QUALITY STANDARDS

Cancer Survivorship

Care for Adults in All Settings

OCTOBER 2025

Ontario Health

Scope of This Quality Standard

This quality standard addresses care for adults age 18 and over who are living with, through, and beyond a cancer diagnosis (cancer survivors). The quality standard focuses on the assessment, management, and follow-up care of cancer survivors in Ontario. The quality standard addresses the health and well-being of cancer survivors of all cancer types and applies to all adult health settings, including hospitals, regional cancer centres, emergency departments, primary and long-term care and other home and community care settings. The quality standard does not address cancer screening, care for patients in workup for cancer, treatment pathways, palliative care, or end-of life care. Although this quality standard does not address care for patients in workup for cancer or treatment pathways, it outlines high-quality survivorship care that is initiated early in the cancer journey to support long-term wellness, improved quality of life, and proactive management of health risks.

What Is a Quality Standard?

Quality standards outline what high-quality care looks like for conditions or processes where there are large variations in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive. They:

- Help patients, families, and care partners know what to ask for in their care
- Help clinicians know what care they should be offering, based on evidence and expert consensus
- Help health care organizations measure, assess, and improve their performance in caring for patients

Quality standards and their accompanying patient guides are developed by Ontario Health in collaboration with clinicians, patients, and care partners across Ontario.

For more information, contact QualityStandards@OntarioHealth.ca.

Quality Statements to Improve Care: Summary

These quality statements describe what high-quality care looks like for people living with, through, and beyond a cancer diagnosis (cancer survivors).

Quality Statement 1: Comprehensive Assessment at Regular Intervals

Cancer survivors receive a comprehensive assessment of their survivorship care needs at regular intervals. Assessments are documented in an individualized, person-centred care plan that is updated regularly. Survivors with identified needs receive or are referred to appropriate care and services.

Quality Statement 2: Transitions in Care, Care Coordination, and Primary Care Integration

Cancer survivors transition between levels of cancer care as appropriate for their needs. Transitions in care for survivors involve care coordination, shared care, and support between health care teams and settings, ensuring integration with primary care.

Quality Statement 3: Psychosocial Support

Cancer survivors and their care partners have access to regular psychosocial screening (as part of a comprehensive assessment) to identify any psychosocial needs or barriers to accessing care. Survivors with unmet psychosocial needs receive information and support or are referred for treatment.

Quality Statement 4: Patient Education and Self-Management

Cancer survivors receive comprehensive education about survivorship care, both during and after active treatment. They are offered self-management support and strategies to address their survivorship care needs, with the goal of optimizing their health and quality of life.

Quality Statement 5: Accessible, Culturally Safe, Equitable Care

Cancer survivors receive care in a health care system that is accessible, compassionate, and culturally responsive to their traditions, values, and linguistic and other needs. Health care teams work to build trust, remove barriers to accessing care, and provide equitable care, giving special consideration to First Nations, Inuit, Métis, urban Indigenous people, and equity-deserving populations.

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A Note on Terminology

Cancer survivors: The meaning of "cancer survivor" has evolved to reflect that survivorship outcomes are influenced by care decisions earlier in the continuum and that survivorship is an expectation of treatment. As such, Ontario Health's cancer survivorship program considers a cancer survivor to be a person living with, through, and beyond a cancer diagnosis.[1] While this terminology may not resonate with everyone, it is used in the context of the health care team working in partnership with anyone living with, through, and beyond a cancer diagnosis, that aligns with the person's unique needs and goals of care.[2]

Why This Quality Standard Is Needed

Cancer survivorship in Ontario is increasing, with a 33% increase in the number of survivors between 2019/20 and 2023/24.[3] As of March 31, 2023, there were 753,023 cancer patients in Ontario living with a current or previous cancer diagnosis. Projections indicate a further 16% increase in cancer survivorship by 2027/28. Of cancer survivors in the 2023/24 cohort, 7.5% were adolescent and young adults (AYAs) who were diagnosed between the ages of 18 and 40, 58% were older adults (aged ≥ 60 years), and more than half (58%) were female.[3]

Cancer survivors experience tiredness and significant psychosocial needs, with depression, well-being, anxiety, and pain being the top reported symptoms across multiple cancer types.[3] Cancer can have a considerable impact on a person's mental health both during and after they have completed their treatment. Among breast, colon, and rectal cancer survivors who completed the Edmonton Symptom Assessment System tool in 2023/24, 16% to 20% reported at least 1 symptom of high severity, and about a quarter of survivors (28%–32%) had at least 1 symptom of moderate severity. These findings suggest that there are substantial unmet needs among cancer survivors and highlight opportunities for improving the quality of cancer survivorship care.

With the increasing number of cancer survivors,[3] disparities stemming from health inequities also persist. Factors such as race and ethnicity, socioeconomic status, geography, and age have been identified to consistently influence outcomes throughout the cancer survivorship trajectory.[4] These factors often intersect, driving increased inequities, thus highlighting the need for increased support and availability of resources for cancer survivors.

According to the Ontario Provincial Survivorship Report,[3] enrollment with primary care decreased in 2021/22, with higher levels of material deprivation (e.g., unemployment, lack of high school degree). A higher proportion of cancer survivors (15%) who are categorized as "most deprived" were not enrolled with a primary care clinician, compared to 10% among survivors categorized as "least deprived." Given primary care providers' role in providing safe and effective long-term follow-up care for cancer survivors,[5] primary care enrollment status is a critical piece in achieving improved and equitable health outcomes.

Geography also contributes to disparities in cancer survivorship care, as it affects access to timely health care and services. In Ontario, cancer survivors travelled on average 32.6 km from their homes

to a regional cancer center for an in-person visit in 2019 to 2022, with those in the North West and North East travelling longer distances (65 and 105 km, respectively).[3] Further, although enrollment with primary care clinicians was largely consistent across regions in Ontario, the North West had the highest percentage (i.e., 24%) of cancer survivors not enrolled with a primary care clinician.

