP on top of follow-up care	23	70	Social Professional Role and Identity	"I have a very good family physician that I've seen for many, many years, and she's very on the ball, so I really haven't used any of that. " - Surv_3
	Sharing information	My SCP helps me share information with my family	1	1	Knowledge	"It would certainly be helpful if you have families who, say older people, you know, have maybe a son or a daughter who comes home and says, "what's the doctor say?", well, if you've got a document like this or if the person is knowledgeable at all, like if the person maybe took grade 10

						biology, you can actually go onto Google and look up some of the words. They can look through this document and get a pretty good idea of what's going on." - Surv_14
		The information in my SCP is helpful to provide to other doctors	7	12	Knowledge	"I know that my family physician is going to be retiring in the next little while, is that information going to be given to the new physician that I find? So, if you can access it, you can provide it to your new physician as well." - Surv_3
		My SCP helps me communicate with pharmacist	1	1	Knowledge	"It could help with whoever you have to communicate with, which could be your pharmacist." - Surv_14
	SCP is important resource about my cancer history	I know I have my SCP to refer to	14	29	Knowledge	"When I got it, I kept it, so what I did with my care plan is I kept it. And I remember when I left, I thought "This will be really handy if I need to know this information in the future", and I tucked it away, and I found it very easily." - Surv_5
		I refer back to my SCP to know the cancer drugs I received	3	3	Knowledge	"I mean one example like I said, I did look up not too long ago was I saw something about one of the drug names, and I thought, "oh, I think I had that one" and then I looked it up to see if that was you know, one of the drugs that I had taken." - Surv_1
		I refer back to my SCP if I have any questions	1	1	Knowledge	"What I really appreciate was the numbers in there, of places I could reach for more information. So, if I had had a problem, I had somewhere

						to reach, and it was in the little booklet that I had." - Surv_5
		I use the SCP to know when to stop taking medication	1	1	Knowledge	"I also refer back to it to see when I can stop taking the estrogen blocker." - Surv_9
		I use the physical activity guidelines in SCP	5	7	Knowledge	"The most helpful one actually it was said to be doing more walking, basically, be more active." - Surv_23
Descriptions of How SCPs Have Been Used in the "real world"		I use the SCP to refer to information about my cancer treatment	7	10	Knowledge	"I mean it was great to have the summary of everything that had gone on, the treatment, 'cause I have a terrible memory, and so it was great to know when I had my mastectomies and what my medicines were and what was expected as follow-up, it was great to have that." - Surv_2
		I use the SCP to look up specific dates	3	3	Knowledge	"Those dates are really important, and that's really helpful for me." - Surv_17
		I use the SCP to refer to information about my cancer history	4	5	Knowledge	"I think the most useful information was the history on the type of cancer and the size of tumor." - Surv_3
		The SCP gives me direction for my follow-up care	23	69	Knowledge	"I just follow the plan, you know, my doctor arranges for mammograms and I know how often I'm supposed to have them." - Surv_6 "I was really happy I had it because I was able to kind of manage all that and understand what needs to be done

						afterwards, it's providing me the knowledge." - Surv_10
	My SCP gives me direction	I have a phone number to call	3	4	Knowledge	"I kept in contact with the girl so that we wouldn't have to keep calling the cancer clinic. We had her to call." - Surv_4
		I refer to the SCP to make sure my FU appointments are on time	5	5	Knowledge	"So, at the beginning I was referring to my care plan more often, because I didn't want my family doctor to slip on anything and to forget to schedule something, but it never happened. So, really, I was double-checking to make sure that everything was on track." - Surv_13
		I make follow up appointments with the right person	3	7	Skills	"Yes, I did use it because it had a great summary of all my treatments and when, and then it had some kind of reminders about follow-ups, like who and where and when I would you know, have my follow-ups like annual mammograms, for example, and where would I do that and with whom." - Surv_8
		I used the SCP to check that nothing falls through the cracks	2	2	Skills	"My care provider has always been on-track, but certainly, it's one way of making sure that nothing falls through the cracks, so it's always on my phone, in my calendar." - Surv_13
		I used the SCP to manage my follow-up care	5	7	Skills	"Even though I work in healthcare, I can get lost very easily, the volume of information that you have to sort of manage, so, for me the booklet and having it all sort of together in one file was good." - Surv_8

	Keeping track of follow-up	I will use my SCP when I have questions	2	2	Intention	“If you’ve got some concerns, you pull it out.” - Surv_6
		I will use my SCP again in the future	2	2	Intention	“Hopefully I won’t need to use it again, however, if I do, I will certainly be glad to have it.” - Surv_2
		Being prompted to refer back to SCP	3	3	Memory, Attention and Decision Processes	“I didn’t really use it until recently, a couple of weeks ago, to look up my treatment.” - Surv_2
		Creating reminders for oneself	3	5	Memory, Attention and Decision Processes	“I have an iPhone. So, what I did was I put on all the appointments, as I should be getting, for example, a CT scan once a year. So, I simply put it my phone, as a reminder and I did the same thing with blood work and colonoscopy and so on.” - Surv_28
		I added the SCP to my phone for emergencies	1	1	Memory, Attention and Decision Processes	“I have it in front of me, I took pictures, it’s in my phone so if ever there is an emergency everything is in my phone.” - Surv_13
		I used a calendar to make sure I booked appointments	1	1	Memory, Attention and Decision Processes	“I know what needs to be done and just to make sure that my doctor is on top of things, I just added it to my calendar so every 6 months it pops up.” - Surv_13
		I would forget about my treatment if I did not have a SCP	6	9	Memory, Attention and Decision Processes	“I wouldn’t remember the information about my treatments if I didn’t have that summary there.” - Surv_8
		SCP is a reminder for follow up	8	13	Memory, Attention and Decision Processes	“It reminded both of us that maybe it was time for me to have a bone density test, which I did have, she arranged that.” - Surv_2

	Recommendations	Wanting different formatting for SCP	5	16	Behavioural Regulation	"Put important things or things that are really, that we need to pay attention to, should be, I would say, in a different font or, so they jump out and my eyes are gonna go there, not just to the whole page, "oh my god, more stuff to read"." - Surv_17
		I can't use my SCP because it is outdated	2	4	Behavioural Regulation	"Like, a perfect example is right at the beginning, it lists my cancer care team. Well, my family physician is retired, I understand the surgeon I had retired, um, I think one of the oncologists retired, I don't know about the other oncologists, um, I know that my reconstruction surgeon um, moved away, so, what replaced these people? Who would I go to if I needed something, like where do I start?" - Surv_1
	Seeing SCP as unimportant	I didn't see the SCP as important	1	2	Intention	"I guess I didn't feel the importance of it enough to make use of it." - Surv_17
		I don't need to use the SCP someone will call me	2	2	Intention	"I was honestly just expecting that I would be contacted by my oncologist." - Surv_12
		I put it away and forgot about it	5	11	Memory, Attention and Decision Processes	"I've just basically put it away and totally forget about it." - Surv_5 "I was quite surprised to find it in my file, here, so. Had I not filed it, I would have told you I really knew nothing about it." - Surv_14

Forgot/ Didn't understand care plan /not engaged in follow up care		Reminders to do self-exams	1	4	Behavioural Regulation	"Maybe a reminder of how to actually do it, some little card or something, like there's more to it than just putting your hand on your boob." - Surv_9
		The SCP did not meet my needs or not applicable to me	2	10	Behavioural Regulation	"I think that it was more geared towards other types of cancers where particularly with me, because I had colon cancer and because it dealt with a lot of my stomach muscles and my stomach area, I went through a bit of a different thing as per like someone would for four other types of cancers kind of deal, so certain parts of it didn't really pertain to me." - Surv_21
	Lack of awareness of SCP	I could lose my SCP	2	2	Memory, Attention and Decision Processes	"It's very easy to disappear somewhere." - Surv_1
		Not remembering receiving SCP	1	2	Memory, Attention and Decision Processes	"I don't I honestly don't recall ever receiving anything along that line." - Surv_27
		Not sure if received SCP	1	1	Memory, Attention and Decision Processes	"I really can't remember what the plan looked like, I had – like I said, I had so many different pamphlets to know where to call." - Surv_4
	Not initially seeing value in SCP	I wish I knew how important the SCP is	2	6	Intention	"I know whenever I got this and I went through it, it should have clicked with me more, how – what an important document it is, I don't know why it didn't more." - Surv_12
		It would be helpful if people were reminded to use their SCP	1	1	Behavioural Regulation	"I would say they might need to be reminded a bit more often." - Surv_6

	Practical Factors	Difficulties with FU care due to different EMRs	4	7	Environmental Context and Resources	“[small community] is on [hospital EMR] but if I go for any procedure in [another small community], it’s not on [hospital EMR], so we avoid going to the [small community] hospital for anything like that.” - Surv_19
		Distance for FU	5	8	Environmental Context and Resources	“I think there is a rural-urban divide in terms of the ease by which I can come, and - I'm going for a scan tonight, for example, even though it's at 10 o'clock, I mean, it's not going to be that big of a deal for me to get there. It would be for somebody, you know, living two hours outside of the city.” - Surv_20
		Medications not available in small community	1	2	Environmental Context and Resources	“Went to get my prescriptions that were required and they didn’t have them. So, they had to be ordered in, I’m assuming nobody else in the community at that time was requiring those types of medications, so there was a couple of days gap in there.” - Surv_9
		Impact of pandemic on follow-up care	3	4	Environmental Context and Resources	“Especially with Covid, sometimes things are not lost, but delayed, and then delayed again.” - Surv_8
		Local supports	4	10	Environmental Context and Resources	“If I wanted to get a CT, I’d have to go to [another small community], book that, whereas when I was in Ottawa, everything was there. Everything was there. The CT, the blood, all of that.” - Surv_19

Factors influencing use of SCP		Socio-economic differences	3	7	Environmental Context and Resources	"Well, I know there was all sorts of support programs out there that, you know, that survivors would get together and talk about, but again, because I couldn't get to those things without paying an arm and a leg for a taxi, I missed out on all of that stuff." - Surv_9
		Accessibility of health care	1	2	Behavioural Regulation	"I've been able to contact her through email for a number of years and it's very, very handy, because a lot of this stuff, as we're finding out in the pandemic, just needs a talk or a text, you know. It doesn't need you to go into the office and take time, it's just like yes or no answers for some of these things or they just send a requisition off or something." - Surv_5
		I don't use the Personal Needs Section because it's Blank	2	3	Behavioural Regulation	"Apparently, I never got the needs assessment to them before the meeting, so when it says my personal needs, I haven't got any listed." - Surv_2
	Social Factors	Family Support	11	19	Social Influences	"My wife is on top of it all the time, she keeps notes and journals and writes it on the calendar, but if I was alone, (laughs) I probably wouldn't keep on to all of this stuff." - Surv_19
		Feeling isolated	1	1	Social Influences	"I can imagine people living up in those, you know, 16-floor of a condo building... you live with 1200 other people and you don't know the name of one of them... you haven't got a clue of the people who are around you or where they've come from, and so a

						document like this would be super to have.” - Surv_14
		Support amongst cancer survivors	6	19	Social Influences	“If you have experienced it yourself, you’re the best subject-matter expert for someone else to learn from. It’s like if you’ve never experienced, you know, the death of a parent for example, how can anyone really talk to anyone about it who hasn’t experienced it themselves?” - Surv_1
		Not relating to others	2	8	Social Influences	“And you know, we talk, and I see them when we socialize, and obviously, my experience is now with my digestive system and elimination system is very different from theirs.” - Surv_14
		Relating to others	5	12	Social Influences	“We’re all in the same boat... and just to know that you’re not alone... as I say with my friend, my colleague, she’s commented that she really just felt so alone and she’s learned so much just from listening and you know, working through other things that different people experience and she’s like, “wow, yeah, I understand that, I’ve been there”." - Surv_7
		Wanting peer support	5	11	Behavioural Regulation	“Like, I mean for example... let’s say there’s a bunch of people that are survivors, they’ve been discharged, and they meet up a couple times a year to do some kind of fundraiser... or participating in run for the cure, or just getting together to have a glass of wine, cross-country skiing, whatever, sort of compare notes on things.” - Surv_1

	Emotional Factors	Accepting discharge difficult	3	4	Emotion	“I don’t know if others experience the same thing as I, but it was quite disturbing as a matter of fact.” - Surv_9
		Feel like getting better care at cancer centre	5	7	Emotion	“I felt like I was going to be better cared for at the cancer centre than I was going to be with my own physician. Not because she’s not good, just because that’s all they do, is cancer.” - Surv_3
		Not comforting to be discharged	2	2	Emotion	“After the first surgery when we were discharged home with a [medical device], which was a whole other world for us, we thought, “oh my God, we’re not ready to be home and be dealing with this on our own.”” - Surv_16
		Emotional toll of cancer treatment	4	4	Emotion	“And the emotional needs, you know physically it’s not easy to have surgeries, and to have chemo, it’s tough stuff. But personally, for me, the physical stuff was nothing compared to the emotional stuff, so to have that information on the care plan if you needed it would have been absolutely crucial.” - Surv_2
		Fear of recurrence	4	6	Emotion	“You hold your breath, I mean, literally, hold your breath, until you – even five years after, until you get the results... but to be able to go on the next morning, and get the lab results, you go, *phew*, like, okay.”” - Surv_16
		Feeling comforted by SCP	12	21	Emotion	“I guess it’s not hope but just knowing that the support was there too. Like

						that I was being able to go from one hospital to your family doctor, you know, that was the link, the bridge, and I was thankful for that bridge." - Surv_10
		Feeling ready for discharge	1	1	Emotion	Sometimes you think you're not ready or you're not sure if you're ready or are you strong enough, and I remember thinking, "okay, now I'm ready and I'm strong enough", and then the nurses – it's kind of, you know, that's the message they're giving you, you know, it's, well done, carry on, all the best, and this little booklet here is gonna help you." - Surv_8
		Frustrating to set up FU appointments	1	1	Emotion	"It took me 9 phone calls to get the requisition. And I ended up getting somebody in Dr. X's office that wasn't charged with it at all, and she said, "I told them this would happen, I told them", that was very frustrating." - Surv_16
		Happy about discharge	5	5	Emotion	"I mean I was happy about that, it's all good news when you graduate from the cancer centre, there was nothing sad about it for me, you're so grateful that things have gone the way they have, they've turned out, the outcomes have been good." - Surv_8
		Humor	1	1	Emotion	"I don't need mammograms as my oncologist liked to say, "You have no mams to gram", which I thought was hysterical." - Surv_2

		In shock	2	2	Emotion	“I didn’t really have any problems in that manner, I was probably in shock the whole time, anyway, but my doctor was a great help.” - Surv_4
		“Men need to be tough”	1	1	Emotion	“And as you start to get stronger, you start to feel more confident about talking to your doctor about it, because being a male, you know, speaking with my doctor, it's not something we normally do, you know? I grew up in an environment where being a man, you kind of take it. You got to be tough.” - Surv_21
		Moving on with life	1	2	Emotion	“There’s a definite feeling when you’ve finished your final treatment that’s like, okay, let’s get on with life again. Enough of this (laughs). There is that feeling as well, that you just don’t want to have to think about it for a while. “ - Surv_7
		My cancer is an emotional trigger	1	2	Emotion	“It kind of implies to me that I still have it. This is “my cancer”, well no, I never asked for it in the first place, so the sense of ownership with the word “my”, you know, as far as I’m concerned, it’s done, it’s gone, for the time being, knock on wood, but, yeah, that’s just an observation.” - Surv_1
		Survivor's guilt	1	1	Emotion	“Yeah, survivor’s guilt, yeah, knowing that my thing went, because I know other women that during that period that passed away, and then other women that had a lump after going through what we had been through she found a lump not even a year afterwards so she had to go

						through that again. So, it's, it's yeah, maybe a bit of guilt." - Surv_10
		Trusting PCP or healthcare system	6	14	Emotion	"I have total faith in this new doctor because she was very, very, very thorough, and she questioned everything." - Surv_4
		Uncertainty and unknown at discharge	6	15	Emotion	"It's kind of two-fold I guess, one is a sense of "okay, I'm free" (laughs) "I can go on my merry way", but then the second there's always this, "Okay, so now, who's watching over me?" Sort of, double-edged sword, but for the most part, positive, very positive. But overwhelming. I can tell you that the day I left with this in my hand, I probably just sat in my car in the parking lot and just cried. And I'm not a big crier, it just was like, this huge kind of, unknown, release." - Surv_1
		Why assume I need all this survivorship stuff?	2	4	Emotion	"I'm like, okay, I just ran an hour yesterday, I'm completely healthy here, except I just had this cancer thing come up and so, I felt like, "oh wow, like they have all this other stuff to deal with" and I can see where this plan would be good for them going forward and other health concerns, how things would affect it, but I didn't have any of that. I had none of that." - Surv_1

Appendix J
Belief Statements PCPs

Overall Theme	Belief Statements	# of PCPs reporting	# of Utterances	TDF Domain	Example Quote
Coordination of Care with Other Specialists and Health Care Professionals	Follow up guidelines	7	18	Knowledge	"I'm also aware that the guidelines will change, right? Will the plan still be up-to-date in 5, 10 years? I wouldn't know where to find the guidelines or how to implement them" - PCP_6 "From my perspective, once it goes on to colonoscopy, it's no longer easy. Guidelines and recommendations are very conflicting." - PCP_10 "The real key for me is, "this is what I want you to do on the follow up. These are the issues that are still going on."" - PCP_13
	SCP contains relevant info	10	27	Knowledge	"I always appreciate it that whenever I get the reports it's always written like, "we are starting these medications, these are the side-effects"." - PCP_5 "I do. I do. I feel like that care plan I found very helpful. It does provide the necessary information I would say absolutely." - PCP_9

	SCP outlines tasks for PCPs	10	27	Knowledge	“I mean it’s a nice little summary at the beginning of it, but a lot of the other stuff, I read it once, but that’s not the part that I refer to. I’m going to refer to that last page that says, “every 6 months, do this”. -PCP_2 “Because it's well done, like just a quick spreadsheet with like, "here’s the system and here's the problem and here's what you need to do.”” - PCP_10
	I book tests, appointments, respond to concerns, etc.	13	47	Social Professional Role and Identity	“I see them, order tests for them, you know, troubleshoot if they’re having issues.” - PCP_1 “Whenever I receive anything I go through each and every step, and I always book an appointment with my patient, I go through all the details with them and tell them how it will be in the future” - PCP_5
	I can solve problems using the SCP	2	5	Social Professional Role and Identity	What if the patient wanted to stop their medications early? It's super good to be able to go back and say, “oh, okay, that's what they suggested”, and talk to the patient about it.” - PCP_13 “I need to, in the middle of a meeting, go back and say, “OK, this was related to your cancer. Let's go back and just see what the cancer care guide said about how we're supposed to pull this out. OK, great. This is our follow-up, boom, and we're going to do this.” - PCP_13

	The specialists create the plan, I follow it	4	6	Social Professional Role and Identity	“I follow whatever the oncologist has told me.” - PCP_5 “I follow what the specialist had asked me to do.” - PCP_12
	Easy/straightforward aspects of care	8	17	Beliefs about Capabilities	“Everything is very clear, and so we never had an issue in implementing it, because it’s really patient-focused.” - PCP_5 “I find it very easy to look at, very easy to follow and very easy to allow me to do my job, because it's easier to send myself a postdated message for all the little things that I need to do. So, I find it very practical and straightforward and to the point and well summarized.” - PCP_10
	I can handle it	3	7	Beliefs about Capabilities	“The follow-up care is fairly simple, not much of a challenge.” - PCP_4
	Layout of SCP makes things clear	5	10	Environmental Context and Resources	“I like the tabular, easy-to-read format.” - PCP_7 “Because it's well done, like just a quick spreadsheet with like, "here’s the system and here's the problem and here's what you need to do.” - PCP_10

