Guideline Resource Unit
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Follow-Up Model of Care for Cancer Survivors

Effective Date: May 2025

Cancer Care Alberta

Clinical Practice Guideline SUPP-024 – V1
http://www.ahs.ca/guru

Background

Advances in cancer care have improved survival rates, allowing more patients to live longer with and beyond cancer[1-3]. As a result, the number of cancer survivors continues to grow, increasing the demand for ongoing follow-up care. The rising demand places considerable strain on the healthcare system, particularly at a time when cancer care resources are already stretched thin[4]. Alberta's cancer care workforce is overburdened and under resourced, leading to prolonged wait times for patients requiring care. The province's target is for patients to see an oncologist within four weeks of diagnosis[5] however as of December 2023, the average wait time to see a medical oncologist is 8 weeks while the wait to see a radiation oncologist is approximately 13 weeks[6]. The growing disparity is exacerbated by a mismatch between rising cancer incidents and workforce expansion. Between 2013 and 2022 the number of new cancer cases in Alberta increased by 40% while the number of oncologists grew by only 20% during the same period[4]. Without effective strategies to optimize follow-up care, these challenges will continue to impact patient outcome and healthcare system efficiency.

Establishing a standardized follow-up model of care for cancer survivors will help alleviate pressure on the overburdened oncology system by transitioning stable survivors out of oncologist care in a timely and structured manner. The limited available evidence suggests overall, cancer survivorship care in primary care has similar effects on clinical and patient-reported outcomes compared with secondary care[7]. Capacity can be increased for newly diagnosed and high-risk cancer patients who require urgent oncologic intervention. At the same time, clear guidelines will ensure that cancer survivors continue to receive high quality, coordinated follow-up care. This approach balances the need for system efficiency while maintaining comprehensive care for survivors.

Definitions

To create clarity around the concepts in this guideline, the following definitions are provided:

- **Survivors**: Patients who have completed primary cancer treatment and have no evidence of active disease. Individuals who may be receiving ongoing adjuvant hormonal therapy are also considered to be survivors.
- **Follow-up care**: A set of activities and processes aimed at:
    - Cancer Prevention including primary (lifestyle modification), secondary (cancer screening), and tertiary (early detection of recurrent or new cancers) cancer prevention.
    - Rehabilitation and management of the short-term and long-term effects of cancer and its treatment (e.g., side effects, complications).
    - Address psychosocial and financial concerns.
    - Coordination of care.
- **Primary care provider (PCP)[8]**: A healthcare provider or a team responsible for managing a patient’s overall health and serving as the first contact for new health concerns. PCPs can include, but are not limited to family physicians, general practitioners, nurse practitioners, and

family health teams.

- **Specialist team**: A team of healthcare providers with advanced training in a specific area of medicine, such urology, hematology, or surgery.
- **Most responsible provider (MRP)**[9]: The MRP is a regulated healthcare professional (e.g., physician, nurse practitioner) who is responsible for directing and coordinating care for patients. In follow-up, their role includes, but are not limited to, ordering surveillance tests, prescribing medications, assessing needs for and coordinating supportive care, and updating the follow-up care plan.

Goals of This Document

The recommendations aim to provide guidance and reference to healthcare providers on implementing optimal delivery of follow-up care for all cancer survivors by clarifying roles and responsibilities, while complementing existing resources such as the Transfer of Care letters. Please note that this document is not a substitute for workforce planning.

Research Questions

1. What criteria should be used to discharge patients with survivorship care plans from Cancer Care Alberta (CCA) facilities?
2. How many years post-treatment should cancer survivors be discharged?
3. What information should be included in follow-up care plans for cancer survivors?

Search Strategy

This guideline was developed to outline the follow-up model of care recommendations for cancer survivors. We consulted with the Cancer Care Medical Librarian for this literature search. It was informed by the results of articles published between 2019-2025 (see **Appendix A**). This guideline was informed by the following clinical practice guidelines:

- Follow-Up Model of Care for Cancer Survivors-Cancer Care Ontario, 2019[8]
- ESMO Expert Consensus Statements on Cancer Survivorship: promoting high-quality survivorship care, 2022[10]

Target Population

The recommendations outlined in this guideline apply to all cancer survivors, regardless of their cancer type, except those enrolled in a clinical trial.

