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Survivorship care plans: Is there buy-in from community oncology providers?

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Abstract

Background—The Institute of Medicine recommended that cancer survivors and their primary care providers receive survivorship care plans (SCPs) to summarize cancer treatment and plan ongoing care. However, the use of SCPs remains limited.

Methods—Oncology providers at 14 National Cancer Institute Community Cancer Centers Program (NCCCP) hospitals completed a survey regarding their perceptions of SCPs, including barriers to implementation, strategies for implementation, the role of oncology providers, and the importance of topics in SCPs (diagnosis, treatment, recommended ongoing care, and the aspects of ongoing care that the oncology practice will provide).

Results—Among 245 providers (70% response rate), 52% reported ever providing any component of an SCP to patients. The most widely reported barriers were lack of personnel and time to create SCPs (69% and 64% of respondents, respectively). The most widely endorsed

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A survey of 245 community oncology providers found that despite widespread enthusiasm for survivorship care plans (SCPs) among primary care providers and survivors, provision of SCPs by oncology providers will likely remain limited unless oncology practices receive additional resources to overcome significant implementation barriers. We found tempered enthusiasm for SCPs among oncology providers, many of whom 1) perceived limited value for survivors or 2) did not feel responsible for SCP dissemination.

strategy among those using SCPs was the use of a template with pre-specified fields; 94% of those who used templates found them helpful. For each topic of an SCP, while 87%-89% of oncology providers felt it was very important for primary care providers to receive the information, only 58%-65% of respondents felt it was very important for patients to receive the information. Further, 33%-38% of respondents had mixed feelings about whether it was oncology providers' responsibility to provide SCPs.

Conclusions—Practices need additional resources to overcome barriers to implementing SCPs. We found resistance toward SCPs, particularly the perceived value for the survivor and the idea that oncology providers are responsible for SCP dissemination.

Keywords

oncologist; survivorship; communication; quality of healthcare; primary healthcare

Introduction

There are 13.7 million people with a history of cancer living in the United States, 64% of whom have survived at least five years.[1] Offsetting the benefit of long-term survival, many cancer survivors face significant health issues, such as ongoing risks of second cancers, recurrence, and late effects (consequences of the cancer and its treatment).[1–6]

In 2005, the Institute of Medicine (IOM) recognized that cancer survivors may experience an inadequate transition from oncology-focused care to primary care.[2] The roles of oncology and primary care providers remain ill-defined after treatment is complete.[7,8] Often survivors continue to receive follow-up care from their oncology providers, resulting in the neglect of their general health.[9] To facilitate improved coordination of post-treatment care between oncology and primary care providers, the IOM proposed the use of survivorship care plans (SCPs).[2] SCPs are personalized documents presented to cancer patients at the end of treatment that summarize key aspects of cancer treatment and recommend appropriate ongoing medical care and self management.[2] The purpose of the SCP is both to educate survivors and create a portable document that can be shared with primary care providers to facilitate coordinated care. Survivors and primary care providers have responded positively to the concept of SCPs.[10–25] Survivorship experts have widely endorsed SCPs, and multiple professional societies and accrediting agencies have encouraged their use.[1,8,26–32] Starting in 2015, the Commission on Cancer will evaluate the utilization of SCPs as a metric of quality of care.[33]

Persistent barriers to SCP use have been identified by oncology providers, who are faced with selecting or creating a template, compiling information (often from multiple sources) about survivors, and discussing and distributing the SCPs. Oncology providers generally feel positive about SCPs, but report some hesitation in integrating SCPs into clinical practice.[10,15,34,35] Indeed, the implementation of SCPs nationwide has been slow, with a recent report showing that fewer than half of NCI-designated cancer centers use SCPs for their breast or colorectal cancer survivors.[10] Among community and academic cancer programs in the Southeastern United States, fewer than a quarter of providers in each program use SCPs for their survivors.[36]