	Looking up information	2	3	Knowledge	“I’ll be honest, sometimes I have to Google them. Or if I'm not sure, I’ll ask our pharmacist.” - PCP_7
	Not knowing about side effects of Cancer treatment	5	6	Knowledge	“I'm kind of in deep water is when it comes to dealing with possible side effects of, you know, some of the medications that they may be continuing on.” - PCP_8
	I don’t know exactly what treatment by patient is receiving	7	12	Knowledge	“It’s not always clear to me, like sometimes I don’t get the way that the medication treatment methods are for patients, that’s more challenging, and I don’t know exactly what treatment they’re on.” - PCP_1
	Deferring to specialists	9	23	Social Professional Role and Identity	“But I suppose if there were concerns, generally I would consult back to the cancer center.” - PCP_9 “So unfortunately, it adds more of a load to the specialists, I know. But unfortunately, I often just like refer off to a specialist, just try to see them once or twice and then tell me what to do.” - PCP_10

	I don't know if me or the specialist follows the patient	1	4	Social Professional Role and Identity	"I guess the biggest problem is when it's the unclear who is doing the follow-up for the cancer, because a lot of the patients are followed in specialty clinics initially following their cancer treatment, and then at some point the family physician takes over but it's not always made clear, so then you have patients who, I'm not sure who is following them exactly for that aspect of their health." - PCP_1
	I don't know what to do if test results are abnormal	2	4	Social Professional Role and Identity	"And then if the test results high, then what do I do, do I send the patient for an ultrasound, do I send them for all of that?" - PCP_2
	I don't know whose responsibility this task is	4	5	Social Professional Role and Identity	"Yeah, right, because then whose responsibility is it to organize the follow-up?" - PCP_11
	Follow-up care tasks are outside of my scope of practice	3	6	Social Professional Role and Identity	"I think that for me, knowing which chemotherapy agent causes which long-term side-effect is really outside of my scope, you know?" - PCP_6
	Challenges providing follow-up care	7	15	Beliefs about Capabilities	"It's always possible that things can falls through the cracks or the patients goes for a test and I don't get the result back" - PCP_

	Colleagues to consult with	1	1	Environmental Context and Resources	"I think all of us have various levels of, you know, of being comfortable with picking up the phone and calling our colleagues there. Some of us may be a bit more unsure about doing that, some of us are, quite frankly, fine with it. So, I think it also probably has to do with experience and contacts." - PCP_8
	Description of access to therapy and psychosocial support for patients	6	11	Environmental Context and Resources	"I feel for the solo practitioners that don't have an allied health team, because they would not be able to provide the referral to counselling that is covered, right? It's fine for our patients that have good coverage or money to pay for therapy, that's not an issue, because they will find their own therapy, they will book their assessment, but the reality is that that's often few and far between, right?" - PCP-6
	Did not receive SCP	2	3	Environmental Context and Resources	"Patients have been already diagnosed with cancer when I inherited them so I wouldn't have received the package necessarily, could have probably went to their previous physician or I just recently diagnosed their cancer. So, they're still not like that five years out. So, I have not yet received one." - PCP_10
	EMR issues and benefits	9	15	Environmental Context and Resources	"I find EMR very user friendly and very easy to do record searches. And with regards to preventative care bonuses and everything like that, it always forces us to also do the extra added effort" - PCP_10
	Format of receipt of SCPs	10	14	Environmental Context and Resources	"These days everything pretty much comes through electronically." - PCP_1 "They send us this letter." - PCP_12

	Impact of pandemic on follow up care	3	4	Environmental Context and Resources	“I think because of the COVID it was the time, because of delaying the scans and delaying investigations and delaying things. And of course, it created a lot of stress for the patients too, because given that fact that they were on medications, and some are still on medications, right, so they are very worried to go into the hospital to do the tests, so some delay on the patient's part, some delay in the system's part.” - PCP_5 “So, most of the time in the hospital it’s only the patient himself, especially in the COVID situation right now, nobody is allowed to go inside the hospital with the patient, and then they feel really, really overwhelmed and not able to deal with the situation” - PCP_5
	Logistical issues	11	30	Environmental Context and Resources	“What gets in the way... I guess, I mean, because it’s a document that is sent to us, um, retrieving it, trying to get on the EMR, it’s just you know, making sure that it is readily available to any provider that goes through that patient's chart, it’s more logistics about finding it and making sure you’re ordering at the appropriate time.” - PCP_7
	Using E-Consult	3	7	Environmental Context and Resources	“E-consult is quite useful, but the one big pet peeve is that it’s not readily integrated into EMR, but that’s a conversation for another day.” - PCP_6

	Clarity needed	3	3	Behavior Regulation	“I think having that be clearer on the wellness paper that we get that, you know, “here's how you would go about calling us and contacting us if you have any concerns or questions, here are the patient's ongoing care needs.” - PCP_8
	Format or mode of delivery suggestions	7	19	Behavior Regulation	“No, I would just say if you make it into a one-page summary, it would be much better received than getting the five or six pages that we get.” - PCP_11
	More information on social support	5	6	Behavior Regulation	“But if they're going to put a space and at that particular word “summary” had been bolded, I would have found it in two seconds. So, I know those things sound awfully nitpicky, but for us, finding it, that's the key. It's those little details. I can pull this out in two seconds and that's what makes a difference for me.” - PCP_13
	More information (in general)	6	8	Behavior Regulation	“I think the one that primary care providers get now could be a bit more detailed. Um, and a little bit more information.” - PCP_2
	Patient Education	3	5	Behavior Regulation	“Just because you’re no longer at the cancer centre doesn't mean you’re no longer a cancer patient. Lots of times, the patient’s feedback is, “they don’t want to see me anymore, or they’re done with me”, as in, cancer is not anything I have to worry about anymore. It’s just the emphasis that no, you’re not done with cancer surveillance, it’s the follow-up now that is going to be at the hands of your primary provider.” - PCP_3

	Someone to call	2	2	Behavior Regulation	"I understand that we don't want to give private phone numbers to patients, but like, a support physician line, that could be an option. I mean I don't care if no one answers the phone the minute I call, but I do like to have a – like, to not have to go through locating." - PCP_2
	Updating plan or patient information	5	5	Behavior Regulation	"Maybe like, you could also have a database like which patients are discharged from their care, like, they could, every five years or so we could send out an updated survivorship care plan with new medicines incorporated you know, that kind of thing. " - PCP_1
Collaboration between PCP and Survivor	Patients should take responsibility too	7	17	Social Professional Role and Identity	"Emphasizing the patient's role in taking ownership for their own health. I think that is key, and really sending the message that yes, you're being called back to Dr. X every 6 months, but now it's going to be your responsibility to call your family doctor for your follow-up exam, right? And like, work collaboratively with them to improve your health." - PCP_6
	Description of cancer patient population ** Contextual, neither barrier nor enabler	8	21	Environmental Context and Resources	"I don't have a large practice of people who are cancer survivors, just because my practice is more young-ish." - PCP_2 "I think the four cancers we see the most, would be lung, colon, breast, and prostate, that we're asked to follow-up on." - PCP_4
	I keep the patient on schedule	5	6	Social Influences	"It's up to my system or my office to kind of, um, keep that patient on schedule." - PCP_3

					“So just to say that if I’m not careful, they won’t notice either that they didn’t come.” - PCP_12
	I provide patients with what they are asking for	6	6	Social Influences	“So, if a patient says “oh I’m having this”, like for example having trouble swallowing or something, I know that they have new medication, and I can at least reassure them that it’s that, and what can be done in that case.” - PCP_5 “Give her the care that she wanted in the space that she wanted it.” - PCP_13
	Patient emotion effects behavior	7	13	Social Influences	“Lots of them can still read it and understand it, but I think at the end of the day, they don’t feel comfortable advocating for their own care.” - PCP_2 “Depending on the level of worry that people still carry with them, we might do a little bit more, certainly not less than the plan of care is suggesting, maybe a little bit more, just because people may be, you know, a little too worried, but that’s all individual” - PCP_4
	Patient intention effects behaviour	8	16	Social Influences	"The majority of cancer survivors will be a little bit more aware of bodily symptoms, associate them with their cancer experience, so, our index of suspicion is higher, that this person is a little bit more aware of his or her symptoms.” - PCP_4

					"Whatever is mentioned I usually follow exactly, unless the patient doesn't want it." - PCP_5
	Patient reminds PCP	4	4	Social Influences	"There's a back-up because I have it in my file, and the patient has it in hers, so it's unlikely that we're going to miss, so I don't think scheduling is a big problem, because there's two of us that are putting reminders in our agendas." - PCP_4 "Many of my patients do phone and say, you know, "I'm due for my colon, or I'm due for my mammo", and I say, "yes, we've already ordered them." - PCP_6
	Patient missing appointments	3	6	Social Influences	"I schedule an appointment with that patient, but if that patient misses the appointment and doesn't reschedule, then they very easily could be lost to follow-up." - PCP_3
	Impression of patient emotion	10	26	Emotion	"Lots of times, the patient's feedback is, "they don't want to see me anymore", or "they're done with me", or whatever, as in, cancer is not anything I have to worry about anymore." - PCP_3 "I think the transition can be a little bit anxiety-provoking for patients since they've had all of their treatment with their oncologist. And then you have the follow up. And I think that that point of transition back to their

					primary care provider can be a bit anxiety-provoking.” - PCP_8
Acceptance and understanding of PCPs being in charge of follow-up care	I am used to or accept this role	9	25	Social Professional Role and Identity	“I think it just flows, you know, if someone has had minimally invasive breast cancer five years ago, it’s just normal and natural that you say “you can fly off the nest now and go to your physician, resume regular screenings”. - PCP_4
	It’s more for me to do	4	7	Beliefs about consequences	“All of a sudden there’s more work, for what I was considering at that point a shared patient.” - PCP_3 “It does force us to be more proactive in ordering, especially for checking.” - PCP_7
	Using SCP will have a positive outcome	2	2	Beliefs about consequences	“I don't think on that they're impressed upon, you know, like, yes, you might have, you know, this breast cancer treatment is over, but, you know, really in the medical world, we know that it's never really over with breast cancer. That's why they need to follow up, so I don't know if they really appreciate that.” - PCP_11
	Follow-up care is important	2	3	Intention	“I think that whether myself or any other family physician will certainly feel very entrusted in the care, and we’ll make, you know, we’ll make these patients special in their minds.” - PCP_4

	I create reminders for myself	9	18	Memory, Attention and Decision Process	“I would still have to set myself a bunch of reminders, so I take 15-20 minutes, go through the care plan, set all my reminders, then I’m good to go.” - PCP_6
	Experience with SCPs ** limited conclusions can be drawn from this	1	1	Environmental Context and Resources	“I’ve only had the one patient who I’ve done the survivorship plan for, for colon cancer. “ - PCP_1
	Positive emotions around follow up care	5	11	Emotion	"So, it's actually very fulfilling to be able to kind of reconnect with them and to kind of see them, as they kind of go on to restart the kind of next chapter after having successfully gone through the treatment process. I think it's very, it's very rewarding.” - PCP_8
	Negative emotions around follow-up care	5	10	Emotion	“I find what’s not clear is what they’re gonna do if I find something, that I find a little annoying, to be quite honest” - PCP_2 “So, it does become a lot, it didn’t seem like – I wouldn’t say dumping, but offloading.” - PCP_6 “For me, it’s this worry, because everybody is scared, and for us we’re scared of missing something.” - PCP_12

Appendix K
BCTs linked to TDF Domains: Survivors

Barrier /Enabler	Belief Statement	Content within Belief Statement	TDF Domain	Applicable BCTs	Implementation ideas
Enabler	I know I can refer to my SCP	Referring back to SCP to answer questions Remember cancer treatment Track and schedule follow-up appointments Know when to stop taking medication Look up dates SCP has important information	Knowledge	4.1 Instruction on how to perform behaviour. 4.2 Information about antecedents 5.1 Information about health consequences 5.3 Information about social and environmental consequences *2.2 Feedback on behaviour*	4.1 Provide instructions about how to use the information in the SCPs - To refer to cancer treatment - To refer to information about health care team - To refer to important dates - To track and schedule follow-up care 5.1 Provide reasoning for using SCP - Follow-up care - Managing side effects - Ongoing surveillance for new and recurring cancers
Enabler	Meeting with a nurse about the SCP helped me understand it	Nurses explained the process of follow-up care SCP was thoroughly reviewed by a nurse	Knowledge	4.1 Instruction on how to perform behaviour. 4.2 Information about antecedents 5.1 Information about health consequences	4.1 Provide instructions about how to use the information in the SCPs - To refer to cancer treatment - To refer to information about health care team

		Nurses emphasized the importance of using the SCP Nurses explained why SCP would be helpful Nurse helped me understand what to expect in follow-up care		5.3 Information about social and environmental consequences *2.2 Feedback on behaviour*	- To refer to important dates - To track and schedule follow-up care 5.1 Provide reasoning for using SCP - Follow-up care - Managing side effects - Ongoing surveillance for new and recurring cancers
Enabler	My SCP helps me share information with others	Communication with pharmacist Share information with family Share information with other doctors	Knowledge	4.1 Instruction on how to perform behaviour. 4.2 Information about antecedents 5.1 Information about health consequences 5.3 Information about social and environmental consequences *2.2 Feedback on behaviour*	4.1 Instruct how to use SCP as a communication tool to inform others about one's cancer history, treatment, and follow-up plan
Enabler	The SCP gives me direction for my follow-up care	The SCP tells me what to expect The SCP tells me what I need to do	Knowledge	4.1 Instruction on how to perform behaviour. 4.2 Information about antecedents 5.1 Information about health consequences	4.1 Describe how SCPs contain information about what to expect in follow-up care 4.1 Instruct survivors on how to refer to the follow-up tasks schedule

		The SCP reminds me to consult with my PCP		5.3 Information about social and environmental consequences *2.2 Feedback on behaviour*	4.1 Instruct survivors on how to make sure their follow-up tests and appointments are scheduled on time using the instructions in the SCP
Enabler	I can call a nurse navigator to have my questions answered	Phone number to nurse navigator	Skills	4.1 Instruction on how to perform behaviour 8.1 Behavioural practice/rehearsal 8.7 Graded tasks *1.2 Problem-solving* *6.1 Demonstration of the behaviour* *8.6 Generalisation of target behaviour*	4.1 Instructing that nurse navigator can be called 4.1 Nurse navigator can provide instruction on how to do self-exams, instruction on how to look up and interpret test results, instruction on how to use SCP to make FU appointment with the right person at the right time
Enabler	I look up and can interpret my test results	Using patient facing electronic medical records to view test results	Skills	4.1 Instruction on how to perform behaviour 8.1 Behavioural practice/rehearsal 8.7 Graded tasks *1.2 Problem-solving* *6.1 Demonstration of the behaviour* *8.6 Generalisation of target behaviour* *10.9 Self-Reward*	4.1 Provide instructions on how to access patient-facing EMR 6.1 Demonstrate how to access and view tests results using patient-facing EMR 8.1 Have patients practice accessing their patient-facing EMR
Enabler	I made the follow-up appointment	Scheduled and attended	Skills	4.1 Instruction on how to perform behaviour	1.2 Problem-solve ways to schedule and attend appointments

	with the right person	appointments with PCP Attended follow-up appointments (e.g., CT scan, colonoscopy)		8.1 Behavioural practice/rehearsal 8.7 Graded tasks *1.2 Problem-solving* *6.1 Demonstration of the behaviour* *8.6 Generalisation of target behaviour* *10.9 Self-Reward*	4.1 Provide instructions on when to schedule a follow-up appointment with PCP
Enabler	I used the SCP to check that nothing falls through the cracks	I also keep track of my follow-up care with my PCP	Skills	4.1 Instruction on how to perform behaviour 8.1 Behavioural practice/rehearsal 8.7 Graded tasks *1.2 Problem-solving* *6.1 Demonstration of the behaviour* *8.6 Generalisation of target behaviour* *10.9 Self-Reward*	4.1 Instruct survivors on how to refer to the follow-up tasks schedule 4.1 Instruct survivors on how to make sure their follow-up tests and appointments are scheduled on time using the instructions in the SCP
Enabler	I used my SCP to manage my follow-up care	SCP provided most important information in one place Making sure follow-up tests are	Skills	4.1 Instruction on how to perform behaviour 8.1 Behavioural practice/rehearsal 8.7 Graded tasks *1.2 Problem-solving*	4.1 Instruct survivors on how to refer to the follow-up tasks schedule 4.1 Instruct survivors on how to make sure their follow-up tests and appointments are scheduled

		happening when they should happen		*6.1 Demonstration of the behaviour* *8.6 Generalisation of target behaviour* *10.9 Self-reward*	on time using the instructions in the SCP
Enabler	I contacted by oncologist when needed	Oncologist available to my PCP when needed for check-in	Social Professional Role and Identity	*3.1 Social Support (unspecified)* *6.1 Social comparison* *9.1 Credible source* *13.5 Identity associated with changed behaviour*	3.1 Communicate with healthcare team about availability/appropriateness of longer-term support
Enabler	Discussed SCP with PCP	Knowing PCP had SCP too Met with PCP and discussed SCP	Social Professional Role and Identity	*3.1 Social Support (unspecified)* *6.1 Social comparison* *9.1 Credible source* *13.5 Identity associated with changed behaviour*	3.1 PCP and survivor both have information needed to ensure follow-up care needs met
Enabler	I am responsible for my follow-up too	I make sure follow-up tests are ordered and not forgotton I am in charge of my health I want to be proactive I have more time than my PCP to make sure I have follow-up	Social Professional Role and Identity	*3.1 Social Support (unspecified)* *6.1 Social comparison* *9.1 Credible source* *13.5 Identity associated with changed behaviour*	3.1 Support PCP in ensuring follow-up care needs met 13.5 View self as active member of follow-up care team

		appointments scheduled			
Enabler/ Barrier	My doctor is not on top of my follow-up care so I am	PCP not automatically scheduling follow-up appointments	Social Professional Role and Identity	*3.1 Social Support (unspecified)* *6.1 Social comparison* *9.1 Credible source* *13.5 Identity associated with changed behaviour*	3.1 Support PCP in ensuring follow-up care needs met by initiating contact and scheduling follow-up appointments 3.1 Bring SCP to appointments, use it to communicate follow-up needs with PCP 13.5 View self as active member of follow-up care team
Enabler	My PCP and oncologist work together	Perceptions that PCPs and oncologists are working together on follow-up care and SCP	Social Professional Role and Identity	*3.1 Social Support (unspecified)* *6.1 Social comparison* *9.1 Credible source* *13.5 Identity associated with changed behaviour*	9.1 PCPs and oncologists are coordinating follow-up cancer care 9.1 SCP supported by oncologists and PCP
Barrier	My PCP is not a cancer specialist	Doubting PCP's knowledge of cancer Knowing PCPs are not a cancer specialist	Social Professional Role and Identity	*3.1 Social Support (unspecified)* *6.1 Social comparison* *9.1 Credible source* *13.5 Identity associated with changed behaviour*	3.1 Remind survivors that PCPs can consult with oncologists if cancer-specific issues arise that are beyond the scope of the PCP's practice 9.1 Have oncology specialists explain why PCPs are the best provider for follow-up cancer care

Barrier	Needing support from other HCPs	Needs not being met in primary care, going to other HCPs for support Wanting to speak to HCPs other than PCP (e.g, nurse, counseller, oncologist)	Social Professional Role and Identity	*3.1 Social Support (unspecified)* *6.1 Social comparison* *9.1 Credible source* *13.5 Identity associated with changed behaviour*	3.1 Remind survivors that PCPs can consult with oncologists if cancer-specific issues arise that are beyond the scope of the PCP's practice 9.1 Have oncology specialists explain why PCPs are the best provider for follow-up cancer care
Enabler	PCP helps problem-solve when needed	Concerns about medication, side effects, long term impact of treatment discussed with PCP PCP looks into patient concerns and gets back to them with solution	Social Professional Role and Identity	*3.1 Social Support (unspecified)* *6.1 Social comparison* *9.1 Credible source* *13.5 Identity associated with changed behaviour*	3.1 PCP listens to and responds to patient concerns about follow-up cancer care
"Barrier" of SCP use Enabler of follow-up care	PCP on top of my follow-up care	I can depend on my PCP to make sure everything is done for my follow-up care My PCP automatically arranges appointments so I don't have to use my SCP	Social Professional Role and Identity	*3.1 Social Support (unspecified)* *6.1 Social comparison* *9.1 Credible source* *13.5 Identity associated with changed behaviour*	4.1 Instruct survivors on how to refer to the follow-up tasks schedule 4.1 Instruct survivors on how to make sure their follow-up tests and appointments are scheduled on time using the instructions in the SCP