Survivors of childhood and AYA cancers are particularly susceptible to the long-term and late effects of cancer, including an increased risk of chronic health problems, impaired fertility, secondary cancers, poor psychosocial health, and financial toxicity (i.e., the direct, indirect, and emotional costs to patients following a cancer diagnosis).[4] Despite these known risks, childhood and AYA cancer survivors are at high risk of being lost to follow-up.[6,7] Older adults may also be more susceptible to increased negative health outcomes during and after cancer treatment due to factors such as reduced immune function and higher rates of comorbidities.[6]

The increasing number of cancer survivors in Ontario, as well as the high level of unmet needs and disparities experienced by cancer survivors, highlights the need for a quality standard outlining key opportunities for improving cancer survivorship care in Ontario. The *Cancer Survivorship* quality standard builds upon existing Ontario Health priorities, including the Ontario Cancer Plan 6 (2024–2028) strategic objective to "*Establish integrated survivorship services to improve the patient and care partner experience,*"[8] and Ontario's Primary Care Action Plan[9] and Systemic Treatment Models of Care.[10] In addition, survivorship is listed as a strategic priority within the First Nations, Inuit, Métis, and Urban Indigenous Cancer Strategy to improve tools and e resources for Indigenous patients to receive the necessary support to navigate the cancer system and, survivorship journey successfully.[11]

Measurement to Support Improvement

The Cancer Survivorship Quality Standard Advisory Committee identified 6 overarching indicators to monitor the progress being made toward improving care for cancer survivors in Ontario. These indicators are intended for use by those looking to implement the Cancer Survivorship quality standard, including clinicians working in regional or local roles. Measurement details are available in the technical specifications.

Indicators That Can Be Measured Using Provincial Data

- Percentage of cancer survivors who are enrolled with a primary care clinician
- Percentage of cancer survivors who obtain health care assessments at regular intervals (i.e., at least every 12 months)
- Percentage of cancer survivors who have access to, are referred to, and visit with cancer specialists during follow-up

Indicators That Can Be Measured Using Only Local Data

- Percentage of clinicians who are knowledgeable about referral options in cancer survivorship care
- Percentage of cancer survivors who receive evidence-based education and resources on cancer survivorship
- Percentage of cancer survivors who self-report improvements in general health and well-being

Quality Statement 1: Comprehensive Assessment at Regular Intervals

Cancer survivors receive a comprehensive assessment of their survivorship care needs at regular intervals. Assessments are documented in an individualized, person-centred care plan that is updated regularly. Survivors with identified needs receive or are referred to appropriate care and services.

Sources: Australian Clinical Guidelines, 2024[12] | Children's Oncology Group, 2023[13] | Multinational Association for Supportive Care in Cancer and American Society of Clinical Oncology, 2024[14] | National Comprehensive Cancer Network, 2024[15]

Definitions

Comprehensive assessment of survivorship care needs: Adequately addressing survivorship care needs includes a regular assessment of any problems related to survivorship care, problem-solving and self-management support, goal setting, and action planning. The comprehensive assessment includes, but is not limited to[16-19]:

- Screening for and monitoring late and long-term effects of treatment (e.g., fatigue, cardiovascular disease, lymphedema, anxiety, depression, trauma and distress, cognitive function, pain, sexual health and fertility, sleep disorders, etc.)
- Current disease status and surveillance for cancer spread and recurrence
- Preventive health needs (e.g., cancer screening, including assessment of eligibility for high-risk screening programs, immunization, smoking cessation, infection prevention, etc.)
- Review of systems that may have been impacted by cancer or cancer treatment, as appropriate (e.g., cardiovascular, genitourinary, respiratory, endocrine, neurological)
- Psychosocial needs (see quality statement 3)
- Review of goals of care
- Rehabilitation needs (e.g., functional status, cognitive recovery, return to school or work)
- Physical activity status (e.g., activities of daily living, exercise)
- Physical health (e.g., weight management, blood pressure)
- Immunization – consider vaccination options that are aligned with standard doses and schedules recommended based on the cancer survivor's age and individual needs

Some examples of validated tools used for assessment include the Edmonton Symptom Assessment System – Revised (ESAS-R),[20] the MD Anderson Symptom Inventory,[21] the Fear of Cancer Recurrence Inventory Short Form,[17]and the Cancer Care Monitor.[22]

Regular intervals: The assessment of survivorship care needs should be conducted at least annually (advisory committee consensus) by a clinician, or ideally by an interprofessional health care team in collaboration with the cancer survivor and their care partners (the circle of care), who work together to establish a care plan in alignment with the person's needs and goals of care.[23] Assessments may begin as early as 6 months after diagnosis (advisory committee consensus). The composition of the interprofessional health care team could vary depending on where the survivor receives care and, on the services needed. The care team may include professionals such as primary care clinicians, oncologists, nurse practitioners, surgeons, registered nurses, social workers, dieticians, psychologists, and others.

Individualized, person-centered care plan: This is a written document (physical or digital, aligned with the cancer survivors' preference) that is culturally sensitive and customized to a person's faith traditions, culture, values, beliefs, wishes, and unique health needs. The care plan includes, but is not limited to[19]:

- Surveillance
- Discussion of care expectations
- Management of comorbidities and effects of treatment
- List of signs and symptoms of recurrence
- Dietary recommendations
- Exercise programs
- Rehabilitation needs (e.g., physical therapy, and speech therapy)
- Psychosocial supports (see quality statement 3)
- Contact information of the treatment team
- Clinician or health care team responsible for follow-up care

The care plan is developed with the cancer survivor in collaboration with their care team, and care partners, as appropriate. Care plans should be communicated in person and in writing (printed or electronic) and shared with the cancer survivor, their health care team, and care partners (if the cancer survivor consents).