A potential problem for the implementation of SCPs is the lack of evidence of benefit of SCP use. The only randomized trial to date that investigated outcomes following SCP use found that among patients with early-stage breast cancer, receiving an SCP was not associated with a change in cancer-related distress, quality of life, and other health outcomes.[37] These findings may discourage oncologists from embracing the use of SCPs. We hypothesize that there are two major barriers to the widespread uptake of SCPs: the lack of resources to integrate SCPs into busy clinical practices and buy-in from oncology providers. Our aim was to assess community oncology providers' opinions about SCPs, including perceptions of: the importance of SCPs, the responsibility of oncology providers to provide SCPs, barriers to SCP use, and the usefulness of implementation strategies employed at their practices. Community oncology providers are critical in understanding SCP plan use, because the majority of cancer patients receive care in community settings.[38] Importantly, we included non-physician oncology providers who often are responsible for SCP use.[39–42] The oncology providers in our survey came from hospitals within the National Cancer Institute Community Cancer Centers Program (NCCCP), an NCI-funded program of cancer centers at community hospitals in the United States. The NCCCP was developed to achieve quality and research objectives in cancer care, including the identification of evidence-based survivorship care services. Having committed to the development of SCPs as part of the NCCCP program deliverables, these oncology providers are in a unique position to provide insight into the use of SCPs.

Methods

Study population

We contacted the Principal Investigators at each NCCCP site and invited them to collaborate on the study. We recruited oncology providers from the fourteen NCCCP sites who agreed to collaborate. Eligible participants were medical and radiation oncologists, nurse practitioners, clinical nurse specialists, and physician assistants who provided chemotherapy, radiation therapy, or hormone therapy to adult cancer patients. Fellows and residents were excluded. We excluded surgeons, because generally only a minority of their patients are cancer patients, and the topic may be less relevant to them.

Instrument

Our questionnaire assessed oncology providers' opinions about SCPs, specifically regarding practice characteristics, use of SCPs, perceived value of SCPs, and barriers and facilitators to the implementation of SCPs. Of note, some NCCCP sites have multiple oncology clinics. Individual survey respondents commented on SCP use within their clinics, not within the entire NCCCP site. We described the SCP in terms of four topics outlined by the IOM: 1) cancer diagnosis, 2) cancer treatment, 3) recommended ongoing care, and 4) what aspects of care the oncology practice will provide. We asked whether the respondent or other clinicians in their practice provide written summaries of these four topics for their patients at the completion of cancer treatment. We investigated buy-in by eliciting beliefs about SCPs and their commitment to providing SCPs – specifically, whether it was considered important for patients and primary care providers to receive SCPs and whether providing SCPs to patients is the responsibility of oncology providers. We selected barriers and facilitators from the literature on SCP implementation.[15,19,25,35,43–45] We listed eight barriers and asked whether each is (or would be) a problem for their practice. Similarly, we listed seven strategies and asked whether they were used and, if so, which were helpful. Using an open-ended response, we asked respondents who provide SCPs how long it typically takes to complete a report.. Finally, we elicited comments about barriers, strategies, and SCPs in general. We pilot-tested the questionnaire at one NCCCP site and edited the survey for the main study.

Recruitment and data collection

At each NCCCP site, a site lead invited eligible providers to participate. The site lead gave a gift card to each respondent. Site leads returned completed anonymous questionnaires to Memorial Sloan-Kettering Cancer Center (MSKCC) for analysis. Surveys were distributed between September 2011 and June 2012, with each site enrolling participants for one to two months until all eligible providers had either participated or chosen not to participate. This study was deemed exempt from Institutional Review Board at MSKCC and at all of the participating sites.

Statistical Analysis

We reported participant characteristics, SCP use, opinions on SCP provision, perceived barriers, and perceived value of implementation strategies using descriptive statistics. Differences between physicians and non-physicians (advanced practice nurses and physician assistants) were assessed with t-tests and chi-squared statistics. Missing responses were removed from the analysis on a question-by-question basis.