Recommendations

Discharging the Patient

The following criteria should be used to discharge patients from CCA facilities with **follow-up care plans** no later than 1-year post-treatment:

- Cancer in complete remission
  - no active cancer, including patients on post-adjuvant therapy for non-metastatic disease
- Likelihood of relapse in the next 2 years <50%
- >1 month from last CCA-requiring systemic/radiation therapy
  - Patients on hormone therapy alone should also be discharged[*]
- MRP available to follow patient
  - May be a PCP or a specialist. This decision should be made through a dialogue between PCP and the specialist team responsible for follow-up care planning. Which provider to assume the MRP role should be decided based on the following criteria:
    - Severity and risk of treatment complications, long-term and late effects
    - Need for specialized procedures that can only be provided by specialist teams

Follow-up Care Planning[8,10,11]

If the patient receives more than one modality of treatment (e.g., surgery, radiation, and/or systemic treatment), one of these specialist teams should assume the responsibility for follow-up care planning near the completion of the treatment.

- The specialty team should work with the survivor and all relevant care teams (e.g., surgical, radiation, and/or systemic) to develop a follow-up care plan.
- The follow-up care plan should be comprised of two components:

  (a) A treatment summary including but not limited to:
    - Cancer diagnosis
    - Treatment(s) received

  (b) A plan for follow-up care based on the needs of the patient, including but not limited to:
    - Appropriate guidelines/recommendations for follow-up care (e.g., primary prevention/lifestyle modification, established screening programs, recommended surveillance plan including visit assessments and tests to detect relapse)

[*] Patients diagnosed with endometrial cancer or endometrial hyperplasia with atypia who are undergoing hormonal therapy are required to be seen for biopsies and ultrasounds and should not be discharged from CCA facilities.

- A list of signs and symptoms of recurrence
- Short-term and long- term effects of cancer and its treatment
- Psychosocial, rehabilitation/return to work, financial needs
- Instructions for referral or re-entry into the cancer system if there is suspicion of recurrence or second cancers
- Contact information of the treatment team who prepared the plan of care and the provider who will be responsible for ongoing follow-up care.

The survivor should receive a copy of the follow-up care plan and review it with the MRP and other members of the care team to ensure that the survivor understands the care plan and its goals. Please see **Appendix B** for links to existing CCA follow-up care plans/ transfer of care plans.

Surveillance[8]

Surveillance is a critical component of follow-up care, ensuring early detection of cancer recurrence, second cancers, and any long-term medical or psychosocial effects of cancer and its treatment. Surveillance should be structured, systematic and carried out in accordance with existing evidence-based clinical guidance. Please see **Appendix C** for links to existing CCA follow-up guidelines.

Metrics

These recommendations will serve as a guiding document for building a robust provincial measurement strategy to enable data-driven improvements in follow-up care delivery in Alberta. This strategy will include the development of indicators to understand patterns of follow-up care, monitor concordance with guideline-recommended practices, and measure the impact on patients, providers, and the healthcare system. Some key metrics include the uptake of Transfer of Care letters, the time between the end of active treatment and discharge, and the number of post-treatment follow-up visits.