Appropriate care and services: Cancer survivors should receive care and services in alignment with their unique health needs and goals of care, such as returning to work after treatment, eating a balanced diet or enjoying their favorite food again, playing with children or grandchildren, being able to remain physically active (e.g., walk for 15 minutes), etc. Where applicable, survivors should be referred to the appropriate health care services or recommended to community-based support to meet their needs.

Rationale

Cancer survivors often experience late and long-term effects of treatment, including fatigue, pain, cognitive changes, and emotional distress, which may not be immediately apparent after treatment ends.[24] However, cancer survivors are often not up-to-date with recommended follow-up tests.[25] Regular follow-up assessments ensure that these short- and long-term effects of treatment are identified early and managed appropriately to improve quality of life.[12-15]

Comprehensive assessments should address not only physical health but also mental health, social support systems, and other practical concerns (e.g., stress due to financial concerns). They should leverage the expertise of an interprofessional health care team that includes primary care clinicians, oncologists, nurse practitioners, surgeons, registered nurses, social workers, traditional healers, Knowledge Keepers and Elders, Indigenous Navigator, etc.[15] The care model should be adaptable to suit the various settings (such as in-person or virtual) in which clinicians operate, ensuring that all aspects of the cancer survivor's health and wellbeing are considered.[26,27]

By taking a patient-centered approach, follow-up care can be tailored to individual unique needs, adjusting interventions as necessary.[28] Routine assessments that are well-documented help health care teams track changes over time and allow for proactive management of emerging health concerns.[29]

What This Quality Statement Means

For Cancer Survivors

You should be offered an assessment of your physical health, mental health, and overall wellbeing at least once a year. This assessment should be done by a clinician with expertise in managing cancer survivorship needs. Your clinician should use this assessment to complete or update your care plan. With your consent, they should also share this plan with everyone on your health care team so that the team has the information they need to give you the best care to meet your unique needs.

For Clinicians

Perform and document a comprehensive assessment at least annually for cancer survivors to develop and manage individualized, person-centred care plans. Share the assessments and care plans with the cancer survivor and their health care team (with the cancer survivor's consent). For survivors with identified needs, consult with and/or refer them to appropriate resources, care, or community services, as appropriate.

For Organizations and Health Services Planners

Ensure that training, systems, processes, and resources are in place to support the interprofessional care team in performing comprehensive assessments at least annually for cancer survivors and developing and managing individualized, person-centred care plans.

Ensure that comprehensive assessments can be delivered in person or virtually through telemedicine or other technologies in collaboration with the clinician and health care team, as needed when people

are unable to travel. Ensure systems, processes, and resources are in place to document and share comprehensive assessments and care plans between members of the health care team.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of cancer survivors who have at least 1 follow-up assessment with their clinician every 12 months
- Percentage of cancer survivors who report having an individualized, person-centered care plan
- Percentage of cancer survivors who report receiving referral to appropriate care and services

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 2: Transitions in Care, Care Coordination, and Primary Care Integration

Cancer survivors transition between levels of cancer care as appropriate for their needs. Transitions in care for survivors involve care coordination, shared care, and support between health care teams and settings, ensuring integration with primary care.

Sources: Australian Clinical Guidelines, 2024[12] | Children's Oncology Group, 2023[13] | Multinational Association for Supportive Care in Cancer and American Society of Clinical Oncology, 2024[14] | National Comprehensive Cancer Network, 2024[15]

Definitions

Levels of cancer care: Cancer survivors may transition between different levels of cancer care intensity, ranging from acute treatment phases to periods of active surveillance. To effectively support these transitions, risk assessments should be conducted and survivorship care delivered at levels that reflect the changing demands throughout the cancer care continuum. These levels may include primary care, specialized care (i.e., delivered in regional cancer centres or family physicians specializing in oncology), intermediate level care (e.g., survivorship clinics), and palliative care, with coordinated communication between levels to address the cancer survivor's unique health care needs.

For more information on palliative care, pain, and symptom management, please see Ontario Health's *Palliative Care,*[30] *Opioid Prescribing for Acute Pain*,[31] and *Opioid Prescribing for Chronic Pain*[32] quality standards, and Ontario Health (Cancer Care Ontario)'s Guidelines on Management of Pain in Cancer and/or Palliative Care.

Care coordination, shared care, and support between health care teams, and settings: Coordinated care within and between primary care and other members of the interprofessional health care team that includes supported self-management, intermediate level care, and subspecialty care clinicians is encouraged. Health care team members across levels of cancer care collaborate and work together to manage the cancer survivor's care in a model that best suits the cancer survivors health.[14,33] Depending on the cancer type, stage of disease, and need for specialized follow-up or intervention, transition of care to intermediate-level or a primary care clinician may occur when deemed clinically

appropriate, with referral back to subspeciality care as needed.[19] This should include, but is not limited to[16]:

- Systematic management of transitions between clinicians, with clearly defined roles and responsibilities for cancer centres and survivorship clinics during the transition
- Clear and timely communication between the cancer survivor and their clinicians
- Monitoring care plans, continuity of care, and goals of care and adjusting the care plan as needed
- Supporting referrals between clinicians and other members of the interprofessional health care team

Primary care integration: This refers to connecting cancer survivors to members of a primary care team, such as a family doctor or a nurse practitioner, ensuring that the primary care team is well connected with other clinicians from different levels of care, and that a combination of in-person and virtual modalities are available to improve access.[34]

Rationale

As cancer survivorship continues to increase, care coordination is vital and successfully navigating between levels of cancer care will enhance the patient experience. Well-planned transitions prevent gaps in follow-up care, including reducing the risk of missed appointments and delayed cancer screenings, as well as improved recurrence detection. Managing long-term and late effects of treatment is imperative in the survivorship journey and coordination ensures appropriate monitoring and management of the cancer survivors' health outcomes and well-being.