Results

Across the fourteen sites, 245 oncology providers (70% of eligible providers, range 28%-100% across sites) completed the survey, with an average of 17.5 participants per site (standard deviation = 5.8) (Table 1). There was no difference in profession between participants and non-participants ($p>0.05$). Each survey item had fewer than 10% of responses missing, with the exception of two items: the amount of time to complete an SCP (an open-ended question) and whether limiting the content of the SCP was a useful strategy (11% and 13% of responses missing, respectively).

Use of SCPs

Fewer than half of respondents reported that they ever provide their patients with summaries of diagnosis, summaries of treatment, recommendations for ongoing care, or information about what aspects of care the oncology practice will provide (38%, 39%, 48%, and 49%, respectively) (Table 2). However, 52% of providers (N=128) ever provide any component of an SCP to their patients, and this did not vary by the profession of the respondent. Three quarters of respondents (N=183) reported that they or someone at their practice ever provides any component of an SCP to the respondent’s patients. In each clinic where SCPs were provided by the respondent or another person, SCPs were provided by oncologists, non-physician clinicians, and social workers, working alone or in combination.

Among the 128 participants who reported that they ever give any component of SCPs to their patients, 66% (N=85) estimated in open-ended format how long it takes on average to complete. Just under half (48%, N=41) reported that it takes 15 minutes or less, 22% (N=19) reported between 16 minutes and a half hour, 12% (N=10) between 31 minutes and an hour. Sixteen percent (N=14) reported that it takes over a day. We dichotomized the time for SCP completion near the median (15 minutes or less vs. more than 15 minutes), and we found that more non-physicians reported taking more than 15 minutes than did physicians (72% and 32%, respectively, $p<0.05$).

Importance of SCPs

Fifty-eight percent to 65% of respondents felt it was very important for patients to receive information regarding the topics in an SCP (i.e., diagnosis, treatment, recommended care, and aspects of care followed by the oncology practice) (Table 3). Across topics, 87%-89% of respondents felt receiving an SCP was very important to primary care providers. Physicians were less likely than non-physicians to feel information was very important for patients across all topics (47%-56% for physicians compared to 82%-90% for non-physicians, all $p<0.05$). Similarly, physicians were less likely than non-physicians to feel information was very important for primary care providers across all topics (82%-85% for physicians compared to 93%-95% for non-physicians, all $p<0.05$) except the importance of providing information about diagnosis (88% for physicians and 92% for non-physicians, n.s.) (Data not shown).

Between 60% and 65% of respondents felt that providing summaries of each topic was definitely the responsibility of oncology providers, and 33%-38% of respondents had mixed feelings about whether it was the oncology providers' responsibility (Table 3). Opinions differed by provider type. Physicians were less likely than non-physicians to feel it was definitely the responsibility of oncology providers to provide summaries, compared to having mixed feelings or feeling it was definitely not their responsibility (48%-50% among physicians compared with 78%-87% among non-physicians, all $p<0.05$) (Data not shown).

Barriers to SCP use

The most widely reported barrier to implementing SCPs was adequate personnel to complete the SCP (69%, N=170), followed by time to collect information to complete the SCP (64%, N=156) (Table 4). Twenty-nine respondents added that constructing the SCP, specifically collecting treatment information and creating the report or template, poses a difficulty. Thirteen respondents volunteered that patients either do not understand or do not want additional information.