Enabler	Being an advocate for myself	The SCP helps me be involved in my follow-up care Messaging around SCP is that survivors are meant to advocate for their follow-up care needs SCP helps communicate needs to PCPs	Beliefs about Capabilities	1.2 Problem solving 4.1 Instruction on how to perform behaviour 6.1 Demonstration of the behaviour 8.1 Behavioural practice/rehearsal 8.7 Graded tasks 15.1 Verbal persuasion about capability 15.3 Focus on past success 15.4 Self-talk *1.1 Goal setting (behaviour)* *2.6 Biofeedback* *10.4 Social reward* *11.2 Reduce negative emotions*	4.1 Advise the survivor how best to advocate for their follow-up care (i.e.,g suggest they bring their SCP to doctor's appointments, suggest they ask questions, be familiar with contents of SCP) 6.1 Demonstrate to survivors how to bring up the SCP to PCP (i.e., identify the information in SCP that is most important to bring up with their PCP) 15.3 Remind survivors that they have experience managing their healthcare through cancer diagnosis and treatment, remind them that using the SCP will be easy 15.3 Ask survivors to think if times when they successfully communicated with PCP/managed other aspects of their health with their PCP, show how following SCP is similar to how they worked with their PCP before cancer
Enabler	Confidence in ability to manage	Attending meeting with nurse helped	Beliefs about Capabilities	1.2 Problem solving 4.1 Instruction on how to perform behaviour	4.1 Instruct survivors on how to refer to the follow-up tasks schedule

	follow-up care	me feel confident to use my SCP SCP made it clear what I needed to do and helped me feel comfortable doing so SCP easy/straightforward to use		6.1 Demonstration of the behaviour 8.1 Behavioural practice/rehearsal 8.7 Graded tasks 15.1 Verbal persuasion about capability 15.3 Focus on past success 15.4 Self-talk *1.1 Goal setting (behaviour)* *2.6 Biofeedback* *10.4 Social reward* *11.2 Reduce negative emotions*	4.1 Instruct survivors on how to make sure their follow-up tests and appointments are scheduled on time using the instructions in the SCP 15.3 Remind survivors that they have experience managing their healthcare through cancer diagnosis and treatment, remind them that using the SCP will be easy 15.3 Ask survivors to think if times when they successfully communicated with PCP/managed other aspects of their health with their PCP, show how following SCP is similar to how they worked with their PCP before cancer
Enabler	Using the SCP will help prevent cancer recurrence	Preventing recurrence the most important factor influencing SCP use	Beliefs about Consequences	5.1 Information about health consequences 5.2 Salience of consequences 5.3 Information about social and environmental consequences 5.5 Anticipated regret 5.6 Information about emotional consequences 9.2 Pros and cons	5.1 Provide reasoning for using SCP - Follow-up care - Managing side effects - Ongoing surveillance for new and recurring cancers

				6.3 Comparative imagining of future outcomes 10.1 Material incentive (behaviour) 10.8 Incentive (outcome) 10.10 Reward (outcome)	
Enabler	Use SCP when changing SCP or other HCP	I use the SCP to keep my new PCP on track Share SCP with new healthcare provider	Intention	1.1 Goal setting (behaviour) 5.1 Information about health consequences 10.8 Incentive (outcome) *1.9 Commitment* *6.3 Information about others' approval* *13.4 Valued self-identity*	1.1 Use SCP to communicate with HCP the follow-up tasks that need to be completed
Barrier	I did not see the SCP as important	I didn't know why SCP was important Did not initially see value in SCP Viewing SCP as more paperwork, not knowing that I needed to use SCP	Intention	1.1 Goal setting (behaviour) 5.1 Information about health consequences 10.8 Incentive (outcome) *1.9 Commitment* *6.3 Information about others' approval* *13.4 Valued self-identity*	1.1 Encourage survivors to view the follow-up tasks as goals to achieve 5.1 Provide information on the purpose of SCPs (to help with managing side effects, checking for recurrence or a new cancer)
Barrier	I don't need to use the SCP, someone will call me	Belief that they will be contacted by oncologist or PCP for follow-up care	Intention	1.1 Goal setting (behaviour) 5.1 Information about health consequences 10.8 Incentive (outcome) *1.9 Commitment*	1.1 Encourage survivors to view the follow-up tasks as goals to achieve 5.1 Provide information on the purpose of SCPs (to help with

				6.3 Information about others' approval *13.4 Valued self-identity*	managing side effects, checking for recurrence or a new cancer)
Enabler	I was driven to use the SCP to make sure I received good care	Using the SCP to make sure follow-up tasks complete on time	Intention	1.1 Goal setting (behaviour) 5.1 Information about health consequences 10.8 Incentive (outcome) *1.9 Commitment* *6.3 Information about others' approval* *13.4 Valued self-identity*	1.1 Use SCP to communicate with HCP the follow-up tasks that need to be completed
Enabler	I will use my SCP when I have questions	Referring to SCP when have concerns Referring to SCP when have questions about cancer treatment or follow-up care	Intention	1.1 Goal setting (behaviour) 5.1 Information about health consequences 10.8 Incentive (outcome) *1.9 Commitment* *6.3 Information about others' approval* *13.4 Valued self-identity*	1.1 Encourage survivors to refer to their SCP when they have a question or concern
Barrier	I could lose my SCP	Paper version misplaced	Memory, Attention and Decision Processes	7.1 Prompts/Cues 11.3 Conserving mental resources *1.9 Commitment* *7.8 Associative learning* *8.4 Habit reversal*	11.3 Take photo of SCP on phone 11.3 Place SCP in an accessible and easy to remember place
Barrier	I put it away and forgot about it	Filing SCP with other paperwork	Memory, Attention and Decision Processes	7.1 Prompts/Cues 11.3 Conserving mental resources *1.9 Commitment*	7.1 Print SCP on coloured paper 11.3 Take photo of SCP on phone

				7.8 Associative learning *8.4 Habit reversal*	11.3 Place SCP in an accessible and easy to remember place
Enabler	I would forget about my treatment if I did not have a SCP	Having a record on cancer treatment helpful	Memory, Attention and Decision Processes	7.1 Prompts/Cues 11.3 Conserving mental resources *1.9 Commitment* *7.8 Associative learning* *8.4 Habit reversal*	11.3 Provide a brief cancer history and treatment summary in SCP
Barrier	Not sure if received a care plan	Can't remember if received an SCP	Memory, Attention and Decision Processes	7.1 Prompts/Cues 11.3 Conserving mental resources *1.9 Commitment* *7.8 Associative learning* *8.4 Habit reversal*	7.1 Print SCP on coloured paper 11.3 Take photo of SCP on phone 11.3 Place SCP in an accessible and easy to remember place
Enabler	Use SCP as a reminder for follow-up care schedule	Creating reminders for follow-up appointments using the SCP Referring to SCP to refresh memory of follow-up care SCP includes written information that could have been forgotten	Memory, Attention and Decision Processes	7.1 Prompts/Cues 11.3 Conserving mental resources *1.9 Commitment* *7.8 Associative learning* *8.4 Habit reversal*	7.1 Suggest to survivors that they put reminders in their calendar for follow-up appointments 7.1 Use questions about follow-up care as a prompt to refer back to SCP 7.1 Keep SCP in a visible location 11.3 Take a photo of SCP on phone so you don't have to look for the paper copy every time

					11.3 Place the SCP somewhere easily memorable and accessible
Barrier	Difficulties with follow-up care due to different EMRs	Incompatible EMRs between PCPs, community hospitals and cancer centres making communication difficult Time consuming to receive medical records, requisitions, etc. making it difficult to follow SCP	Environmental Context and Resources	3.2 Social support (practical) 7.1 Prompts/cues 7.5 Remove aversive stimulus 12.1 Restructuring the physical environment 12.2 Restructuring the social environment 12.3 Avoidance/reducing exposure to cues for the behaviour 12.5 Adding objects to the environment *1.3 Problem-solving* *11.3 Conserving mental resources*	12.1 Create avenues to share follow-up information with patients and their PCP 12.1 Provide patients with access to their requisitions, test results, notes, etc. so they can share with other healthcare professionals
Barrier	Long distance to receive follow-up care	Cancer survivors living outside of Ottawa describing the challenges with having to travel long distances for follow-up tests Medications not available in rural locations	Environmental Context and Resources	3.2 Social support (practical) 7.1 Prompts/cues 7.5 Remove aversive stimulus 12.1 Restructuring the physical environment 12.2 Restructuring the social environment 12.3 Avoidance/reducing exposure to cues for the behaviour 12.5 Adding objects to the environment	3.2 Suggest volunteer organizations for driving 12.2 Arrange for medications to be picked up when patient is already at the cancer centre for an appointment 12.5 Special order cancer medications to local pharmacy

		Driving, or finding someone else to drive to appointments		*1.3 Problem-solving* *11.3 Conserving mental resources*	
Enabler/ Barrier	Local supports	Feeling supported by family doctor Feeling supported by local programs for nursing support Difficulties getting appointment with doctors who are busy	Environmental Context and Resources	3.2 Social support (practical) 7.1 Prompts/cues 7.5 Remove aversive stimulus 12.1 Restructuring the physical environment 12.2 Restructuring the social environment 12.3 Avoidance/reducing exposure to cues for the behaviour 12.5 Adding objects to the environment *1.3 Problem-solving* *11.3 Conserving mental resources*	3.2 Help survivors locate practical supports 7.1 Encourage survivors to use SCP to advocate for follow-up appointments locally
Enabler	Received SCP at discharge meeting	Descriptions of receipt of SCP	Environmental Context and Resources	3.2 Social support (practical) 7.1 Prompts/cues 7.5 Remove aversive stimulus 12.1 Restructuring the physical environment 12.2 Restructuring the social environment 12.3 Avoidance/reducing exposure to cues for the behaviour	3.2 Explain SCPs and how to use them in follow-up care 7.1 Provide SCPs to patients

				12.5 Adding objects to the environment *1.3 Problem-solving* *11.3 Conserving mental resources*	
Enabler	Received SCP in the mail	Descriptions of receiving SCPs in the mail	Environmental Context and Resources	3.2 Social support (practical) 7.1 Prompts/cues 7.5 Remove aversive stimulus 12.1 Restructuring the physical environment 12.2 Restructuring the social environment 12.3 Avoidance/reducing exposure to cues for the behaviour 12.5 Adding objects to the environment *1.3 Problem-solving* *11.3 Conserving mental resources*	3.2 Provide other avenues to receive SCPs when they cannot be provided in person 7.1 Provide survivors with a copy of their SCP to review and use for follow-up care
Barrier	Socio-economic differences influencing SCP use	Unable to pay for travel to cancer centre Lacking insurance for medications	Environmental Context and Resources	3.2 Social support (practical) 7.1 Prompts/cues 7.5 Remove aversive stimulus 12.1 Restructuring the physical environment 12.2 Restructuring the social environment	1.3 Help survivors look for ways to get their follow-up tests completed – family support, community support 1.3 Help survivors look for resources (e.g., compassionate funding) for medications

				12.3 Avoidance/reducing exposure to cues for the behaviour 12.5 Adding objects to the environment *1.3 Problem-solving* *11.3 Conserving mental resources*	3.2 Suggest volunteer organizations for driving
Enabler	Attended discharge meeting	Attending discharge meeting helped understand the purpose of SCPs Attending discharge meeting helped understand what to expect in follow-up care with PCP	Environmental Context and Resources	3.2 Social support (practical) 7.1 Prompts/cues 7.5 Remove aversive stimulus 12.1 Restructuring the physical environment 12.2 Restructuring the social environment 12.3 Avoidance/reducing exposure to cues for the behaviour 12.5 Adding objects to the environment *1.3 Problem-solving* *11.3 Conserving mental resources*	3.2 Providing avenues for oncology specialists (e.g., nurses) to explain follow-up care and how to use SCP
Enabler	Attended WBCP education class	Attending class helped understand the purpose of SCPs Attending class helped understand what to expect in	Environmental Context and Resources	3.2 Social support (practical) 7.1 Prompts/cues 7.5 Remove aversive stimulus 12.1 Restructuring the physical environment	3.2 Providing avenues for oncology specialists (e.g., nurses) to explain follow-up care and how to use SCP

		follow-up care with PCP		12.2 Restructuring the social environment 12.3 Avoidance/reducing exposure to cues for the behaviour 12.5 Adding objects to the environment *1.3 Problem-solving* *11.3 Conserving mental resources*	
Enabler	Family support	Family members attending appointments, driving, caregiving Family members arranging follow-up appointments based on SCP	Social Influences	3.1 Social support (unspecified) 3.2 Social support (practical) 6.1 Social comparison 6.3 Information about others' approval 10.4 Social reward *2.1 Monitoring of behaviour by others without feedback* *12.2 Restructuring the social environment*	3.2 Suggest that survivors share their SCP with their family members to ensure follow-up tasks completed in a timely manner 3.2 Suggest that survivors ask family members for help when needed
Enabler	Support amongst cancer survivors	Peer support Sharing ways to cope with side effects of treatment, share feelings and challenges	Social Influences	3.1 Social support (unspecified) 3.2 Social support (practical) 6.1 Social comparison 6.3 Information about others' approval 10.4 Social reward	3.1 Provide information about peer supports in SCP

		Relating to others who have had similar experiences		*2.1 Monitoring of behaviour by others without feedback* *12.2 Restructuring the social environment*	
Barrier	Accepting discharge from cancer centre difficult	Beliefs that survivors would receive better care at the cancer centre Uncertainty around discharge Discomfort around identifying as a "cancer survivor"	Emotion	11.2 Reduce negative emotions *5.5 Anticipated regret* *5.6 Information about emotional consequences* *12.6 Body changes* *13.2 Framing/reframing*	11.2 Reframe follow-up care in primary care settings as a positive event (i.e., healthy enough for discharge from cancer centre) 11.2 Provide education on what to expect in follow-up care and how to use SCP 11.2 Provide information resources on cancer survivorship 11.2 Provide psychosocial resources to help survivors cope
Barrier	Emotional toll of cancer treatment impacting SCP use	Processing the stressful events associated with cancer diagnosis and treatment Fear of cancer recurrence Guilt, frustration	Emotion	11.2 Reduce negative emotions *5.5 Anticipated regret* *5.6 Information about emotional consequences* *12.6 Body changes* *13.2 Framing/reframing*	11.2 Ask survivors about their emotional functioning 11.2 Provide survivors space to speak about their feelings 11.2 Provide psychosocial resources to help survivors cope

		Having to be "tough"			
Enabler	Feeling comforted by SCP	Feeling taken care of through follow-up SCP viewed as a connection between oncology and PCP – not being left alone SCP provides peace of mind SCP outlines what to expect in follow-up; survivors feel prepared	Emotion	11.2 Reduce negative emotions *5.5 Anticipated regret* *5.6 Information about emotional consequences* *12.6 Body changes* *13.2 Framing/reframing*	11.2 Provide messaging around the purpose of SCPs and how they are developed by oncology team 11.2 Provide messaging and reassurance that discharge from cancer centre is a positive event – means healthy 11.2 Provide messaging that the SCP is meant to help with transition back to primary care for follow-up
Barrier	Electronic version of SCP wanted	Electronic SCP would be easier to access Electronic version to update and add notes Electronic version in addition to paper version Electronic version accessible through patient facing EMR	Behavioural Regulation	1.2 Problem solving 2.3 Self-monitoring of behaviour 4.2 Information about antecedents 8.2 Behaviour substitution 11.2 Reduce negative emotions 11.3 Conserving mental resources *1.1 Goal setting (behaviour)* *1.4 Action planning* *1.6 Discrepancy between current behaviour and goal*	1.2 Encourage patients to re-format their own SCP so it makes sense for them (i.e., colour, larger font, rearranging content, etc.) 1.2 Create updateable SCP

		Electronic copy available in case lose the paper version Rearrange format of SCP and add in colours		*1.8 Behavioural contract* *2.4 Self-monitoring outcome(s) of behaviour* *8.3 Habit formation* *8.4 Habit reversal* *14.2 Punishment*	
Barrier	Would be helpful to review the SCP with a healthcare professional	Talking to a healthcare professional about SCP would be reassuring Talking to a healthcare professional to understand purpose of SCP Would have wanted to know how important the SCP is (i.e., not just paperwork)	Behavioural Regulation	1.2 Problem solving 2.3 Self-monitoring of behaviour 4.2 Information about antecedents 8.2 Behaviour substitution 11.2 Reduce negative emotions 11.3 Conserving mental resources *1.1 Goal setting (behaviour)* *1.4 Action planning* *1.6 Discrepancy between current behaviour and goal* *1.8 Behavioural contract* *2.4 Self-monitoring outcome(s) of behaviour* *8.3 Habit formation* *8.4 Habit reversal* *14.2 Punishment*	1.2 Create instructional videos about the purpose of SCPs and how to use them 1.2 Check-ins from the cancer centre
Barrier	Wanting extra individualized supports	Guidance for long term cancer survivors	Behavioural Regulation	1.2 Problem solving 2.3 Self-monitoring of behaviour	1.2 Website with supplementary resources for survivors' individualized interests/needs

		Follow-up from cancer centre Blank personal needs section in SCP More information about diet, side effects, health and fitness, alternative medicine Reminders to use SCPs and do self-exams Wanting more information about cancer history and treatment Wanting a way to ask questions to cancer specialist Wanting peer support		4.2 Information about antecedents 8.2 Behaviour substitution 11.2 Reduce negative emotions 11.3 Conserving mental resources *1.1 Goal setting (behaviour)* *1.4 Action planning* *1.6 Discrepancy between current behaviour and goal* *1.8 Behavioural contract* *2.4 Self-monitoring outcome(s) of behaviour* *8.3 Habit formation* *8.4 Habit reversal* *14.2 Punishment*	1.2 If needs assessments are not filled out, provide generic resources on website to consult (include link in SCP) 1.2 Provide resources on community supports (i.e., on website, psychologists, telephone number to ask questions, what to do if no longer have a PCP, etc.) 1.2 Provide resources for long term survivors, health and fitness, psychological support, diet, side effects, alternative medicines 1.2 Create avenues for peer support 1.2 Reminders to do follow-up, reminders to do self-exams 1.2 Put a general telephone number to contact the WBCP in several locations (like a refrigerator magnet, card for wallet) 1.2 Check-ins from cancer centre