A risk-based approach aligned with evidence-based standards or care pathways (e.g., Ontario Health (Cancer Care Ontario) Follow-up Care, Surveillance Protocols, and Secondary Prevention Measures for Survivors of Colorectal Cancer)[35] should be used to determine the frequency, duration, and type of continued follow-up with oncologists for cancer- and cancer treatment–related outcomes.[36] This should be done in coordination with primary care clinicians/teams and other members of the survivor's interprofessional health care team.[19] Primary care teams play a pivotal role not only in monitoring general health, but also in coordinating follow-up for cancer-related outcomes.[37] Connecting cancer survivors to a primary care team, including primary care clinicians and nurse practitioners, promotes comprehensive, longitudinal care beyond the active treatment phase.[26]

For more information on transitions, please see Ontario Health's *Transitions From Youth to Adult Health Care Services* and *Transitions Between Hospital and Home* quality standards.

What This Quality Statement Means

For Cancer Survivors

Your care does not stop when treatment ends. You may move between different types of care depending on your needs. These transitions are meant to make sure you get the right care at the right time, and that no part of your health is overlooked. To support these transitions, your primary

care clinician, cancer specialists, other members of your health care team, your care partner or a designated navigator should work together and share information, as needed.

For Clinicians

Work with the cancer survivor (and their care partners, where appropriate) and other members of their health care team (e.g., primary care clinicians, cancer specialists) to support their transition between levels of cancer care and the health care services they require. This may involve connecting the cancer survivor with a primary care clinician or cancer specialist, communicating with the health care team, and supporting the survivor, including by identifying a designated navigator. The navigator may be part of the survivor's care circle or a member of their primary care team. If available, you should work with the navigator to coordinate care and provide support during the transition process.

Maintain clear documentation in an individualized care plan to track actions taken, such as referrals made to facilitate coordinated care and follow-up.

For Organizations and Health Services Planners

Ensure systems, processes, and resources are in place for cancer survivors (and their care partners, where appropriate) to transition between levels of cancer care, including primary care, specialized care, intermediate level care, and palliative care. Cancer survivors who are transitioning between health care services should have navigational support available to them to assist with care coordination and support throughout the transition process.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of clinicians (i.e., within a local health unit) who have the knowledge and skills needed to provide evidence-based cancer survivorship care
- Percentage of clinicians (i.e., within a local health unit) who are connected with other clinicians from different levels of care (stratified by primary care clinicians and non-primary care clinicians)

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 3: Psychosocial Support

Cancer survivors and their care partners have access to psychosocial screening (as part of a comprehensive assessment) to identify any psychosocial needs or barriers to accessing care. Survivors with unmet psychosocial needs receive information and support or are referred for treatment.

Sources: Australian Clinical Guidelines, 2024[12] | Children's Oncology Group, 2023[13] | Multinational Association for Supportive Care in Cancer and American Society of Clinical Oncology, 2024[14] | National Comprehensive Cancer Network, 2024[15]

Definitions

Psychosocial screening: Cancer survivors and their care partners should have access to psychosocial screening as part of their comprehensive assessment, with the results documented in an individualized care plan (see quality statement 1). Psychosocial factors, including fear of recurrence, anxiety, depression, and nutrition, as well as each factor's impact on mood, daily activities, and quality of life should be assessed using validated tools, where appropriate.[38]), the Cancer Rehabilitation [20,39] [40]Symptom Assessment Scale.[41]

Psychosocial needs: This includes, but is not limited to[42]:

- Emotional well-being (e.g., anxiety and depression – please see Ontario Health's *Major Depression*[43] and *Anxiety Disorders*[44] quality standards, and Ontario Health (Cancer Care Ontario)'s Symptom Management guides)
- Nutrition
- Employment accommodations
- Housing
- Substance use
- Sexual health and fertility
- Social connectedness
- Sleep disorders (e.g., insomnia – please see Ontario Health's *Insomnia Disorder*[45] quality standard)
- Spiritual needs
- Rehabilitation needs (e.g., cognitive function, functional status)

Information and support: Information and support needed by the cancer survivor and members of their care circle are identified through regular psychosocial screening and provided by their clinicians, as appropriate, depending on the severity of their needs. This includes facilitating connection to community and social services.[14]

Referral for treatment: Depending on the identified needs, cancer survivors are referred for the appropriate psychosocial treatment provided by a psychiatrist, psychologist, social worker, dietitian, physiotherapist, or other clinician trained to provide psychosocial oncology treatment and services.[42]

Rationale

Cancer survivors often face persistent anxiety about recurrence, depression, changes in identity and relationships, and difficulties in social interactions, resuming previous roles at work, school, or in their communities.[46-48] These challenges may be compounded by physical symptoms and functional limitations that remain after treatment. By providing regular psychosocial screening, access to mental health resources, and connection to appropriate community and social supports, clinicians can help patients navigate their transition into survivorship care, improve overall well-being and quality of life, and empower them to participate fully in daily activities.[12]

Psychosocial support addresses the emotional, social, and practical challenges that frequently arise after active treatment.[49] While psychosocial support may be available during active treatment, it is often limited after treatment is complete.[50] Effective psychosocial support during the cancer survivorship journey not only mitigates distress, but also fosters resilience and adaptation, ultimately contributing to better long-term outcomes for cancer survivors.[51,52]

What This Quality Statement Means

For Cancer Survivors

Your clinician should ask you regularly about your emotional health, mental health, and overall well-being. This includes asking if:

- You feel sad or worried a lot of the time
- You feel lonely
- You have questions about resuming or continuing your regular activities

Once your clinician knows how you're feeling, and which things you are struggling with, they can provide information or let you know about services and supports in your community that might help you.

For Clinicians

Ensure that cancer survivors and their care partners receive regular psychosocial screening to identify any emotional, mental, functional, or practical needs, as well as potential barriers to care. When unmet psychosocial needs are identified, promptly provide information, support, and access to relevant resources or refer individuals to appropriate treatment and services. Encourage survivors to engage in self-management of long-term conditions, where appropriate.

Ensure that you collaborate with interprofessional health care teams and community services to address identified needs and support the cancer survivors' overall well-being and access to care.