Strategies for SCP use

To describe the utility of different implementation strategies, we limited our analysis to the 183 respondents who indicated that someone in their practice provides SCPs to their patients. For each of the seven implementation strategies described in the questionnaire, fewer than half of this group reported that the strategy is every used (Table 5). The most commonly used strategy was to delegate the completion of an SCP to a single person (N=73, 40%), and most of those who use this strategy (N=65, 89%) found this helpful. However, 49% of those who reported delegating SCP creation to a single person (N=36) listed multiple people involved in the creation of SCPs, suggesting that delegation of this task to a single person does not happen consistently. All of the strategies were found helpful by at least 74% of respondents who reported using them. The most widely endorsed strategy was the use of a template with pre-specified fields (N=58 out of 62 who use this strategy, 94%). In post hoc chi-squared tests, we found none of the strategies correlated with the time to complete an SCP (all $p<0.05$).

Open-ended comments about timing of SCP delivery

In response to suggestions for a better time to provide SCPs than after treatment completion, 45 respondents volunteered that before or during treatment would be better, including suggestions for early discussions of treatment plans and ongoing conversations throughout treatment.

When asked to volunteer additional strategies that are or would be helpful in their practice, the only new strategy that emerged was the need for training on the use of SCPs, including a specific call for evidence supporting SCP use (9 comments).

Open-ended comments about SCPs

Eighty-eight respondents (36%) provided at least one comment about SCPs. Thirty respondents expressed that SCPs are (or would be) valuable. Three comments expressed an interest in SCPs becoming part of the standard of care for all patients. In contrast, nine comments expressed reservations about the value of SCPs, including the feeling that patients are satisfied with their verbal conversations about survivorship, patient complaints about being billed for SCPs, the additional stress that a large amount of information can cause for a patient, and the uncertain benefit to patients. Two respondents mentioned the lack of published evidence to support benefit of SCPs.

Twenty comments addressed suggestions for the content of SCPs, including recommendations for families, detailed chemotherapy information, separate plans for different cancers, and updates when guidelines change. Two comments addressed targeting the content of SCPs to patient needs, and three comments recommended that SCPs be concise.

Discussion

While oncology leaders, survivorship experts, survivors, and primary care providers all express positive sentiments about SCPs, oncology providers are not uniformly providing them. This is true of our sample of community-based oncology providers in NCCCP hospitals and it has been seen at NCI-designated cancer centers as well.[10] Recognizing the upcoming Commission on Cancer requirement, and the fact that NCCCP providers have incentive to promote quality improvement in survivorship care, one might hypothesize that providers in these two settings would be early adopters of strategies to implement the use of SCPs, suggesting that implementation may be even lower at other practices. Our study provides further insight into why there might still be limited use of this intervention among oncology practices.

Having adequate and appropriately trained staff to complete the SCP is critical for oncology practices. Delegating a single person to complete the SCP was reported as helpful to 89% of the participants who do so, and multiple participants suggested the potential usefulness of a survivorship team approach. Non-physician providers, suggested by two participants, are frequently employed in survivorship care and often fill an important role in SCP implementation.[39,41,46]

SCP use also requires time. Prior studies estimated the time to complete an SCP is between 1 and 2 hours.[16,19,45] Our results suggest a less time-consuming process for most providers, although there was significant variation. It is unknown whether providers in our study are completing entire SCPs or more brief summaries of one or more topics. Regardless, the time to complete an SCP was listed as a challenge by 61% of respondents who provide SCPs and as a potential challenge to 67% of those who do not provide SCPs. The time needed to discuss the SCP with the patient also poses a problem for providers, although our findings suggest that this challenge is less significant.

Similar to other published surveys of oncologists, The majority of both oncologists and non-physician oncology providers in our study think SCPs are somewhat or very important to both survivors and their primary care providers.[15,17] However, providers perceive that SCPs provide greater benefit for primary care providers than for patients, with more than 85% reporting that each topic (diagnosis, treatment, recommended ongoing care, or aspects of oncology care follow-up) was very important for primary care providers and fewer than two-thirds reporting that each topic was very important to patients. It is possible that this perception arose in part from the technical presentation of the American Society of Clinical Oncology survivorship care plans, which likely are more relevant to clinicians than to patients. Ironically, SCPs were conceptualized as a patient-centered intervention that could enable survivors to manage their own health and be informed participants in their ongoing health care. If oncology providers doubt the relevance of SCPs for survivors, they may be less likely to offer SCPs to survivors and, even if they do, the content may be directed more toward primary care providers than survivors themselves.