Appendix L
BCTs linked to TDF Domains: PCPs

Barrier /Enabler	Belief Statement	Content within Belief Statement	TDF Domain	Applicable BCTs	Implementation ideas
Barrier	Wanting additional follow-up guidelines in SCP	Wanting to be provided guidelines when they are updated Information about what to do after the end of follow-up care tasks Information about patient's unmet needs	Knowledge	4.1 Instruction on how to perform behaviour. 4.2 Information about antecedents 5.1 Information about health consequences 5.3 Information about social and environmental consequences *2.2 Feedback on behaviour*	4.1 Provide follow-up guidelines that describes the tasks PCPs are responsible for in the SCP 4.1 Provide information about the guidelines to follow after year 5 and year 10 4.1 Provide information about patient's unmet needs that need to be addressed in follow-up care 4.2 Provide reassurance to PCPs that SCPs will be updated 5.1 Inform PCPs about long term follow-up care planning (i.e., present the research on long term follow-up cancer care) 5.3 Inform PCPs of oncologists' views on longer term cancer survivorship
Barrier	I don't know exactly what treatment my	Not knowing about when cancer medications can stop	Knowledge	4.1 Instruction on how to perform behaviour. 4.2 Information about antecedents	4.1 Provide avenues to receive direction from oncology specialists on • Clarification of ongoing cancer treatment • Clarification on the HCPs following the patient • Advice on when it is ok to stop cancer-specific medications

	patient is receiving	Not knowing how long other specialists are treating/following patients I don't know what cancer medications my patient is taking		5.1 Information about health consequences 5.3 Information about social and environmental consequences *2.2 Feedback on behaviour*	4.2 Educate PCPs on signs that are predictive of when cancer medication can be stopped 5.1 Provide PCPs with information about the consequences of stopping a cancer medication 5.3 Create avenues of communication between other healthcare providers, inform of consequences of following (or not following) the SCP
Enabler	The information in the SCP is helpful or contains relevant information	SCP includes the timing of follow-up tests (e.g., every 6 months) SCP includes information on what tests to order SCP provides specific guidelines for each patient SCP contains information on the dates	Knowledge	4.1 Instruction on how to perform behaviour. 4.2 Information about antecedents 5.1 Information about health consequences 5.3 Information about social and environmental consequences *2.2 Feedback on behaviour*	4.1 Provide PCPs with information on the type and frequency of follow-up tests and examinations 4.1 Provide PCPs with information on specific needs of each patient 4.1 Provide PCPs with treatment summary that includes dates

		when test was last ordered			
Enabler	I look up information when needed	Looking up side effects of cancer medications Looking up the role of each specialists when extra information is needed	Knowledge	4.1 Instruction on how to perform behaviour. 4.2 Information about antecedents 5.1 Information about health consequences 5.3 Information about social and environmental consequences *2.2 Feedback on behaviour*	4.1 Include information on resources to find accurate information on the common side effects of cancer medications (up to date?) 4.1 Include contact information for specialists also following patients in the SCP
Barrier	I don't know the side effects of cancer-specific medications	Not comfortable managing side effects of cancer-specific medications Lack of knowledge on side effects of cancer treatment Not knowing late and long-	Knowledge	4.1 Instruction on how to perform behaviour. 4.2 Information about antecedents 5.1 Information about health consequences 5.3 Information about social and environmental consequences *2.2 Feedback on behaviour*	4.1 Include information on resources to find accurate information on the common side effects of cancer medications (up to date?)

		term side effects of chemotherapy Wanting information on symptoms to look out for as side effects of cancer treatment			
Enabler	SCP outlines tasks for PCPs	Referring to summary of follow-up instructions (frequency of mammograms, CEA, CT scans, etc.) Appointments and tests can be anticipated and scheduled Information included on managing medications (e.g., Tamoxifen)	Knowledge	4.1 Instruction on how to perform behaviour. 4.2 Information about antecedents 5.1 Information about health consequences 5.3 Information about social and environmental consequences *2.2 Feedback on behaviour*	4.1 Provide information on the follow-up tests, frequency, that is clear 4.2 Provide information on indicators of cancer-specific medication side effects 5.1 Provide information on the evidence supporting follow-up cancer care, the follow-up surveillance and exams 5.1 Present the likelihood of preventing recurrence or a new cancer diagnosis when follow-up tasks are completed in a timely manner 5.3 Inform PCPs that survivors also have a copy of the SCP
Barrier	Deferring to	Defer decisions to	Social Profession	*3.1 Social Support (unspecified)*	3.1 Create avenues for PCPs to consult with oncology specialists when they have questions

	specialists	specialists if patients being followed by specialist Reaching out to patient's oncology team to consult when needed Situations where oncology consult it needed (e.g., new symptoms, managing follow-up 10+ years after treatment) Contacting cancer centre when test results are abnormal Noting contact information of	al Role and Identity	*6.2 Social comparison* *9.1 Credible source* *13.5 Identity associated with changed behaviour*	3.1 Include contact information to consult cancer centre on the SCP 6.2 Show PCPs how other PCPs have managed cancer-specific issues in follow-up care 9.1 Provide resources on cancer-specific medications that are also used by oncologists 9.1 Provide resources on managing cancer survivorship in primary care made by PCPs for PCPs 13.5 Help PCPs view themselves as the best provider for long term follow-up cancer care

		oncologist that followed patient Preferring to work with oncologists Asking oncologists questions Not having contact information of oncology specialists			
Enabler	I book tests, appointments, respond to concerns, etc.	Already familiar with aspects of follow-up care Scheduling appointments for next few years as per SCP schedule Booking initial appointment	Social Professional Role and Identity	*3.1 Social Support (unspecified)* *6.2 Social comparison* *9.1 Credible source* *13.5 Identity associated with changed behaviour*	3.1 Advise patients to call their PCPs if they have concerns/need an appointment 3.1 PCPs encourage patients to contact them when needed 3.1 Oncology/cancer centre personnel encouraging patients to consult their PCP 3.1 PCP office contacts patient to schedule initial appointment after receipt of SCP 6.2 Show PCPs how other PCPs have managed scheduling for follow-up care 6.2 Show PCPs how other PCPs have addressed patients' psychosocial concerns

		with patient post-discharge Both patients and PCPs following guidelines provided by cancer centre Descriptions of how psychosocial concerns are managed (e.g., anxiety, low mood)			9.1 Mental health professionals provide resources with online interventions, community interventions, bibliotherapy for common psychosocial concerns (anxiety, mood, fear of recurrence, fear of progression, etc). 13.5 Help PCPs view themselves as supported in managing follow-up care 13.5 Help PCPs to view themselves as capable of managing follow up cancer care
Enabler	I can solve problems using the SCP	Referring to recommendations in. care plan to answer patient questions Referring to dates to schedule follow-ups in recommended time frame Referring to contact	Social Professional Role and Identity	*3.1 Social Support (unspecified)* *6.2 Social comparison* *9.1 Credible source* *13.5 Identity associated with changed behaviour*	3.1 Remind PCPs that they have oncology support 9.1 SCPs are created by oncology specialists 13.5 Remind PCPs that they are capable of managing follow-up care

		information included in the SCP			
Barrier	I don't know what to do if tests are abnormal	When to be concerned about abnormal test results What are the next steps after abnormal test results Managing patients' anxiety around abnormal test results Differences in normal range vs concerning range for caner survivors Test results associated with signs of recurrence	Social Professional Role and Identity	*3.1 Social Support (unspecified)* *6.2 Social comparison* *9.1 Credible source* *13.5 Identity associated with changed behaviour*	3.1 Create avenues for PCPs to consult with oncology specialists when they have questions 3.1 Include contact information to consult cancer centre on the SCP 6.2 Show PCPs how other PCPs have managed abnormal test results 9.1 Provide resources that oncology professionals use when managing abnormal test results

Enabler	Patients should take responsibility too	Important to engage patients in their follow-up care Encouraging patients to schedule and keep track of follow-up guidelines	Social Professional Role and Identity	*3.1 Social Support (unspecified)* *6.2 Social comparison* *9.1 Credible source* *13.5 Identity associated with changed behaviour*	3.1 Provide SCP to both survivors and PCPs 3.1 PCPs discuss SCP with patients; encourage patients to use their SCP to make sure follow-up tasks are completed on time 6.2 Provide examples of how other survivors have used SCPs/have found SCPs helpful in navigating follow-up care 9.1 Remind patients that oncology specialists created the SCP 9.1 PCPs recommend using SCPs 13.5 Encourage survivors to see themselves as self-managers of their own follow-up care/active members of their healthcare team
Enabler	The specialists create the plan, I follow it	Oncologists have expertise in follow-up care Following SCP exactly Appreciating oncology detailed notes	Social Professional Role and Identity	*3.1 Social Support (unspecified)* *6.2 Social comparison* *9.1 Credible source* *13.5 Identity associated with changed behaviour*	3.1 Oncologists create SCPs to help PCPs manage follow-up care 3.1 SCPs contain specific directions on how PCPs should approach follow-up cancer care 9.1 SCPs created by oncology specialists 13.5 Oncologists viewing PCPs as the best provider for follow-up cancer care in the community

Enabler	Used to or accepts role	PCPs seeing themselves as the most appropriate provider for follow-up cancer care PCPs being part of cancer detection and initial diagnosis and seeing it as natural process to be responsible for their follow-up care PCPs see themselves as part of continuity of care	Social Professional Role and Identity	*3.1 Social Support (unspecified)* *6.2 Social comparison* *9.1 Credible source* *13.5 Identity associated with changed behaviour*	3.1 PCPs sharing approach to follow-up cancer care with other PCPs 6.2 Show PCP outcomes in follow-up care are the same as oncology outcomes in follow-up care 6.2 Show PCPs evidence that follow-up cancer care in primary care settings is safe 13.5 Explaining to PCPs how follow-up care is within their usual role of managing chronic illness 9.1 Oncologists and researchers confirming PCPs are most appropriate healthcare provider 9.1 PCPs telling other PCPs about their experiences providing follow-up cancer care 13.5 Help PCPs view themselves as important and appropriate health care providers in their patients' cancer team
Barrier	Tasks outside of scope of practice	Cancer-specific medication management Feeling unsure about	Social Professional Role and Identity	*3.1 Social Support (unspecified)* *6.2 Social comparison* *9.1 Credible source*	3.1 Provide avenues to consult with specialists 3.1 Provide avenues to refer patients to specialists 3.1 Provide PCPs with connections to other PCPs, share resources and practices on managing follow-up care

		changing cancer guidelines Managing side effects of cancer medication, uncomfortable managing side effects of cancer treatments		*13.5 Identity associated with changed behaviour*	9.1 Oncologists provide resources they use to manage follow-up care
Barrier	Challenges providing follow-up care	Ordering follow-up tests is not straight forward Lack of clarity around whether tests ordered or not/received Unable to reach correct person to check if tests were ordered	Beliefs about Capabilities	1.2 Problem solving 4.1 Instruction on how to perform behaviour 6.1 Demonstration of the behaviour 8.1 Behavioural practice/rehearsal 8.7 Graded tasks 15.1 Verbal persuasion about capability 15.3 Focus on past success 15.4 Self-talk *1.1 Goal setting (behaviour)* *2.6 Biofeedback*	1.2 Identify barriers to following SCP, create avenues to make the process of contacting the cancer centre and ordering follow-up tests smoother 1.2 Identify barriers to tracking follow-up care tasks, problem solve ways to manage increased workload, automate tracking 4.1 Provide clear instructions on the best ways to order and check status of follow-up tests 4.1 Provide clear directions on how to communicate with cancer centre to ask questions

		Patients calling cancer centre and turned back to PCP, PCP unable to solve problem without contacting the cancer centre PCPs have a lot to keep track of, unable to keep track of everything		*10.4 Social reward* *11.2 Reduce negative emotions*	
Enabler	Easy/ straightforward aspects of care	Knowing the patients for a long time makes follow-up cancer care easier The SCP makes follow-up care straightforward and easy to follow Easy to provide	Beliefs about Capabilities	1.2 Problem solving 4.1 Instruction on how to perform behaviour 6.1 Demonstration of the behaviour 8.1 Behavioural practice/rehearsal 8.7 Graded tasks 15.1 Verbal persuasion about capability 15.3 Focus on past success 15.4 Self-talk	4.1 Include straightforward follow-up recommendations for PCPs to follow in SCP 4.1 Encourage PCPs to read notes from oncology 15.1 Remind PCPs of their longstanding relationships with their patients 15.1 Help PCPs view themselves as capable of performing follow-up care tasks 15.1 Highlight how follow-up tasks are similar to the tasks they already do when managing chronic illness

		follow-up cancer care Oncology notes make follow-up easier		*1.1 Goal setting (behaviour)* *2.6 Biofeedback* *10.4 Social reward* *11.2 Reduce negative emotions*	15.3 Encourage PCPs to think about times when they have successfully manage follow-up cancer care or other chronic illness 15.4 Encourage PCPs to remind themselves that they can follow the tasks of follow-up tasks
Enabler	I can handle it	Descriptions of how PCPs communicate with survivors about SCPs and follow-up care SCP has tasks laid out in a practical and summarized way Increased workload is manageable	Beliefs about Capabilities	1.2 Problem solving 4.1 Instruction on how to perform behaviour 6.1 Demonstration of the behaviour 8.1 Behavioural practice/rehearsal 8.7 Graded tasks 15.1 Verbal persuasion about capability 15.3 Focus on past success 15.4 Self-talk *1.1 Goal setting (behaviour)* *2.6 Biofeedback* *10.4 Social reward* *11.2 Reduce negative emotions*	4.1 Include straightforward follow-up recommendations for PCPs to follow in SCP 4.1 Encourage PCPs to read notes from oncology 15.1 Remind PCPs of their longstanding relationships with their patients 15.1 Help PCPs view themselves as capable of performing follow-up care tasks 15.1 Highlight how follow-up tasks are similar to the tasks they already do when managing chronic illness 15.3 Encourage PCPs to think about times when they have successfully manage follow-up cancer care or other chronic illness 15.4 Encourage PCPs to remind themselves that they can follow the tasks of follow-up tasks

Barrier	It's more for me to do	Now have to order follow-up tests More work for PCP despite perceiving survivors as a shared patient with oncology Viewing follow-up cancer care as offloading Increased workload have to manually set up reminders More checking to make sure test orders went through and results received	Beliefs about Consequences	5.1 Information about health consequences 5.2 Salience of consequences 5.3 Information about social and environmental consequences 5.5 Anticipated regret 5.6 Information about emotional consequences 9.2 Pros and cons 9.3 Comparative imagining of future outcomes 10.1 Material incentive (behaviour) 10.8 Incentive (outcome) 10.10 Reward (outcome)	5.1 Provide rational for PCPs performing tasks of follow-up care 5.1 Inform cancer centres of the health consequences for survivors with a convoluted process of ordering follow-up tests, checking to see if the order when through, and receiving test results. 5.1 Outline how follow-up care is important for meeting survivors' needs, surveillance for new/recurring cancers, psychosocial concerns, managing late and long term side effects of treatment, comorbid illness 5.3 Inform cancer centres of increased workload on PCPs with discharge back to primary care and follow-up 5.3 Provide rationale that it makes sense to clear up space in cancer centre and have PCPs provide follow-up cancer care even though it's more work 5.6 Inform cancer centres of the stress and frustration around ordering tests and receiving results in a timely manner 5.6 Inform cancer centres of the sense PCPs have of the aspects of follow-up care that would be better managed by oncology specialists 5.6 Inform cancer centres of PCPs' feelings that follow-up tasks are being offloaded onto primary care 9.2 Prompt cancer centres to consider the pros and cons of offloading certain tasks to PCPs

					9.2 Prompt cancer centres to consider the pros and cons of continued involvement/shared care with PCPs; oncology specialists being available for consults with PCPs 9.3 Prompt PCPs to imagine the outcomes of taking the time to manually add reminders vs. not manually adding reminders for follow up tasks in EMR 9.3 Prompt cancer centres to imagine outcomes of streamlining PCPs' ability to consult, order tests, and receive results vs. not streamlining these processes 9.3 If cancer centre is overburdened, patient care may not be as high, show reasoning for this model of care on outcomes, justify increase in workload 10.1 Financial renumeration for PCPs providing follow-up cancer care
Enabler	Using SCP will have a positive outcome	Follow-up is important for long term health Bringing patients back to primary care is a good outcome	Beliefs about Consequences	5.1 Information about health consequences 5.2 Salience of consequences 5.3 Information about social and environmental consequences 5.5 Anticipated regret	5.1 Provide rationale for PCPs performing tasks of follow-up care 5.1 Provide information about health outcomes for cancer survivors who receive follow-up care in primary care settings 5.6 Feel good about taking care of cancer survivor patients

				5.6 Information about emotional consequences 9.2 Pros and cons 9.3 Comparative imagining of future outcomes 10.1 Material incentive (behaviour) 10.8 Incentive (outcome)	
Enabler	Follow-up care is important (general statement)	PCPs seeing their patients who are cancer survivors as special Providing follow-up care as a family physician is meaningful	Intention	1.1 Goal setting (behaviour) 5.1 Information about health consequences 10.8 Incentive (outcome) *1.9 Commitment* *6.3 Information about others' approval* *13.4 Valued self-identity*	13.4 Encourage PCPs to reflect on the ways they are there for their patients through cancer and post-cancer treatment 13.4 Encourage PCPs to reflect on their relationships with their patients
Enabler	I create reminders for myself	Using "flags" or reminder features in electronic medical records systems	Memory, Attention and Decision Processes	7.1 Prompts/Cues 11.3 Conserving mental resources *1.9 Commitment* *7.8 Associative learning*	7.1 Using reminders feature in electronic medical records system to keep track of follow-up care tasks and frequency 11.3 Setting reminders or automate tracking the completion and frequency of follow-up tasks

		Setting future reminders that coincide with the follow-up guidelines in SCP		*8.4 Habit reversal*	
Barrier	Descriptions of access to psychosocial supports	Challenges to find psychosocial supports for patients Family care team including mental health support Difficulties finding affordable psychological supports for patients Limited number of sessions available for cancer survivors in family health	Environmental Context and Resources	3.2 Social support (practical) 7.1 Prompts/cues 7.5 Remove aversive stimulus 12.1 Restructuring the physical environment 12.2 Restructuring the social environment 12.3 Avoidance/reducing exposure to cues for the behaviour 12.5 Adding objects to the environment *1.3 Problem-solving* *11.3 Conserving mental resources*	3.2 Provide or link to resources that are low-cost or free to address needs for psychological services 3.2 Create list of community based mental health services, easily accessible 3.2 Check in with patients regularly about their mental health/psychosocial needs 7.1 Add reminders to check in with patients about their mental health/psychosocial needs 12.5 Add a card with a link to resources, add in a page with the SCP that has community resources for mental health supports 12.5 Add a list of places to refer patients for psychosocial supports in the community

		teams, free or low cost services			
Barrier and Enabler	Descriptions of cancer patient population	Few cancer survivor patients in their practice Cancer survivor patients who have been cancer-free for decades Practice with many breast cancer survivors Practice with cancer survivors across the lifespan Patients unable to attend appointments	Environmental Context and Resources	3.2 Social support (practical) 7.1 Prompts/cues 7.5 Remove aversive stimulus 12.1 Restructuring the physical environment 12.2 Restructuring the social environment 12.3 Avoidance/reducing exposure to cues for the behaviour 12.5 Adding objects to the environment *1.3 Problem-solving* *11.3 Conserving mental resources*	3.2 Provide resources/guidelines on managing follow-up cancer care across the lifespan 3.2 Provide resources to patients who need support to attend follow-up appointments
Barrier	Did not receive the SCP	Inherited cancer survivors	Environmental Context	3.2 Social support (practical) 7.1 Prompts/cues	3.2 Provide streamlined ways to receive patients' SCPs

		when replaced retiring PCP, no access to SCPs	and Resources	7.5 Remove aversive stimulus 12.1 Restructuring the physical environment 12.2 Restructuring the social environment 12.3 Avoidance/reducing exposure to cues for the behaviour 12.5 Adding objects to the environment *1.3 Problem-solving* *11.3 Conserving mental resources*	3.2 Ask survivors to share a copy of their SCP with their new PCP
Barrier and Enable r	EMR issues and benefits	SCP easy to find in EMR Easy to set up reminders in EMR Faxed SCPs automatically go into EMR E-consult not integrated into PCPs' EMR	Environme ntal Context and Resources	3.2 Social support (practical) 7.1 Prompts/cues 7.5 Remove aversive stimulus 12.1 Restructuring the physical environment 12.2 Restructuring the social environment 12.3 Avoidance/reducing	3.2 Patients having access to their SCP through patient-accessible EMR and sharing information with their PCP 3.2 Cancer or survivorship centres providing access to patient's current PCPs when changes occur 3.2 Delegate inputting reminders to another staff member if possible 7.1 Using EMR to set reminders for follow-up care tasks 7.1 Using EMR to make it easier to find SCP when needed

