

# QUALITY STANDARDS

## Placemat for Cancer Survivorship

This document is a resource for clinicians that summarizes content from the [Cancer Survivorship](#) quality standard.

### Quality Statement (QS) 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. Cancer survivors with identified needs receive or are referred to appropriate care and services.

Perform and document a comprehensive assessment at least annually for cancer survivors to develop and manage individualized, person-centred care plans.

Assessments may begin as early as 6 months after diagnosis. Ongoing assessments may vary by cancer type or stage, treatment, unique needs, goals of care, or at the discretion of the health care team and the cancer survivor's agreement.

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.

### QS 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 cancer survivors involve care coordination, shared care, and support between health care teams and settings, ensuring integration with primary care.

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 identifying a designated navigator. The navigator may be part of the survivors' 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 more information on transitions in care, please see Ontario Health's quality standards [Transitions From Youth to Adult Health Care Services](#) and [Transitions Between Hospital and Home](#).

### QS 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. Cancer survivors with unmet psychosocial needs receive information and support or are referred for treatment.

Ensure that cancer survivors and their care partners receive psychosocial screening to identify any social and emotional needs, and physical and functional needs, as well as potential barriers to accessing care (e.g., racial or ethnic discrimination). When unmet psychosocial needs are identified, promptly provide information, support, and access to relevant resources or refer individuals to appropriate treatment and services. Encourage cancer 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 survivor's overall well-being and access to care.



## QS 4: Patient Education and Self-Management

Cancer survivors receive comprehensive, health-literate 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.

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.

## QS 5: Accessible, Culturally and Linguistically Responsive, Equitable Care

Cancer survivors receive care in a health care system that is accessible, compassionate, and responsive to their culture, 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, Métis, Inuit, urban Indigenous communities, racialized populations, Francophones, and additional equity-deserving populations.

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-responsive, 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*, in the [Cancer Survivorship](#) quality standard). 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.

## Resources

- [Cancer Survivorship](#) quality standard and patient guide
- [Community Service Locator](#) from the Canadian Cancer society
- Ontario Health (Cancer Care Ontario) Resources:
  - [Cancer Pathway Maps](#)
  - [Follow-Up Model of Care for Cancer Survivors: Recommendations for the Delivery of Follow-up Care for Cancer Survivors in Ontario](#)
  - [Managing Symptoms, Side-Effects and Wellbeing](#)

Need this information in an accessible format? 1-877-280-8538, TTY 1-800-855-0511, [info@OntarioHealth.ca](mailto:info@OntarioHealth.ca)

Document disponible en français en contactant [info@OntarioHealth.ca](mailto:info@OntarioHealth.ca)

ISBN 978-1-4868-9653-0 (PDF)

© King's Printer for Ontario, 2026