The perceived minimized relevance of SCPs for survivors is also troubling in light of the impending workforce shortages in both oncology and primary care.[28,38,47–50] Oncology practices will likely feel increasing pressure to stop seeing cancer survivors, and survivors may have difficulty seeking ongoing primary care. Survivors will need to take an active role in seeking informed care, whether from an oncology or primary care provider (or both), and a survivor-centered SCP is critical in assisting their self-management and assuring continued comprehensive survivorship care.

We found ambivalence about whether oncology providers should be responsible for providing SCPs. Just under two-thirds of respondents felt that oncology providers were definitely responsible for providing information to their patients, and roughly a third reported mixed feelings about oncology providers being responsible. Despite mixed feelings, oncology providers are in the best position to disseminate personalized information regarding diagnosis and treatment – the aspect of SCP completion that likely takes the most time. In contrast, although oncology providers are in the best position to provide information about what follow-up care is recommended, some of this information may not differ within subgroups of cancer survivors and, therefore, need not be personalized for each patient. For example, while recommendations for DEXA scans depend on specific criteria and require personalization, many cancer-specific SCPs provided by the American Society of Clinical Oncology offer a generic list of ongoing tests and visits with recommended frequency, making it unnecessary for oncology providers to document this information for every survivor's SCP.[51–54] Similarly, a description of what aspects of care the oncology provider intends to oversee likely does not vary widely, if at all, between patients. (For example, whether an oncologist takes responsibility for surveillance colonoscopy likely does not vary between colorectal cancer survivors.) Despite some ambivalence about whether they should provide this information, of all parties involved, the oncology providers who complete and disseminate SCPs are in the best position to clarify their preferred division of responsibilities. If generic information can easily be entered into SCPs, resources can be directed toward the more time-consuming entry of patient-specific data.

Comments by respondents confirmed that while oncology providers find SCPs to be a good idea, there are also mixed feelings about the benefit of these documents. A minority of respondents use the strategies we listed for implementing SCPs. Even considering that some respondents may be unaware of how SCPs are implemented in their practices, the rates of use (12–40%) are low. Some strategies, such as integrating SCPs into an electronic record, are difficult to enact. However, simpler strategies, such as using existing SCP templates or limiting the content of the SCP to a brief summary, are rarely in place. Because there is not yet evidence regarding which elements of SCPs improve outcomes, choosing concise templates and limiting content can be challenging. However, choices about content may be informed from a growing body of literature on survivor and primary care provider needs, which emphasize the salient preferences for information among survivors (particularly information on self-management, signs of recurrence, and coordination of providers) and primary care providers (including information about coordination of care, recommendations for surveillance, and information about late effects). [10,21,55–57].

Although it is a less simple strategy to enact, automatically populating SCPs from the electronic health record could capitalize on data already being entered for clinical use and simplify SCP use in the long run. With an electronic platform linked to medical records, patient-specific information that could be used to direct ongoing care (such as medical data relevant to whether DEXA scans are necessary for breast cancer survivors) as well as more general guidelines for follow-up could be directly imported into the SCP, minimizing the need to manually enter information. Some data relevant to treatment and diagnosis may already be captured for cancer registries. An electronic health record could facilitate the use of these data for the SCP. In our study, only 16% of respondents who provide SCPs have them integrated into the electronic health record, suggesting one way to facilitate the implementation of SCPs.

Finally, there were significant differences in the perspectives of oncologists and non-physician oncology providers. Oncologists were less likely than their counterparts to feel that receiving an SCP is important – both to survivors and their primary care providers. Oncologists were also less likely than non-physicians to feel that oncology providers are definitely responsible for providing SCPs. These differences underscore the increased involvement of non-physician clinicians in providing survivorship care (and SCPs).[39,41] While physicians may be focused primarily on treatment and surveillance, non-physicians may have a broader perspective on comprehensive survivorship needs, including the need to communicate about ongoing care with patients and primary care providers.