		Takes time to input reminders for follow-up tasks from SCPs in to EMR Difficult to find SCP in EMR Asking patients to check the patient accessible EMR		exposure to cues for the behaviour 12.5 Adding objects to the environment *1.3 Problem-solving* *11.3 Conserving mental resources*	12.1 Provide electronic versions of SCPs that can automatically be uploaded into EMRs 12.5 Choose EMRs that work for how PCPs prefer to organize themselves (format of prompts, automation, etc.) 12.5 Choose EMR that automatically uploads faxed SCPs 12.5 Integrate e-consult into EMR
Enabler & Barrier	Format and receipt of SCPs	SCPs received electronically Faxed SCPs uploaded electronically to EMR automatically Paper-based EMRs	Environmental Context and Resources	3.2 Social support (practical) 7.1 Prompts/cues 7.5 Remove aversive stimulus 12.1 Restructuring the physical environment 12.2 Restructuring the social environment 12.3 Avoidance/reducing	12.1 Provide electronic versions of SCPs that can automatically be uploaded into EMRs 12.5 Choose EMR that automatically uploads faxed SCPs

				exposure to cues for the behaviour 12.5 Adding objects to the environment *1.3 Problem-solving* *11.3 Conserving mental resources*	
Enabler	Layout of SCP makes things clear	Table of follow-up tasks and frequency are easy to read SCP makes tasks for PCP clear	Environmental Context and Resources	3.2 Social support (practical) 7.1 Prompts/cues 7.5 Remove aversive stimulus 12.1 Restructuring the physical environment 12.2 Restructuring the social environment 12.3 Avoidance/reducing exposure to cues for the behaviour 12.5 Adding objects to the environment *1.3 Problem-solving* *11.3 Conserving mental resources*	3.2 Provide information in SCP in a clear and succinct way 12.5 Include a table in the SCP briefly outlining the tasks and frequencies of these follow-up care tasks 12.5 Make the follow-up tasks table easy to locate
Barrier	Logistical issues	Other healthcare	Environmental	3.2 Social support (practical)	3.2 Include all healthcare providers and roles for patients in the SCP

	around communication	providers prescribing medication that PCP is not aware of	Context and Resources	7.1 Prompts/cues 7.5 Remove aversive stimulus 12.1 Restructuring the physical environment 12.2 Restructuring the social environment 12.3 Avoidance/reducing exposure to cues for the behaviour 12.5 Adding objects to the environment *1.3 Problem-solving* *11.3 Conserving mental resources*	12.5 Include contact information of the healthcare providers involved in follow-up care in SCP 12.5 Create avenues to easily communicate with other healthcare providers 12.5 Provide access to share notes among the healthcare providers providing follow-up care to survivors
Enabler	Using e-consult	Having to write out all patient information each time need a consult Good to be able to write to oncologist through e-consult platform	Environmental Context and Resources	3.2 Social support (practical) 7.1 Prompts/cues 7.5 Remove aversive stimulus 12.1 Restructuring the physical environment 12.2 Restructuring the social environment 12.3 Avoidance/reducing	3.2 Avenues to connect to oncology specialists 3.2 Create an environment where consulting cancer specialists is common, appropriate, and welcome 12.5 Creating portals to easily connect with specialists 12.5 Connecting patient EMR to e-consult to auto-populate patient information

				exposure to cues for the behaviour 12.5 Adding objects to the environment *1.3 Problem-solving* *11.3 Conserving mental resources*	
Enabler	I keep the patient on schedule	Reminders in EMR prompt contact with survivors	Social Influences	3.1 Social support (unspecified) 3.2 Social support (practical) 6.1 Social comparison 6.3 Information about others' approval 10.4 Social reward *2.1 Monitoring of behaviour by others without feedback* *12.2 Restructuring the social environment*	3.2 Have PCP office call survivors when a follow-up tasks is due 6.3 Remind patients of the recommended tasks, approved by oncology specialists and PCPs
Enabler	I provide patients with what they are	PCPs providing reassurance to patients	Social Influences	3.1 Social support (unspecified) 3.2 Social support (practical) 6.1 Social comparison	3.1 PCPs support and reassure survivors 3.1 PCPs listening to survivors' concerns 3.1 PCPs discuss decision-making and helping patients meet their needs

	asking for	Addressing anxiety and depression Helping patients make informed decisions		6.3 Information about others' approval 10.4 Social reward *2.1 Monitoring of behaviour by others without feedback* *12.2 Restructuring the social environment*	3.1 Listen and support survivors with mental health concerns 3.2 Suggest/provide resources and referrals to address patients' mental health concerns
Barrier and Enabler	Patient emotion affects PCP behaviour	Patients being comfortable receiving follow-up care from PCPs Patients being anxious about cancer survivorship Reviewing SCP with patients more often Providing reassurance	Social Influences	3.1 Social support (unspecified) 3.2 Social support (practical) 6.1 Social comparison 6.3 Information about others' approval 10.4 Social reward *2.1 Monitoring of behaviour by others without feedback* *12.2 Restructuring the social environment*	3.1 Taking time in appointments to discuss patient concerns, anxiety, fears 3.1 Taking time to reassure patients that following the SCP is a good way to monitor for new/recurring cancers 3.1 Answer patients' questions, prioritizing with patients to meet their most pressing needs 3.1 Using the SCP to provide reassurance to survivors that they will receive appropriate follow-up care 3.1 Reminding patients that their PCPs has been/will continue to be involved in their healthcare 3.2 Provide survivors with education on follow-up care when needed, refer to resources in language of patients' choice 6.3 PCPs state their approval of patient bringing up their concerns

		Answering questions Patient's frustration around follow-up care (e.g., unsure where to find francophone resources) so PCPs have to provide education on follow-up care Patients come into appointments wanting to prioritize other health concerns			
Enabler	Patient reminds PCP	Patients call to book appointments according to the SCP PCPs seeing patients as a	Social Influences	3.1 Social support (unspecified) 3.2 Social support (practical) 6.1 Social comparison	3.2 Encourage survivors to use their SCP to make appointments 6.3 Provide encouragement/approval when patients initiate appointments

		"back up" to remind them of follow-up appointments needed		6.3 Information about others' approval 10.4 Social reward *2.1 Monitoring of behaviour by others without feedback* *12.2 Restructuring the social environment*	
Barrier	Patients missing appoint ments	Patients feeling well so they post pone follow-up appointments Patients no show and no rescheduling	Social Influences	3.1 Social support (unspecified) 3.2 Social support (practical) 6.1 Social comparison 6.3 Information about others' approval 10.4 Social reward *2.1 Monitoring of behaviour by others without feedback* *12.2 Restructuring the social environment*	3.2 Explain the importance of follow-up care even when feeling well 3.2 Increase accessibility when age, weather, disability, socio-economic, and other factors influence whether a patient can attend and appointment (e.g., virtual or telephone appointments, home visits, etc.) 6.3 Highlight approval of oncology and primary care to follow SCP
Barrier and	Impressi ons of	Patients are happy to receive	Emotion	11.2 Reduce negative emotions	11.2 Open up discussions around mental health, provide resources (books, articles, videos, community supports)

Enabler	patient emotion	follow-up care from their PCP Patients experiencing mental health concerns		*5.5 Anticipated regret* *5.6 Information about emotional consequences* *12.6 Body changes* *13.2 Framing/reframing*	13.2 Encourage patients to reflect on how they are healthy enough to be discharged from the cancer centre
Barrier	Negative emotions around follow-up care	Feeling annoyed at logistical issues when following SCP Frustration around perceived "offloading" onto PCPs Fear of missing something cancer related	Emotion	11.2 Reduce negative emotions *5.5 Anticipated regret* *5.6 Information about emotional consequences* *12.6 Body changes* *13.2 Framing/reframing*	11.2 Designate supports to handle logistical issues 11.2 Create a clear way to order and receive follow-up tests 11.2 Provide clear avenues for PCPs to consult with oncology when needed to feel less like cancer follow-up is offloaded to primary care 13.2 Reframe "offloading" to managing chronic illness 13.2 Reframe fear of missing signs of cancer recurrence, to surveillance of new/recurring cancers
Enabler	Positive emotions providing follow-up care	Cancer survivors seen as special patients Patients being happy to return to	Emotion	11.2 Reduce negative emotions *5.5 Anticipated regret* *5.6 Information about emotional consequences*	5.6 Patients may feel happy/relieved to return to primary care 5.6 Being involved in longstanding patients' cancer care can strengthen relationship 5.6 Share with PCPs about positive feelings associated with follow-up in primary care settings

		follow-up in primary care settings Stronger relationships with patients cancer survivors		*12.6 Body changes* *13.2 Framing/reframing*	
Barrier	Clarity needed	SCPs should include: When hormone replacement therapy ends Contact information of oncology specialists or cancer centre	Behavioural Regulation	1.2 Problem solving 2.3 Self-monitoring of behaviour 4.2 Information about antecedents 8.2 Behaviour substitution 11.2 Reduce negative emotions 11.3 Conserving mental resources *1.1 Goal setting (behaviour)* *1.4 Action planning* *1.6 Discrepancy between current behaviour and goal* *1.8 Behavioural contract* *2.4 Self-monitoring outcome(s) of behaviour* *8.3 Habit formation*	11.3 Conserve mental resources by including contact information directly on SCP for PCPs to consult with oncology specialists

				8.4 Habit reversal *14.2 Punishment*	
Barrier	Format or mode of delivery suggestions	Format of table with follow-up tasks most helpful Wanting electronic versions of SCPs that are compatible with different EMRs Putting table on the first page of SCP Send SCP as a single short document	Behavioural Regulation	1.2 Problem solving 2.3 Self-monitoring of behaviour 4.2 Information about antecedents 8.2 Behaviour substitution 11.2 Reduce negative emotions 11.3 Conserving mental resources *1.1 Goal setting (behaviour)* *1.4 Action planning* *1.6 Discrepancy between current behaviour and goal* *1.8 Behavioural contract* *2.4 Self-monitoring outcome(s) of behaviour* *8.3 Habit formation* *8.4 Habit reversal* *14.2 Punishment*	11.3 Conserving mental resources by creating an easy to read table of follow-up tasks 11.3 Conserving mental resources by creating electronic versions of SCPs 11.3 Conserving mental resources by putting follow-up table on first page of SCP 11.3 Conserving mental resources by creating a one-page version of the SCP
Barrier	More information on social support	Cancer support groups	Behavioural Regulation	1.2 Problem solving 2.3 Self-monitoring of behaviour 4.2 Information about antecedents	1.2 Look for/ create community based resources 1.2 Create a list of community resources for cancer survivors

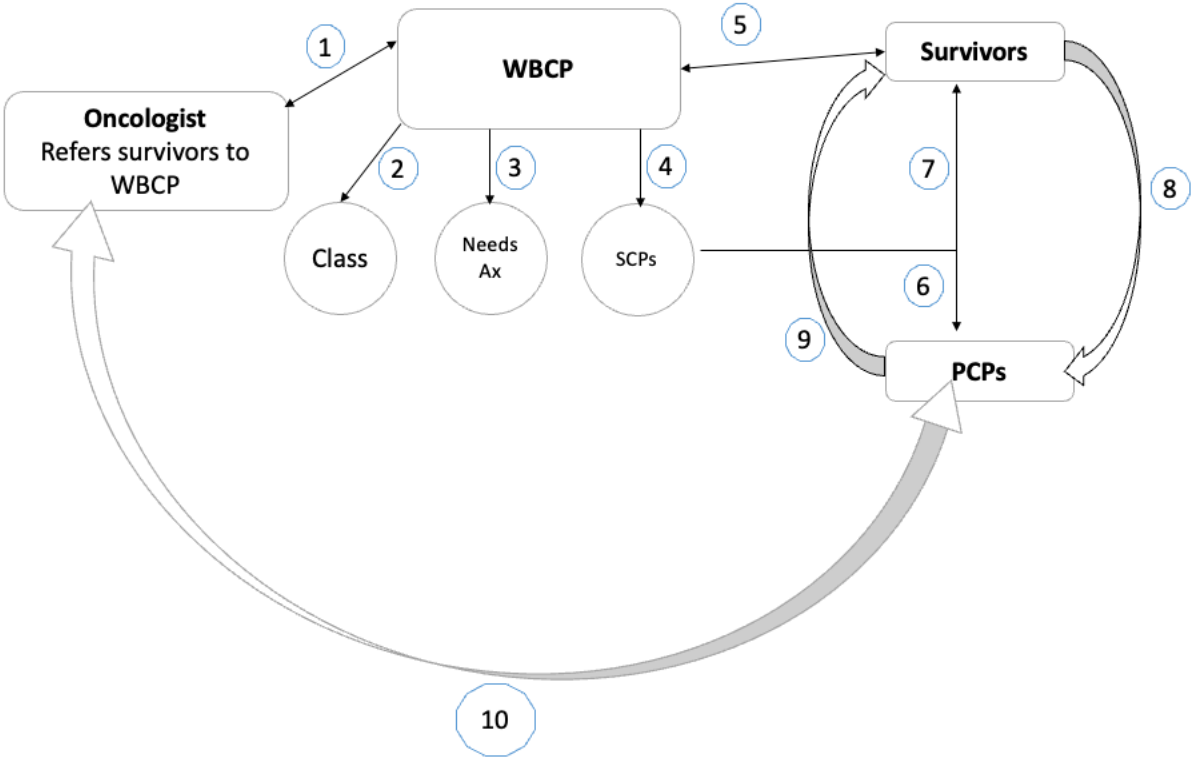
	for survivors	Psychological services/ counselling services Contact with social workers to help coordinate unmet needs		8.2 Behaviour substitution 11.2 Reduce negative emotions 11.3 Conserving mental resources *1.1 Goal setting (behaviour)* *1.4 Action planning* *1.6 Discrepancy between current behaviour and goal* *1.8 Behavioural contract* *2.4 Self-monitoring outcome(s) of behaviour* *8.3 Habit formation* *8.4 Habit reversal* *14.2 Punishment*	1.2 Connect with community-based cancer supports (e.g., Cancer Care Ontario, Breast Cancer Society) 1.2 Create avenues for contact with oncology-based social workers/social workers with experience working with cancer survivors
Barrier	More information in general	More information about cancer treatment More information about psychosocial needs and how to address them	Behavioural Regulation	1.2 Problem solving 2.3 Self-monitoring of behaviour 4.2 Information about antecedents 8.2 Behaviour substitution 11.2 Reduce negative emotions 11.3 Conserving mental resources	1.2 Problem-solve avenues for information e.g., contact with oncology specialists, resources and approaches used by other PCPs 11.3 Create a webpage with up to date information about cancer survivorship – include link in correspondence 11.3 Add a link to resources in SCP for more information 11.3 Add contact information for cancer support services in community

		More information on how to consult with survivorship program Common issues in longer term cancer survivors		*1.1 Goal setting (behaviour)* *1.4 Action planning* *1.6 Discrepancy between current behaviour and goal* *1.8 Behavioural contract* *2.4 Self-monitoring outcome(s) of behaviour* *8.3 Habit formation* *8.4 Habit reversal* *14.2 Punishment*	
Barrier	Patient education		Behavioural Regulation	1.2 Problem solving 2.3 Self-monitoring of behaviour 4.2 Information about antecedents 8.2 Behaviour substitution 11.2 Reduce negative emotions 11.3 Conserving mental resources *1.1 Goal setting (behaviour)* *1.4 Action planning* *1.6 Discrepancy between current behaviour and goal*	1.2 Refer to resources provided by survivorship programs 1.2 Encourage survivors to utilize survivorship program resources 4.2 Explain to survivors the importance of tracking their symptoms and reporting them to PCP 4.2 Explain to survivors that they need to engage in their follow up care by keeping track of follow-up tests 1.2 Review SCP with survivor regularly

				1.8 Behavioural contract *2.4 Self-monitoring outcome(s) of behaviour* *8.3 Habit formation* *8.4 Habit reversal* *14.2 Punishment*	
Barrier	Contact information to oncology specialists	Wanting a physician support line to oncology specialists	Behavioural Regulation	1.2 Problem solving 2.3 Self-monitoring of behaviour 4.2 Information about antecedents 8.2 Behaviour substitution 11.2 Reduce negative emotions 11.3 Conserving mental resources *1.1 Goal setting (behaviour)* *1.4 Action planning* *1.6 Discrepancy between current behaviour and goal* *1.8 Behavioural contract* *2.4 Self-monitoring outcome(s) of behaviour* *8.3 Habit formation* *8.4 Habit reversal*	1.2 Provide a clear way for PCPs to contact oncology for support 1.2 Include information for PCPs to contact oncology in the PCP version of the SCP

				14.2 Punishment	
Barrier	Updating plan or patient information	Wanting an electronic SCP that is updateable	Behavioural Regulation	1.2 Problem solving 2.3 Self-monitoring of behaviour 4.2 Information about antecedents 8.2 Behaviour substitution 11.2 Reduce negative emotions 11.3 Conserving mental resources *1.1 Goal setting (behaviour)* *1.4 Action planning* *1.6 Discrepancy between current behaviour and goal* *1.8 Behavioural contract* *2.4 Self-monitoring outcome(s) of behaviour* *8.3 Habit formation* *8.4 Habit reversal* *14.2 Punishment*	1.2 Revising SCPs electronically on an ongoing basis 1.2 Revising SCPs in regular intervals (e.g., yearly)

Appendix M
Implementation Recommendations Flowchart and Manual



1. Oncologist refers survivors to Wellness Beyond Cancer Program to be discharged back to their PCP

2. The WBCP provides survivors with an Education Class about what to expect in follow-up care

3. The WBCP provides a needs assessment to populate the SCP

4. The WBCP creates SCPs using electronic medical records system

5. Survivors interact with the WBCP as needed until discharge. There is also a rapid re-entry program for survivors should they have a new or recurrent cancer.

6. PCP receives SCP from the WBCP, a discharge note is included with contact information for support from oncology specialists if needed

7. Survivors receive a copy of their SCP which is reviewed with an oncology nurse via phone, one-on-one meetings, and group meetings.

8. Survivors interact with their PCPs to discuss SCP, arrange follow-up tests, report ongoing health concerns as needed, report their unmet needs.

9. PCPs interact with survivors to organize follow-up tests, discuss the SCPs, treat ongoing health concerns, coordinate help for unmet needs of survivors

10. PCPs and oncology interact with one another when booking follow up tests and receiving results and interacting when support is needed

Relationship 1: Oncologist refers survivors to Wellness Beyond Cancer Program to be discharged back to their PCP

Relationship	**Recommendation**	**Purpose**	**How?**	**Target(s)**	**Actor(s)**
1	Develop a survivorship program	To facilitate the transition back to primary care for follow-up after completion of active cancer treatment	Please see Rushton et al 2015, Pan-Canadian Guideline (Howell, 2011)	Breast and colorectal cancer survivors	Oncology nurses, oncologists, other healthcare providers, hospital administrators
1	Create avenues for peer support	To provide individualized supports	Provide information about community resources Offer peer support groups in survivorship program	Breast and colorectal cancer survivors	Health care professionals, peer support leaders
1	Reminders to do follow-up	To provide individualized supports	Based on needs assessment identify survivors who would benefit from reminders of follow-up care tasks	Breast and colorectal cancer survivors cancer survivors requesting follow-up reminders	Administration or oncology-based healthcare professionals.
1	Reminders to do self exams	To provide individualized supports	Based on needs assessment identify survivors who would benefit from reminders of follow-up care tasks	Breast and colorectal cancer survivors cancer survivors requesting follow-up reminders	Administration or oncology-based healthcare professionals.

1	Regular check ins from cancer centres	To provide individualized supports e.g., to have questions answered and ensure survivors still have a PCP	From records of discharged patients in system	Breast and colorectal cancer survivors cancer survivors requesting follow-up reminders	Administration or oncology-based healthcare professionals.