For Organizations and Health Services Planners

Ensure that clinicians have the necessary skills, tools, and resources to assess and address any unmet psychosocial needs of cancer survivors and care partners. Ensure that standardized protocols for psychosocial assessment, referral pathways, relevant information, and support are available and accessible to cancer survivors.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of cancer survivors who receive regular psychosocial oncology screening, including mental health, post-treatment
- Percentage of cancer survivors who report having appropriate access to culturally competent psychosocial oncology supports
- Percentage of cancer survivors who report feeling their mental and psychosocial health is satisfactory or better

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 4: Patient Education and Self-Management

Cancer survivors receive comprehensive education about survivorship care, both during and after active treatment. They are offered self-management support and strategies to address their survivorship care needs, with the goal of optimizing their health and quality of life.

Sources: Multinational Association for Supportive Care in Cancer and American Society of Clinical Oncology, 2024[14] | National Comprehensive Cancer Network, 2024[15]

Definitions

Comprehensive education: Cancer survivors receive education in alignment with individual needs that includes[14,53]:

- Post-treatment needs (e.g., treatment-related effects and health risks)
- Treatment summaries and comprehensive assessments (see quality statement 1)
- Guidance on follow-up care, surveillance, and symptoms that may warrant medical attention
- Potential long-term and late effects of treatment (e.g., chronic health problems, impaired fertility, secondary cancers, financial toxicity)
- Education on self-management skills in alignment with self-management capacity and health literacy
- Information on community services available and appropriate referrals when needed
- Information on ongoing research and data on cancer survivorship (e.g., co-designing or participating in clinical trials and research studies, and patient-reported outcome measurements)

Self-management support: Self-management support involves a collaborative relationship between patients (and their care partners, where appropriate) and clinicians to identify the need for education and supportive interventions. The aim of self-management support is to enhance skills and confidence of cancer survivors in managing their health and well-being in alignment with their care needs and phase of life.[54,55] Accessing these interventions can also serve as a pathway for survivors to build the knowledge and skills to manage their health independently. Supportive interventions could include, but are not limited to:

- Structured exercise programs

- Goal-setting and action planning
- Peer support
- Behavioural coaching
- Psychosocial supports and services (see quality statement 3)
- Educational, vocational, and employment support services
- Cancer rehabilitation services (e.g., physiotherapists, occupational therapists, speech-language therapists, kinesiologists, osteopaths, dietitians, physiatrists, exercise specialists, physiologists, and neuropsychologists)

Cancer survivors should be empowered to inform clinicians of appropriate support services. Referrals may be required to ensure service utilization and care provision.

Strategies to address survivorship care needs: Strategies that can optimize a cancer survivor's overall health and quality of life can include, but are not limited to[33,53,56-58]:

- Engaging in a range of physical activities (e.g., aerobic and resistance exercises) at varying intensity levels tailored to the survivors' abilities and preferences
- Minimizing prolonged sedentary activity by incorporating movement throughout the day
- Exploring physical and/or occupational therapy options when home exercise programs are unsafe or impractical
- Consulting with a clinician for weight management in a way that supports metabolic health and aligns with individual needs
- Following a predominantly nutrient-rich plant-based diet and limiting the consumption of red meats, processed meats, processed foods, refined sugars, and alcohol, if at all [15] that is tailored to the survivors' faith traditions, culture, and unique health needs (see quality statement 5)
- Discontinuing use of cigarettes, other commercial tobacco products, and e-cigarettes, including avoiding secondary exposure to cigarette smoke
- Aiming to get sufficient sleep on a regular basis (please see Ontario Health's *Insomnia Disorder*[45] quality standard)
- Practicing sun safety (e.g., using broad-spectrum sunscreen, avoiding tanning beds, seeking shade during peak sunlight hours, or wearing protective clothing)

Rationale

After the completion of a structured cancer treatment program, many survivors often face a gap in post-treatment guidance and self-management support.[59,60] Without clear information and patient education throughout their cancer journey, cancer survivors may feel uncertain about what to expect and how to manage their overall health.[59,60] As a result, cancer survivors may be left to navigate the

health care system on their own and rely solely on the information they seek out themselves, which can be overwhelming and inconsistent.[61,62]

Maintaining a healthy lifestyle contributes to improvements in overall health and quality of life.[53] For some cancers, such as colorectal, ovarian, and breast cancers,[63] a healthy lifestyle may also reduce the risk of cancer recurrence and increase survival.[53] By equipping cancer survivors with self-management support and survivorship strategies aimed at optimizing their lifestyle and quality of life, it not only improves long-term outcomes but also fosters confidence in their cancer survivorship journey.[64]

What This Quality Statement Means

For Cancer Survivors

You should receive clear and comprehensive information about cancer survivorship that outlines what to expect throughout your cancer survivorship journey. This may include information on your care plan, potential long-term and late effects of treatment, and post-treatment needs. Your clinician should also identify community support services or ongoing research studies that align with your care needs and phase of life. You should also receive information on things you could do to improve your quality of life, such as practical tips about nutrition, physical activity, sleep, and healthy behaviours.

For Clinicians

Offer cancer survivors timely, accessible, comprehensive information during and after active treatment. This includes personalized care plans, education on potential long-term and late effects from treatment, and guidance to support their post-treatment needs. Ensure that patients clearly understand their care plans, including information on their follow-up care, surveillance protocols, and any symptoms to monitor.

Empower cancer survivors with self-management strategies that align with their care needs and strategies to optimize overall health and quality of life. Identify and inform patients about available community support services and ongoing research studies and facilitate connections to those resources. Outline strategies such as healthy nutrition, physical activity, quality sleep, and sun safety that could improve their quality of life. Lastly, foster a collaborative environment by actively involving care-partners in these discussions, supporting coordinated care.