Our study has limitations. Respondents may have been unaware of who else in the practice provides SCPs. One potential ramification of this is that providers who do not use SCPs may not be aware of the challenges involved. To explore this possibility, we conducted a sensitivity analysis of the barrier items, limiting the analysis to the 128 providers who themselves provide SCPs. Among respondents who personally provide SCPs to their patients, the same patterns of barriers were present as with the entire sample, with personnel and time to complete the SCP endorsed by the highest proportions of respondents, suggesting that those who do not personally provide SCPs still understand challenges involved in implementation. It is important to include responses of all participants, regardless of SCP use, as the perception of barriers may be responsible for whether providers use SCPs. Finally, the list of barriers and strategies that we presented in our questionnaire may not be complete. However, write-in responses reiterated many of the barriers and strategies presented, and few new barriers and strategies were suggested.

To our knowledge, this is the first study to explicitly describe barriers to SCP use, strategies for SCP implementation, and buy-in from oncology providers. With a high response rate (70%) from both non-physician and physician oncology providers at community hospitals across the United States, we found that resource issues to create information-rich SCPs pose a significant barrier to creating SCPs. Despite broad approval of SCPs by survivors and primary care providers, implementation will likely remain limited unless resources become available to overcome significant barriers. Existing strategies to reduce burden are rarely used, and oncology providers may benefit from training focusing on implementation strategies, as some respondents suggested. Community cancer centers aiming to provide SCPs (perhaps in response to Commission on Cancer accreditation standards) can help by working to enable the linkage of SCPs to electronic medical records. More critically, we found limited buy-in for SCP use, particularly in terms of the perceived value for the survivor and the idea that oncology providers are responsible for SCP use. Addressing practical challenges may not be enough to earn the buy-in of oncology providers. Ultimately, oncology providers are key stakeholders who do the work involved in providing SCPs to survivors, and they need to feel that this work is worth the effort. Proponents of SCP use may benefit from extending education about the information survivors and primary care providers want from SCPs, emphasizing the importance of the SCP as a tool to improve care coordination.

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Table 1

Participant characteristics (N=245)

	N	(%)
Profession of participants		
Physician		
Medical oncology	117	(48)
Radiation oncology	37	(15)
Nurse practitioner or clinical nurse specialist	66	(27)
Physician assistant	25	(10)
Participants at each site		
Billings Clinic Cancer Center (MT)	15	(6)
Geisinger Medical Center Cancer Institute (PA)	21	(9)
Gundersen Lutheran Center for Cancer & Blood Disorders (WI)	18	(7)
Hartford Hospital, Helen and Harry Gray Cancer Center (CT)	20	(8)
Lehigh Valley Hospital, John and Dorothy Morgan Cancer Center (PA)	29	(12)
Mercy Cancer Center (IA)	14	(6)
Norton Cancer Institute (KY)	12	(5)
Penrose Cancer Center (CO)	19	(8)
Providence Portland Medical Center (OR)	19	(8)
Seton Family of Hospitals (TX)	4	(2)
Spartanburg Regional Hospital, Gibbs Regional Cancer Center (SC)	14	(6)
St. Elizabeth Cancer Center (NE)	21	(9)
St. Luke’s Regional Medical Center (ID)	22	(9)
St. Mary’s Health Care, The Lacks Cancer Center (MI)	17	(7)
	Mean	**(SD)**
Patients seen per week [a]	36	(25)

[a] N=230 due to missing responses, SD= Standard deviation

Table 2

Provision of SCP components (N=245)