Relationship 2: The WBCP provides survivors with an Education Class about what to expect in follow-up care

Relationship	**Recommendation**	**Purpose**	**How?**	**Target(s)**	**Actor(s)**
2	Provide education to survivors about how to use SCPs	To provide reasoning for the purpose of using SCPs To provide clear messaging about survivors' role in actively participating in their own follow-up cancer care Advise survivors on how best to advocate for their own follow-up care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
2	Provide examples of how other survivors have used SCPs/have found SCPs helpful in	To engage survivors in their follow-up care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back	Oncology Nurses, other healthcare providers/peers that have

	navigating follow-up care	To encourage patients to schedule and keep track of follow-up tasks		to PCPs for follow-up	expertise in follow-up care/survivorship
2	Remind survivors that oncology specialists created the SCP	To engage survivors in their follow-up care To encourage patients to schedule and keep track of follow-up tasks	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
2	Encourage survivors to see themselves as self-managers of their own follow-up care/active members of healthcare team	To engage survivors in their follow-up care To encourage patients to schedule and keep track of follow-up tasks	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
2	Provide instructions about how to use the information in the SCPs □ To refer to cancer treatment □ To refer to information about health care team □ To refer to important dates	To demonstrate how SCPs can and are meant to be used	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship

	□ To track and schedule follow-up care				
2	Provide reasoning for using SCP □ Follow-up care □ Managing side effects □ Ongoing surveillance for new and recurring cancers	To demonstrate how SCPs can and are meant to be used To engage survivors in their follow-up care To encourage patients to schedule and keep track of follow-up tasks	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
2	Instruct how to use SCP as a communication tool to inform others about one's cancer history, treatment, and follow-up plan	To show how SCP can use used to share information with other health care providers	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
2	Describe how SCPs contain information about what to expect in follow-up care	To outline the process of follow-up cancer care Provide direction about follow-up with primary care provider	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
2	Instruct survivors on how to refer to	To provide direction on how survivors can	Group classes, in-person, online, recorded	Breast and colorectal cancer survivors who are	Oncology Nurses, other healthcare

	the follow-up tasks schedule	engage with follow-up care using their SCP	video, written instruction,	discharged back to PCPs for follow-up	providers/peers that have expertise in follow-up care/survivorship
2	Instruct survivors on how to make sure their follow-up tests and appointments are scheduled intime using the instructions in the SCP	To provide direction on how survivors can engage with follow-up care using their SCP	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
2	Remind survivors that PCPs can consult with oncologist if cancer specific issues arise that are beyond the scope of the PCP's practice	To address survivors' hesitation about having follow-up in primary care rather than from cancer specialists To address survivors' doubts about their primary care provider's cancer knowledge	Group classes, in-person, online, recorded video, written instruction, In person, over the telephone, virtual appointments	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship Primary care providers
2	Have oncology specialists explain why PCPs are the best provider for follow-up cancer care	To address survivors' hesitation about having follow-up in primary care rather than from cancer specialists To address survivors' doubts about their	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship

		primary care provider's cancer knowledge			
	Encourage survivors to view the follow-up tasks as goals to achieve	To help survivors see the value in SCP To clarify that survivors are meant to use the SCP (not just file it with other paperwork)	Group classes, in-person, online, recorded video, written instruction, In person, over the telephone, virtual appointments	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship Primary care providers
2	Encourage survivors to refer to their SCP when they have a question or concern	To demonstrate how other survivors have found SCP useful To highlight the cancer history and treatment summary as an important reference in the SCP	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
2	Suggest to survivors that they put reminders in their calendar for follow-up appointments	To show how survivors can use their SCP to make sure the follow-up tasks are completed in time	Group classes, in-person, online, recorded video, written instruction, In person, over the telephone, virtual appointments	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship Primary care providers

2	Use questions about follow-up care as a prompt to refer back to SCP	Provide examples of ways the SCP can be helpful to survivors	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
2	Encourage survivors to use SCP to advocate for follow-up appointments locally	To help survivors living in rural or remote areas find local supports that meet their needs	Group classes, in-person, online, recorded video, written instruction, In person, over the telephone, virtual appointments	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship Primary care providers
2	Provide avenues for oncology specialists (e.g., nurses) to explain follow-up care and how to use SCP	To help survivors understand the purpose of the SCP, and the expectation that they	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
2	Suggest that survivors share their SCP with their family members to ensure follow-up	Suggest family support in follow-up care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in

	tasks completed in a timely manner		In person, over the telephone, virtual appointments		follow-up care/survivorship Primary care providers
2	Suggest that survivors ask family members for help when needed	To help ensure that follow-up cancer care is provided on time	Group classes, in-person, online, recorded video, written instruction, In person, over the telephone, virtual appointments	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship Primary care providers
2	Reframe follow-up care in primary care settings as a positive event (i.e., healthy enough for discharge from cancer centre)	To help survivors experiencing difficulties accepting discharge from cancer centre after completion of primary treatment	Group classes, in-person, online, recorded video, written instruction, In person, over the telephone, virtual appointments	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship Primary care providers
2	Provide education on what to expect in follow-up care and how to use SCP	To help survivors experiencing difficulties accepting discharge from cancer centre after completion of primary treatment	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in

		To address uncertainty around discharge To address beliefs that survivors would receive better follow-up care at the cancer centre	In person, over the telephone, virtual appointments		follow-up care/survivorship Primary care providers
2	Provide resources on cancer survivorship	To help survivors experiencing difficulties accepting discharge from cancer centre after completion of primary treatment To address uncertainty around discharge To address beliefs that survivors would receive better follow-up care at the cancer centre	Group classes, in-person, online, recorded video, written instruction, In person, over the telephone, virtual appointments	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship Primary care providers
2	Provide psychosocial resources to help survivors cope	To help survivors process the stress associated with cancer diagnosis and treatment To help survivors cope with fear of cancer recurrent To help survivors cope with concerns	Conduct needs assessment to populate SCP PCPs regularly ask about psychosocial concerns	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship Primary care providers

2	Encourage patients to reformat their own SCP so it makes sense for them (i.e., colour, larger font, rearranging content, etc.)	To help increase usability of SCP Encourage survivors to tailor their SCPs to make them easier to use	Group classes, in-person, online, recorded video, written instruction, In person, over the telephone, virtual appointments	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship Primary care providers
2	Create instructional videos about the purpose of SCPs and how to use them	To provide an alternative method to review SCP with a healthcare professional	Generic video available online	Breast colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship Primary care providers

Relationship 3: The WBCP provides a needs assessment to populate the SCP

Relationship	**Recommendation**	**Purpose**	**How?**	**Target(s)**	**Actor(s)**
3	Include a comprehensive needs assessment to guide completion of SCP	To help survivors identify their needs after cancer treatment	Questionnaire in person, online, through medical chart.	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology nurses, oncologists, other healthcare providers, hospital administrators

		Flag these unmet needs in SCPs for healthcare providers			
3	Provide information in SCP about patient's unmet needs that need to be addressed in follow-up care	To inform primary care providers of unmet needs of survivors being discharged back into their care	Conduct a needs assessment and include unmet needs in SCP	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up PCPs	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
3	Suggest volunteer organizations for driving	To help survivors living outside of urban center attend follow-up tests and appointments	Conduct a needs assessment including concerns about attending appointments Include resources on volunteer organizations that	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship Primary care providers Admin in survivorship programs or cancer centre
3	Arrange for medications to be picked up when patient is already at the cancer centre for an appointment	To ensure survivors living in rural areas have access to the medications prescribed as part of their follow-up care	Conduct a needs assessment including information about where patient lives Coordinate with patient who live a distance from the	Breast and colorectal cancer survivors who live in rural/remote areas Pharmacies in rural/remote areas	Cancer survivorship programs, cancer centres Primary care providers

			cancer centre to provide medication when they are at the hospital for follow-up Ensure the patient's pharmacy has access to the medications needed as part of follow-up care		
3	Special order cancer medications to local pharmacy	To ensure survivors living in rural areas have access to the medications prescribed as part of their follow-up care	Ensure the patient's pharmacy has access to the medications needed as part of follow-up care	Breast and colorectal cancer survivors who live in rural/remote areas Pharmacies in rural/remote areas	Cancer survivorship programs, cancer centres Primary care providers
3	Help survivors locate practical supports	To provide individualized supports (e.g., nursing support, scheduling appointment with busy primary care provider)	Needs assessment Checking in with patients on an ongoing basis regarding unmet needs Providing information about community resources	Breast and colorectal cancer survivors	Cancer survivorship programs, cancer centres Primary care providers

3	Help survivors look for ways to get their follow-up tests completed – family support, community support	To provide individualized supports based on patient needs (e.g., unable to pay for medications, travel for follow-up)	Needs assessment Checking in with patients on an ongoing basis regarding unmet needs Providing information about community resources	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Cancer survivorship programs, cancer centres Primary care providers
3	Help survivors look for resources (e.g., compassionate funding) for medications	To provide individualized supports based on patient needs (e.g., unable to pay for medications)	Needs assessment Checking in with patients on an ongoing basis regarding unmet needs Providing information about community resources	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Cancer survivorship programs, cancer centres Primary care providers
3	Website with supplementary resources for survivors' individuals interests/needs	Provide extra individualized supports E.g., follow-up from cancer centre, blank personal needs section in SCP More information about diet, side effects,	Generic resources e.g., brochures, handouts, weblinks available online	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Cancer survivorship programs, cancer centres

		health and fitness, alternative medicines Reminders to use SCPs and do self-exams Peer support			
3	If needs assessments are not filled out, provide generic resources on website to consult	Provide extra individualized supports	Generic resources e.g., brochures, handouts, weblinks available online	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Cancer survivorship programs, cancer centres
3	Reminders to do follow-up, reminders to do self-exams	Provide extra individualized supports	Regular follow-up phone calls from survivorship program/cancer centres Reminders from PCP	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Cancer survivorship programs, cancer centres Primary care providers
3	Create avenues for peer support	To facilitate patients' request for peer support	Resource list of peer support groups	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Cancer survivorship programs, cancer centres Primary care providers

Relationship 4: The WBCP creates individualized SCPs using electronic medical records system

Relationship	**Recommendation**	**Purpose**	**How?**	**Target(s)**	**Actor(s)**
4	Mental health professionals provide resources with online	To provide accessible avenues for psychosocial support	Resources available on website	Breast and colorectal cancer survivors who are	Mental health professionals with experience working

	interventions, community interventions, bibliography for common psychosocial concerns (anxiety, mood, fear of recurrence, fatigue, sexual concerns, etc.)			discharged back to PCPs for follow-up	with cancer survivors Cancer survivorship programs
4	Provide SCP to both survivors and PCPs	To engage both PCPs and survivors in follow-up cancer care	Provide a copy of SCP to patient and provide a copy of SCP to PCP using usual channels of sending notes to PCPs	Primary care providers Breast and Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Creators and distributors of SCPs
4	Print SCP on coloured paper	To make SCPs easier to find amongst other paper work. To prompt survivors to look at SCP	Provide a copy of the SCP on specialty paper	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Creators and distributors of SCPs
4	Provide a brief cancer history and treatment summary in SCP	To provide a record of important information for survivors and PCPs	Include a brief cancer history and treatment summary in SCP	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Creators and distributors of SCPs

		to refer to when needed		Primary care providers	
4	Provide information about peer supports in SCP	To address survivors' reported needs to have social support from other cancer survivors	Include information about peer support in SCP Provide a link on website with information about peer support	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Cancer survivorship programs, cancer centres Primary care providers
4	Create updateable SCP	To address changing follow-up needs, applicable recommendations for long term survivorship care To update follow-up guidelines	To add in more information throughout follow-up To provide updated recommendations	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Creators and distributors of SCPs
4	Provide resources on community supports (i.e., on website, psychologists, telephone number to ask questions, what to do if no longer have a PCP, etc.)	To help survivors navigate supports for individual needs, changes in PCP due to retirement or move) To provide survivors with a place to ask questions	Resources available on website Telephone number to contact for support in navigating psychosocial needs	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Cancer survivorship programs, cancer centres Primary care providers

4	Provide resources for long term survivors, health and fitness, psychological support, diet, side effects, alternative medicines	To provide individualized supports	Resources available on website	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Cancer survivorship programs, cancer centres Primary care providers

Relationship 5: Survivors interact with the WBCP as needed until discharge. There is also a rapid re-entry program for survivors should they have a new or recurrent cancer.
No specific recommendations emerged from the data associated with this relationship. Please note: this is offered by the WBCP (Ruston et al., 2015).

Relationship 6: PCP receives SCP from the WBCP, a discharge note is included with contact information for support from oncology specialists if needed

Relationship	**Recommendation**	**Purpose**	**How?**	**Target(s)**	**Actor(s)**
6	Provide follow-up guidelines that describe the tasks PCPs are responsible for in the SCP	To inform PCPs of the follow-up tasks they are responsible for	Providing SCP	PCPs	Creators and distributors of SCPs
6	Provide information about the guidelines to follow after year 5 and year 10	To address PCPs concerns around long term follow-up after the time period the SCP covers	Updating SCP	PCP	Creators and distributors of SCPs
6	Provide avenues to receive direction from oncology specialists on:	To facilitate consultations with oncology specialists	Provide contact information to oncology specialists on SCP	PCP	Creators and distributors of SCPs

	Clarification of ongoing cancer treatment; clarifications on the HCPs following the patient; advice on when it is ok to stop cancer-specific medications				
6	Educate PCPs on signs that are predictive of when cancer medication can be stopped	To address PCPs' questions	Provide a link to resources on cancer specific medications in SCPs Provide contact information to consult with oncology specialists	PCP	Creators and distributors of SCPs Oncology specialists
6	Provide PCPs with information about the consequences of patient request to stop a cancer medication	To address PCPs' questions	Provide a link to resources on cancer specific medications in SCPs Provide contact information to consult with oncology specialists	PCP	Creators and distributors of SCPs Oncology specialists

6	Create avenues of communication between other healthcare providers, inform of consequences of following (or not following) the SCP	To clarify the other healthcare providers and treatments involved in patient care	Include contact information of patient's healthcare team involved in follow-up care in SCP	PCP	Creators and distributors of SCPs
6	Provide PCPs with information on the type and frequency of follow-up tests and examinations	To inform PCPs of the follow-up tasks they are responsible for in follow-up cancer care	Include information about the type and frequency of follow-up tests and examinations in SCP	PCP	Creators and distributors of SCPs Oncology specialists
6	Provide PCPs with information on specific needs of each patient	To inform PCPs of individualized needs of cancer survivors returning to primary care for follow-up	Conduct a needs assessment and include unmet needs in SCP	PCP	Creators and distributors of SCPs
6	Provide PCPs with treatment summary that includes dates	To provide useful information to PCPs as they provide follow-up cancer care	Include treatment summary in SCP	PCP	Creators and distributors of SCPs
6	Provide information on the follow-up tests, frequency in a clear way	To present follow-up tasks and their frequency in an easy to read format	Include a table with follow-up tasks and frequency in SCP	PCP	Creators and distributors of SCPs
6	Provide information on indicators of cancer-specific	To address PCPs' questions	Provide a link to resources on the side effects of cancer specific	PCP	Creators and distributors of SCPs

	medication side effects		medications in SCPs Provide contact information to consult with oncology specialists		Oncology specialists
6	Provide information on the evidence supporting follow-up cancer care, the follow-up surveillance and exams	To promote PCP buy-in and rationale for recommended follow-up tasks	Provide a link to resources in SCP for PCPs to consult if interested	PCP	Creators and distributors of SCPs Oncology specialists
6	Present the likelihood of preventing recurrence or a new cancer diagnosis when follow-up tasks are completed in a timely manner	To promote PCP buy-in and rationale for recommended follow-up tasks	Provide a link to resources in SCP for PCPs to consult if interested	PCP	Creators and distributors of SCPs Oncology specialists
6	Inform PCPs that survivors also have a copy of the SCP	To promote the expectations that survivors are meant to be involved in managing their follow-up care	Provide information that survivors also have copy of SCP in notes accompanying SCP	PCP	Creators and distributors of SCPs Oncology specialists
6	Show PCPs how other PCPs have managed scheduling for follow-up care	To demonstrate how the tasks of follow-up care in within the purview	Provide a link to resources in SCP for PCPs to consult if interested	PCP	Creators and distributors of SCPs

		of tasks already performed by PCPs			Oncology specialists
6	Show PCPs how other PCPs have addressed patients' psychosocial concerns	To help PCPs learn from their peers when they have questions about providing follow-up cancer care	Provide a link to resources in SCP for PCPs to consult if interested	PCP	Provide a link to resources in SCP for PCPs to consult if interested
6	Help PCPs view themselves as supported in managing follow-up care	Reinforce that the tasks of follow-up care in within the purview of tasks already performed by PCPs	Provide SCP with the necessary information needed for PCPs to provide follow-up cancer care	PCP	Creators and distributors of SCPs Oncology specialists
6	Remind PCPs that they have oncology support	To address PCPs' concerns about providing follow-up cancer care	Include contact information to oncology specialists in SCP	PCP	Creators and distributors of SCPs Oncology specialists
6	SCPs are created by oncology specialists	To provide credibility and reassurance in providing follow-up care using SCPs	Provide messaging that SCP prepared by oncology specialists from a cancer centre/survivorship program in correspondence around SCP	PCP	Creators and distributors of SCPs Oncology specialists
6	Remind PCPs that they are capable of managing follow-up care	Highlight how tasks of follow-up care are within the scope of practice of	Provide messaging with SCP that tasks assigned to PCPs	PCPs	Creators and distributors of SCPs

		what PCPs already do (e.g., examinations, ordering tests, etc.) Encourage confidence in PCPs that they can provide follow-up cancer care	are already a part of everyday practice		Oncology specialists
6	Oncologists create SCPs to help PCPs manage follow-up care	To support PCPs in their role of providing follow-up cancer care	Provide messaging that SCP prepared by oncology specialists from a cancer centre/survivorship program in correspondence around SCP	PCP	Creators and distributors of SCPs Oncology specialists
6	SCPs contain specific directions on how PCPs should approach follow-up cancer care	To support PCPs in their role of providing follow-up cancer care	Provide messaging that SCP prepared by oncology specialists from a cancer centre/survivorship program in correspondence around SCP	PCP	Creators and distributors of SCPs Oncology specialists
6	SCPs created by oncology specialists	To support PCPs in their role of providing follow-up cancer care	Provide messaging that SCP prepared by oncology specialists from a cancer	PCP	Creators and distributors of SCPs

			centre/survivorship program in correspondence around SCP		Oncology specialists
6	Oncologists viewing PCPs as the best provider for follow-up care in the community	To support PCPs in their role of providing follow-up cancer care	Provide messaging that SCP prepared by oncology specialists from a cancer centre/survivorship program in correspondence around SCP	PCP	Creators and distributors of SCPs Oncology specialists
6	PCPs share approach to follow-up care with other PCPs	Peer support around providing follow-up care	Encourage PCPs to reach out to peers for support	PCP	Creators and distributors of SCPs Oncology specialists
6	Show PCP outcomes in follow-up care are the same as oncology outcomes in follow-up care	To promote PCP buy-in and rationale for recommended follow-up tasks	Provide a link to resources in SCP for PCPs to consult if interested	PCP	Creators and distributors of SCPs Oncology specialists
6	Show PCPs evidence that follow-up cancer care in primary care settings is safe	To promote PCP buy-in and rationale for recommended follow-up tasks	Provide a link to resources in SCP for PCPs to consult if interested	PCP	Creators and distributors of SCPs Oncology specialists

6	Explain to PCPs how follow-up care is within their usual role of managing chronic illness	Highlight how tasks of follow-up care are within the scope of practice of what PCPs already do (e.g., examinations, ordering tests, etc.) Encourage confidence in PCPs that they can provide follow-up cancer care	Provide messaging with SCP that tasks assigned to PCPs are already a part of everyday practice	PCPs	Creators and distributors of SCPs Oncology specialists
6	Oncologists and researchers confirming PCPs are most appropriate healthcare provider	To promote PCP buy-in and rationale for recommended follow-up tasks	Provide a link to resources in SCP for PCPs to consult if interested	PCP	Creators and distributors of SCPs Oncology specialists
6	PCPs telling other PCPs about their experiences providing follow-up cancer care	Peer support around providing follow-up care	Encourage PCPs to reach out to peers for support	PCP	Creators and distributors of SCPs Oncology specialists
6	Help PCPs view themselves as important and appropriate health care providers in their patients' cancer team	Facilitate PCPs accepting their role in follow-up cancer care	Provide messaging with SCP that tasks assigned to PCPs are already a part of everyday practice; that PCPs are	PCPs	Creators and distributors of SCPs Oncology specialists

			important in cancer survivorship		
6	Include straightforward follow-up recommendations for PCPs to follow in SCP	To provide PCPs with the information they need to provide follow-up care To make it easy to provide follow-up cancer care To specify the tasks PCPs are responsible for in follow-up cancer care	Include clearly laid out follow-up care recommendations in the SCP	PCP	Creators and distributors of SCPs Oncology specialists
6	Encourage PCPs to read notes from oncology	Oncology notes can provide additional information that would be useful to PCPs	Send oncology notes to survivors' PCPs	PCP	Creators and distributors of SCPs Oncology specialists
6	Remind PCPs of their longstanding relationships with their patients	Knowing their patients for a long time makes follow-up care easier	Provide messaging highlighting the importance of the relationship between patients and their PCP	PCP	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship Other PCPs