For Organizations and Health Services Planners

Ensure that systems, processes, and resources are in place to enable clinicians to provide cancer survivors with self-management strategies and comprehensive education about cancer survivorship care throughout their cancer journey. Build in processes that allow clinicians to integrate culturally relevant content during and after treatment that is tailored to the unique needs of each cancer survivor.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of cancer survivors who report receiving accessible information (e.g., in their language), supports, and resources for self-management of their own health and wellbeing
- Local availability of appropriate programs and services that provide resources for cancer survivorship

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 5: Accessible, Culturally Safe, Equitable Care

Cancer survivors receive care in a health care system that is accessible, compassionate, and culturally responsive to their traditions, values, and linguistic and other needs. Health care teams work to build trust, remove barriers to accessing care, and provide equitable care, giving special consideration to First Nations, Inuit, Métis and urban Indigenous people, and equity-deserving populations.

Sources: Multinational Association for Supportive Care in Cancer and American Society of Clinical Oncology, 2024[14] | National Comprehensive Cancer Network, 2024[15]

Definitions

Health care system: The health care system includes cancer clinics, survivor clinics, primary care clinics and their staff, regulated professionals (e.g., doctors, nurses), and unregulated professionals (e.g., personal support workers, volunteers).

Culturally responsive: Creating a culturally safe environment and providing care that is responsive to a person's faith traditions, health practices, values, and beliefs. Culturally responsive care aims to reduce health disparities and improve health outcomes.[65,66] It may include, but is not limited to:

- Recommendations on culturally relevant food to optimize overall health and quality of life (see quality statement 4)
- Providing information on accessing appropriate prostheses, such as wigs in various hair textures and mastectomy bras that match the person's skin tone
- Use of inclusive language (e.g., women and gender diverse people with a cervix), and diverse visual images representative of diverse equity-deserving groups, ages, and genders
- Providing information on access to culturally specific care providers and culturally relevant spaces (e.g., Indigenous healing spaces, traditional healers, Knowledge Keepers, Elders, Indigenous Navigators)
- Creating psychologically safe spaces for sharing, recognizing that people have different cultural beliefs regarding stigma and comfort seeking out supports for mental health

Linguistic and other needs: This may include, but is not limited to, providing resources in different languages and formats, including translation services where appropriate, as part of care provision in alignment with individual needs and health literacy.[8]

Build trust: This includes building reciprocal relationships between the cancer survivor and their health care team that is respectful, ethical, caring, and responsive. Trust between the cancer survivor and their health care team ensures an effective relationship by engaging patients in their own care.[67]

Remove barriers to accessing care: Health care teams and organizations work to recognize and remove systemic barriers that hinder or deter cancer survivors from accessing health care and community and social services. Such barriers may include, but are not limited to:

- Patients' (and their care partners') difficulty navigating the health care system or having frequent interactions with the health care system
- Patients' (and their care partners') limited knowledge of cancer survivorship care
- Services being concentrated in urban areas
- Limited language options for programming or educational materials

Equitable care: This refers to receiving barrier-free access to high-quality care that is free from racism and discrimination by addressing the social determinants of health.[8,33] Equitable care may require differential treatment and resource distribution to enable fairness and justice in care delivery and health outcomes. [68]

First Nations, Inuit, Métis, urban Indigenous people, and equity-deserving populations: This includes providing care that supports and meets the needs of First Nations, Inuit, Metis, and urban Indigenous peoples, Black communities, Francophone populations, adolescents and young adults, older people, and populations disproportionately impacted by systemic barriers to care such as geographic and jurisdictional disparities in accessing care, racism in the health care system, people experiencing poverty, homelessness, or precarious housing, and people without a primary care clinician.[8]

Rationale

Certain populations, such as racial and ethnic minorities, older adults, rural residents, 2SLGBTQIA+ individuals, Indigenous people, and low-income groups face significant barriers to cancer survivorship care.[69] Costs associated with survivorship care, including expenses for follow-up visits, medications, rehabilitation, and mental health services may further exacerbate these disparities.[70-72] Patients who are not provided care in a culturally safe environment may become frustrated with the health care system and avoid health care encounters, which significantly impacts health outcomes and overall well being.[73,74]

Providing accessible, culturally safe, and equitable care is essential for improving experiences and outcomes for cancer survivors, particularly those from Indigenous, and equity-deserving populations.[14] When care is tailored to recognize and honour the unique cultural, linguistic, and social needs of individuals, it builds trust and empowers cancer survivors to participate actively in their health journey, optimizing their health outcomes.[75]

What This Quality Statement Means

For Cancer Survivors

Your health care team should always treat you with dignity and compassion. They should be respectful of your culture, language, and traditions. You should be given the opportunity to be as healthy as possible. This means that you should be able to get high-quality health care when you need it, no matter where you seek care (for example, at your doctor's office, virtually, or at the hospital).

For Clinicians

Treat cancer survivors with respect, dignity, and compassion, and work to establish trust with them. Ensure that you and your health care team are equipped with the knowledge and skills needed to provide care in a culturally competent, anti-racist, and anti-oppressive way that recognizes the intersectional identities of cancer survivors (see Appendix 3, Guiding Principles, *Acknowledging the Impact of Racism and Intersectionality*). See the person for who they are as an individual, actively listen to them, work to understand their needs and priorities, and provide timely, high-quality care to ensure information is clear and meaningful to them.

For Organizations and Health Services Planners

Ensure systems, processes, and resources are in place to enable health care teams to provide care that is accessible, compassionate, and culturally responsive. Ensure frameworks are in place for breaking down barriers to accessing high-quality care. For more information, please see Ontario Health's *Equity, Inclusion, Diversity and Anti-Racism Framework* and *First Nations, Inuit, Métis and Urban Indigenous Health Framework*. To support the development of tailored services, consider using the *Health Equity Impact Assessment Tool* as a practical decision-making tool to support an equity analysis in addressing racism, anti-Indigenous, and anti-Black racism.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of cancer survivors who report receiving health care that is culturally responsive and free from barriers or discrimination
- Percentage of cancer survivors who report their relationship with their clinician as being respectful, ethical, caring, and built on trust
- Local availability of resources and training in culturally responsive care for all members of the health care team

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Appendix 1: About This Quality Standard

How to Use This Quality Standard

Quality standards inform patients, clinicians, and organizations about what high-quality care looks like for health conditions or processes deemed a priority for quality improvement in Ontario. They are based on the best evidence.