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Appendix A: Search Strategy

Database	Date	Search Terms	Limits/Filters
PubMed	Dec.17 2024	(("primary health care"[MeSH Terms] OR ("primary"[All Fields] AND "health"[All Fields] AND "care"[All Fields]) OR "primary health care"[All Fields] OR ("primary"[All Fields] AND "care"[All Fields]) OR "primary care"[All Fields]) AND "follow-up"[All Fields] AND ("cancers"[All Fields] OR "cancerated"[All Fields] OR "canceration"[All Fields] OR "cancerization"[All Fields] OR "cancerized"[All Fields] OR "cancerous"[All Fields] OR "neoplasms"[MeSH Terms] OR "neoplasms"[All Fields] OR "cancer"[All Fields] OR "cancers"[All Fields]) AND ("survivorship"[MeSH Terms] OR "survivorship"[All Fields] OR "survivorships"[All Fields]))	Published in the last 5 years, English, Humans
PubMed; MEDLINE (Ovid); EMBASE; CINAHL; MEDLINE (Ebsco); TRIP	*Jan. 27 2025	"cancer survivor*" AND (discharge OR "patient discharge" OR "discharge plan*") AND ("cancer care" OR "oncology care" OR "cancer center*" OR "cancer centre*") NOT (hospital* OR inpatient*) (cancer OR neoplasm* OR carcinoma OR tumor* OR tumour*) AND survivor* AND (discharge OR "patient discharge" OR "discharge plan*") AND ("cancer care" OR "oncology care" OR "cancer center*" OR "cancer centre*") NOT (hospital* OR inpatient*) "cancer survivor*" AND (discharge OR "patient discharge" OR "discharge plan*") AND ("cancer care" OR "oncology care" OR "cancer center*" OR "cancer centre*") NOT (hospital* OR inpatient*) AND (time OR "optimal time") (cancer OR neoplasm* OR carcinoma OR tumor* OR tumour*) AND survivor* AND (discharge OR "patient discharge" OR "discharge plan*") AND ("cancer care" OR "oncology care" OR "cancer center*" OR "cancer centre*") NOT (hospital* OR inpatient*) AND (time OR "optimal time") "cancer survivor*" AND (discharge OR "patient discharge" OR "discharge plan*") AND ("cancer care" OR "oncology care" OR "cancer center*" OR "cancer centre*") NOT (hospital* OR inpatient*) AND (survival OR recurrence OR reoccurrence OR "patient satisfaction") (cancer OR neoplasm* OR carcinoma OR tumor* OR tumour*) AND survivor* AND (discharge OR "patient discharge" OR "discharge plan*") AND ("cancer care" OR "oncology care" OR "cancer center*" OR "cancer centre*") NOT (hospital* OR inpatient*) AND (survival OR recurrence OR reoccurrence OR "patient satisfaction") "cancer survivor*" AND (discharge OR "patient discharge" OR "discharge plan*") AND ("cancer care" OR "oncology care" OR "cancer center*" OR "cancer centre*") NOT (hospital* OR inpatient*) AND (time OR "optimal time") AND (survival OR recurrence OR reoccurrence OR "patient satisfaction") (cancer OR neoplasm* OR carcinoma OR tumor* OR tumour*) AND survivor* AND (discharge OR "patient discharge" OR "discharge plan*") AND ("cancer care" OR "oncology care" OR "cancer center*" OR "cancer centre*") NOT (hospital* OR inpatient*) AND (time OR "optimal time") AND (survival OR recurrence OR reoccurrence OR "patient satisfaction")	Published in the last 5 years, English, Humans
PubMed; MEDLINE (Ovid); EMBASE;	*Jan. 27 2025	"cancer survivor*" AND ("follow up care" OR "follow-up care" OR "after care" OR after-care OR aftercare OR "after treatment" OR after-treatment) AND ("general practitioner*" OR "general practice physician*" OR "family doctor*" OR "family physician*")	Published in the last 5 years,

CINAHL; MEDLINE (Ebsco); TRIP		(cancer OR neoplasm* OR carcinoma OR tumor* OR tumour*) AND survivor* AND (“follow up care” OR “follow-up care” OR “after care” OR after-care OR aftercare OR “after treatment” OR after-treatment) AND (“general practitioner*” OR “general practice physician*” OR “family doctor*” OR “family physician*”) “cancer survivor*” AND (“follow up care” OR “follow-up care” OR “after care” OR after-care OR aftercare OR “after treatment” OR after-treatment) AND (“general practitioner*” OR “general practice physician*” OR “family doctor*” OR “family physician*”) AND (survival OR recurrence OR reoccurrence OR “patient satisfaction”) (cancer OR neoplasm* OR carcinoma OR tumor* OR tumour*) AND survivor* AND (“follow up care” OR “follow-up care” OR “after care” OR after-care OR aftercare OR “after treatment” OR after-treatment) AND (“general practitioner*” OR “general practice physician*” OR “family doctor*” OR “family physician*”) AND (survival OR recurrence OR reoccurrence OR “patient satisfaction”)	English, Humans

*Search performed by Marcus Vaska, Cancer Care Medical Librarian, KRS

Appendix B: Follow-Up Care/ Transfer of Care Plans:

All Transfer of Care Letters are available in Connect Care and on www.ahs.ca/GURU.