6	Help PCPs view themselves as capable of performing follow-up care tasks	Highlight how many follow-up care tasks are already part of PCPs' everyday practice (e.g., examinations, ordering tests)	Provide messaging with SCP that tasks assigned to PCPs are already a part of everyday practice; that PCPs are important in cancer survivorship	PCPs	Creators and distributors of SCPs Oncology specialists
6	Highlight how follow-up tasks are similar to the tasks they already do when managing chronic illness	Highlight how tasks of follow-up care are within the scope of practice of what PCPs already do (e.g., examinations, ordering tests, etc.) Encourage confidence in PCPs that they can provide follow-up cancer care	Provide messaging with SCP that tasks assigned to PCPs are already a part of everyday practice	PCPs	Creators and distributors of SCPs Oncology specialists
6	Encourage PCPs to think about times when they have successfully managed follow-up cancer care or other chronic illness	Highlight how tasks of follow-up care are within the scope of practice of what PCPs already do (e.g., examinations, ordering tests, etc.) Encourage confidence in PCPs	Provide messaging with SCP that tasks assigned to PCPs are already a part of everyday practice	PCPs	Creators and distributors of SCPs Oncology specialists

		that they can provide follow-up cancer care			
6	Provide rationale for PCPs performing tasks of follow-up care	Outline issues with overburdened cancer centres Follow-up important for long term health Patients returning to primary care is a good outcome	Messaging in notes or correspondence around the rationale for having PCPs manage follow-up cancer care for some survivors	PCPs	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
6	Outline how follow-up care is important for meeting survivors' needs, surveillance for new/recurring cancers, psychosocial concerns, managing late and long-term side effects of treatment, comorbid illness	To contribute to PCP buy in To highlight PCPs value in providing follow-up cancer care	Messaging in notes or correspondence around the important outcomes associated with follow-up cancer care	PCPs	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
6	Provide rationale that it makes sense to clear up space in cancer centre and have PCPs provide follow-up cancer	Outline issues with overburdened cancer centres	Messaging in notes or correspondence around the rationale for having PCPs manage follow-up	PCPs	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship

	care even though it's more work	Follow-up important for long term health Patients returning to primary care is a good outcome To contribute to PCP buy in To highlight PCPs value in providing follow-up cancer care	cancer care for some survivors		
6	Prompt PCPs to imagine the outcomes of taking the time to manually add reminders vs. not manually adding reminders for follow-up tasks in EMR	To address PCP frustration around increased workload To suggest ways to manage workload	Online resources with tips and tricks PCPs sharing information and approaches to follow-up care	PCP	Creators of SCPs Other PCPs
6	If cancer centre is overburdened, patient care may not be as high, show reasoning for this model of care on outcomes, justify increase in workload for PCPs	Provide rationale for "offloading" cancer follow-up care to PCPs	Messaging in notes or correspondence around the rationale for having PCPs manage follow-up cancer care for some survivors	PCPs	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship

6	Financial renumeration for PCPs providing follow-up cancer care	To account for increased workload for PCPs	Policy change (local, provincial)	PCPs	Policy makers
6	Encourage PCPs to reflect on the ways they are there for their patients through cancer and post-cancer treatment	PCPs are part of survivors' cancer experience Share that other PCPs find providing follow-up care is meaningful	Online resources with tips and tricks PCPs sharing information and approaches to follow-up care	PCP	Creators of SCPs Other PCPs
6	Encourage PCPs to reflect on their relationships with their patients	PCPs are part of survivors' cancer experience Share that other PCPs find providing follow-up care is meaningful	Online resources with tips and tricks PCPs sharing information and approaches to follow-up care	PCP	Creators of SCPs Other PCPs
6	Provide or link to resources that are low-cost or free to address needs for psychological services Add a card with a link to resources, add in a page with	To address challenges finding psychosocial supports for patients	List of resources on website, link in SCP or correspondence from cancer centre	PCPs	Mental health professionals with expertise in working with cancer survivors Other PCPs

	the SCP that has community resources for mental health supports				Creators and distributors of SCPs
6	Provide resources/guidelines on managing follow-up cancer care across the lifespan	To update follow-up care recommendations To meet the information needs of PCPs providing long term follow-up care	List of resources on website, link in SCP or correspondence from cancer centre	PCPs	Oncology specialists
6	Prompt PCPs to consider how they would feel about taking care of cancer survivor patients (i.e., feel good, helpful)	Highlight how using SCPs can be positive	Messaging in notes or correspondence around the rationale for having PCPs manage follow-up cancer care for some survivors	PCPs	Oncology specialists Other PCPs
6	Provide streamlined ways to receive patients' SCPs for inherited/new patients	To ensure survivors' PCPs have a copy of their SCP To address issue where EMRs are not compatible across settings	Have contact information for PCPs to reach cancer centre to notify they need the SCP Use existing communication methods to share SCP with patient's new SCP	PCPs Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Creators and distributers of SCPs Cancer centre Patient facing EMR Other PCPs

			Message in notes encouraging PCPs to share their old notes with PCPs taking over their practice Provide an easy way for cancer survivors to access and share their SCP with healthcare professionals		
6	Provide electronic versions of SCPs that can be automatically uploaded into EMRs	To efficiently share SCP with PCPs Reduce workload transferring paper or faxed copy into PCPs' EMR	PCPs choosing EMRs that allow for electronic version of incoming faxes, correspondence Cancer centres updating systems, working with IT to provide electronic versions of SCP	PCPs Cancer centres	PCPs Administration at PCP offices Cancer centres IT departments and administration
6	Integrate e-consult into EMR	To streamline ways to consult with oncology specialists To allow EMRs to auto populate e-consult to reduce	PCPs choosing EMRs that allow for electronic version of incoming faxes, correspondence	PCPs Cancer centres	PCPs Administration at PCP offices Cancer centres IT departments and administration

		workload associated with consulting with oncology specialists	Cancer centres updating systems, working with IT to provide electronic versions of SCP		
6	Include all healthcare providers and roles for patients in the SCP	To facilitate communication between providers involved in follow-up cancer care To inform PCPs of other treatments survivors are receiving	Include contact information of healthcare providers and their role in follow-up cancer care in SCP or correspondence associated with the SCP Survivors telling PCP the health care providers who are also involved in follow-up care	PCPs	Creators and distributers of SCPs Cancer survivors
6	Create avenues to easily communicate with other healthcare providers	To clarify roles and treatments provided in follow-up care	Include contact information of healthcare providers and their role in follow-up cancer care in SCP or correspondence associated with the SCP Survivors telling PCP the health care providers who are	PCPs	Creators and distributers of SCPs Cancer survivors

			also involved in follow-up care		
6	Provide access to share notes among the healthcare providers providing follow-up care to survivors	To share information and keep PCP informed of other aspects of follow-up care	Include contact information of healthcare providers and their role in follow-up cancer care in SCP or correspondence associated with the SCP PCP contact other healthcare providers requesting they be copied on medical notes Cancer survivors asking their healthcare providers to share notes with their PCP	PCPs	Healthcare providers PCPs Cancer survivors Creators and distributers of SCPs
6	Conserve mental resources by including contact information directly on SCP for PCPs to consult with oncology specialists	To support PCPs in managing follow-up cancer care To reduce workload looking	Include contact information to reach oncology specialists for consults	PCPs	Creators and distributers of SCPs

		for oncology contacts			
6	Conserving mental resources by putting follow-up table on first page of SCP	To clearly outline the follow-up tasks that are the responsibility of PCPs (i.e., PCPs don't have to search for this information)	Rearranging SCP so follow-up table is on first page	PCPs	Creators and distributors of SCPs
6	Conserving mental resources by creating a one-page version of the SCP	Key information about follow-up care in one place	Include follow-up tasks and frequency and contact information to cancer centre in SCP Offer a shortened and more detailed SCP	PCPs	Creators and distributors of SCP
6	Problem-solve avenues for information e.g., contact with oncology specialists, resources and approaches used by other PCPs	Peer support from other PCPs on navigating follow-up care	Provide messaging that encourages PCPs to consult with one another	PCPs	Cancer survivorship programs PCPs
6	Create a webpage with up to date information about	To address information needs of PCPs	Create a website with more detailed information for	PCPs	Oncology specialists (nurses, medical doctors)

	cancer survivorship (include link in correspondence or SCP)		PCPs who would find it useful e.g., more information about cancer treatment, common psychosocial needs, how to consult with survivorship programs, common issues in longer term cancer survivors		
6	Add a link to resources in SCP for more information	To make it easy for PCPs to find credible information about cancer and cancer survivorship	Include a link to a webpage with more information on SCP	PCP	Creators and distributors of SCPs
6	Add contact information for cancer support services in community	To make it easy for PCPs to find credible information about community cancer supports	Include a link to a webpage with more information on SCP	PCP	Creators and distributors of SCPs
6	Include information for PCPs to contact oncology in the PCP version of the SCP	Make it easier for PCPs to consult with oncology specialists	Add best contact information to cancer centre on PCP version of the SCP	PCP	Creators and distributors of SCPs

Relationship 7: Survivors receive a copy of their SCP which is reviewed with an oncology nurse via phone, one-on-one meetings, and group meetings.

Relationship	Recommendation	Purpose	How?	Target(s)	Actor(s)
7	Advise patients to call their PCPs if they have concerns/need an appointment	To demonstrate how survivors can use their SCP to engage in their own follow-up care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
7	Oncology/cancer centre personnel encourage patients to consult with their PCP	To demonstrate how survivors can use their SCP to engage in their own follow-up care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
7	Provide resources to patients who need support to attend follow-up appointments	Tailored resources based on population served (e.g., rural, urban)	Create a web page with additional information	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
7	Ask survivors to share a copy of their SCP with PCPs (e.g.., if PCP changes)	To provide PCP with access to SCP	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
7	Highlight approval of oncology and primary care to follow SCP	To encourage buy in around being involved in follow-up care and using SCP	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in

					follow-up care/survivorship PCPs
7	Look for/create community-based resources	To help cancer survivors find supports to address their unmet needs	Web search, Funding review Research community resources, online resources	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
7	Create a list of community resources for cancer survivors	To help cancer survivors find supports to address their unmet needs	Webpage Link to webpage in SCP Paper resources	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
7	Connect with community-based cancer supports (e.g., Wellspring, Canadian Cancer Society)	To help cancer survivors find supports to address their unmet needs	Webpage Link to webpage in SCP Paper resources	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
7	Provide instructions about how to use the information in the SCPs: - to refer to cancer treatment, - to refer to information	To demonstrate how SCPs can and are meant to be used	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship

	about health care team - To refer to important dates - To track and schedule follow-up care				
7	Provide reasoning for using SCP - Follow-up care - Managing side effects - Ongoing surveillance for new and recurring cancers	- To demonstrate how SCPs can and are meant to be used - To engage survivors in their follow-up care To encourage patients to schedule and keep track of follow-up tasks	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
7	Provide instructions on how to access patient-facing EMR	Survivors can use patient-facing EMR to learn and share the results of follow-up tests	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship Administrative support
7	Demonstrate how to access and view test results using patient-facing EMR	Survivors can use patient-facing EMR to learn and share	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are	Oncology Nurses, other healthcare providers/peers that have expertise in

		the results of follow-up tests		discharged back to PCPs for follow-up	follow-up care/survivorship Administrative support
7	Have survivors practice accessing their patient-facing EMR	Survivors can use patient-facing EMR to learn and share the results of follow-up tests	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship Administrative support
7	Instruct survivors on how to refer to the follow-up tasks schedule	To demonstrate how SCPs can and are meant to be used To show that survivors are expected to involved in their follow-up cancer care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
7	Instruct survivors on how to make sure their follow-up tests and appointments are scheduled on time using the instructions in the SCP	To demonstrate how SCPs can and are meant to be used To show that survivors are expected to involved in their follow-up cancer care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship

7	Advise the survivor how best to advocate for their follow-up care (i.e., suggest they bring their SCP to doctor's appointments, suggest they ask questions, be familiar with contents of SCP)	To demonstrate how SCPs can and are meant to be used To show that survivors are expected to involved in their follow-up cancer care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
7	Demonstrate to survivors how to bring up the SCP to PCP (i.e., identify the information in SCP that is most important to bring up with their PCP)	To demonstrate how SCPs can and are meant to be used To show that survivors are expected to involved in their follow-up cancer care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
7	Remind survivors that they have experience managing their healthcare through cancer, diagnosis and treatment, remind them that using the SCP will be easy	To reassure survivors that they are capable of navigating their follow-up care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship

7	Ask survivors to think of times when they successfully communicated with PCP/managed other aspects of their health with their PCP, show how following SCP is similar to how they worked with their PCP before cancer	To reassure survivors that they are capable of navigating their follow-up care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
7	Take photo on SCP on phone	To have a copy of the SCP that is easily accessible/shareable To have an electronic copy of SCP in case the original is lost	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
7	Place SCP in an accessible and easy to remember place	To prevent losing SCP	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
7	Help survivors locate practical supports	To provide individualized supports (e.g., nursing support, scheduling	Needs assessment Checking in with patients on an ongoing basis	Breast and colorectal cancer survivors	Cancer survivorship programs, cancer centres

		appointment with busy primary care provider)	regarding unmet needs Providing information about community resources Additional information available online		Primary care providers
7	Encourage survivors to use SCP to advocate for follow-up appointments locally	To help survivors living in rural or remote areas find local supports that meet their needs	Group classes, in-person, online, recorded video, written instruction, In person, over the telephone, virtual appointments	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship Primary care providers
7	Provide other avenues to receive SCPs when they cannot be provided in person	To ensure cancer survivors have access to SCP	Add SCP in patient-facing EMR Provide SCP via mail	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Distributors of SCPs
7	Provide survivors with a copy of their SCP to review and use for follow-up care	To provide survivors with the information needed to participate in follow-up care To help survivors lean what to expect	Create SCPs and provide them to cancer survivors	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Cancer centres Cancer survivorship programs Oncology specialists

		in follow-up cancer care with their PCP			
7	Provide messaging around the purpose of SCPs and how they are developed by oncology team	To facilitate buy-in to use SCP To help survivors be active members of follow-up care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
7	Provide messaging and reassurance that discharge form cancer centre is a positive event – means healthy	To facilitate buy-in to use SCP To help survivors be active members of follow-up care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
7	Provide messaging that the SCP is meant to help with the transition back to primary care for follow-up	To facilitate buy-in to use SCP To help survivors be active members of follow-up care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship

Relationship 8: Survivors interact with their PCPs to discuss SCP, arrange follow-up tests, report ongoing health concerns as needed, report their unmet needs.

Relationship	**Recommendation**	**Purpose**	**How?**	**Target(s)**	**Actor(s)**
8	Patients having access to their SCP thought patient-accessible EMR and sharing information with their PCP	To share SCP with PCP and others involved in follow-up care	Patient facing EMR available to survivors SCP included on patient-facing EMR	Breast and colorectal cancer survivors	Cancer centres Policy makers IT

8	Share with PCPs about positive feelings associated with follow-up in primary care settings	To note the positive consequences of being involved in patients' follow-up cancer care	Share with PCPs in correspondence the potential positive feelings associated with providing follow-up cancer care Have PCPs share the positive aspects of providing follow-up cancer care with other PCPs	PCPs	Creators/distributors of SCPs Other PCPs
8	Instruct how to use SCP as a communication tool to inform others about one's cancer history, treatment, and follow-up plan	To demonstrate how SCPs can and are meant to be used To show that survivors are expected to involved in their follow-up cancer care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
8	Describe how SCPs contain information about what to expect in follow-up care	To demonstrate how SCPs can and are meant to be used To show that survivors are expected to	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship

		involved in their follow-up cancer care			
8	Instruct survivors on how to refer to the follow-up tasks schedule	To demonstrate how SCPs can and are meant to be used To show that survivors are expected to involved in their follow-up cancer care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
8	Instruct survivors on how to make sure their follow-up tests and appointments are scheduled on time using the instructions in the SCP	To demonstrate how SCPs can and are meant to be used To show that survivors are expected to involved in their follow-up cancer care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
8	PCP and survivor both have information in the SCP needed to ensure follow-up care needs are met	To engage both PCPs and survivors in follow-up cancer care	Provide a copy of SCP to patient and provide a copy of SCP to PCP	Primary care providers Breast and colorectal cancer survivors	Creators and distributors of SCPs
8	Patients support PCP in ensuring	Help cancer survivors view	Group classes, in-person, online,	Breast and colorectal cancer	Oncology Nurses, other healthcare

	follow-up care needs met	themselves as responsible for their follow-up care too	recorded video, written instruction,	survivors who are discharged back to PCPs for follow-up	providers/peers that have expertise in follow-up care/survivorship
8	View self as active member of follow-up care team	To ensure that follow-up care is being completed in a timely manner	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship PCPs
8	Bring SCP to appointments, use it to communicate follow-up needs with PCP	To demonstrate how SCPs can and are meant to be used To show that survivors are expected to involved in their follow-up cancer care	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship
8	Provide avenues for oncology specialists (e.g., nurses) to explain follow-up care and how to use SCP	To demonstrate how SCPs can and are meant to be used To show that survivors are expected to involved in their	Group classes, in-person, online, recorded video, written instruction,	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	Oncology Nurses, other healthcare providers/peers that have expertise in follow-up care/survivorship

		follow-up cancer care			

Relationship 9: PCPs interact with survivors to organize follow-up tests, discuss the SCPs, treat ongoing health concerns, coordinate help for unmet needs of survivors

Relationship	**Recommendation**	**Purpose**	**How?**	**Target(s)**	**Actor(s)**
9	PCPs encourage patients to contact them when needed	To highlight how survivors can engage in their follow-up care, help make sure follow-up tasks complete	In-person, virtually, via telephone, during appointments	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCPs
9	PCP office contacts patient to schedule initial appointment after receipt of SCP	To initiate follow-up cancer care with survivors	In-person, virtually, via telephone, during appointments	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCPs
9	PCPs discuss SCPs with patient; encourage patients to use their SCP to mange sure follow-up tasks are completed on time	To engage cancer survivors in follow-up care with PCP	In-person, virtually, via telephone, during appointments	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCPs
9	PCPs recommend survivors use their SCPs	To engage cancer survivors in follow-up care with PCP	In-person, virtually, via telephone, during appointments	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCPs

9	Use reminders feature in electronic medical records system to keep track of follow-up care tasks and frequency	To help PCPs easily keep track of follow-up care	Choose EMR that has features that would be useful for keeping track of follow-up tasks	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCPs
9	Setting reminders or automate tracking the completion and frequency of follow-up tasks	To help PCPs easily keep track of follow-up care	Choose EMR that has features that would be useful for keeping track of follow-up tasks	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCPs
9	Create list of community based mental health services	To provide options for mental health supports in community	Look for and connect with community based mental health resources	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCPs
9	Check in with patients regularly about their mental health/psychosocial needs	To identify and help with survivors' changing needs	Ask survivors about new/changing needs at regular appointments Validate and gently ask about psychosocial needs	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCPs
9	Add reminders to check in with patients about their mental health/psychosocial needs	To identify and help with survivors' changing needs	Ask survivors about new/changing needs at regular appointments	Breast and colorectal cancer survivors who are discharged back	PCPs

			Validate and gently ask about psychosocial needs	to PCPs for follow-up	
9	Delegate inputting reminders to another staff member if possible	To reduce workload when planning follow-up care appointments using SCP	PCPs delegate to administrative supports available	Administrative supports in PCP office	PCP
9	Using EMR to set reminders for follow-up tasks	To schedule and keep track of follow-up appointments in SCP	Set aside time to unput reminders for follow-up tasks using SCP	PCP Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	Using EMR to make it easier to find SCP when needed	To efficiently access SCP when needed	Choose EMR that has a function to search, highlight important documents	PCP Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	Choose EMR that works for how PCPs prefer to organize themselves (format of prompts, automation, etc.)	To efficiently access and use SCP when needed	Choose EMR that has a function to search, highlight important documents	PCP Breast and colorectal cancer survivors who are discharged back	PCP

				to PCPs for follow-up	
9	Choose EMR that automatically uploads faxed SCPs	To efficiently access and use SCP when needed	Choose EMR that works for how PCPs prefer to organize themselves	PCP Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	Have PCP office call survivors when a follow-up task is due	To help ensure follow-up tasks are completed in a timely manner	Identify and track when follow-up tasks are due and ask staff to call patients to schedule an appointment	PCP Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP Administrative staff at PCP office
9	Remind patients of the recommended tasks, approved by oncology specialists and PCPs	To reassure survivors that they are receiving the recommended follow-up cancer care with PCP	Ask survivors about new/changing needs at regular appointments Validate and gently ask about psychosocial needs	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	PCPs support and reassure survivors	To support cancer survivors post cancer treatment	Ask survivors about new/changing needs at regular appointments	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP

			Validate and gently ask about psychosocial needs		
9	PCPs listen to survivors' concerns	To support cancer survivors post cancer treatment	Ask survivors about new/changing needs at regular appointments Validate and gently ask about psychosocial needs	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	PCPs discuss decision-making and helping patients meet their needs	Help survivors make informed decisions about their follow-up care (e.g., wanting to stop taking medications, wanting different treatment, not interested in engaging in follow-up care) Address and validate anxiety	Ask survivors about new/changing needs at regular appointments Validate and gently ask about psychosocial needs	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	Listen and support survivors with mental health concerns	To identify and help with addressing mental health concerns	Ask survivors about new/changing needs at regular appointments	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP

			Validate and gently ask about psychosocial needs		
9	Suggest/provide resources and referrals to address patients' mental health concerns	To provide options for mental health supports in community	Look for and connect with community based mental health resources	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCPs
9	Take time in appointments to discuss patient concerns, anxiety, fears	To identify and help with addressing mental health concerns	Ask survivors about new/changing needs at regular appointments Validate and gently ask about psychosocial needs	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	Taking time to reassure patients that following SCP is a good way to monitor for new/recurring cancers	To address patient concerns about receiving follow-up care by PCP	Be open to discussing patient concerns	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	Answer patients' questions, prioritizing with patients to meet their most pressing needs	To address patient concerns about receiving follow-up care by PCP	Be open to discussing patient concerns	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP

9	Using the SCP to provide reassurance to survivors that they will receive appropriate follow-up care	To address patient concerns about receiving follow-up care by PCP	Be open to discussing patient concerns	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	Remind patients that their PCP has been/will continue to be involved in their healthcare	To address patient concerns about receiving follow-up care by PCP	Be open to discussing patient concerns	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	Provide survivors with education on follow-up care when needed, refer to resources in language of patient's choice	To answer survivors' questions/concerns about follow-up cancer care To provide education about the SCP and follow-up in patients' preferred language (e.g., French)	Encourage patients to share questions/concerns in appointments	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	PCPs state their approval of patient bringing up their concerns	To encourage a collaborative environment where survivors feel comfortable engaging in their follow-up cancer care	Be open and verbally approve of survivors sharing their concerns with PCP	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP

9	Encourage survivors to use their SCP to make appointments	To encourage survivors to be involved in their follow-up care To ensure that follow-up tasks are completed in a timely manner	Discuss ways the patient can use the SCP to keep track of follow-up appointments Back-up in case PCP forgets In-person, telephone, virtual appointments	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	Provide encouragement/approval when patients initiate appointments	To encourage a collaborative environment where survivors feel comfortable engaging in their follow-up cancer care	Be open and verbally approve of survivors sharing their concerns with PCP	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	Explain the importance of follow-up care even when feeling well	Help survivors make informed decisions about their follow-up care (e.g., wanting to stop taking medications, wanting different treatment, not interested in engaging in follow-up care)	Ask survivors about new/changing needs at regular appointments Validate and gently ask about psychosocial needs	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP

		Share rationale for follow-up tasks in SCP to prevent and find new/recurring cancer			
9	Increase accessibility when age, weather, disability, socio-economic, and other factors influence whether a patient can attend an appointment (e.g., virtual or telephone appointments, home visits, etc.)	To help make sure follow-up tasks are conducted in a timely manner	Offer follow-up appointments in multiple formats	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	Open up discussions around mental health, provide resources (books, articles, videos, community supports)	To help meet patient's needs	Ask about mental health concerns at follow-up appointments Provide resources	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	Encourage patients to reflect on how they are healthy enough to be discharged from the cancer centre	To address patient concerns about being discharged from cancer centre back to primary care for follow-up	Listen and respond to patient's concerns about being discharged back to primary care Validate patient's feelings toward follow up care	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP

9	Patients feel happy/relieved to return to primary care	Note how patient emotions can influence follow-up relationship with SCP	Validate patient's feelings toward follow up care	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	Being involved in longstanding patients/ cancer care can strengthen relationship	Note positive relationships between PCPs and survivors	PCPs remind themselves of strong relationships with their patients	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
	Problem-solve with patients to schedule and attend appointments	To help make sure follow-up tasks are conducted in a timely manner	Offer follow-up appointments in multiple formats	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	Provide instructions on when to schedule a follow-up appointment with PCP	To help make sure follow-up tasks are conducted in a timely manner Instruct how to use SCP, share expectation that survivors be involved in their follow-up cancer care	Instruct how to use SCP, share expectation that survivors be involved in their follow-up cancer care Over the phone, in appointments	Breast and colorectal cancer survivors who are not aware of the tasks and frequency of follow-up care	PCP
9	Instruct survivors on how to refer to the follow-up tasks schedule on SCP	To help make sure follow-up tasks are	Instruct how to use SCP, share expectation that	Breast and colorectal cancer survivors who are	PCP

		conducted in a timely manner Instruct how to use SCP, share expectation that survivors be involved in their follow-up cancer care	survivors be involved in their follow-up cancer care Over the phone, in appointments	not aware of how to use SCPs	
9	Instruct survivors on how to make sure their follow-up tests and appointments are scheduled on time using the instructions in the SCP	To help make sure follow-up tasks are conducted in a timely manner Instruct how to use SCP, share expectation that survivors be involved in their follow-up cancer care	Instruct how to use SCP, share expectation that survivors be involved in their follow-up cancer care Over the phone, in appointments	Breast and colorectal cancer survivors who are not aware of how to use SCPs	PCP
9	PCPs listens to and responds to patient concerns about follow-up cancer care	To help survivors with problem-solving health-related challenges	Invite survivors to share their health concerns in appointments with PCPs	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	Ask survivors about their emotional functioning	To identify and address survivors' needs	Validate patient's emotions, offer support/resources	Breast and colorectal cancer survivors who are discharged back	PCP

				to PCPs for follow-up	
9	Provide survivors with space to speak about their feelings	To identify and address survivors' needs	Validate patient's emotions, offer support/resources	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP
9	Provide psychosocial resources to help survivors cope	To address survivors' needs	Validate patient's emotions, offer support/resources	Breast and colorectal cancer survivors who are discharged back to PCPs for follow-up	PCP

Relationship 10: PCPs and oncology interact with one another when booking follow up tests and receiving results and interacting when support is needed

Relationship	**Recommendation**	**Purpose**	**How?**	**Target(s)**	**Actor(s)**
10	Provide information about the guidelines to follow after year 5 and year 10	To update SCPs on new and changing research	Notes or updates to SCP	PCPs	Oncology specialists Cancer survivorship programs Cancer centre
10	Provide reassurance to PCPs that SCPs will be updated	To address PCP concerns and informational needs when providing longer-	Notes Messaging in around long-term follow-up cancer care	PCPs	Oncology specialists

		term follow-up care			Cancer survivorship programs Cancer centre
10	Inform PCPs about long term follow-up care planning (i.e., present the research on long term follow-up cancer care)	To address PCP concerns and informational needs when providing longer-term follow-up care	Sending notes with updated information	PCPs	Oncology specialists Cancer survivorship programs Cancer centre
10	Inform PCPs of oncologists' views on longer term cancer survivorship	To address PCP concerns and informational needs when providing longer-term follow-up care	Sending notes with updated information	PCPs	Oncology specialists Cancer survivorship programs Cancer centre
10	Include information on resources to find accurate information on the common side effects of cancer medications	To address PCP concerns and informational needs when providing longer-term follow-up care	Include resources in SCP, Notes with updated information	PCPs	Oncology specialists Cancer survivorship programs Cancer centre
10	Include contact information for specialists also following patients in the SCP	To facilitative communication with healthcare providers	Add information about healthcare professionals involved in follow-up care	PCPs	Oncology specialists

		involved in follow-up care			Cancer survivorship programs Cancer centre
10	Create avenues for PCPs to consult with oncology specialists when they have questions	To facilitate consults between PCP and oncology when needed	Add contact information for oncology specialists in SCP	PCPs	Oncology specialists Cancer survivorship programs Cancer centre
10	Show PCPs how other PCPs have managed cancer-specific issues in follow-up care	To support PCPs providing follow-up care	Encourage PCPs to reach out to their network for tips and tricks	PCPs	Other PCPs Cancer survivorship programs Cancer centre
10	Provide resources on cancer-specific medications that are also used by oncologists	To address PCP concerns and informational needs when providing longer-term follow-up care	Include resources in SCP, Notes with updated information Link to additional information about cancer specific medications in SCP	PCPs	Oncology specialists Cancer survivorship programs Cancer centre
10	Provide resources on managing cancer survivorship in primary care	To support PCPs taking on the role of providing	Develop SCP	PCP	Oncology specialists

		follow-up cancer care			Cancer survivorship programs Cancer centre
10	Help PCPs view themselves as the best provider for long-term follow-up cancer care	To encourage confidence in PCP's role in providing follow-up care	Share research on follow-up care in primary care settings Share how tasks of follow-up cancer care are already in line with daily practice	PCP	Other PCPs Cancer survivorship programs Cancer centre
10	Create avenues for PCPs to consult with oncology specialists when they have questions	To facilitate consults between PCP and oncology when needed To support PCPS providing follow-up cancer care	Add contact information for oncology specialists in SCP	PCPs	Oncology specialists Cancer survivorship programs Cancer centre
10	Include contact information to consult with cancer centre on the SCP	To facilitate consults between PCP and oncology when needed To support PCPS providing follow-up cancer care	Add contact information for oncology specialists in SCP	PCPs	Oncology specialists Cancer survivorship programs Cancer centre

10	Show PCPs how other PCPs have managed abnormal test results	To support PCPs providing follow-up care	Encourage PCPs to reach out to their network for tips and tricks	PCPs	Other PCPs Cancer survivorship programs Cancer centre
10	Provide resources that oncology professionals use when managing abnormal test results	To support PCPS providing follow-up cancer care	Add contact information for oncology specialists in SCP	PCPs	Oncology specialists Cancer survivorship programs Cancer centre
10	Provide avenues to consult with specialists	To facilitate consults between PCP and oncology when needed To support PCPS providing follow-up cancer care	Add contact information for oncology specialists in SCP	PCPs	Oncology specialists Cancer survivorship programs Cancer centre
10	Provide avenues to refer patients to specialists	To facilitate consults between PCP and oncology when needed To support PCPS providing follow-up cancer care	Add contact information for oncology specialists in SCP	PCPs	Oncology specialists Cancer survivorship programs Cancer centre

10	Provide PCPs with connections to other PCPs, share resources and practices on managing follow-up care	To support PCPs providing follow-up care	Encourage PCPs to reach out to their network for tips and tricks	PCPs	Other PCPs Cancer survivorship programs Cancer centre
10	Oncologists provide resources they use to manage follow-up care	To support PCPs taking on the role of providing follow-up cancer care	Link in SCP to webpage with more information about follow-up cancer care	PCP	Oncology specialists Cancer survivorship programs Cancer centre
10	Identify barriers to following SCP, create avenues to make the process of contacting the cancer centre and ordering follow-up tests smoother	To support PCPs taking on the role of providing follow-up cancer care	Regular communication between PCPs and cancer centres or survivorship centres	PCP	Oncology specialists Cancer survivorship programs Cancer centre
10	Identify barriers to tracking follow-up care tasks, problem-solve ways to manage increased workload, automate tracking	To support PCPs and reduce their workload when providing follow-up cancer care	Ask PCPs about issues providing follow-up care Update protocols for sending SCPs and automating tracking	PCP	Oncology specialists Cancer survivorship programs Cancer centre

10	Provide clear instructions on the best ways to order and check status of follow-up tests	To support PCPs and reduce their workload when providing follow-up cancer care To address logistical factors negatively impacting follow-up care	Create avenues to order and see results of follow-up tasks Share instructions with SCP when sent to PCP	PCP	Cancer survivorship programs Cancer centre
10	Provide clear directions on how to communicate with cancer centre to ask questions	To support PCPs and reduce their workload when providing follow-up cancer care To address logistical factors negatively impacting follow-up care	Share instructions with SCP when sent to PCP	PCP	Cancer survivorship programs Cancer centre
10	Inform cancer centres of the health consequences for survivors with a convoluted process of ordering follow-up tests, checking to see if the order went through, and receiving test results	To support PCPs and reduce their workload when providing follow-up cancer care To address logistical factors negatively impacting follow-up care	Create avenues to order and see results of follow-up tasks Share instructions with SCP when sent to PCP	PCP	Cancer survivorship programs Cancer centre

10	Inform cancer centres of increased workload on PCPs with discharge back to primary care and follow-up	To address logistical factors negatively impacting follow-up care	Include contact information to cancer centre or survivorship program in SCP Provide messaging that the cancer centre or survivorship program wants feedback from PCPs	PCP	Cancer survivorship programs Cancer centre
10	Inform cancer centres of the frustration around ordering tests and receiving results in a timely manner	To address logistical factors negatively impacting follow-up care	Include contact information to cancer centre or survivorship program in SCP Provide messaging that the cancer centre or survivorship program wants feedback from PCPs	PCP	Cancer survivorship programs Cancer centre
10	Inform cancer centres of the sense PCPs have of the aspects of follow-up care that would be better managed by oncology specialists	To address logistical factors negatively impacting follow-up care	Include contact information to cancer centre or survivorship program in SCP Provide messaging that the cancer centre or survivorship program wants feedback from PCPs	PCP	Cancer survivorship programs Cancer centre
10	Inform cancer centres of PCPs' feelings that follow-	To address logistical factors negatively	Include contact information to cancer	PCP	Cancer survivorship programs

	up tasks are being offloaded onto primary care	impacting follow-up care	centre or survivorship program in SCP Provide messaging that the cancer centre or survivorship program wants feedback from PCPs		Cancer centre
10	Prompt cancer centers to consider the pros and cons of offloading certain tasks to PCPs	To problem solve increased workload on SCPs	Include contact information to cancer centre or survivorship program in SCP Provide messaging that the cancer centre or survivorship program wants feedback from PCPs	PCP	Cancer survivorship programs Cancer centre
10	Prompt cancer centres to consider the pros and cons of continued involvement/shared care with PCPs; oncology specialists being available for consults with PCPs	To problem solve increased workload on SCPs To consider models of care that would ensure survivors are receiving follow-up care they need	Include contact information to cancer centre or survivorship program in SCP Provide messaging that the cancer centre or survivorship program wants feedback from PCPs	PCP	Cancer survivorship programs Cancer centre
10	Prompt cancer centres to imagine outcomes of streamlining PCPs' ability to consult, order tests, and	To problem solve increased workload on SCPs	Include contact information to cancer centre or survivorship program in SCP	PCP	Cancer survivorship programs

	receive results vs. not streamlining these processes	To address PCPs' frustration and challenges providing follow-up care	Provide messaging that the cancer centre or survivorship program wants feedback from PCPs		Cancer centre
10	Cancer centres or survivorship programs providing access to SCP when survivors have a new PCP	To ensure that PCPs have access to their patients' SCPs	Survivors update change in PCP to cancer centre	PCP	Breast and colorectal cancer survivors Cancer centre/ Cancer survivorship programs
10	Clear avenues to connect with oncology specialists	To support PCPs taking on the role of providing follow-up cancer care	Contact information to oncology specialists in SCP	PCP	Oncology specialists Cancer survivorship programs Cancer centre
10	Create an environment where consulting cancer specialists is common, appropriate, and welcome	To support PCPs taking on the role of providing follow-up cancer care	Contact information to oncology specialists in SCP Messaging in correspondence re: SCPs	PCP	Oncology specialists Cancer survivorship programs Cancer centre

10	Create portals to easily connect with specialists	To support PCPs taking on the role of providing follow-up cancer care	Include contact information to cancer centre or survivorship program in SCP Provide messaging that the cancer centre or survivorship program wants feedback from PCPs	PCP	Cancer survivorship programs Cancer centre
10	Connect patient EMR to e-consult to auto-populate patient information	To reduce workload on PCP	Update SCPs to be sent electronically Choose EMRs that have an auto-populate function	PCP	PCP Cancer survivorship programs
10	Designate supports to handle logistical issues	To support PCPs and reduce their workload when providing follow-up cancer care To address logistical factors negatively impacting follow-up care	Involve IT Share instructions with SCP when sent to PCP	PCP	Cancer survivorship programs Cancer centre IT
10	Create a clear way to order and receive follow-up tests	To support PCPs and reduce their workload when providing follow-up cancer care	Create avenues to order and see results of follow-up tasks	PCP	Cancer survivorship programs Cancer centre

		To address logistical factors negatively impacting follow-up care	Share instructions with SCP when sent to PCP		
10	Provide clear avenues for PCPs to consult with oncology when needed to feel less like cancer follow-up is offloaded to primary care	To support PCPs and reduce their workload when providing follow-up cancer care To address logistical factors negatively impacting follow-up care	Share instructions with SCP when sent to PCP	PCP	Cancer survivorship programs Cancer centre IT
10	Reframe “offloading” to managing chronic illness	To address and validating increased workload for PCPs to provide follow-up cancer care	Messaging in notes or correspondence around SCP	PCP	Cancer survivorship programs Cancer centre
10	Reframe fear of missing signs of cancer recurrence to surveillance of new/recurring cancers	To address PCPs’ concerns about missing signs and symptoms of cancer	Messaging in notes or correspondence around SCP	PCP	Cancer Survivorship programs Cancer centre
10	Create avenues for contact with oncology-based social workers or social works	To help PCPs when addressing their patients’	Include list of resources or link to resources in SCP	PCP	Cancer survivorship program

	with experience working with cancer survivors	psychosocial needs			Cancer centre
10	Provide a clear way for PCPs to contact oncology for support	To help PCPs provide follow-up cancer care	Include contact information to consult with oncology specialists in SCP	PCP	Cancer survivorship program Cancer centre
10	Revising SCPs in regular intervals (e.g., yearly)	To provide updated information to PCPs	Electronic version of SCP that can be updated Send out a new SCP with updates Send updates vs. notes/correspondence with SCP	PCP	Cancer survivorship program Cancer centre
10	Discussing with survivors and PCPs and oncology specialists about availability/appropriateness of longer-term support	To ensure long term follow-up care needs managed in primary care	Consults with PCPs and oncology specialists Consults with PCPs, survivors and oncology specialists	PCP	Cancer survivorship program Cancer centre
10	PCPs and oncologists are coordinating follow-up cancer care	To ensure survivors receive follow-up cancer care	Regular consults with PCPs and oncology specialists	PCP	Cancer survivorship program Cancer centre
10	SCP supported by oncologists and PCPs	To promote survivors' buy-in to using SCPs	Messaging in education, discharge meeting, videos, websites on SCPs	Survivors	PCP

					Cancer survivorship program Cancer centre
10	Create avenues to share follow-up information with patients and their PCP	To help PCPs provide follow-up cancer care	Include contact information to consult with oncology specialists in SCP	PCP	Cancer survivorship program Cancer centre
10	Provide patients with access to their requisitions, test results, notes etc. so they can share with other healthcare professionals	To help PCPs provide follow-up cancer care To help survivors share information when having their follow-up care needs met	Include contact information to consult with oncology specialists in SCP	PCP	Cancer survivorship program Cancer centre
10	Check-ins from the cancer centre	To ensure survivors receive follow-up cancer care To address changes, problems, concerns	Yearly intervals Phone call, letter, email with contact information to cancer centre or survivorship program	PCP	Cancer survivorship program Cancer centre