	Always		**Sometimes**		**Never**		**Don't Know**	
Component of SCP	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
By provider								
Diagnosis	20	(8)	74	(30)	141	(58)	10	(4)
Treatment	20	(8)	77	(31)	136	(56)	12	(5)
Recommended ongoing care	45	(18)	74	(30)	117	(48)	9	(4)
What aspects of care your practice will follow-up	46	(19)	73	(30)	116	(47)	10	(4)
By other person in practice								
Diagnosis	19	(8)	101	(41)	77	(31)	48	(20)
Treatment	19	(8)	103	(42)	73	(30)	50	(20)
Recommended ongoing care	27	(11)	107	(44)	65	(27)	46	(19)
What aspects of care your practice will follow-up	32	(13)	99	(40)	64	(26)	50	(20)

Table 3

Opinions on value of and responsibility for providing SCPs (N=245)

Importance of receiving a written report with information summarizing…	**Very Important**		**Somewhat Important**		**Not at all Important**		**Don’t Know**	
	N	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
Diagnosis								
For the patient	143	(58)	83	(34)	10	(4)	9	(4)
For the primary care provider	218	(89)	23	(9)	3	(1)	1	(<1)
Treatment								
For the patient	149	(61)	79	(32)	6	(2)	11	(4)
For the primary care provider	215	(88)	27	(11)	2	(1)	1	(<1)
Recommended Ongoing Care								
For the patient	160	(65)	67	(27)	5	(2)	13	(5)
For the primary care provider	215	(88)	27	(11)	2	(1)	1	(<1)
What aspects of care your practice will follow-up								
For the patient	146	(60)	78	(32)	9	(4)	12	(5)
For the primary care provider	213	(87)	29	(12)	2	(1)	1	(<1)
Is it the responsibility of oncology providers to give patients a report summarizing…	**Definitely**		**Mixed Feelings**		**Definitely Not**		**Don’t Know**	
Diagnosis	148	(60)	92	(38)	5	(2)	0	(0)
Treatment	152	(62)	88	(36)	4	(2)	1	(<1)
Recommended ongoing care	159	(65)	81	(33)	4	(2)	1	(<1)
What aspects of care your practice will follow-up	151	(62)	88	(36)	5	(2)	1	(<1)

Table 4

Barriers to the creation and distribution of SCPs (N=245)

	This is / would be a problem		**This is not / would not be a problem**		**Not Sure**	
	N	**(%)**	**N**	**(%)**	**N**	**(%)**
Personnel to complete the SCP	170	(69)	59	(24)	16	(7)
Time to collect information	156	(64)	74	(30)	15	(6)
Time to discuss the SCP with the patient	112	(46)	118	(48)	15	(6)
Personnel to discuss the SCP	112	(46)	115	(47)	18	(7)
Resources unrelated to time or personnel	105	(43)	103	(42)	37	(15)
Institutional support	82	(33)	132	(54)	31	(13)
Support from colleagues	54	(22)	163	(67)	28	(11)
Medical or legal issues	42	(17)	169	(69)	34	(14)

Table 5

Value of strategies for the implementation of SCPs among providers who use them (N=183)

	Used in Practice		**Helpfulness of Strategy**					
			Helpful		**Not Helpful**		**Don’t Know**	
	N	**(%)**	**N**	**(%)**	**N**	**(%)**	**N**	**(%)**
Delegate completion of SCP to one person	73	(40)	65	(89)	2	(3)	6	(8)
Integrate SCP into survivorship visit	66	(36)	57	(86)	3	(5)	6	(9)
Use template with pre-specified fields	62	(34)	58	(94)	3	(5)	1	(2)
Limit the content of SCP	54	(30)	48	(89)	0	(0)	6	(11)
Bill for completion/discussion	39	(21)	31	(79)	5	(13)	3	(8)
Limit SCP delivery to certain patients	31	(17)	23	(74)	6	(19)	2	(6)
Integrate SCP into electronic health record	25	(14)	20	(80)	3	(12)	2	(8)