Guidance on how to use quality standards and their associated resources is included below.

For Cancer Survivors

This quality standard consists of quality statements. These describe what high-quality care looks like for adults age 18 and over who are cancer survivors.

Within each quality statement, we have included information on what these statements mean for you as a patient.

In addition, you may want to download this accompanying patient guide on cancer survivorship to help you and your family have informed conversations with your clinicians. Inside, you will find information and questions you may want to ask as you work together to make a plan for your care.

For Clinicians and Organizations

The quality statements within this quality standard describe what high-quality care looks like for adults age 18 and over who are cancer survivors. They are based on the best evidence and designed to help you know what to do to reduce gaps and variations in care.

Many clinicians and organizations are already providing high-quality, evidence-based care. However, there may be elements of your care that can be improved. This quality standard can serve as a resource to help you prioritize and measure improvement efforts.

Tools and resources to support you in your quality improvement efforts accompany each quality standard. These resources include indicators and their definitions, available in the technical specifications. Measurement is key to quality improvement. Collecting and using data when implementing a quality standard can help you assess the quality of care you are delivering and identify gaps in care and areas for improvement.

There are also a number of resources online to help you, including:

- Our patient guide on cancer survivorship, which you can share with patients and families to help them have conversations with you and their other clinicians. Please make the patient guide available where you provide care
- Our measurement resources, including the technical specifications for the indicators in this quality standard, the “case for improvement” slide deck to help you to share why this standard

was created and the data behind it, and our measurement guide containing supplementary information to support the data collection and measurement processes

- Our placemat, which summarizes the quality standard and includes links to helpful resources and tools
- Our *Getting Started Guide*, which includes links to templates and tools to help you put quality standards into practice. This guide shows you how to plan for, implement, and sustain changes in your practice
- Quorum, an online community dedicated to improving the quality of care across Ontario. This is a place where clinicians can share information and support each other, and it includes tools and resources to help you implement the quality statements within each standard

How the Health Care System Can Support Implementation

As you work to implement this quality standard, there may be times when you find it challenging to provide the care outlined due to system-level barriers or gaps. These challenges have been identified and documented as part of the development of the quality standard, which included extensive engagement with clinicians and lived experience advisors and a careful review of available evidence and existing programs. Many of the levers for system change fall within the purview of Ontario Health, and as such we will continue to work to address these barriers to support the implementation of quality standards. We will also engage and support other provincial partners, including the Ministry of Health or other relevant ministries, on policy-level initiatives to help bridge system-level gaps.

In the meantime, there are many actions you can take on your own, so please read the standard and act where you can.

Appendix 2: Glossary

Term	Definition
Adults	People aged 18 years and older.
Cancer survivor	A person living with, through, and beyond a cancer diagnosis.
Care partner	An unpaid person who provides care and support in a nonprofessional capacity, such as a parent, other family member, friend, or anyone else identified by the person with [condition]. Other terms commonly used to describe this role include “caregiver,” “informal caregiver,” “family caregiver,” “carer,” and “primary caregiver.”
Clinicians	Regulated professionals who provide care to patients or clients. Examples are nurses, nurse practitioners, occupational therapists, pharmacists, physicians, physiotherapists, psychologists, social workers, and speech-language pathologists.
Culturally appropriate care[76]	Care that incorporates cultural or faith traditions, values, and beliefs; is delivered in the person’s preferred language; adapts culture-specific advice; and incorporates the person’s wishes to involve family or community members.
Family	The people closest to a person in terms of knowledge, care, and affection; this may include biological family or family of origin, family through marriage, or family of choice and friends. The person defines their family and who will be involved in their care.
Health care team	Clinicians, as well as people in unregulated professions, such as administrative staff, behavioural support workers, child life specialists, patient transport staff, personal support workers, recreational staff, spiritual care staff, and volunteers.
Primary care	A setting where people receive general health care (e.g., screening, diagnosis, and management) from a clinician who the person can access directly without a referral. This is usually the primary care clinician, family physician, nurse practitioner, or other clinician with the ability to make referrals, request laboratory testing, and prescribe medications.
Primary care clinician	A family physician (also called a primary care physician) or nurse practitioner.
Psychosocial oncology[77]	Interventions that improve the patient experience, support patients and their care circle through the cancer continuum, and enhance quality of life by addressing the social, practical, psychological, emotional, spiritual, functional and quality-of-life impact of cancer.
Transitions in care	These occur when patients transfer between different care settings (e.g., hospital, primary care, long-term care, home and community care) or between different clinicians during the course of an acute or chronic illness.

Appendix 3: Values and Guiding Principles

Values That Are the Foundation of This Quality Standard

This quality standard was created and should be implemented according to the *Patient, Family and Caregiver Declaration of Values for Ontario*. This declaration "is a vision that articulates a path toward patient partnership across the health care system in Ontario. It describes a set of foundational principles that are considered from the perspective of Ontario patients and serves as a guidance document for those involved in our health care system."

These values are:

- Respect and dignity
- Empathy and compassion
- Accountability
- Transparency
- Equity and engagement

A quality health system is one that provides good access, experience, and outcomes for all people in Ontario, no matter where they live, what they have, or who they are.

Guiding Principles

In addition to the above values, this quality standard is guided by the principles outlined below.

Acknowledging the Impact of Colonization

Clinicians should acknowledge and work toward addressing the historical and present-day impacts of colonization in the context of the lives of Indigenous Peoples throughout Canada. This work involves being sensitive to the impacts of intergenerational and present-day traumas and the physical, mental, emotional, and social harms experienced by Indigenous people, families, and communities, as well as recognizing their strength and resilience. This quality standard uses existing clinical practice guideline sources that may not include culturally relevant care or acknowledge traditional Indigenous beliefs, practices, and models of care.