- Generic- Physician Letter, Patient Letter
- CAR-T Cell Therapy- Physician Letter
- Early Stage Breast Cancer- Physician Letter, Patient Letter
- DCIS Post-Mastectomy- Physician Letter, Patient Letter
- Uveal Melanoma, Class 1- Physician Letter
- Uveal Melanoma, Class 2- Physician Letter
- Colorectal Cancer- Physician Letter, Patient Letter
- Rectal Cancer- Physician Letter, Patient Letter
- Prostate Cancer- EBRT- Physician Letter, Patient Letter
- Non-Seminoma Testicular Cancer- Physician Letter, Patient Letter
- Seminoma Testicular Cancer- Physician Letter, Patient Letter
- Cervical Cancer- Physician Letter, Patient Letter
- Endometrial Cancer- Physician Letter, Patient Letter
- Head and Neck Cancer- Physician Letter, Patient Letter
- CLL Cancer- Physician Letter, Patient Letter
- Diffuse Large B-cell Lymphoma- Physician Letter, Patient Letter
- Hodgkin Lymphoma- Physician Letter, Patient Letter
- Indolent Non-Hodgkin Lymphoma- Physician Letter, Patient Letter

Appendix C: Follow-Up Guidance:

Follow-up guidelines:

- Post-Autologous Transplant
- Post-Allogeneic Transplant
- Post CAR T-cell Therapy
- Early-Stage Breast Cancer
- Soft Tissue Sarcoma

Guidelines mentioning follow-up care:

- Brain Metastases
- Seizure Management in Adults with Brain Tumours
- Uveal Melanoma
- Adenocarcinoma of the Pancreas
- Early Esophageal Cancer, Dysplastic, and Non-Dysplastic Barrett's Esophagus
- Colorectal Cancer Surveillance (Stage I, II, and III)
- Early-Stage Rectal Cancer
- Very Early-Stage HCC
- Non-Muscle Invasion Bladder Cancer
- Muscle Invasive Bladder Cancer
- Upper Tract Urothelial Tumours
- Locally Advanced/ Metastatic Bladder Cancer
- Localized Prostate Cancer
- Advanced/Metastatic Prostate Cancer
- Renal Cell Carcinoma
- Testicular Germ Cell Tumours
- Cancer or Uterine Cervix
- Uterine Sarcoma
- Acute Lymphoblastic Leukemia in Adults
- Acute Myeloid Leukemia
- Acute Promyelocytic Leukemia
- Chronic Lymphocytic Leukemia
- Lymphoma
- Advanced Non-Small Cell Lung Cancer: Driver Mutation Negative
- Thymic Neoplasms
- Desmoid Tumours

Development and Revision History

This guideline was reviewed and endorsed by the Alberta Provincial Tumour Team Council, which includes medical oncologists, radiation oncologists, surgical oncologists and gynecologic oncology. A detailed description of the methodology followed during the guideline development process can be found in the Guideline Resource Unit Handbook.

This guideline was originally developed in 2025.

Maintenance

A formal review of the guideline will be conducted in 2030. If critical new evidence is brought forward before that time, however, the guideline working group members will revise and update the document accordingly.

Abbreviations

CAR, chimeric antigen receptor; CCA, Cancer Care Alberta; CLL, chronic lymphocytic leukemia; DCIS, ductal carcinoma in situ; EBRT, External Beam Radiation Therapy; HCC, hepatocellular cancer; KRS, knowledge resource services; MRP, most responsible provider; PCP(s), primary care provider(s).

Disclaimer

The recommendations contained in this guideline are a consensus of the Alberta Provincial Tumour Teams and are a synthesis of currently accepted approaches to management, derived from a review of relevant scientific literature. Clinicians applying these guidelines should, in consultation with the patient, use independent medical judgment in the context of individual clinical circumstances to direct care.

Funding Source

Financial support for the development of Cancer Care Alberta's evidence-based clinical practice guidelines and supporting materials comes from the Cancer Care Alberta operating budget; no outside commercial funding was received to support the development of this document.

All cancer drugs described in the guidelines are funded in accordance with the Outpatient Cancer Drug Benefit Program, at no charge, to eligible residents of Alberta, unless otherwise explicitly stated. For a complete list of funded drugs, specific indications, and approved prescribers, please refer to the *Outpatient Cancer Drug Benefit Program Master List*.

Conflict of Interest Statements

Xanthoula Kostaras has nothing to disclose.

Dr. Vanessa Krause has nothing to disclose.

Wendy Pak has nothing to disclose.

Monika Podkowa has nothing to disclose.

Michael Sidra has nothing to disclose.

Dr. Doug Stewart has nothing to disclose.

Rachel Vanderploeg has nothing to disclose.

Citation

Kostaras X, Krause V, Pak W, Podkowa M, Sidra M, Stewart D, Vanderploeg R. Cancer Care Alberta, Alberta Health Services (2025). Follow-Up Model of Care for Cancer Survivors, Version one. Accessed [Month, Year]. Available from: www.ahs.ca/guru

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