Acknowledging the Impact of Racism

Many people in Ontario experience racism and discrimination in their interactions with the health care system, negatively affecting the quality, safety, and effectiveness of the health care they receive.[78] Racism refers to systemic discrimination that is deeply embedded in organizational cultures, policies, directives, practices, or procedures; it causes harm by excluding, displacing, marginalizing, and perpetuating unfair barriers and treatment towards Black, Indigenous, South Asian, and other

racialized populations.[68] These populations often face profound disparities in accessing and receiving timely, anti-racist, anti-oppressive, culturally appropriate, and culturally responsive health care.[78-80] To advance health equity and achieve better outcomes for all, the harmful effects and impacts of racism and discrimination must be explicitly identified and addressed.[68] Adopting an anti-racist and anti-oppressive approach recognizes the existence of racism and people's intersectional identities; it then actively seeks to identify, reduce, and remove racially inequitable outcomes, power imbalances, and the structures that sustain those inequities.[68]

French Language Services

In Ontario, the *French Language Services Act* guarantees an individual's right to receive services in French from Government of Ontario ministries and agencies in 27 designated areas and at government head offices.[81]

Intersectionality

Intersectionality refers to the differences in experiences with discrimination and injustice that people have based on social categorizations such as race or ethnicity, class, age, and gender, and the interaction of these experiences with compounding power structures (e.g., media, education system). These interconnected categorizations create overlapping and interdependent systems of discrimination or disadvantage. For example, the stigma experienced by cancer survivors can vary depending on clinical and demographic characteristics such as racial or ethnic background or age, as well as other characteristics such as language barriers or perceived socioeconomic status. Understanding how the various aspects of people's identities intersect can provide insights into the complexities of the processes that cause health inequities and how different people experience stigma and discrimination.

Social Determinants of Health

Homelessness and poverty are 2 examples of economic and social conditions that influence people's health, known as the social determinants of health. Other social determinants of health include employment status and working conditions, race and ethnicity, food security and nutrition, gender, housing, immigration status, social exclusion, and residing in a rural or urban area. Social determinants of health can have strong effects on individual and population health; they play an important role in understanding the root causes of poorer health. People with a mental illness or addiction often live under very stressful social and economic conditions that worsen their mental health,[82,83] including social stigma, discrimination, and a lack of access to education, employment, income, and housing.[84]

Chronic Disease Self-Management

Cancer survivors and their families, care partners, and personal supports should receive services that are respectful of their rights and dignity and that promote shared decision-making and self-management.[85] Further, people should be empowered to make informed choices about the services that best meet their needs.[83] Cancer survivors should engage with their clinicians in informed, shared decision-making about their treatment options. Each person is unique and has the right to determine their own path toward mental health and well-being.[85]

Trauma-Informed Care

Trauma-informed care is health care that reflects an understanding of trauma, the impact that traumatic experiences can have on human beings, and the potential to traumatize or retraumatize patients when providing them with care.[86,87] A trauma-informed approach does not necessarily involve addressing the trauma directly. Rather, it involves acknowledging that a person may have experienced a previous traumatic event that may contribute to their current health concerns, and taking steps to reduce opportunities for traumatization (e.g., using active strategies around consent, attending to individual patient needs, recognizing the inherent power imbalance in clinician–patient relationships, and facilitating greater patient agency and choice in all interactions).[88,89] A trauma-informed approach emphasizes the creation of an environment in which a person can feel comfortable disclosing trauma, and it involves understanding, respecting, and responding to the effects of trauma.[87-89]

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About Us

We are an agency created by the Government of Ontario to connect, coordinate, and modernize our province's health care system. We work with partners, providers, and patients to make the health system more efficient so everyone in Ontario has an opportunity for better health and well-being.

Survivorship Program

This quality standard was developed in partnership with the Ontario Health (Cancer Care Ontario) Survivorship Program. This program aims to improve patient care and experience during the survivorship phase, strengthen survivorship care by promoting best practices in follow-up care, deepen understanding of survivorship demographics and care patterns, and enhance experiences for patients, care partners, and clinicians during transitions. Key initiatives include implementing provincial recommendations on appropriate models of follow-up care, evaluating high-quality follow-up care, developing evidence-based tools for clinicians, and fostering collaboration between cancer and primary care to support person-centred, equitable care.

Equity, Inclusion, Diversity, and Anti-Racism

Ontario Health is committed to advancing equity, inclusion and diversity and addressing racism in the health care system. As part of this work, Ontario Health has developed an *Equity, Inclusion, Diversity and Anti-Racism Framework*, which builds on existing legislated commitments and relationships and recognizes the need for an intersectional approach. Unlike the notion of equality, equity is not about sameness of treatment. It denotes fairness and justice in process and in results. Equitable outcomes often require differential treatment and resource redistribution to achieve a level playing field among all individuals and communities. This requires recognizing and addressing barriers to opportunities for all to thrive in our society.

First Nations, Inuit, Métis, and Urban Indigenous Health Framework

In 2024, Ontario Health launched the *First Nations, Inuit, Métis and Urban Indigenous Health Framework*. The Framework provides a platform to build upon in discussions with partners on the development of a First Nations, Inuit, Métis and Urban Indigenous Health Plan. The Health Plan will provide focused areas for actions for Ontario Health, First Nations, Inuit, Métis and urban Indigenous partners, and health system partners to work together to improve Indigenous health and eliminate inequities, including racism. This Framework outlines the commitment Ontario Health to First Nations, Inuit, Métis and urban Indigenous partners to work together to develop a First Nations, Inuit, Metis and Urban Indigenous Health Plan.

For more information about Ontario Health, visit OntarioHealth.ca.

Looking for More Information?

Visit hqontario.ca or contact us at QualityStandards@OntarioHealth.ca if you have any questions or feedback about this quality standard.

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